PHARMACY & THERAPEUTICS COMMITTEE

Tuesday, December 19th, 2023
5:00pm – 7:00pm

Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Location: Microsoft Teams
Meeting ID: 219 123 811 870
Password: UGFodC

IMPORTANT PUBLIC HEALTH AND SAFETY MESSAGE REGARDING PARTICIPATION AT ALAMEDA ALLIANCE FOR HEALTH COMMITTEE MEETINGS

STATE OR LOCAL OFFICIALS CONTINUE TO IMPOSE OR RECOMMEND MEASURES TO PROMOTE SOCIAL DISTANCING. AS A RESULT OF THE COVID-19 VIRUS, AND RESULTING ORDERS AND DIRECTION FROM THE PRESIDENT OF THE UNITED STATES, THE GOVERNOR OF THE STATE OF CALIFORNIA, AND THE ALAMEDA COUNTY HEALTH OFFICER, THE PUBLIC WILL NOT BE PERMITTED TO PHYSICALLY ATTEND THE ALAMEDA ALLIANCE FOR HEALTH MEETING TO WHICH THIS AGENDA APPLIES.

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE" 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT bochoa@alamedaalliance.org . YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE FOLLOWING LINK: Microsoft Teams Meeting OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: +1 510-210-0967,530319844# IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA. IF YOU PARTICIPATE BY TELEPHONE, YOU MAY SUBMIT ANY COMMENTS VIA THE E-COMMENT EMAIL ADDRESS DESCRIBED ABOVE OR PROVIDE COMMENT DURING THE MEETING AT THE END OF EACH TOPIC.

PLEASE NOTE: THE ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE COMMMITTEE WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.

AGENDA

ITEM	DESCRIPTION	TIME	VOTE
I)	**Call to order** *Steve O'Brien, MD, Chief Medical Officer – Alameda Alliance* • Agenda Overview	2 min	-
II)	**Informational Updates** *Steve O'Brien, MD, Chief Medical Officer – Alameda Alliance* *Helen Lee, PharmD, MBA, Senior Pharmacy Director – Alameda Alliance* • Anthem, ICF-DD, Adult Expansion • CGM • Medi-Cal Rx • Medi-Cal Rx MCDAC (See Next Page)	15 min	-
III)	**Pharmacy Utilization Reports (Quarter 3, 2023)** *Helen Lee, PharmD MBA, Senior Pharmacy Director – Alameda Alliance* • Top 50 Drugs by Cost • Top 50 PA Reviewed Drugs	2 min	-

MCDAC Drug	Indication	CDL Status	Recommendation Based on - Safety, Efficacy, Essential Need, Misuse Potential, etc.
Entyvio (vedolizumab) 108mg/0.68ml single dose prefilled syringe and pen	Ulcerative colitis (UC)	F-PA	Keep F-PA
Olumiant (baricitinib) 1mg, 2mg and 4 mg tablets	Adults with moderately to severe Rheumatoid arthritis (RA); COVID-10 hospitalized adults requiring supplmental oxygen, non-invasive or invasive mechanical ventilation or extracorporeal memberane oxygenation (ECMO); alopecia areata	F-PA	Keep F-PA
Sohonos (palovarotene) 1mg, 1.5mg, 2.5mg, 5mg and 10mg capsules	Reduction in volume of new heterotropic ossification in adults; pediatric fibrodysplasia ossificans progressiva (FOP)	F-PA	Keep F-PA
Ycanth (cantharidin) topical solution 0.7% single use applicator	Molluscum contagiosum	F-PA	Keep F-PA

ADJOURN TO CLOSED SESSION *(Pursuant to California Government Code Title 5, §54954.5(h))*

Discussion will Concern: *Review and Recommendations to changes to the AAH Formulary and utilization management for selected drug classes*
Estimated Date of Public Disclosure: 12/19/2023 *(formulary changes only; no trade secrets will be disclosed)*

IV) E-Voting Material/Consent Agenda

The following items have been sent to the voting committee for review via E-voting

Helen Lee, PharmD, MBA, Senior Pharmacy Director – Alameda Alliance
Benita Ochoa, CPhT, Lead Pharmacy Technician – Alameda Alliance
(All matters listed on the Consent Calendar are to be approved with one motion unless a member of the P&T Committee removes an item for separate action. Any consent calendar item for which separate action is requested shall be heard as the next Agenda item in closedsession.)

Monographs/Class Reviews	Changes
Urinary tract antispasmodics	• No change
Ketone test strips	• No change
Topical antivirals	• No change
Prenatal vitamins	• No change
Physician Administered Drug (PAD) Guidelines	**Changes**
Oral and Injectable Oncology Medications	• No change
Injectable/Specialty Medications	• No change
Viltepso	• No change
Medication Request Guidelines (MRGs)	**Changes**
Urinary Incontinence Agents (part of Urinary tract antispasmodics class review)	• Change brand/generic status of Toviaz

10 min EV

Growth Hormone	• Add Ngenla & Sogroya
Corticotropin	• No change
Testosterone Agents	• No change
Self-administered Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)	• Minor wording clarifications
Fentanyl Citrate	• Remove duplicate medication listing
Proton Pump Inhibitors (PPIs)	• Update product listings to align with brand/ generic availability
Gattex (teduglutide)	• No change
Butorphanol (Stadol NS)	• No change
Step Therapy Exception	• No change
Prior Authorization Exception	• No change
Diclofenac sodium (Solaraze) 3% gel	• No change
Hepatitis B Drugs	• No change
Blood Glucose Testing Supplies	• No change
Inhaled Corticosteroids/Long-Acting Beta-Agonists (ICS/LABA) Combinations	• No change
Agents for graft versus host disease	• No change
Ranolazine (Ranexa, Aspruzyo)	• No change
Injectable Methotrexate	• No change
Temazepam (Restoril)	• No change
Janus Kinase Inhibitors for Nonsegmental Vitiligo	• No change
Endari	• No change
Thalomid (thalidomide)	• No change
Topical Diclofenac	• No change
Otezla (apremilast) for Behcet Disease	• No change
Korlym (mifepristone)	• No change
Rayaldee (calcifediol ER)	• No change
Tetracycline Antibiotics	• No change
Budesonide Nebulization Solution (Pulmicort Respules)	• No change
Ophthalmic Anti-Inflammatory Agents	• No change
dalfampridine (Ampyra)	• No change

Oral and Injectable Oncology Medications	• No change
Interim Formulary Updates	
• See p. 111 in packet	
Summary of PAD Updates	
• See p. 112 in packet	
Pharmacy Policy & Procedure Updates	
• RX-003 – Exception Review Process	• Drug monitoring language update (per DHCS contract)
• RX-005 – PT Committee Roles and Scope	• Evidence-Based Decision Making, language update (per mock NCQA trial recommendation)
• RX-010 – Drug Utilization Management	• FWA (per DHCS APL 23-026) and QIHEC (per DHCS contract) language updates
• RX-013 – Physician Facility-Administered Drugs (PAD) Prior Authorization Review Process	• Policy process updates (e.g., COC)
• RX-014 – Physician Facility-Administered Drugs (PAD) PA List Management	• NEW policy outlining PAD list management
ED Oversight	
• None	
90 Day Maintenance List updates	
• None	
P&T Meeting Minutes	
• P&T Meeting Minutes Q3 September 26, 2023	

V) New Business

Natalee Felten, PharmD, Pharmacist – PerformRx

- Essential Health Benefits (EHB) Formulary Benchmark Analysis and Recommendations

New PADs

- Myasthenia Gravis Agents
- Veopoz
- Lantidra
- Bleeding Disorder Products

New MRGs

- Ocaliva
- Non-Formulary/Prior Authorization Required Medications
- Sohonos

VI) Class Reviews, Monographs, and Recommendations

Natalee Felten, PharmD, Pharmacist – PerformRx

45 min V

1. Jesduvroq monograph + new MRG
2. Lodoco Monograph + new MRG
3. Insulins
4. Pneumonia vaccine comparator
5. Neurotoxins

VII) Medication Request Guidelines

Rahel Negash, PharmD, Pharmacist – Alameda Alliance

1. Injectable/Specialty Medications MRG - RETIRE
2. Brand Medications When a Generic or Biosimilar is Available - RETIRE
3. Non-Formulary and PA Required Medications without Drug-Specific Criteria- RETIRE
4. Movement Disorders
5. Isotretinoin capsules
6. Gonadotropin Releasing Hormone (GNRH) Agonists
7. Oral Anti-Fungals
8. Immunizations
9. Anti-Obesity Medications

VIII) Physician Administered Drug (PAD) Policies

Natalee Felten, PharmD, Pharmacist – PerformRx

1. Complement inhibitors
2. Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents
3. Healthcare professional (HCP) administered/IV Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)
4. Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention
5. Specialty Biologic Agents for FDA approved indications - RETIRE

IX) Informational Updates on New Developments in Pharmacy

Natalee Felten, PharmD, Pharmacist – PerformRx — 2 min

- New Product Review -

X) Old Business

Natalee Felten, PharmD, Pharmacist – PerformRx — 2 min

- None -

RECONVENE IN OPEN SESSION

XI) Public Comment

XII) Adjournment

PHARMACY & THERAPEUTICS COMMITTEE

Tuesday, December 19th, 2023
5:00pm – 7:00pm

ACTION / FOLLOW-UP ITEMS		
ITEM	**DUE DATE**	**RESPONSIBLE**

FUTURE P&T MEETINGS	
NEXT MEETING	**2024 P&T MEETINGS**
March 19 2024	June 11, 2024
	September 24, 2024
	December 17, 2024

The Alameda Alliance for Health Pharmacy & Therapeutics Committee welcomes you to its meetings and your interest is appreciated. If you wish to speak on a matter on the agenda, you will have the opportunity to do so in the order determined by the Chair. If you wish to speak on a matter not on the agenda, please wait until the Chair asks for public comments at the end of the regular agenda. Please be brief and limit your comments to the specific subject under discussion.

Note: Only matters within the jurisdiction of the Alameda Alliance for Health Pharmacy & Therapeutics Committee may be addressed. If necessary, the Chair may limit the total time to be devoted to public comment on any item, and the time allotted to individual speakers, to ensure sufficient time for the consideration of all matters on the agenda.

This meeting is wheelchair accessible. Please contact Helen Lee at 510-747- 6241 or hlee@alamedaalliance.org at least 72 hours before the meeting to request agenda materials in an alternative format, or any other reasonable disability-related accommodations or services that may be necessary for you to participate in and enjoy the benefits of the meeting.

636 IHSS Top 50 Drugs by Cost for 3rd Quarter 2023

- The top 50 drugs accounted for **987 claims** for **513 members** and cost **$1,127,219,** which is a decrease of $100,402 in spend from the previous quarter.
- Biktarvy has risen from number 2 to number 1, with 20 claims for 8 members.
- Ozempic has risen to number 2 from number 7, with 70 claims for 36 members. There was an increase of 27 claims and of 10 members from the previous quarter. This is likely due to both guideline placement as well as media sensation.
- Vemlidy is up to number 3 with 42 claims for 18 members. This medication is managed via the Hepatitis B MRG, which was loosened during Q4 2022 P&T to require trial and failure of, or reason not to use, entecavir (previously generic Viread and entecavir).
- Tagrisso moved up to number 4 from number 10 in the last quarter. This is an increase of one claim since last quarter. This medication is managed via the Oncology MRG.
- Verzenio is at number 5 and Humira is at 6, both with 3 claims for one member. Brand Humira will be taken off formulary over the next few months Q4 2023 and the lower cost biosimilars will be preferred instead.

Rank	DDID	Label Name	Claims	Unique Members	Total Cost
1	201625	BIKTARVY 50-200-25 MG TABLET	20	8	$74,148.45
2	221271	OZEMPIC 0.25-0.5 MG/DOSE PEN	70	36	$63,352.44
3	195609	VEMLIDY 25 MG TABLET	42	18	$63,088.22
4	190947	TAGRISSO 80 MG TABLET	3	1	$47,818.85
5	199758	VERZENIO 100 MG TABLET	3	1	$41,811.96
6	202548	HUMIRA 40 MG/0.4ML SYRINGE KIT	3	1	$40,327.71
7	214809	SKYRIZI 150 MG/ML PEN	2	2	$38,807.70
8	218096	RINVOQ ER 45 MG TABLET	3	1	$33,911.43
9	209911	OZEMPIC 1 MG/DOSE (4 MG/3 ML)	37	20	$33,400.99
10	170343	JAKAFI 5 MG TABLET	2	1	$32,949.21
11	120505	SPRYCEL 20 MG TABLET	2	1	$28,163.70
12	197146	COSENTYX SNRDY 300 MG DOSE-2PEN	4	1	$27,193.88

Rank	DDID	Label Name	Claims	Unique Members	Total Cost
13	177191	ELIQUIS 5 MG TABLET	50	19	$26,731.74
14	193034	OCALIVA 5 MG TABLET	3	1	$26,255.05
15	185813	TRULICITY 1.5 MG/0.5 ML PEN	28	15	$25,207.79
16	192668	CABOMETYX 20 MG TABLET	1	1	$24,394.12
17	122702	JANUVIA 100 MG TABLET	45	19	$23,533.10
18	218338	OZEMPIC 2 MG/DOSE (8 MG/3 ML)	26	12	$23,464.39
19	185810	TRULICITY 0.75 MG/0.5 ML PEN	25	13	$22,530.69
20	182488	GLATIRAMER 40MG/ML SYRINGE	4	1	$21,351.32
21	165796	ABIRATERONE 250MG TABLET	3	1	$20,938.20
22	201117	STEGLATRO 15 MG TABLET	61	28	$20,201.27
23	202545	HUMIRA 40 MG/0.4ML PEN	3	1	$20,141.34
24	187789]	HUMIRA 40 MG/0.8 ML PEN	3	1	$20,141.34
25	201116	STEGLATRO 5 MG TABLET	54	28	$19,934.10
26	219135	SKYRIZI 360 MG/2.4 ML CARTRIDGE	1	1	$19,522.26
27	192429	TALTZ 80 MG/ML AUTOINJECTOR	3	1	$19,516.62
28	207962	RYBELSUS 14 MG TABLET	21	8	$19,090.57
29	207961	RYBELSUS 7 MG TABLET	20	9	$18,101.61
30	197908	TYMLOS 3120 MCG/1.56 ML PEN INJECTR	7	2	$17,168.70
31	190802	GENVOYA TABLET	4	2	$14,951.44
32	204204	SHINGRIX 50 MCG/0.5ML IM SUSP	73	71	$14,344.00

Rank	DDID	Label Name	Claims	Unique Members	Total Cost
33	197463	DUPIXENT 300 MG/2 ML SYRINGE	4	1	$14,234.28
34	182336	FARXIGA 10 MG TABLET	25	10	$13,543.85
35	205122	ACTEMRA ACTPEN 162 MG/0.9 ML	3	1	$12,752.43
36	184849	JARDIANCE 25MG TABLET	22	7	$12,474.64
37	212379	CABENUVA ER 600 MG-900 MG SUSP	2	1	$12,326.34
38	212378	CABENUVA ER 400 MG-600 MG SUSP	3	1	$11,545.83
39	93533	ENTECAVIR 0.5 MG TABLET	26	13	$11,502.05
40	217440	APRETUDE ER 600 MG/3 ML VIAL	3	2	$11,265.41
41	185186	TRIUMEQ 600-50-300 MG TABLET	3	1	$10,400.40
42	192096	ODEFSEY 200-25-25 MG TABLET	3	1	$10,203.82
43	170142	XARELTO 20 MG TABLET	19	9	$9,819.43
44	127437	FREESTYLE LITE TEST STRIP	120	78	$9,750.53
45	183204	OTEZLA 30 MG TABLET	2	1	$9,014.92
46	215736	INSULIN GLARGINE-YFGN U100 PEN	64	38	$8,382.48
47	177548	ALOGLIPTIN 25 MG TABLET	48	19	$7,535.37
48	181560	ACTEMRA ACTPEN 162 MG/0.9 ML	3	1	$6,935.43
49	178911	CREON DR 36000-114000 UNIT CAPSULE	4	2	$6,741.33
50	212085	TRULICITY 4.5 MG/0.5 ML PEN	7	2	$6,296.75
TOTAL			**987**	**513**	**$1,127,219.48**

Medi-Cal Top 50 Drugs by Cost for 3rd Quarter 2023

- The top 50 drugs accounted for **29,064 claims** for **24,900 members** and cost **$40,105,907.36,** which is an increase of $365,050.20 in spend from the previous quarter.
- Ozempic has risen from the number 5 to number 2, with 1484 claims for 1173 members. This is an increase of 303 claims from last quarter.
- Humira is down to number 3 from number 2 with 117 claims for 89 members. This is a decrease of 4 claims since last quarter.
- Stelara has moved down to the number 5 spot from number 3, with 42 claims for 38 members. This is a decrease of 6 claims from last quarter.

Rank	GCN	Label Name	Claims	Unique Members	Total Cost
1	44426	BIKTARVY 50-200-25 MG TABLET	647	534	$4,593,258.47
2	53536	OZEMPIC 0.25-0.5 MG/DOSE PEN	1484	1173	$1,966,884.47
3	43506	HUMIRA(CF) PEN 40 MG/0.4 ML	117	89	$1,901,749.81
4	36723	JARDIANCE 25 MG TABLET	1350	1253	$1,816,727.73
5	28159	STELARA 90 MG/ML SYRINGE	42	38	$1,682,246.35
6	36716	JARDIANCE 10 MG TABLET	1023	928	$1,291,109.42
7	42624	VEMLIDY 25 MG TABLET	375	327	$1,270,957.80
8	48208	OZEMPIC 1 MG/DOSE (4 MG/3 ML)	661	569	$1,084,764.27
9	49591	SKYRIZI 150 MG/ML PEN	55	45	$1,075,994.22
10	40133	TAGRISSO 80 MG TABLET	38	27	$1,010,075.71
11	97400	JANUVIA 100 MG TABLET	714	658	$1,000,007.77
12	48277	DUPIXENT 300 MG/2 ML PEN	120	94	$867,305.11
13	27418	INVEGA SUSTENNA 234 MG/1.5 ML	142	98	$848,320.33
14	40092	GENVOYA TABLET	103	83	$834,148.55
15	97724	ENBREL 50 MG/ML SURECLICK	57	50	$807,902.01

Rank	GCN	Label Name	Claims	Unique Members	Total Cost
16	25200	FREESTYLE LITE TEST STRIP	3901	3614	$781,240.22
17	97005	HUMIRA PEN 40 MG/0.8 ML	58	48	$753,083.55
18	33935	ELIQUIS 5 MG TABLET	701	564	$747,168.77
19	37789	COSENTYX SNRDY 300MG DOSE-2PEN	59	45	$725,211.19
20	98637	BASAGLAR 100 UNIT/ML KWIKPEN	1306	1118	$699,538.30
21	40953	DESCOVY 200-25 MG TABLET	181	145	$691,100.01
22	47136	TRIKAFTA 100-50-75 MG/150 MG	15	10	$671,389.78
23	46965	RYBELSUS 7 MG TABLET	335	308	$656,943.53
24	37171	TRULICITY 1.5 MG/0.5 ML PEN	347	297	$628,312.63
25	44014	HUMIRA(CF) PEN 80 MG/0.8 ML	10	10	$564,950.82
26	34394	FARXIGA 10 MG TABLET	436	377	$564,633.94
27	47426	VYONDYS-53 100 MG/2 ML VIAL	2	2	$556,879.20
28	37633	ODEFSEY TABLET	90	65	$537,698.37
29	49099	CABENUVA ER 600 MG-900 MG SUSP	67	62	$519,544.48
30	37682	ABILIFY MAINTENA ER 400 MG SYR	105	77	$512,342.81
31	22913	ALBUTEROL HFA 90 MCG INHALER	11278	9383	$512,045.52
32	38702	INVEGA TRINZA 819 MG/2.63 ML	53	50	$511,896.37
33	43968	SYMTUZA 800-150-200-10 MG TAB	71	54	$511,840.80
34	36999	TRIUMEQ 600-50-300 MG TABLET	74	57	$486,825.98
35	37169	TRULICITY 0.75 MG/0.5 ML PEN	299	256	$472,807.06
36	49754	WEGOVY 2.4 MG/0.75 ML PEN	202	153	$446,603.20

Rank	GCN	Label Name	Claims	Unique Members	Total Cost
37	43924	ENBREL 50 MG/ML MINI CARTRIDGE	36	28	$439,747.45
38	52125	OZEMPIC 2 MG/DOSE (8 MG/3 ML)	255	216	$429,192.22
39	46966	RYBELSUS 14 MG TABLET	193	172	$417,885.04
40	43222	DUPIXENT 300 MG/2 ML SYRINGE	59	53	$415,062.94
41	39858	STRENSIQ 80 MG/0.8 ML VIAL	2	1	$411,866.40
42	30819	XARELTO 20 MG TABLET	347	302	$409,512.26
43	47258	IBRANCE 125 MG TABLET	17	10	$404,307.42
44	44495	ZTLIDO 1.8% TOPICAL SYSTEM	950	863	$399,311.14
45	54456	FERRIPROX 1,000 MG TAB(2X/DAY)	6	4	$387,850.59
46	43148	ILARIS 150 MG/ML VIAL	7	7	$383,058.88
47	48574	TRULICITY 3 MG/0.5 ML PEN	184	157	$366,688.10
48	36172	OTEZLA 30 MG TABLET	45	37	$348,962.12
49	35079	TIVICAY 50 MG TABLET	122	96	$346,246.22
50	94200	DEXCOM G6 SENSOR	323	293	$342,708.03
TOTAL			**29,064**	**24,900**	**$40,105,907.36**

636 IHSS Top 50 Prior Authorization Requests by Volume for 3rd Quarter 2023

- Top 50 PA requests = 113. There were 168 total PA requests for quarter 3.
  - 55 requests (49%) were approved. This approval rate is higher, by 15%, than what was observed last quarter.
  - 58 requests (51%) were denied or partially approved.
- Vemlidy 25 mg is new at number one and had a total of 10 requests, from which there were 5 approvals, 2 denials and 3 partial approvals.
  - Vemlidy requires a diagnosis of Hepatitis B, and trial and failure of, intolerance to, or inability to use entecavir tablets.
- Lidocaine 5% patch is at number 2 and had 8 requests with 1 approval.
  - This medication requires a diagnosis of neuropathic pain and a trial and failure of gabapentin or pregabalin and one other formulary alternative used for neuropathic pain or morphine MME $\leq$ 50 for 3 months.
- Jardiance 10mg is at number 3 with 7 requests (along with the 25mg tablet, in total it had 10 requests) with 1 approval.
  - The formulary alternative is Steglatro, with trial and failure of metformin.
- Ozempic 0.25-0.5mg/dose pen is at number 4 with 6 requests for that strength, which is the starting dose.
  - Ozempic requires a trial and failure of metformin.
- Wegovy 0.25mg/0.5ml is at number 5 and had a total of 6 requests for that strength, which is the starting dose.
  - There were 10 total requests for this medication in the top 50, for the various strengths.
  - Wegovy requires a diagnosis of obesity or history of heart attack, despite diet and exercise, and requires trial and failure of, or reason not to use Qsymia and Contrave.

RANK	DRUGS	Total	Approved		Denied		Partially Approved	
1	VEMLIDY 25MG TABLET	10	5	50.0%	2	20.0%	3	30.0%
2	LIDOCAINE 5% PATCH	8	1	12.5%	6	75.0%	1	12.5%
3	JARDIANCE 10 MG TABLET	7	1	14.29%	6	85.71%	0	0.0%
4	OZEMPIC 0.25-0.5 MG/DOSE PEN	6	4	66.67%	2	33.33%	0	0.0%
5	WEGOVY 0.25 MG/0.5 ML PEN	6	3	50.0%	3	50.0%	0	0.0%
6	ENTECAVIR 0.5 MG TABLET	5	3	60.0%	0	0.0%	2	40.0%
7	FARXIGA 10 MG TABLET	5	5	100.0%	0	0.0%	0	0.0%
8	DICLOFENAC DR 75 MG TABLET	4	4	100.0%	0	0.0%	0	0.0%
9	CEFEPIME 2 GM IV SOL	3	2	66.67%	0	0.0%	1	33.33%
10	FARXIGA 5 MG TABLET	3	1	33.33%	2	66.67%	0	0.0%
11	JARDIANCE 25 MG TABLET	3	1	33.33%	1	33.33%	1	33.33%
12	SAXENDA 18 MG/3ML PEN	3	0	0.0%	1	33.33%	2	66.67%

RANK	DRUGS	Total	Approved		Denied		Partially Approved	
13	STEGLATRO 5 MG TABLET	3	2	66.67%	0	0.0%	1	33.33%
14	TACROLIMUS 0.1% OINTMENT	3	3	100.0%	0	0.0%	0	0.0%
15	CEQUA 0.09% OPHTH SOL	2	1	50.0%	1	50.0%	0	0.0%
16	LINZESS 72 MCG CAPSULE	2	0	0.0%	2	100.0%	0	0.0%
17	NURTEC 75 MG ODT TABLET	2	0	0.0%	2	100.0%	0	0.0%
18	QSYMIA ER 3.75-23 MG CAPSULE	2	1	50.0%	1	50.0%	0	0.0%
19	RINVOQ ER 45 MG TABLET	2	1	50.0%	1	50.0%	0	0.0%
20	WEGOVY 0.5 MG/0.5 ML PEN	2	1	50.0%	0	0.0%	1	50.0%
21	WEGOVY 1 MG/0.5 ML PEN	2	0	0.0%	2	100.0%	0	0.0%
22	XIIDRA 5% EYE DROPS	2	2	100.0%	0	0.0%	0	0.0%
23	ACETYLCYSTEINE 10% INHAL SOL	1	1	100.0%	0	0.0%	0	0.0%
24	ADDERALL XR 30 MG CAPSULE	1	0	0.0%	1	100.0%	0	0.0%
25	ALPRAZOLAM 1 MG TABLET	1	0	0.0%	0	0.0%	1	100.0%
26	AMPHETAMINE-DEXTROAMPHET ER 30 MG CAPSULE	1	1	100.0%	0	0.0%	0	0.0%
27	BASAGLAR 100 UNIT/ML KWIKPEN	1	0	0.0%	1	100.0%	0	0.0%
28	BELBUCA 300 MCG FILM	1	1	100.0%	0	0.0%	0	0.0%
29	BELSOMRA 20 MG TABLET	1	0	0.0%	1	100.0%	0	0.0%
30	BISACODYL 10 MG SUP	1	1	100.0%	0	0.0%	0	0.0%
31	BREO ELLIPTA 200-25 MCG/ACT INHALER	1	0	0.0%	1	100.0%	0	0.0%
32	BRIMONIDINE 0.33% GEL	1	1	100.0%	0	0.0%	0	0.0%
33	BRINZOLAMIDE 1% OPHTH SUSP	1	0	0.0%	1	100.0%	0	0.0%
34	CALCIPOTRIENE 0.005 % OIN	1	1	100.0%	0	0.0%	0	0.0%
35	CHOLESTYRAMINE 4 GM PACKET	1	1	100.0%	0	0.0%	0	0.0%
36	CIPRO HC 0.2-1 % OTIC SUSP	1	1	100.0%	0	0.0%	0	0.0%
37	CLIMARA 0.05 MG/24HR PATCH	1	0	0.0%	0	0.0%	1	100.0%
38	COSENTYX SNRDY 300MG DOSE-2PEN	1	1	100.0%	0	0.0%	0	0.0%
39	CYCLOSPORINE 0.05% OPHTH EMULSION	1	1	100.0%	0	0.0%	0	0.0%
40	DESVENLAFAXINE ER 25 MG TABLET	1	1	100.0%	0	0.0%	0	0.0%
41	DESVENLAFAXINE ER 50 MG TABLET	1	1	100.0%	0	0.0%	0	0.0%
42	DIFICID 200 MG TABLET	1	1	100.0%	0	0.0%	0	0.0%
43	DOXYCYCLINE HYC 100 MG CAPSULE	1	0	0.0%	1	100.0%	0	0.0%

RANK	DRUGS	Total	Approved		Denied		Partially Approved	
44	DOXYCYCLINE HYC 100 MG TABLET	1	0	0.0%	1	100.0%	0	0.0%
45	EDARBI 40 MG TABLET	1	1	100.0%	0	0.0%	0	0.0%
46	EMGALITY 120 MG/ML PEN	1	0	0.0%	1	100.0%	0	0.0%
47	ENBREL 50 MG/ML SYRINGE	1	0	0.0%	1	100.0%	0	0.0%
48	ENDOMETRIN 100 MG VAG INSERT	1	0	0.0%	0	0.0%	1	100.0%
49	FINASTERIDE 1 MG TABLET	1	0	0.0%	1	100.0%	0	0.0%
50	FLUOCINOLONE 0.01 % CREAM	1	0	0.0%	1	100.0%	0	0.0%
TOTAL		**113**	**55**	**49%**	**43**	**38%**	**15**	**13%**

Medi-Cal Top 50 Prior Authorization Requests by Volume for 3rd Quarter 2023

- The top 50 drugs accounted for **172,215 claims** for **152,634 members** and cost **$3,731,543.80.**
- Albuterol remains at the number 1 spot with 11,278 claims for 9,383 members. A decrease of 740 claims from last quarter.
- Ibuprofen moved up to number 3 from number 4 with 7,737 claims for 7,008 members. This is an increase of 95 claims from last quarter.
- Fluticasone has dropped down to number 4 from number 2 with 7,268 claims for 6,704 members. This is an decrease of 2,238 claims from last quarter.
- Aspirin has risen from number 3 to number 2 with 7,895 claims for 7,301 members. This is an increase of 245 claims from last quarter.
- Loratadine remains at the number 5 spot with 5,437 claims for 4,786 members. This is an decrease of 749 claims from last quarter.

Rank	GCN	Label Name	Claims	Unique Members	Total Cost
1	22913	ALBUTEROL HFA 90 MCG INHALER	11278	9383	$512,045.52
2	00161	ASPIRIN EC 81 MG TABLET	7895	7301	$85,292.60
3	35742	IBUPROFEN 600 MG TABLET	7737	7008	$110,440.38
4	62263	FLUTICASONE PROP 50 MCG SPRAY	7268	6704	$145,859.64
5	60563	LORATADINE 10 MG TABLET	5437	4786	$89,464.82
6	43721	ATORVASTATIN 20 MG TABLET	4988	4689	$67,588.08
7	45680	DICLOFENAC SODIUM 1% GEL	4936	4254	$132,991.84
8	49291	CETIRIZINE HCL 10 MG TABLET	4848	4397	$78,283.21
9	02683	AMLODIPINE BESYLATE 5 MG TAB	4622	4165	$63,175.37
10	43722	ATORVASTATIN 40 MG TABLET	4612	4271	$67,175.31
11	16965	ACETAMINOPHEN 500 MG CAPLET	4355	3972	$57,622.76
12	02682	AMLODIPINE BESYLATE 10 MG TAB	4329	3940	$60,872.37
13	04348	OMEPRAZOLE DR 20 MG CAPSULE	4056	3486	$63,344.13

Rank	GCN	Label Name	Claims	Unique Members	Total Cost
14	25200	FREESTYLE LITE TEST STRIP	3901	3614	$781,240.22
15	10857	METFORMIN HCL 1,000 MG TABLET	3778	3514	$63,710.71
16	00781	GABAPENTIN 300 MG CAPSULE	3755	3054	$55,325.44
17	10810	METFORMIN HCL 500 MG TABLET	3547	3195	$55,095.74
18	46430	FAMOTIDINE 20 MG TABLET	3431	3021	$49,742.41
19	12486	HYDROCODONE-ACETAMIN 5-325 MG	3308	2463	$46,004.95
20	43720	ATORVASTATIN 10 MG TABLET	3130	2909	$44,723.64
21	40120	PANTOPRAZOLE SOD DR 40 MG TAB	3114	2609	$44,140.61
22	94422	VITAMIN D2 1.25MG(50,000 UNIT)	2927	2685	$44,685.65
23	70330	HYDROCODONE-ACETAMIN 10-325 MG	2888	1267	$55,814.36
24	39661	AMOXICILLIN 500 MG CAPSULE	2880	2675	$38,473.51
25	86212	POLYETHYLENE GLYCOL 3350 POWD	2818	2622	$72,473.65
26	35744	IBUPROFEN 800 MG TABLET	2785	2428	$45,335.67
27	09101	DOCUSATE SODIUM 100 MG SOFTGEL	2746	2441	$36,746.45
28	04695	FEROSUL 325 MG TABLET	2615	2340	$36,312.08
29	00223	VITAMIN D3 25 MCG TABLET	2611	2447	$33,500.55
30	14851	LOSARTAN POTASSIUM 50 MG TAB	2517	2303	$35,231.35
31	31242	TRIAMCINOLONE 0.1% OINTMENT	2512	2353	$48,404.21
32	35793	NAPROXEN 500 MG TABLET	2495	2211	$42,084.69
33	16391	TRAZODONE 50 MG TABLET	2476	1927	$40,229.36

Rank	GCN	Label Name	Claims	Unique Members	Total Cost
34	20045	ONDANSETRON ODT 4 MG TABLET	2401	2225	$35,341.44
35	99882	VITAMIN D3 50 MCG SOFTGEL	2388	2298	$30,499.87
36	94781	FOLIC ACID 1 MG TABLET	2359	2026	$39,508.51
37	34824	HYDROCHLOROTHIAZIDE 25 MG TAB	2285	2071	$30,893.59
38	16965	ACETAMINOPHEN 500 MG TABLET	2246	2039	$24,399.24
39	48191	TAMSULOSIN HCL 0.4 MG CAPSULE	2239	1958	$33,341.80
40	14850	LOSARTAN POTASSIUM 25 MG TAB	2168	1981	$29,218.36
41	39802	CEPHALEXIN 500 MG CAPSULE	2161	2025	$31,408.81
42	94200	FREESTYLE 28G LANCETS	2129	2042	$43,103.11
43	14853	LOSARTAN POTASSIUM 100 MG TAB	2013	1859	$30,053.58
44	30952	HYDROCORTISONE 2.5% OINTMENT	1970	1858	$34,752.96
45	42193	FLUCONAZOLE 150 MG TABLET	1967	1680	$24,669.72
46	00780	GABAPENTIN 100 MG CAPSULE	1905	1629	$26,741.85
47	13943	HYDROXYZINE HCL 25 MG TABLET	1888	1541	$31,124.68
48	46431	FAMOTIDINE 40 MG TABLET	1880	1641	$26,012.78
49	89863	METFORMIN HCL ER 500 MG TABLET	1867	1715	$34,264.98
50	47261	LISINOPRIL 10 MG TABLET	1754	1612	$22,777.24
TOTAL			**172,215**	**152,634**	**$3,731,543.80**

Urinary Tract Antispasmodics

Executive Summary

CLASS OVERVIEW

Overactive bladder (OAB), which may occur with or without incontinence, and urinary incontinence (UI), are underdiagnosed and undertreated and can significantly impact quality of life. Urinary incontinence, in particular, is associated with increased rates of depression and altered activities of daily living as a coping mechanism. Urinary tract antispasmodics are used in the treatment of OAB and urge urinary incontinence (UUI) in both men and women, adults and children. Antispasmodic agents can be categorized by mechanism of action into two types: antimuscarinics and β-3 agonists. Antimuscarinics act by antagonizing the effects of acetylcholine on muscarinic receptors reducing smooth muscle tone, increasing bladder capacity and decreasing detrusor overactivity. Antimuscarinics include oxybutynin (Ditropan® XL, Oxytrol®, Gelnique®), darifenacin, fesoterodine (Toviaz®), solifenacin (Vesicare®), tolterodine (Detrol®/Detrol® LA), trospium and flavoxate. The marketed β-3 agonists Gemtesa® (vibegron) and Myrbetriq® (mirabegron) act by activating β-3 adrenergic receptors in the bladder thereby relaxing the detrusor smooth muscle and increasing bladder capacity. Due to anticholingeric properties, antimuscarinics tend to have more side effects compared to β-3 agonists; this is a factor to be considered when selecting an appropriate therapeutic agent.

Various United States guidelines are available for the treatment of OAB/urge incontinence, most directed toward the treatment in women. The American Urological Association (AUA)/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU) published guidelines pertaining to treatment of non-neurogenic OAB in adults, including male patients, updated in 2019. The American College of Physicians (ACP) published Nonsurgical Management of Urinary Incontinence in Women: A Clinical Practice Guideline from the American College of Physicians in 2014. Annals of Internal Medicine International guidelines pertaining to the treatment of UI, pelvic organ prolapse (POP), and fecal incontinence were published by the Sixth International Consultation on Incontinence Recommendations of the International Scientific Committee in 2018 and put forth recommendations for both non-neurogenic and neurogenic UI. Specific guideline recommendations are presented later in this review.

UTILIZATION FINDINGS

There were 40 claims for 24 members, for a total cost of $4,494.53, with an average cost per claim of $112.36. The most highly utilized medication in the class was oxybutynin (Ditropan® XL) 5 mg, 10 mg, 15 mg ER tablet, with 14 claims, followed by Myrbetriq® (mirabegron) 25 mg, 50 mg ER tablet, with 10 claims. Myrbetriq is also the most costly in the class. There were no prior authorization requests.

RECOMMENDATIONS

- No changes.

PRODUCT TABLE (7/1/2023 - 9/30/2023)

Medication	Rx	Current Status	Recommendation
Antimuscarinics - Rx			
Tolterodine (Detrol®) 1 mg, 2 mg tablet	2	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at point of sale for members 65 years or older.	No change
Tolterodine (Detrol® LA) 2 mg, 4 mg ER capsule	2	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at point of sale for members 65 years or older.	No change
Oxybutynin 2.5 mg, 5 mg tablet	9	F -5mg NF-2.5mg	No change
Oxybutynin 5 mg/5 mL oral syrup	0	F	No change
Oxybutynin (Ditropan® XL) 5 mg, 10 mg, 15 mg ER tablet	14	F	No change
Gelnique® (oxybutynin) 10 % (100 mg/gram) transdermal gel packet	0	F-PA	No change
Oxytrol® (oxybutynin) 3.9 mg/24 hr transdermal patch	0	NF	No change
Flavoxate 100 mg tablet	0	F-PA	No change
Trospium 20 mg tablet	0	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at point of sale for members 65 years or older.	No change
Trospium 60 mg ER capsule	0	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at point of sale for members 65 years or older.	No change
Fesoterodine (Toviaz®) 4 mg, 8 mg ER tablet	0	F-PA	No change
Solifenacin (Vesicare®) 5 mg, 10 mg tablet	3	F	No change
Vesicare LS™ (solifenacin) 1 mg/mL oral suspension	0	NF	No change
Darifenacin 7.5 mg, 15 mg ER tablet	0	F-PA	No change
Antimuscarinics - OTC			
Oxytrol® For Women (oxybutynin) 3.9 mg/24 hour transdermal patch	0	NF	No change
Beta-3 Agonists			
Myrbetriq® (mirabegron) 25 mg, 50 mg ER tablet	10	F-PA	No change
Myrbetriq® (mirabegron) 8 mg/mL ER oral suspension	0	F-PA	No change
Gemtesa® (vibegron) 75 mg tablet	0	NF	No change

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary; X = Excluded

CLINICAL SUMMARY

OAB, which may occur with or without incontinence, and UI, are underdiagnosed and undertreated and can significantly impact quality of life. A clinical diagnosis of OAB, as defined by the International Continence Society, includes "urinary urgency, usually accompanied by frequency and nocturia, with or without urinary incontinence, in the absence of urinary tract infection or other obvious pathology. Because diagnosis of OAB is based on symptom assessment, the quality of life impact of OAB is a critical component in seeking treatment. Urinary incontinence, in particular, is associated with increased rates of depression and altered activities of daily living as a coping mechanism. In population-based studies, the prevalence of OAB ranges from 7% to 27% in men and 9% to 43% in women, with symptoms of OAB worsening with age. UUI is consistently more common in women than men. Risk factors for OAB include age over 40 years, current smoking, obesity, diabetes, and prior vaginal delivery.

Urinary tract antispasmodics are used in the treatment of OAB and urinary urge incontinence in both men and women, adults and children. Antispasmodic agents can be categorized by mechanism of action into two types: antimuscarinics and β-3 agonists. Antimuscarinics act by antagonizing the effects of acetylcholine on muscarinic receptors reducing smooth muscle tone, increasing bladder capacity and decreasing detrusor overactivity. Antimuscarinics include oxybutynin (Ditropan® XL, Oxytrol®, Gelnique®), darifenacin, fesoterodine (Toviaz®), solifenacin (Vesicare®), tolterodine (Detrol®/Detrol® LA), trospium and flavoxate. The marketed β-3 agonists Gemtesa® (vibegron) and Myrbetriq® (mirabegron) act by activating β-3 adrenergic receptors in the bladder thereby relaxing the detrusor smooth muscle and increasing bladder capacity. Due to anticholingeric properties, antimuscarinics tend to have more side effects compared to β-3 agonists; this is a factor to be considered when selecting an appropriate therapeutic agent. There are no drugs to treat OAB or UI in the pipeline and slated for approval in the coming year.

INDICATIONS, DOSING and ADMINISTRATION

Medication	Indications	Dosing/Administration
Oxybutynin (Ditropan® XL, Gelnique®, Oxytrol®)	OAB with symptoms of urinary urge incontinence, urgency, frequency, urinary leakage, dysuria	Oral: – Immediate release (IR): 5 mg 2 to 3 times daily, adjust dose as needed in 5 mg increments every 2 weeks; max dose: 5 mg 4 times daily – Extended release (ER): 5 to 10 mg once daily, adjust dose as needed in 5 mg increments at weekly intervals; max dose: 30 mg once daily Topical gel: 1 sachet (100 mg/g) once daily Transdermal (TDS): One patch (3.9 mg) twice weekly (every 3 to 4 days); change on the same 2 days each week OTC labeling (*Oxytrol®* only): One patch (3.9 mg) every 4 days
	OAB symptoms due to a neurological condition (e.g., spina bifida) in patients ≥ 6 years (*Ditropan® XL* only)	
Fesoterodine (Toviaz®)	OAB with symptoms of urinary urge incontinence, urgency, or frequency	4 mg orally once daily; may increase to max dose of 8 mg once daily based on response/tolerability
	Neurogenic detrusor overactivity (NDO) in pediatric patients ≥ 6 years of age and weighing > 25 kg	– Patients > 25 kg to ≤ 35 kg: 4 mg orally once daily; may increase to 8 mg once daily based on response/tolerability – Patients > 35 kg: 4 mg orally once daily; after 1 week increase to 8 mg once daily; max dose: 8 mg/day
Tolterodine (Detrol®, Detrol® LA)	OAB with symptoms of urinary urge incontinence, urgency, or frequency	IR: 2 mg orally twice daily; lower to 1 mg twice daily based on response/tolerability ER: 4 mg orally once daily; lower to 2 mg once daily based on response/tolerability
Darifenacin		7.5 mg orally once daily, may be increased to 15 mg once daily after a minimum of 2 weeks
Trospium		IR: 20 mg orally twice daily ER: 60 mg orally once daily in the morning
Flavoxate	Symptomatic relief of dysuria, nocturia, suprapubic pain, urgency, frequency, and incontinence in patients with cystitis, urethritis, urethrocystitis, urethrotrigonitis, and prostatitis	100 to 200 mg orally 3 to 4 times daily; reduce the dose when symptoms improve
Solifenacin (Vesicare®, Vesicare LS™)	OAB with symptoms of urinary urge incontinence, urgency, or frequency (*Vesicare®* only)	5 mg orally once daily, may increase to 10 mg once daily
	NDO in pediatric patients ≥ 2 years of age (*Vesicare LS™* only)	– 9 to 15 kg: 2 mg orally once daily, may titrate every 3 weeks to lowest effective dose; max dose: 4 mg/day – 15 kg to 30 kg: 3 mg orally once daily, may titrate every 3 weeks to lowest effective dose; max dose: 5 mg/day – 30 kg to 45 kg: 3 mg orally once daily, may titrate every 3 weeks to lowest effective dose; max dose: 6 mg/day

Medication	Indications	Dosing/Administration
		– 45 kg to 60 kg: 4 mg orally once daily, may titrate every 3 weeks to lowest effective dose; max dose: 8 mg/day – > 60 kg: 5 mg orally once daily, may titrate every 3 weeks to lowest effective dose; max dose: 10 mg/day
Myrbetriq® (mirabegron)	OAB in adults with symptoms of UI, urgency, or frequency, as monotherapy or in combination with solifenacin *(tablets* only)	25 mg orally once daily, may increase to 50 mg once daily after 4 to 8 weeks based on response/tolerability
	NDO in pediatric patients ≥ 3 years of age and weighing ≥ 35 kg	Tablets: 25 mg orally once daily; after 4 to 8 weeks, the dose may be increased to 50 mg orally once daily Granules for oral suspension: 3 ml (24 mg) to 6 ml (48 mg) orally once daily depending on patient weight; after 4 to 8 weeks, the dose may be increased if needed up to a max dose of 10 ml (80 mg) once daily
Gemtesa® (vibegron)	OAB in adults with symptoms of urge UI, urgency, and frequency	75 mg orally once daily

BOXED WARNINGS and CONTRAINDICATIONS

Medication	Boxed Warnings	Contraindications
Oxybutynin (Ditropan® XL, Gelnique®, Oxytrol®)	None	Hypersensitivity to oxybutynin or any component of the formulation; patients with or at risk for uncontrolled narrow-angle glaucoma, urinary retention, gastric retention, or conditions with severely decreased GI motility OTC labeling (*Oxytrol®* only): Do not use in the following settings – if experiencing symptoms of urinary tract infection (UTI) such as dysuria, fever or chills, hematuria, unexplained lower back or side pain, pyuria, or foul-smelling urine – in male patients – < 18 years of age – stress incontinence – urinary, gastric retention – glaucoma – hypersensitivity to oxybutynin
Fesoterodine (Toviaz®) Tolterodine (Detrol®, Detrol® LA) Darifenacin Trospium Solifenacin (Vesicare®, Vesicare LS™)		Hypersensitivity to the active ingredient or any component of the formulation; patients with or at risk for uncontrolled narrow-angle glaucoma, urinary retention, or gastric retention *Tolterodine and fesoterodine* only*:* Hypersensitivity to either drug (both are metabolized to 5-hydroxymethyl tolterodine [HMT]) *Trospium ER* only: severe renal impairment (CrCl < 30 mL/min)
Flavoxate		Pyloric or duodenal obstruction; gastrointestinal hemorrhage; obstructive intestinal lesions; ileus; achalasia; obstructive uropathies of lower urinary tract (e.g., benign prostatic hypertrophy [BPH])
Myrbetriq® (mirabegron)		Hypersensitivity to the active ingredient or any component of the formulation
Gemtesa® (vibegron)		

WARNINGS/PRECAUTIONS

Medication	Warnings/Precautions
Oxybutynin (Ditropan® XL, Gelnique®, Oxytrol®) Fesoterodine (Toviaz®) Tolterodine (Detrol®, Detrol® LA) Darifenacin Trospium Solifenacin (Vesicare®, Vesicare LS™)	Concerns related to adverse effects: – Angioedema: Of the face, lips, tongue, and/or larynx has been reported – CNS effects: Anticholinergic effects may impair physical or mental abilities – Heat prostration: May occur in the presence of increased environmental temperature – QT prolongation: Caution in patients with a history of QT prolongation or those receiving QT interval prolonging medications (*tolterodine* and *solifenacin* only); prolongation may be more likely in CYP2D6 poor metabolizers or in the presence of inhibitors of CYP2D6 and CYP3A4 (*tolterodine* only) Disease-related concerns: – Alzheimer disease (AD): Anticholinergics may adversely affect the clinical course of AD in patients receiving cholinesterase inhibitors – Bladder outlet obstruction (BOO): Increased risk of urinary retention in patients with BOO – GI obstructive disorders: Increased risk of gastric retention in patients with decreased GI motility or gastrointestinal obstructive disorders – Glaucoma: May exacerbate angle-closure glaucoma – Myasthenia gravis: May exacerbate condition – *Oxybutynin* only ○ Hiatal hernia: Use with caution ○ Hyperthyroidism: May exacerbate hyperthyroidism ○ Parkinson disease: May aggravate symptoms ○ Caution due to limited experience in hepatic/renal impairment – *Tolterodine* only: Dose adjustment required in hepatic/renal impairment – *Fesoterodine* only: Not recommended in severe hepatic impairment; dose adjust in severe renal impairment (CrCl <30 mL/min) – *Darifenacin* only: Dose adjust in moderate hepatic impairment, not recommended in severe hepatic impairment – *Trospium* only: Caution in moderate or severe hepatic impairment; dose adjust IR formulation in renal impairment – *Solifenacin* only: Dose adjust in moderate hepatic impairment, not recommended in severe hepatic impairment; dose adjust in severe (CrCl <30 mL/minute) renal impairment Concurrent drug therapy issues: – Drug-drug interactions: ○ *Tolterodine* only: Lower dose when used concomitantly with CYP3A4 inhibitors ○ *Trospium* only: Use caution with other medications that are eliminated by active tubular secretion Dosage form specific issues: – *Oxybutynin* only ○ ER formulation: Drug is contained within a nondeformable matrix, the use of which has been rarely associated with obstruction in patients with stricture/narrowing of the GI tract ○ Topical gel: Cover the treated area with clothing after gel has dried to prevent unintended exposure; skin irritation may occur; contains ethanol, do not expose to open flame or smoking until dry ○ TD patch: May contain conducting metal (e.g., aluminum), remove prior to MRI – *Trospium* only ○ ER formulation: Ethanol should not be ingested within 2 hours of the administration of the ER formulation; may increase incidence of drowsiness – *Solifenacin* only ○ Propylene glycol: Some dosage forms may contain propylene glycol; use caution as large amounts are potentially toxic

Medication	Warnings/Precautions
Flavoxate	Concerns related to adverse effects: – CNS effects: Anticholinergic effects may impair physical or mental abilities Disease-related concerns: – Glaucoma: Use with caution Concurrent drug therapy issues: – Sedatives: Use with other sedative drugs or ethanol may potentiate CNS effects
Myrbetriq® (mirabegron)	Concerns related to adverse effects: – Angioedema: Of the face, lips, tongue, and/or larynx has been reported Disease-related concerns: – Hepatic impairment: Use with caution in mild to moderate hepatic impairment; dose adjust in moderate hepatic impairment; use is not recommended in severe hepatic impairment – Hypertension (HTN): Use with caution in patients with controlled and less severe HTN; use is not recommended in patients with uncontrolled HTN – Renal impairment: Use with caution; dose adjust in patients with severe renal impairment; use is not recommended in end-stage renal disease (ESRD) (eGFR < 15 mL/min/1.73 m^2 with or without hemodialysis) Dosage form specific issues: – Product interchangeability: ER granules and ER tablets are not interchangeable; products should not be combined to achieve a total dose; select appropriate product based on patient's indication and weight; granules are not approved for adult use
Gemtesa® (vibegron)	Disease-related concerns: – BOO: Increased risk of urinary retention in patients with BOO and in patients using concomitant muscarinic antagonists – Hepatic impairment: Not recommended in severe hepatic impairment – Renal impairment: Not recommended for use in patients with ESRD (eGFR < 15 mL/min/1.73 m^2 with or without hemodialysis)

PRACTICE GUIDELINES

Lightner DJ, Gomelsky A, Souter L, Vasavada SP. Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults: AUA/SUFU Guideline Amendment. J Urol. 2019 Sep;202(3):558-563.

First-Line Treatments:

- Clinicians should offer behavioral therapies (e.g., bladder training, bladder control strategies, pelvic floor muscle training, fluid management) as first line therapy to all patients with OAB (Standard; Evidence strength: Grade B)
- Behavioral therapies may be combined with pharmacologic management (Recommendation; Evidence strength: Grade C)

Second-Line Treatments:

- Clinicians should offer oral anti-muscarinics or oral β3-adrenoceptor agonists as second-line therapy (Standard; Evidence strength: Grade B)
- If an IR and an ER formulation are available, then ER formulations should preferentially be prescribed over IR formulations because of lower rates of dry mouth (Standard; Evidence strength: Grade B)
- Clinicians may consider combination therapy with an anti-muscarinic and β3-adrenoceptor agonist for patients refractory to monotherapy with either antimuscarinics or β3-adrenoceptor agonists. (Option; Evidence strength: Grade B)
- TDS oxybutynin (patch or gel) may be offered (Recommendation; Evidence strength: Grade C)
- If a patient experiences inadequate symptom control and/or unacceptable adverse drug events with one antimuscarinic medication, then a dose modification or a different anti-muscarinic medication or a β3-adrenoceptor agonist may be tried (Clinical Principle).
- Clinicians should not use anti-muscarinics in patients with narrow-angle glaucoma unless approved by the treating ophthalmologist and should use anti-muscarinics with extreme caution in patients with impaired gastric emptying or a history of urinary retention (Clinical Principle).
- Clinicians should manage constipation and dry mouth before abandoning effective anti-muscarinic therapy. Management may include bowel management, fluid management, dose modification or alternative antimuscarinics (Clinical Principle).
- Clinicians must use caution in prescribing anti-muscarinics in patients who are using other medications with anticholinergic properties (Expert Opinion)
- Clinicians should use caution in prescribing anti-muscarinics or β3-adrenoceptor agonists in the frail OAB patient (Clinical Principle)

Third-line Treatments:

- Clinicians may offer intradetrusor onabotulinumtoxinA as third-line treatment in the carefully-selected and thoroughly-counseled patient who has been refractory to first- and second-line OAB treatments. The patient must be able and willing to return for frequent post-void residual evaluation and able and willing to perform self-catheterization if necessary (Option; Evidence strength: Grade C)
- Clinicians may offer peripheral tibial nerve stimulation (PTNS) as third line treatment in a carefully selected patient population (Option; Evidence strength: Grade C)
- Clinicians may offer sacral neuromodulation (SNS) as third line treatment in a carefully selected patient population characterized by severe refractory OAB symptoms or patients who are not candidates for second-line therapy and are willing to undergo a surgical procedure (Recommendation; Evidence strength: Grade C)

Recommendation Definitions

Statement Type	Definition
Standard	Directive statement that an action should (benefits outweigh risks/burdens) or should not (risks/burdens outweigh benefits) be taken based on Grade A (high quality; high certainty) or B (moderate quality; moderate certainty) evidence.
Recommendation	Directive statement that an action should (benefits outweigh risks/burdens) or should not (risks/burdens outweigh benefits) be taken based on Grade C (low quality; low certainty) evidence.

Statement Type	Definition
Option	Non-directive statement that leaves the decision regarding an action up to the individual clinician and patient because the balance between benefits and risks/burdens appears equal or appears uncertain based on Grade A (high quality; high certainty), B (moderate quality; moderate certainty), or C (low quality; low certainty) evidence.
Clinical Principle	A statement about a component of clinical care that is widely agreed upon by urologists or other clinicians for which there may or may not be evidence in the medical literature.
Expert Opinion	A statement, achieved by consensus of the Panel, that is based on members' clinical training, experience, knowledge, and judgment for which there is no evidence.

Evidence Grade	Definition
Grade A	Well-conducted randomized controlled trials (RCT) or exceptionally strong observational studies.
Grade B	RCTs with some weaknesses of procedure or generalizability or generally strong observational studies.
Grade C	Observational studies that are inconsistent, have small sample sizes or have other problems that potentially confound interpretation of data.

Abrams P, Andersson KE, Apostolidis A, et al. Sixth International Consultation on Incontinence Recommendations of the International Scientific Committee: Evaluation and treatment of urinary incontinence, pelvic organ prolapse, and fecal incontinence. Neurourol Urodyn. 2018 Sep;37(7):2271-2272.

Children

Initial management

- Initial treatment for mono-symptomatic nocturnal enuresis should include:
  - Parental and child counseling and motivation
  - Review of bladder diary with attention to night-time polyuria
  - Age-appropriate education and demystification or explanation
- A choice between either bed wetting alarm (Grade A) or anti-diuretic hormone analogues of desmopressin (Grade A). It may be a parental and child choice if advantages and disadvantages are well explained.
- Daytime incontinence should be managed holistically including:
  - Counselling, timed voiding, behavior modification and bowel management when necessary (Grade B)
  - Antimuscarinics may be used if the child has OAB symptoms (Grade A)

Specialized management

- The treatment of incontinence associated with urinary tract anomalies is complex and cannot easily be dealt with in an algorithm. In many children more than one pathology demands treatment. If there are complex congenital abnormalities present, the treatment is mostly surgical and it should be individualized according to the type and severity of the problem.
- Initial treatment should be non-surgical:
  - For stress urinary incontinence (SUI): Pelvic floor muscle training (Grade C)
  - For OAB symptoms: Fluid/voiding regimens and antimuscarinics (Grade A)
  - For voiding dysfunction: Timed voiding, voiding re-education, pelvic floor muscle relaxation (+/- biofeedback), α-blocker therapy, and intermittent catheterization (when post-void residual [PVR] >30% of bladder capacity) (Grade A/B)
  - For bowel dysfunction: High fiber diet and laxatives as appropriate, and transanal irrigation in severe cases (Grade A)

Men

Initial management

- For men with stress, urgency or mixed urgency/stress incontinence, initial treatment should include appropriate lifestyle advice, pelvic floor muscle training, scheduled voiding regimes, behavioral therapies and medication. In particular:
  - Antimuscarinic/β3-adrenoceptor agonists drugs for OAB symptoms with or without urgency incontinence (Grade B) if the patient has no evidence of significant post-void residual urine
  - α-blockers can be added if itis thought that there may also be BOO (Grade C)

Specialized management

- When basic management has been unsuccessful and if the patient's incontinence markedly disrupts his quality of life, then invasive therapies should be considered:
  - For sphincter incompetence the recommended option is the artificial urinary sphincter (Grade B). Other options, such as a male sling, may be considered (Grade C)
  - For refractory idiopathic detrusor overactivity, (with intractable OAB symptoms) the recommended therapies are: Botulinum toxin A (Grade B), and SNS (Grade C)
  - If incontinence is associated with BOO, then consideration should be given to surgical treatment to relieve obstruction (Grade B). α-blockers and/or 5α-reductase inhibitors would be an optional treatment (Grade C)
  - There is increased evidence for the safety of antimuscarinics for OAB symptoms in men, chiefly in combination with an α-blocker (Grade B)

Women

Initial management

- For women with stress, urgency or mixed urinary incontinence, initial treatment should include appropriate lifestyle advice, pelvic floor muscle training (PFMT), scheduled voiding regimes, behavioral therapies and medication. In particular:
  - If estrogen deficiency and/or UTI is found, the patient should be treated at initial assessment and then reassessed after using vaginal estrogens for a suitable period (Grade B)
  - Antimuscarinics/β3-adrenoceptor agonists for OAB symptoms with or without urgency incontinence (Grade A); duloxetine* may be considered for SUI (Grade B)

Specialized management

- Antimuscarinics/β3-adrenoceptor agonists for OAB symptoms with or without urgency incontinence (Grade A); duloxetine* may be considered for SUI (Grade B)
- Refractory urgency incontinence (OAB) secondary to idiopathic detrusor overactivity may be treated by botulinum toxin A (Grade A), sacral nerve stimulation (Grade B) or bladder augmentation/intestinal cystoplasty (Grade D)

Neurogenic Urinary Incontinence

Initial management

- Initial treatment for patients with incontinence due to suprapontine pathology, like stroke, need to be assessed for degree of mobility and ability to cooperate. Initial recommended treatments are behavioral therapy (Grade C) and anti-muscarinic drugs for presumed detrusor overactivity (Grade A). If incontinence persists and if operative procedures are not indicated, then continence products (Grade B) or catheters (Grade C) may be necessary on a long-term basis. These can also be necessary in non-cooperative or less mobile patients.
- Pharmacological detrusor relaxation and/or antibiotics may be useful in cases of persistent bypass leakage and/or recurrent UTI (patients with continuous drainage)

Specialized management

- Antimuscarinics (Grade A)
- α-1 blockers (Grade C)
- Oral cannabinoid agonists (multiple sclerosis) (Grade C)
- β3-adrenoceptor agonist alone or as an add-on to antimuscarinic (Grade D)

Frail Older Men and Women

Initial management

- For the select cognitively intact older person with UI or fecal incontinence, pelvic floor muscle therapy can be considered, but there are few studies (Grade C). Antimuscarinics may be added to conservative therapy of UUI (Grade A-C, depending on agent)

- α-blockers may be cautiously considered in frail men with suspected prostatic obstruction (Grade C). All drugs should be started at the lowest dose and titrated with regular review until either care goals are met or adverse effects are intolerable

**Duloxetine is not approved for use in United States. In Europe it is approved for use in severe stress incontinence (see committee report on pharmacological management for information regarding efficacy, adverse events (AEs), and 'black box' warning by the Food and Drug Administration of the United States).*

Recommendation Definitions

Evidence Grade	Definition
Grade A	High confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect
Grade B	Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate.
Grade C	Low confidence that the evidence reflects the true effect. Further research is likely to change the confidence in the estimate of effect and is likely to change the estimate.
Grade D	Any estimate of effect is very uncertain.

Qaseem A, Dallas P, Forciea MA, et al. Nonsurgical Management of Urinary Incontinence in Women: A Clinical Practice Guideline From the American College of Physicians. Ann Intern Med. 2014 Sep 16;161(6):429-40.

- ACP recommends first-line treatment with pelvic floor muscle training in women with SUI (Grade: Strong recommendation, high-quality evidence)
- ACP recommends bladder training in women with UUI (Grade: Strong recommendation, moderate-quality evidence)
- ACP recommends pelvic floor muscle training with bladder training in women with mixed UI (Grade: Strong recommendation, moderate-quality evidence)
- ACP recommends against treatment with systemic pharmacologic therapy for stress UI (Grade: Strong recommendation, low-quality evidence)
- ACP recommends pharmacologic treatment in women with UUI if bladder training was unsuccessful. Clinicians should base the choice of pharmacologic agents on tolerability, adverse effect profile, ease of use, and cost of medication (Grade: Strong recommendation, high-quality evidence)
- ACP recommends weight loss and exercise for obese women with UI (Grade: Strong recommendation, moderate-quality evidence)

Recommendation Definitions

Strength of Recommendation	Definition
Strong	Benefits clearly outweigh risks and burden OR risks and burden clearly outweigh benefits.
Weak	Benefits finely balanced with risks and burden.

Evidence Grade	Definition
High	High confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect
Moderate	Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate.
Low	Low confidence that the evidence reflects the true effect. Further research is likely to change the confidence in the estimate of effect and is likely to change the estimate.
Insufficient	Evidence either is unavailable or does not permit a conclusion.

CLINICAL TRIALS/SYSTEMATIC REVIEWS/META-ANALYSES

Citation	Design	Endpoints
Khullar V, Amarenco G, Angulo JC, et al. Efficacy and tolerability of mirabegron, a β(3)-adrenoceptor agonist, in patients with overactive bladder: results from a randomised European-Australian phase 3 trial. Eur Urol. 2013 Feb;63(2):283-95. doi: 10.1016/j.eururo.2012.10.016.	Phase 3, 12-week, double-blind, placebo-controlled, parallel group, multicenter clinical trial N=2336 Arms: mirabegron 50 mg, mirabegron 100 mg, an active control (tolterodine ER 4 mg), or placebo QD Inclusion criteria: patients with OAB with symptoms of urge UI, urgency, and urinary frequency Exclusion criteria: patients with significant stress incontinence or mixed stress/urge incontinence where stress is the predominant factor; patients with diabetic neuropathy; patients with symptomatic UTI, chronic inflammation such as interstitial cystitis, bladder stones, previous pelvic radiation therapy or previous or current malignant disease of the pelvic organs	Primary: • Change from baseline to end of treatment in mean number of incontinence episodes per 24 hours • Change from baseline to end of treatment in mean number of micturitions per 24 hours Secondary: Adverse events (AEs)

Results:

Primary:

- Change in mean number of incontinence episodes per 24 hours: Both doses of mirabegron, 50 mg and 100 mg, improved mean number of incontinence episodes per 24 hours (−1.57 [−1.79 to −1.35] and −1.46 [−1.68 to −1.23], respectively, vs placebo −1.17 [−1.39 to −0.95]) to a statistically significant degree ($p<0.05$ for both comparisons).
- Change in mean number of micturitions per 24 hours: Both doses of mirabegron, 50 mg and 100 mg, improved mean number of micturitions per 24 hours (−1.93 [−2.15 to −1.72] and −1.77 [−1.99 to −1.56], respectively, vs placebo −1.34 [−1.55 to −1.12]) to a statistically significant degree ($p<0.05$ for both comparisons).

Secondary: Treatment related AEs were reportedly low, rates of AEs attributable to mirabegron therapy being similar to those of placebo. Mirabegron had low rates of dry mouth compared to the active control tolterodine and rates similar to placebo. Cardiovascular events were monitored. HTN occurred at a rate lower than in the placebo group. Atrial fibrillation and arrhythmia occurred at higher rates than placebo but lower rates than tolterodine.

Conclusion: The authors concluded that mirabegron is both safe and effective in the treatment of OAB.

Citation	Design	Endpoints
Nitti VW, Auerbach S, Martin N, Calhoun A, Lee M, Herschorn S. Results of a randomized phase III trial of mirabegron in patients with overactive bladder. J Urol. 2013 Apr;189(4):1388-95. doi: 10.1016/j.juro.2012.10.017.	Phase 3, 12-week, double-blind, placebo-controlled, parallel group, multicenter clinical trial N=2149 Arms: mirabegron 50 mg, mirabegron 100 mg, or placebo QD Inclusion criteria: patients with OAB with symptoms of urge UI, urgency, and urinary frequency Exclusion criteria: patients with significant stress incontinence or mixed stress/urge incontinence where stress is the predominant factor; patients with diabetic neuropathy; patients with symptomatic UTI, chronic inflammation such as interstitial cystitis, bladder stones, previous pelvic	Primary: • Change from baseline to end of treatment in mean number of incontinence episodes per 24 hours • Change from baseline to end of treatment in mean number of micturitions per 24 hours Secondary: AEs

	radiation therapy or previous or current malignant disease of the pelvic organs	

Results:

Primary:

- Change in mean number of incontinence episodes per 24 hours: Both doses of mirabegron, 50 mg and 100 mg, improved mean number of incontinence episodes per 24 hours (−1.47 [−1.69, −1.25] and −1.63 [−1.86, −1.40], respectively, vs placebo −1.13 [−1.35, −0.91]) to a statistically significant degree ($p<0.05$ for both comparisons).
- Change in mean number of micturitions per 24 hours: Both doses of mirabegron, 50 mg and 100 mg, improved mean number of micturitions per 24 hours (−1.66 [−1.92, −1.40] and −1.75 [−2.01, −1.48], respectively, vs placebo −1.05 [−1.31, −0.79]) to a statistically significant degree ($p<0.05$ for both comparisons).

Secondary: Mirabegron had low rates of dry mouth compared to placebo; rates of other AEs were similar among mirabegron and placebo groups.

Conclusion: The authors concluded that mirabegron is both safe and effective in the treatment of OAB.

Citation	Design	Endpoints
Staskin D, Frankel J, Varano S, Shortino D, Jankowich R, Mudd PN. International Phase III, Randomized, Double-Blind, Placebo and Active Controlled Study to Evaluate the Safety and Efficacy of Vibegron in Patients with Symptoms of Overactive Bladder: EMPOWUR. J Urol. 2020;204(2):316-324.	Phase 3, randomized (5:5:4), double-blind, placebo and active comparator-controlled clinical trial N=1518 Arms: vibegron 75 mg, placebo, or tolterodine ER 4 mg QD Inclusion criteria: ≥ 18 years; symptoms of OAB for ≥ 3 months; average of ≥ 8 micturitions/day and ≥ 1 urge UI episode/day, or an average of ≥ 8 micturitions/day and an average of ≥ 3 urgency episodes/day Exclusion criteria: Total daily urine volume > 3000 mL; lower urinary tract pathology that could be responsible for urgency, frequency, or UI; history of surgery to correct stress UI, POP, or procedural treatments for BPH within prior 6 months; history or evidence of ≥ Stage 2 POP; current use of a pessary for POP; history of elevated post-void residual volume; recent bladder training or electrostimulation; active or recurrent UTI; requirement for an indwelling catheter or intermittent catheterization; recent intradetrusor botulinum toxin; uncontrolled hyperglycemia; evidence of diabetes insipidus; history of injury, surgery, or neurodegenerative diseases that could affect the lower urinary tract or its nerve supply; hematuria, including microscopic	Primary: • Change from baseline in average daily number of micturitions • Change from baseline in average daily number of UUI episodes; UUI is defined as leakage of urine of any amount because the patient felt an urge or need to urinate immediately Secondary: AEs

Results:

Primary:

- Change from baseline in average daily number of micturitions: Micturitions decreased by an adjusted mean of 1.8 episodes/day for vibegron vs. 1.3 for placebo ($P<0.001$) and 1.6 for tolterodine
- Change from baseline in average daily number of UUI episodes: UUI episodes decreased by an adjusted mean of 2.0 episodes/day for vibegron vs. 1.4 for placebo ($P<0.0001$) and 1.8 for tolterodine

Secondary: Among vibegron treated patients, 1.7% discontinued treatment because of AEs vs. 1.1% for placebo and 3.3% for tolterodine; incidence of HTN was 1.7% for vibegron and for placebo

Conclusion: The authors concluded "Once daily 75 mg vibegron provided statistically significant reductions in micturitions, urgency episodes and urge incontinence, and increased the volume per micturition. Treatment was well tolerated with a favorable safety profile."

Citation	Design	Endpoints
Maman K, Aballea S, Nazir J, et al. Comparative efficacy and safety of medical treatments for the management of overactive bladder: a systematic literature review and mixed treatment comparison. Eur Urol. 2014 Apr;65(4):755-65. doi: 10.1016/j.eururo.2013.11.010.	Systematic review (as per Centre for Reviews and Dissemination [CRD] and Preferred Reporting Items for Systematic Reviews and Meta-analysis guidelines) and Bayesian mixed treatment comparison to evaluate the relative safety and efficacy of OAB medications N=44 RCTs; 27,309 participants	Efficacy: micturition frequency, incontinence episodes, UUI (all per 24 hours) Safety: incidence of dry mouth, constipation, blurred vision

Results:

Efficacy:

- Micturition frequency: Mirabegron was found to be as effective as antimuscarinics except solifenacin 10 mg which was found to be more effective (mean difference vs mirabegron 50 mg of −0.584 [95% CrI*, −0.837 to −0.332]).
- Incontinence: Mirabegron was found to be as effective as antimuscarinics; solifenacin (5 mg and 10 mg) were 97% more probable to be effective compared to mirabegron.
- UUI: Mirabegron was found to be as effective as antimuscarinics; solifenacin 10 mg was significantly more efficacious compared to mirabegron (mean difference vs mirabegron 50 mg of −0.422 urgency incontinence episodes per day [95% CrI, −0.786 to −0.060]).

Safety: Antimuscarinics were associated with higher rates of dry mouth and constipation compared to mirabegron and solifenacin had a significantly higher risk of constipation compared to mirabegron with OR ranging from 1.914 (95% CrI, 1.135–3.032) to 7.603 (95% CrI, 2.076–22.660).

Conclusion: The authors concluded that mirabegron had similar efficacy compared to most antimuscarinics and lower rates of dry mouth. A significant strength of this study is that it met the CRD Database of Abstracts of Reviews of Effects (DARE) scientific quality criteria for systematic reviews. This adds to the credibility and reliability of the results and conclusions.

**CrI – Credibility interval*

Citation	Design	Endpoints
Nalliah S, Wg P, Masten Singh PK, Naidu P, Lim V, Ahamed AA. Comparison of efficacy and tolerability of pharmacological treatment for the overactive bladder in women: A network meta-analysis. Aust Fam Physician. 2017 Mar;46(3):139-144.	Systematic review and network meta-analysis (NMA) of RCTs and prospective cohort studies of "commonly prescribed pharmacological agents" for the treatment of OAB sourced from PubMed and Cochrane between July 31, 2000 and July 31, 2015. N=5 studies; 5356 participants	Efficacy: Relative efficacy as measured by OR Safety: Number of AEs (e.g., dry mouth, dry eyes, blurred vision and constipation)

Results:

Efficacy: Solifenacin 10 mg was the most effective followed by oxybutynin 3 mg TDS > solifenacin 5 mg QD > darifenacin 15 mg QD > fesoterodine 8 mg QD > darifenacin 7.5 mg QD > tolterodine 4 mg QD.

Safety: Darifenacin 7.5 mg QD had the fewest AEs, whereas solifenacin 10 mg QD caused the most AEs when compared with every other intervention except oxybutynin 3 mg TDS.

Conclusion: The authors concluded that, considering effectiveness, adverse effects, and cost, solifenacin 5 mg is the drug of choice. This study included relatively few RCTs, and it did not include an assessment of the relative effectiveness or safety of the β3 agonist mirabegron. It was conducted in Australia; it is possible mirabegron was not available in Australia during the search timeframe.

Citation	Design	Endpoints
Kelleher C, Hakimi Z, Zur R, et al. Efficacy and Tolerability of Mirabegron Compared with Antimuscarinic Monotherapy or Combination Therapies for Overactive Bladder: A Systematic Review and Network Meta-analysis. Eur Urol. 2018 Sep;74(3):324-333. doi: 10.1016/j.eururo.2018.03.020. Epub 2018 Apr 23.	A systematic review and NMA of RCTs from 2000 to 2017 assessing mirabegron and antimuscarinics monotherapies and combination therapies for OAB N=64 studies; 46,666 participants	Efficacy: Mean change from baseline for micturition frequency, UUI episodes, and incontinence episodes (all per 24 hours) Safety: Dry mouth, constipation, blurred vision, HTN, urinary retention, UTI, tachycardia, withdrawal for any reason, and withdrawal due to lack of efficacy

Results:

Efficacy:

- Micturition frequency: Efficacy of mirabegron 50 mg did not differ significantly from the other active treatments, except for solifenacin 10 mg monotherapy and solifenacin 5 mg + mirabegron 50 mg (combination), both of which were more efficacious than mirabegron 50 mg (mean change: –0.37 [95% CrI: –0.62, –0.13] and –0.59 [95% CrI: –0.87, –0.30], respectively)
- UUI episodes: Efficacy of mirabegron 50 mg did not differ significantly from the other active treatments, except for solifenacin 5 mg + mirabegron 25 or 50 mg (combinations) and fesoterodine 8 mg, all of which were more efficacious than mirabegron 50 mg monotherapy
- Incontinence episodes: Mirabegron was significantly more efficacious than placebo; no significant differences were observed versus other comparators except for solifenacin 5 and 10 mg monotherapy and solifenacin/mirabegron combinations (all of which were more efficacious than mirabegron)

Safety:

- Dry mouth: The risk with mirabegron 50 mg was similar to that with placebo (OR: 0.82 [95% CrI: 0.65, 1.03]) and significantly lower compared with all other active treatments except for oxybutynin IR 5 mg (OR: 2.99 [95% CrI: 0.68, 13.75])
- Constipation: The risk was significantly lower for mirabegron 50 mg compared with nine active treatments (darifenacin 7.5 and 15 mg, fesoterodine 8 mg, propiverine 20 mg, solifenacin 5 mg + mirabegron 25 or 50 mg, solifenacin 5 and 10 mg, and trospium 60 mg)
- HTN: The risk for mirabegron 50 mg was similar to that for placebo (OR: 0.97 [95% CrI: 0.76, 1.25]) and all other treatments
- Urinary retention: Mirabegron 50 mg had a significantly lower frequency of urinary retention compared with seven active treatments (fesoterodine 4 and 8 mg, oxybutynin IR 9 mg, solifenacin 10 mg, solifenacin 5 mg combined with mirabegron 25 or 50 mg, and trospium 60 mg). No significant differences were seen versus mirabegron 50 mg for the remaining four comparators (placebo, propiverine 20 mg, solifenacin 5 mg, and tolterodine ER 4 mg)
- Blurred vision, UTI, Tachycardia: There were no significant differences
- Withdrawal for any reason: Mirabegron was significantly better tolerated compared with oxybutynin IR (OR: 2.14 [95% CrI: 1.36, 3.37])
- Withdrawal due to lack of efficacy: Mirabegron was significantly better tolerated compared with placebo (OR: 1.95 [95% CrI: 1.21, 3.24])

Conclusion: The authors concluded that "relief of key OAB symptoms produced by mirabegron 50 mg is significantly better than placebo, and similar to a range of common antimuscarinics, with the benefit of significantly fewer bothersome anticholinergic side effects such as dry mouth." Additionally, combination treatment of solifenacin + mirabegron was found to improve efficacy although with additional anticholinergic side effects.

Citation	Design	Endpoints
Lozano-Ortega G, Walker DR, Johnston K, et al. Comparative safety and efficacy of treatments for overactive bladder among older adults: a network meta-analysis. Drugs Aging. 2020;37(11):801-816.	Systematic review and NMA of RCTs among older adults with OAB that reported the safety and efficacy outcomes associated with the use of mirabegron and/or antimuscarinics sourced from PubMed and Cochrane between January 1, 2000 and August 21, 2018. N=21 studies	Efficacy: Incontinence episodes per 24 hours, UUI episodes per 24 hours, micturitions per 24 hours, volume voided per micturition, and urgency episodes per 24 hours

		Safety: Urinary retention, dry mouth, constipation, overall treatment-emergent AEs, and AE-related treatment discontinuations

Results:

Efficacy:

- A similar treatment effect was observed across all efficacy endpoints between mirabegron and antimuscarinics.

Safety:

- Mirabegron was not associated with an increased odds of dry mouth (OR: 0.76 [95% CrI: 0.26, 2.37]) or constipation (OR: 1.08 [95% CrI: 0.39, 3.02]) relative to placebo, whereas antimuscarinics were strongly associated with these events (OR range: 3.78 to 7.85 and 2.12 to 4.66, respectively)
- Mirabegron was associated with similar odds of experiencing AE-related treatment discontinuations relative to placebo (OR: 0.99 [95% CrI: 0.57, 1.70]), while the odds of experiencing an AE-related treatment discontinuation for antimuscarinics had a range of 1.14–3.03 (in most cases, the association was mild)
- No increased odds of experiencing overall treatment-emergent AEs was observed for mirabegron or antimuscarinics (OR range: 1.25 to 1.55), apart from fesoterodine (OR: 2.23 [95% CrI: 1.37, 3.37])

Conclusion: The authors concluded that the safety and efficacy profile of mirabegron remains favorable compared with antimuscarinics among older adults. This includes safety outcomes typically associated with anticholinergic burden, which were less frequently observed in patients treated with mirabegron.

Citation	Design	Endpoints
Su S, Liang L, Lin J, Liu L, Chen Z, Gao Y. Systematic review and meta-analysis of the efficacy and safety of vibegron vs antimuscarinic monotherapy for overactive bladder. Medicine (Baltimore). 2021;100(5):e23171.	Systematic review and NMA of RCTs of vibegron vs. antimuscarinic monotherapy for OAB sourced from PubMed and Cochrane to March 2020. N=3 studies; 1751 participants	Efficacy: Mean number of micturitions episodes per day, mean number of urgency episodes per day, mean number of UUI episodes per day, mean number of incontinence episodes per day, and mean volume voided/micturition Safety: Dry mouth, drug related treatment-emergent AEs, serious AEs, and discontinuations due to AEs

Results:

Efficacy:

- The mean number of micturitions episodes per day (p= 0.16), the mean number of urgency episodes per day (p=0.05), mean number of UUI episodes per day (p=0.11), and mean number of incontinence episodes per day (p=0.14) indicated that vibegron and antimuscarinic therapy had no significant differences in terms of OAB treatment efficacy

Safety:

- With regard to dry mouth and drug related treatment-emergent AEs, vibegron showed better tolerance than antimuscarinics. Serious AEs and discontinuations due to AE did not show a significant difference between the two groups

Conclusion: The authors concluded that the therapeutic effect of vibegron is similar to that of antimuscarinics, but vibegron does not increase the risk of AEs.

Citation	Design	Endpoints
Kennelly M, Wielage R, Shortino D, Thomas E, Mudd PN. Long-term efficacy and safety of vibegron versus mirabegron and	Systematic review and NMA of RCTs of vibegron, mirabegron, and anticholinergics for the treatment of OAB sourced from MEDLINE, Embase and Cochrane and performed on September 16, 2020	Efficacy: Change from baseline to week 48-52 in mean daily total UI episodes, mean daily

anticholinergics for overactive bladder: a systematic review and network meta-analysis. Drugs Context. 2022;11:2022-4-2.	N=6 studies; 2492 participants	micturitions, and volume voided per micturition Safety: AEs

Results:

Efficacy:

- Mean (95% credible interval) change from baseline in total UI episodes for vibegron 75 mg (–2.2; –2.9 to –1.5) showed a significantly greater reduction than mirabegron 50 mg (–1.3; –1.9 to –0.8) and tolterodine 4 mg extended release (–1.6; –2.1 to –1.1)
- No significant differences were observed between vibegron and comparators for daily micturitions or volume voided/micturition

Safety:

- The 4 most common AEs (range) for anticholinergics included dry mouth (5.2–90.0%), constipation (7.7–65.0%), blurred vision (3.8–35.0%) and hypertension (8.6–9.6%)
- The 4 most commonly reported AEs for β3-adrenergic agonists included hypertension (8.8–9.2%), urinary tract infection (5.9–6.6%), headache (5.5%) and nasopharyngitis (4.8–5.2%)

Conclusion: Vibegron was associated with significantly greater improvement in daily total UI episodes at 52 weeks than mirabegron and tolterodine. The most common AE for anticholinergics was dry mouth and for β3-adrenergic agonists was hypertension.

FORMULARY PLACEMENT, UTILIZATION AND COST EXPERIENCE (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST		PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	**Rx**	**Mbrs**	**Total Plan Paid**	**Avg/Rx Plan Paid**	**Total**	**Approved (%)**	**Current**	**Recommend**
Antimuscarinics - Rx								
Tolterodine (Detrol®) 1 mg, 2 mg tablet	2	1	$122.28	$61.14	0	0 (0%)	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at POS for members ≥65 yrs.	No change
Tolterodine (Detrol® LA) 2 mg, 4 mg ER capsule	2	1	$104.59	$52.30	0	0 (0%)	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at POS for members ≥65 yrs.	No change
Oxybutynin 2.5 mg, 5 mg tablet	9	7	$6.18	$0.69	0	0 (0%)	F -5mg NF-2.5mg	No change
Oxybutynin 5 mg/5 mL oral syrup	0	0	$0.00	$0.00	0	0 (0%)	F	No change
Oxybutynin (Ditropan® XL) 5 mg, 10 mg, 15 mg ER tablet	14	9	$26.02	$1.86	0	0 (0%)	F	No change
Gelnique® (oxybutynin) 10 % (100 mg/gram) transdermal gel packet	0	0	$0.00	$0.00	0	0 (0%)	F-PA	No change
Oxytrol® (oxybutynin) 3.9 mg/24 hr transdermal patch	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Flavoxate 100 mg tablet	0	0	$0.00	$0.00	0	0 (0%)	F-PA	No change
Trospium 20 mg tablet	0	0	$0.00	$0.00	0	0 (0%)	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at POS for members ≥65 yrs.	No change
Trospium 60 mg ER capsule	0	0	$0.00	$0.00	0	0 (0%)	F-ST (t/f oxybutynin IR or ER or solifenacin). Pays at POS for members ≥65 yrs.	No change
Fesoterodine (Toviaz®) 4 mg, 8 mg ER tablet	0	0	$0.00	$0.00	0	0 (0%)	F-PA	No change
Solifenacin (Vesicare®) 5 mg, 10 mg tablet	3	1	$0.00	$0.00	0	0 (0%)	F	No change
Vesicare LS™ (solifenacin) 1 mg/mL oral suspension	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Darifenacin 7.5 mg, 15 mg ER tablet	0	0	$0.00	$0.00	0	0 (0%)	F-PA	No change
Antimuscarinics - OTC								
Oxytrol® For Women (oxybutynin) 3.9 mg/24 hour transdermal patch	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Beta-3 Agonists								
Myrbetriq® (mirabegron) 25 mg, 50 mg ER tablet	10	5	$4,235.46	$423.55	0	0 (0%)	F-PA	No change
Myrbetriq® (mirabegron) 8 mg/mL ER oral suspension	0	0	$0.00	$0.00	0	0 (0%)	F-PA	No change
Gemtesa® (vibegron) 75 mg tablet	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TOTAL	**40**	**24**	**$4,494.53**	**$112.36**	**0**	**0 (0%)**		

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary; X = Excluded

PRIOR AUTHORIZATION CRITERIA

Recommendation:

- Change brand/generic status of Toviaz (fesoterodine)

Urinary Incontinence Agents	
Therapeutic Classes (AHFS)	Antimuscarinics and Beta-3-Adrenergic Agonists
Medications	**Formulary, preferred:** Oxybutynin (Ditropan), Oxybutynin ER (Ditropan XL), solifenacin (Vesicare) **Formulary, step therapy required:** Tolterodine (Detrol), Tolterodine ER (Detrol LA), Trospium (Sanctura), Trospium ER (Sanctura XR) **Formulary, prior authorization required:** Darifenacin (Enablex), fesoterodine (Toviaz)~~Toviaz (fesoterodine)~~, flavoxate (Urispas), Myrbetriq (mirabegron) **Non-formulary:** Gemtesa (vibegron), Vesicare LS (solifenacin) oral suspension, Oxytrol (oxybutynin) patch, Gelnique (oxybutynin), Oxytrol for women OTC **Any other non-formulary agent for urinary incontinence**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	Criteria for approval of **tolterodine, tolterodine ER, trospium, or trospium ER:** • Documented trial and failure, intolerance, contraindication, or inability to use oxybutynin or oxybutynin ER or solifenacin for at least 4 weeks (28 days) of therapy within the past 6 months OR • Member aged 65 years or older. Criteria for approval of: **darifenacin, Oxytrol, fesoterodine,~~Toviaz,~~ Gelnique, flavoxate, Gemtesa, Vesicare LS, or Myrbetriq:** • Documented trial and failure, intolerance, contraindication, or inability to use oxybutynin or oxybutynin ER or solifenacin • AND tolterodine, tolterodine ER, trospium, or trospium ER for at least 4 weeks (28 days) of therapy within the past 6 months.
Criteria Statement	Tolterodine, tolterodine ER, trospium, or trospium ER are reserved for members who have used (or cannot/should not use) oxybutynin or oxybutynin ER or solifenacin or are over age 65 years. Darifenacin, Oxytrol, fesoterodine~~Toviaz~~, Gelnique, flavoxate, Gemtesa, Vesicare LS or Myrbetriq are reserved for members who have used (or cannot/should not use) oxybutynin or oxybutynin ER or solifenacin AND tolterodine, tolterodine ER, trospium, or trospium ER.
Last P&T Review Date	~~12/2022~~12/2023

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Ketone Test Strips

Therapeutic Class Review

UTILIZATION:

There was one claim for one member for ketone test strip OTC. There were no prior authorization requests.

RECOMMENDATIONS:

- No changes

FORMULARY PLACEMENT, UTILIZATION AND COST EXPERIENCE (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST		PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	Rx	Mbrs	Total Plan Paid	Avg/Rx Plain Paid	Total	Approved (%)	Current	Recommend
Urine Acetone Test Strips								
Chemstrip® K	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Ketone test strip	1	1	$0.00	$0.00	0	0 (0%)	F-QL (100/30)	No change
ReliOn test strip	0	0	$0.00	$0.00	0	0 (0%)	F-QL (100/30)	No change
Ketostix® reagent strip	0	0	$0.00	$0.00	0	0 (0%)	F-QL (100/30)	No change
CVS Ketone Care test strip	0	0	$0.00	$0.00	0	0 (0%)	F-QL (100/30)	No change
Diascreen 1K reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Urine Glucose/Acetone Test Strips								
Chemstrip® uGK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Keto-Diastix® strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 2GK reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 3 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 4OBL reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 5 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 6 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 7 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 8 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 9 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Diascreen 10 reagent strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Blood Ketone Test Strips								
Fora® GTel Ketone test strip	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Gojji Blood Ketone test strip	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
novaMax® Plus™ Ketone strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Precision Xtra® B-Ketone strips	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TOTAL	**1**	**1**	**$0.00**	**$0.00**	**0**	**0 (0%)**		

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary

Topical Antivirals
Executive Summary

CLASS OVERVIEW

Antiviral agents are medication therapies that demonstrate inhibitory activity against host cells infected with viral DNA or RNA. Each antiviral class has unique activity that involves inhibiting viral DNA synthesis through selective inhibition. Mutations may occur in viral DNA or RNA, viral thymidine kinase, or viral DNA polymerase genes, leading to resistance to these agents. Human papillomavirus (HPV) is responsible for anogenital warts as well as some cervical cancers. Although not considered antiviral agents, topical immunomodulators like imiquimod (Aldara®) and sinecatechins (Veregen®) exhibit antiviral activity against HPV. Imiquimod increases the activity of the patient's own immune system to attack genital warts caused by HPV while sinecatechins' mechanism is unknown but may involve anti-oxidative activity.

Herpes simplex virus (HSV) is responsible for both genital herpes and herpes labialis ("cold sores"). Antiviral therapy can shorten the duration of signs and symptoms of herpes infection and reduce the likelihood of viral shedding but cannot cure the infection. In cells infected with HSV, antivirals inhibit viral DNA synthesis, and topical formulations of acyclovir and penciclovir are available. Primary infection with Varicella Zoster Virus (VZV), a herpesvirus, results in varicella, or chickenpox, characterized by vesicular lesions on the face, trunk, and extremities. Herpes zoster, or shingles, is characterized by painful, unilateral vesicular eruptions resulting from the reactivation of latent VZV infection within the sensory ganglia. It occurs primarily in adults over 60 years of age and can lead to severe pain and postherpetic neuralgia. The herpes zoster vaccines (Zostavax®, Shingrix®) may be used as prophylaxis, however antiviral treatment with acyclovir (Zovirax®), penciclovir (Denavir®), and docosanol (Abreva®) may be used as treatment to reduce the duration of an outbreak. This review will primarily focus on topical antiviral therapies indicated for the treatment of HPV and HSV.

UTILIZATION FINDINGS

There were 7 claims for 5 members, for a total cost of $8 and an average cost per claim of $1. All claims were for imiquimod (Aldara®) 5% cream packet. There were no prior authorization requests.

RECOMMENDATIONS

- No changes

CLINICAL SUMMARY

External anogenital warts (condyloma acuminate) are nonmalignant squamous cell tumors caused by sexual transmission of human papillomavirus (HPV) types 6 and 11. This disease affects approximately 1% of sexually active adults in the United States and Europe with 1 million new cases diagnosed every year. Although not life-threatening and usually asymptomatic, anogenital warts can cause substantial discomfort, pain, social discomfort, and problems with sexual intercourse depending on the size and location. Current topical therapies include self-administered podofilox, imiquimod, sinecatechins, and interferon. The majority of genital warts are cleared by a course of medical therapy, and no treatment is significantly superior to another or appropriate for all patients and all types of warts.

Immune-mediated therapies initiate a local immune response on site and may immediately clear lesions. Imiquimod (Aldara®, Zyclara®) is an immunomodulator used to treat external genital and perianal warts, actinic keratosis, and squamous cell carcinoma. It is a toll-like receptor 7 agonist that causes powerful cytokine induction, stimulating the production of interferon-alpha, tumor necrosis factor, and interleukins-1, 6, and 8. The precise mechanism of action is unknown. Imiquimod is also used off-label for acyclovir resistant herpes simplex virus infection and common warts. Its application and dosage is dependent on the disease being treated.

Veregen® (sinecatechins 15% ointment) is an immunomodulator used to treat external genital and perianal warts. It is composed of a standardized extract of green tea leaves from *Camellia sinensis* containing tea polyphenols, more than 85% of which are catechins. Sinecatechins ointment contains the most biologically active catechin, called (-)-epigallocatechin gallate. Green tea catechins exhibit potent antiviral and antioxidant activity by binding certain enzymes involved in the generation of inflammatory mediators, proteases promoting tumor invasion, and kinases needed in tumor cell signaling. They also promote cell cycle modification and induce apoptosis. These immune-stimulatory, anti-oxidative, antiviral, and antitumor properties are thought to contribute to the therapeutic effect of sinecatechins ointment, but the exact mechanism is unknown. Veregen® is a topical ointment applied three times daily to all external genital and perianal warts until all warts have been cleared and can be used for a maximum of 16 weeks.

Herpes simplex virus (HSV) is a common infection affecting millions of Americans and is characterized by a type 1 (HSV-1) or type two (HSV-2) infection (2015-2016 prevalence was 47.8% for HSV-1 and 11.9% for HSV-2). HSV-1 or herpes labialis may result in vesicular lesions affecting the oral mucosa, commonly referred to as “cold sores,” while HSV-2 is most commonly associated with genital herpes. HSV-1, however, may also lead to clinical disease in the genitalia, liver, lungs, eyes, and central nervous system. An HSV outbreak is considered “primary” if the patient was HSV-seronegative for HSV-1 and HSV-2 before the occurrence of genital lesions. Nonprimary episode infection refers to HSV-2 infection in patients with preexisting HSV-1 immunity and often presents with less severe infection. Along with painful genital lesions, genital HSV infection is associated with fever, malaise, headache, and dysuria lasting two to four weeks if left untreated. Primary infection with Varicella Zoster Virus (VZV), a herpesvirus, results in varicella, or chickenpox, characterized by vesicular lesions on the face, trunk, and extremities. Herpes zoster, or shingles, is characterized by painful, unilateral vesicular eruptions resulting from the reactivation of latent VZV infection within the sensory ganglia. It occurs primarily in adults over 60 years of age and can lead to severe pain and postherpetic neuralgia.

Antiviral therapy can shorten the duration of signs and symptoms of herpes or varicella infection and reduce the likelihood of viral shedding. Current treatment strategies are based on frequency of disease, the severity of symptoms, and the patient's level of concern about transmitting HSV to an uninfected partner. While general approach includes both episodic and suppressive therapy, topical therapy does not have a role in general due to lack of efficacy compared to oral and no effect on reduction of new lesion therapy. It is also not recommended as an add-on therapy. However, agents do remain available and may be chosen based on patient preference despite having minimal clinical benefit.

Acyclovir (Zorivax®) 5% cream/ointment is a synthetic HSV nucleoside analogue DNA polymerase inhibitor used to treat recurrent herpes labilalis (cold sores) in immunocompetent adults and adolescents 12 years and older. The inhibitory activity of acyclovir is highly selective due to its affinity for the enzyme thymidine kinase (TK) encoded by HSV. This viral

enzyme converts acyclovir into acyclovir monophosphate, a nucleotide analogue. The monophosphate is further converted into diphosphate by cellular guanylate kinase and into triphosphate by a number of cellular enzymes. In cell culture, acyclovir triphosphate stops replication of herpes viral DNA. This inhibition is accomplished in 3 ways: 1) competitive inhibition of viral DNA polymerase, 2) incorporation into and termination of the growing viral DNA chain, and 3) inactivation of the viral DNA polymerase. Acyclovir is applied five times daily for four days to all lesions including the outer edge.

Penciclovir (Denavir®) 1% cream is a nucleoside analog HSV DNA polymerase inhibitor indicated for the treatment of recurrent herpes labialis (cold sores) in adults and children 12 years of age or older. In cells infected with HSV-1 or HSV-2, the viral thymidine kinase phosphorylates penciclovir to a monophosphate form that, in turn, is converted by cellular kinases to the active form penciclovir triphosphate. Penciclovir triphosphate inhibits HSV polymerase competitively with deoxyguanosine triphosphate. Consequently, herpes viral DNA synthesis and, therefore, replication are selectively inhibited. Denavir® is applied every 2 hours during waking hours for a period of 4 days. Treatment should be started as early as possible (i.e., during the prodrome or when lesions appears).

Docosanol (Abreva®) 10% cream is a non-prescription product indicated for the treatment of acute episodes of recurrent oral-facial herpes simplex (fever blister or cold sores) in adults. It works by inhibiting the fusion between plasma membrane and the HSV envelope which blocks viral entry into the cell and subsequent viral replication. Docosanol is applied topically 5 times daily and continued until the lesion is healed up to a maximum of 10 days. Treatment is most effective if applied at the first symptoms (pain, itching, burning or tingling) or sign (redness), prior to the formation of a papule or a blister.

Xerese® (acyclovir 5% and hydrocortisone 1% cream) is a combination of a nucleoside analog DNA polymerase inhibitor and a corticosteroid, indicated for the early treatment of recurrent herpes labialis (cold sores) to reduce the likelihood of ulcerative cold sores and to shorten the lesion healing time in adults and children (6 years of age and older). Acyclovir mechanism of action is similar to above-mentioned. Hydrocortisone is the main glucocorticoid secreted by the adrenal cortex. It is used topically for its anti-inflammatory effects which suppress the manifestations of the disease in a wide range of disorders where inflammation is prominent.

INDICATIONS, DOSING and ADMINISTRATION

Medication	Indications	Dosing/Administration
Human Papilloma Virus		
Imiquimod (Aldara®) 5% cream packet	• External genital and perianal warts/condyloma acuminata in patients 12 years or older	• **External genital and perianal warts:** Apply thin layer 3 times per week until total clearance or for a maximum of 16 weeks
Zyclara® (imiquimod) 2.5% cream pump Imiquimod (Zylcara®) 3.75% cream pump Imiquimod (Zyclara®) 3.75% cream		• **External genital and perianal warts:** Apply thin layer (up to 0.25 grams as one packet or one full actuation) once a day until total clearance or for up to 8 weeks • **HSV infection, acyclovir-resistant (off-label):** Apply once daily for 5 consecutive days
Veregen® (sinecatechins) 15% ointment	• External genital and perianal warts *(Condylomata acuminata)* in immunocompetent patients 18 years and older	• Apply a thin layer (~0.5 cm strand) 3 times daily to all warts until clearance or for a maximum of 16 weeks
Herpes Simplex Virus		
Xerese® (acyclovir-hydrocortisone) 5%-1% cream	• Recurrent herpes labialis (cold sores) in adults and children (6 years of age and older)	• Apply 5 times a day for 5 days
Acyclovir (Zovirax®) 5% ointment	• Initial genital herpes and in limited non-life-threatening mucocutaneous Herpes simplex virus infections in immunocompromised patients	• Apply ½ inch ribbon for a 4 inch square surface area every 3 hours (6 times daily) for 7 days
Acyclovir (Zovirax®) 5% cream	• Recurrent herpes labialis (cold sores) in immunocompetent adults and adolescents 12 years and older	• Apply 5 times a day for 4 days
Penciclovir (Denavir®) 1% cream	• Recurrent herpes labialis (cold sores) in adults and children 12 years of age and older	• Apply at first sign or symptom of cold sore or appearance of lesion every 2 hours during waking hours for 4 days
Docosanol (Abreva®) 10% cream		• Apply to affected area of face or lips 5 times daily at first sign of cold sore and continue until healed (maximum 10 days)

BOXED WARNINGS and CONTRAINDICATIONS

Medication	Boxed Warnings	Contraindications
Human Papilloma Virus		
Imiquimod (Aldara®) cream packet Zyclara® (imiquimod) cream pump Imiquimod (Zyclara®) cream pump Imiquimod (Zyclara®) cream Veregen® (sinecatechins) ointment	None.	None.
Herpes Simplex Virus		
Xerese® (acyclovir-hydrocortisone) cream	None.	None.
Acyclovir (Zovirax®) ointment Acyclovir (Zovirax®) cream	None.	None.
Penciclovir (Denavir®) cream	None.	• Hypersensitivity to penciclovir or any component of the formulation
Docosanol (Abreva®) cream	None.	• Hypersensitivity to docosanol or any component of the formulation

WARNINGS/PRECAUTIONS

Medication	Warnings/Precautions
Human Papilloma Virus (HPV)	
Imiquimod (Aldara®) cream packet Zyclara® (imiquimod) cream pump Imiquimod (Zyclara®) cream pump Imiquimod (Zyclara®) cream	**Concerns related to adverse effects:** • Intense local inflammatory reactions including skin weeping or erosion may occur accompanied by systemic symptoms including fever, malaise, and myalgia. May exacerbate inflammatory conditions of the skin including chronic graft-versus-host disease. • May increase the potential for photosensitivity • Flu-like symptoms including arthralgias, chills, fatigue, fever, malaise, myalgias, nausea, and rigors may accompany local inflammatory reactions. • Severe local inflammation of female external genitalia following topical application may lead to severe vulvar swelling and urinary retention. **Disease related concerns:** • Safety and efficacy in immunosuppressed patients have not been established. • Imiquimod has not been evaluated for the treatment of urethral, intravaginal, cervical, rectal, or intra-anal HPV disease **Dosage forms specific issues:** • Some dosage forms contain benzyl alcohol which has been associated with potentially fatal toxicity ("gasping syndrome") in neonates **Other warnings/precautions:** • Not intended for oral, nasal, intravaginal, or ophthalmic use
Veregen® (Sinecatechins) ointment	**Concerns related to adverse effects:** • Local skin reactions are common and include erythema, erosion, edema, itching, and burning; women may be at increased risk **Disease-related concerns:** • Not intended for the treatment of urethral, intravaginal, cervical, rectal, or intra-anal HPV disease **Special populations:** • Safety and efficacy have not been established in immunosuppressed patients **Other warnings/precautions:** • For topical use only • Continue treatment until all warts have been cleared for a maximum of 16 weeks; safety and efficacy > 16 weeks have not been established
Herpes Simplex Virus (HSV)	
Xerese® (acyclovir-hydrocortisone) cream Acyclovir (Zovirax®) ointment Acyclovir (Zovirax®) cream	**Concerns related to adverse effects:** • Cream may be irritating and cause contact sensitization **Disease related concerns:** • Treatment should be with the first signs or symptoms. For genital herpes, physical contact should be avoided when lesions are present but transmission may also occur in the absence of symptoms. There is no data to support use for the prevention of transmission of infection or prevent recurrent infections if no symptoms are present. **Special populations:** • Use and safety has not been studied in immunocompromised patients **Dosage form specific issues:** • Some products may contain milk protein concentrate
Penciclovir (Denavir®) cream	**Special populations:** • The effect of penciclovir has not been established in immunocompromised patients **Other warnings/precautions:** • Should only be used on herpes labialis on the lips and face due to lack of data
Docosanol (Abreva®) cream	**Concerns related to adverse effects:** • Severe allergic reactions including hives, facial swelling, wheezing/difficulty breathing, rash, and shock may occur with use

Medication	Warnings/Precautions
	Dosage form specific issues: • Some dosage forms contain benzyl alcohol which has been associated with potentially fatal toxicity ("gasping syndrome") in neonates **Other warnings/precautions:** • For external use only; apply at first sign or symptoms

PRACTICE GUIDELINES

CDC 2021 Sexually Transmitted Diseases Treatment Guidelines
Centers for Disease Control and Prevention. (2021). Human Papilloma Virus (HPV) Infection. Retrieved from https://www.cdc.gov/std/treatment-guidelines/anogenital-warts.htm
Human Papillomavirus (HPV) Infection – Anogenital warts

- Aim of treatment of anogenital warts is the removal of the warts and amelioration of symptoms
- Treatment results in the resolution of warts in most patients
- If left untreated, warts can resolve spontaneously, remain unchanged, or increase in size or number; however, spontaneous resolution may occur in one year
- Treatment of anogenital warts is guided by wart size, number, site, patient preference, cost of treatment, adverse effects, and provider experience
- Some clinicians employ combination therapy but there is limited evidence regarding the safety and efficacy of this type of treatment regimen
- The recommended regimens for treatment of anogenital warts are:
    - Imiquimod 5% cream should be applied once at bedtime, 3 times/week for up to 16 weeks
    - Imiquimod 3.75% cream should be applied once at bedtime every night for up to 8 weeks
    - Podofilox should be applied to anogenital warts 2 times/day for 3 day, followed by 4 days of no therapy; repeat as needed up to 4 cycles
    - Sinecatechins 15% ointment should be applied 3 times/day with a thin layer until complete clearance of warts is achieved; do not continue for >16 weeks
- Podofilox and sinecatechins should not be used during pregnancy

Centers for Disease Control and Prevention. (2021). Genital HSV Infections. Retrieved from https://www.cdc.gov/std/treatment-guidelines/herpes.htm.
Herpes Simplex Virus (HSV) – Genital herpes

- Goals for use of antiviral medications are to prevent symptomatic genital herpes recurrences and improve quality of life
- All individuals with the first clinical episode of genital herpes should receive antiviral therapy
- Treatment can be extended if healing is incomplete after 10 days of therapy
- Topical therapy with antiviral drugs offers minimal clinical benefit and is not recommended

The American College of Obstetricians and Gynecologists. (2020). Management of Genital Herpes in Pregnancy. Retrieved from https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/05/management-of-genital-herpes-in-pregnancy
Herpes Simplex Virus (HSV) – Genital herpes

- Primary genital herpes infection during pregnancy constitutes a higher risk of perinatal transmission than does recurrent infection
- Antiviral therapy should be administered orally to pregnant women at the time of initial outbreak to reduce the duration and severity of symptoms as well as duration of viral shedding
- Topical antiviral therapy has not been shown to be of benefit and therefore not recommended

CLINICAL TRIALS/SYSTEMATIC REVIEWS/META-ANALYSES

Citation	Design	Endpoints
Rosen T, Nelson A, Ault K. Imiquimod cream 2.5% and 3.75% applied once daily to treat external genital warts in men. Cutis. 2015; 96(4):277-82.	Inclusion Criteria: Patients age 12 and older with 2 to 30 external genital warts and a total wart area of 150mm^2 or greater. Two multicenter, randomized, double-blind, placebo-controlled studies: 447 male subjects received imiquimod cream 3.75%, 2.5%, or placebo once daily until complete clearance or a maximum of 8 weeks, followed by an 8 week follow-up in patients who did not achieve clearance, and a 12-week observational follow-up period for those achieving clearance to assess recurrence.	• Primary efficacy endpoint was complete clearance rate. • Secondary efficacy endpoints included wart count from baseline to the end of study, percentage change in wart count, and median time to complete clearance. Safety was also assessed.
Results: In both studies, complete clearance rates were significantly higher with imiquimod cream 3.75% compared to placebo at weeks 10-16. In study 2, complete clearance rates were significantly higher with imiquimod cream 2.5% compared to placebo from week 14-16. The proportion of male participants with at least a 75% reduction in wart count was statistically superior in the imiquimod cream 3.75% and 2.5% compared to placebo. The percentage change in wart count was statistically significant in the imiquimod cream 3.75% group in both studies but only statistically significant for imiquimod cream 2.5% in one study. The median time to complete clearance was shorter in the active treatment groups compared to placebo but not statistically significant. Less than one-third of male participants experienced adverse events and those that did had generally mild local skin reactions. **Conclusion**: Imiquimod 2.5% and 3.75% cream is safe and exhibited dose-dependent efficacy for complete clearance, percentage change in wart count, and time to complete clearance of anogenital warts.		
Citation	**Design**	**Endpoints**
Hull CM, Harmenberg J, Arlander E, Aoki F, Bring J, Darpö B, Levin MJ, Tyring S, Spruance SL; ME-609 Study Group. Early treatment of cold sores with topical ME-609 decreases the frequency of ulcerative lesions: a randomized, double-blind, placebo-controlled, patient-initiated clinical trial. J Am Acad Dermatol. 2011 Apr;64(4):696.e1-11. doi: 10.1016/j.jaad.2010.08.012.	Inclusion criteria: male and female patients 18 years or older in good health who experience HSL symptoms at least 3 times per year. Participants had to have experienced prodromal symptoms 50% of the time, ulcerative lesions progressed through the vesicle and crust stages 75% of the time. Randomized, double-blind, placebo-controlled trial: 1443 participants were randomized to receive ME-609 (Xerese), acyclovir in ME-609, or the placebo and instructed to apply five times daily for five days at the first sight of recurrent herpes labialis	• Primary endpoint was the prevention of ulcerative herpes labialis lesions
Results: 42% of participants receiving ME-609 did not develop ulcerative lesions compared to 35% of participants treated with acyclovir in ME-609 (P = .014) and 26% of participants receiving the placebo (P<0.0001). The duration of healing time was reduced in participants receiving ME-609 and acyclovir in ME-609 when compared to the participants receiving the placebo (P<0.01 for both). The cumulative lesion area was significantly reduced by 50% in participants receiving ME-609 treatment compared to the placebo (P<0.0001) and the adverse events were similar among all treatments. **Conclusion**: ME-609 significantly decreased the occurrence of ulcerative lesions from cold sores and significantly reduced the cumulative lesion area when compared with the treatment of acyclovir and the placebo.		
Citation	**Design**	**Endpoints**

Tatti S, et al. Obstetrics & Gynecology. 2008; 111 (6):1371-1379.	Inclusion criteria: Male and female patients aged 18 years and older with 2 to 30 anogenital warts ranging from 21-600 mm^2 total wart area. Multicenter, randomized, double-blind, vehicle-controlled trial: 502 subjects applied sinecatechins ointment 15%, 10%, or vehicle three times daily for a maximum of 16 weeks or until complete clearance of all warts, followed by a 12-week treatment-free follow-up to assess recurrence.	• The primary endpoint was the percentage of subjects with complete clearance of all external anogenital warts. • Secondary endpoints included the percentage reduction in size of wart from baseline, local tolerability, and adverse events.
Results: Of the 495 patients treated, 57.2% in the sinecatechins ointment 15% group, 56.3% of patients in the sinecatechins ointment 10% group, and 33.7% of patients in the vehicle group achieved complete clearance of all external anogenital warts ($p<0.001$). Partial clearance rates of at least 50% were reported for 78.4% and 74% of patients in the sinecatechins ointment 15% and 10% compared to 51.5% in the vehicle group. Superiority of sinecatechins ointment 15% and 10% to vehicle was shown at week 4 and 6, respectively, and then at all subsequent visits. Wart recurrence did not show a statistically significant difference between active and vehicle groups. **Conclusion**: Sinecatechins 10% and 5% ointment is safe and effectively cleared anogenital warts in about 55% of patients, achieved partial clearance in about 75% of patients by week 4-6 of treatment but did not improve recurrence rates.		
Citation	**Design**	**Endpoints**
Stockfleth E, Beti H, Orasan R, et al. Topical Polyphenon E in the treatment of external genital and perianal warts: a randomized controlled trial. British Journal of Dermatology. 2008; 158: 1329-1338.	Inclusion criteria: Male and female patients aged 18 and older with 2 to 30 anogenital warts with a total wart area of 12-600mm^2. Multicenter, randomized, double-blind, three-arm parallel-group, vehicle-controlled trial: 503 subjects applied sinecatechins ointment 15%, 10%, or vehicle three times daily until complete clearance of all anogenital warts or for up to 16 weeks, followed by a 12-week treatment-free follow-up period for patients with complete clearance.	• Primary endpoint was the percentage of subjects with complete clearance of all external anogenital warts • Secondary endpoints included complete clearance of baseline warts, total wart number, total wart area, partial clearance, and recurrent and new warts.
Results: About 53% of patients treated with sinecatechins 15% ointment, 51% of patients treated with sinecatechins 10% ointment, and 37% of patients in the vehicle group showed complete clearance of all baseline and new anogenital warts (p=0.01 and 0.03 respectively). Women (60%) responded better than men (45%) in both active groups achieving complete clearance. Time to complete clearance was comparable for both strengths of ointment. About 78% of all patients treated with either strength of sinecatechins showed wart clearance rates of 50% or better. Less than 6% and 4% of patients in sinecatechins 15% and 10%, respectively, experienced wart recurrence during follow-up. The majority of adverse events were mild to moderate local application site reactions. **Conclusion:** Sinecatechins 10% and 15% ointment is safe and effectively cleared anogenital warts in about half of participants, produced wart clearance rates of 50% or better in 78% of patients, and reduced wart recurrence in about 95% of patients with complete clearance.		
Citation	**Design**	**Endpoints**
Spruance SL, Nett R, Marbury T, Wolff R, Johnson J, Spaulding T. Acyclovir cream for treatment of herpes simplex labialis: results of two randomized, double-blind, vehicle-controlled, multicenter clinical trials. Antimicrob Agents	Inclusion criteria: male and female patients 18 years and over in good general health with recurrent episodes of herpes labialis ($\geq$3 episodes in past year) with a history of prodromal symptoms and lesions from greater than 50% of episodes. Two independent, identical, parallel, randomized, double-blind trials: 324 patients received acyclovir and 346 patients received vehicle cream (placebo) in study 1, and	• Primary endpoint included the duration of the herpes labialis episode. • Secondary endpoint included the duration of pain associated with the virus and the formation of lesions

Chemother. 2002 Jul;46(7):2238-43. doi: 10.1128	328 patients received acyclovir and 343 patients received vehicle cream (placebo) in study 2. Patients were advised to apply cream 5times daily for 4 days	
Results: In both studies, acyclovir cream demonstrated statistically significant efficacy on the duration of herpes labialis episodes as well as on the duration of pain associated with the virus. Study 1 showed the duration of the episodes were reduced by 0.5 days (10%; *P* = 0.007), and in Study 2 the episode duration had a reduction of 0.6 days (12%; *P* = 0.006)**.** Study 1 demonstrated a 0.3-day reduction in lesion pain (9%; *P* = 0.017), and in Study 2 lesion pain was reduced by 0.4 days (11%; *P* = 0.014). **Conclusion**: Both studies concluded that there was a statistically significant reduction in the duration in duration of herpes labialis episodes and duration of lesion pain. However, there was no significant results to determine that acyclovir cream prevents the formation of herpes labialis lesions.		
Citation	**Design**	**Endpoints**
Raborn GW, Martel AY, Lassonde M, Lewis MA, Boon R, Spruance SL; Worldwide Topical Penciclovir Collaborative Study Group. Effective treatment of herpes simplex labialis with penciclovir cream: combined results of two trials. J Am Dent Assoc. 2002 Mar;133(3):303-9. doi: 10.14219	inclusion criteria: male and female immunocompetent participants with a history of recurrent herpes simplex labialis or HSL (> 3 episodes per year) that resulted in classical lesions. Two randomized, double-blind, parallel group clinical trials: 3,057 participants applied 1% penciclovir cream or the vehicle control cream (placebo) six times per day during the first day and then every two hours while awake during the next four consecutive days.	• Primary endpoint was efficacy of the topical 1% penciclovir cream in the healing of lesions and pain compared to the placebo
Results: the combined data from both trials indicated that participants treated with penciclovir cream lost lesions 31% faster than participants being treated with the placebo cream (hazard ratio, or HR, = 1.31; 95 percent confidence interval, or CI, 1.20 to 1.42; P = .0001) and penciclovir treated participants also experienced a 28% faster resolution of lesion pain (HR = 1.28; 95 percent CI, 1.17 to 1.39; P = .0001). Also, benefits were seen with penciclovir whether treatment was initiated early (P= 0.001) or later (P=0.0055). **Conclusion:** Penciclovir cream has demonstrated significant efficacy in the healing of classical lesions and resolution of pain associated with recurrent herpes simplex labialis compared to the placebo.		

FORMULARY PLACEMENT, UTILIZATION AND COST EXPERIENCE (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST		PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	**Rx**	**Mbrs**	**Total**	**Avg/Rx**	**Total**	**Approved (%)**	**Current**	**Recommend**
Human Papilloma Virus								
Imiquimod (Aldara®) 5% cream packet	7	5	$8.36	$1.19	0	0 (0%)	F	No change
Zyclara® (imiquimod) 2.5% cream pump	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Imiquimod (Zyclara®) 3.75% cream pump	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Imiquimod (Zyclara®) 3.75% cream	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Veregen® (sinecatechins) 15% ointment	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Herpes Simplex Virus								
Xerese® (acyclovir-hydrocortisone) 5%-1% cream	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Acyclovir (Zovirax®) 5% ointment	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Acyclovir (Zovirax®) 5% cream	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Penciclovir (Denavir®) 1% cream	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Docosanol (Abreva®) 10% cream	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Total	**7**	**5**	**$8.36**	**$1.19**	**0**	**0 (0%)**		

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary

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Prenatal Vitamins

Therapeutic Class Review

UTILIZATION FINDINGS

There were 12 claims for 10 members. The most highly utilized medication was generic “prenatal vitamins tablet” with 7 claims, followed by another generic formulation, “prenatal vitamin tablet” with 3 claims. There were no prior authorization requests.

RECOMMENDATIONS:

- No changes

FORMULARY PLACEMENT, UTILIZATION AND COST EXPERIENCE (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST		PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	Rx	Mbrs	Total Plan Paid	Avg/Rx Plan Paid	Total	Approved (%)	Current	Recommend
Prenatal Vitamins								
PRENA1 CHEW TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAMEDMD REDICHEW RX TAB CHEW	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE AM TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ALIVE PREMIUM PRENATAL GUMMY	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
GERBER GS PRENATAL NOURISH PLS	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ALIVE DAILY SUPPORT PRENATAL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CVS PRENATAL GUMMIES	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CVS PRENATAL GUMMIES	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ONE-A-DAY PRENATAL GUMMY	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL GUMMIES	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE CHEWABLE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL PLUS-DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
KPN PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL MULTIVITAMIN TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL FORTE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
DERMACINRX PRETRATE CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NEONATAL FE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL GUMMIES	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ENBRACE HR SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATABS RX TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
THRIVITE RX TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
KOSHER PRENATAL PLUS IRON TAB	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ELITE-OB CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
OB COMPLETE CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ONE-A-DAY PRENATAL-1 SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE ELITE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
OB COMPLETE WITH DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change

OB COMPLETE PREMIER TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
MINI PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL COMPLETE CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL MULTI TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL VITAMIN TABLET	3	2	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
CVS PRENATAL VITAMINS TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL VITAMIN TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL ONE DAILY TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
RIGHT STEP PRENATAL VIT TAB	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NEONATAL PLUS VITAMIN TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
M-NATAL PLUS TABLET	2	1	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL PLUS TABLET	0	0	$0.00	$0.00	0	0 (0%)	F	No change
PRENATAL VITAMIN PLUS LOW IRON	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
WESTAB PLUS TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
THERANATAL CORE NUTRITION TAB	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
DERMACINRX PRENATRIX CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
DERMACINRX PRENATRYL CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL PLUS VITAMIN-MINERAL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TRICARE PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NIVA-PLUS TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SM PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	F	No change
PRENATAL CAPLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
QC PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	**F**	No change
PRENATAL MULTIVITAMINS TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL VITAMIN TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL VITAMINS TABLET	7	7	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL VITAMINS TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
CLASSIC PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
EQL PRENATAL VITAMIN TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
RA PRENATAL TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PUB PRENATAL VITAMINS TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TRINATE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NEONATAL COMPLETE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CO-NATAL FA TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATABS FA TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change

TRINATAL RX 1 TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
VINATE ONE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL-OB CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NATALVIT TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL 19 CHEWABLE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SE-NATAL 19 CHEWABLE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL 19 CHEWABLE TABLET	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
COMPLETENATE TABLET CHEW	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
PRENATAL MULTI-DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL FORMULA-DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
C-NATE DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VIVA DHA PRENATAL SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
WESNATE DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL PLUS-DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ONE A DAY PRENATAL DHA PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SM ONE DAILY PRENATAL COMBO PK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ONE-A-DAY PRENATAL DHA PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NATAL PNV TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
AZESCO TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ZALVIT TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ZIPHEX TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PNV-SELECT TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SELECT-OB CHEWABLE CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SELECT-OB CHEWABLE CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PNV TABS 20-1 TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PREGENNA TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VINATE II TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NATACHEW TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL-U CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL FORMULA TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VINATE CARE CHEWABLE TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL NANO TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PROVIDA OB CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CONCEPT OB CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
FOLIVANE-OB CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PNV-OMEGA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
OBTREX PRENATAL CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change

INATAL GT TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ATABEX EC CAPLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NESTABS TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NESTABS DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL 19 TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SE-NATAL-19 TABLET	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CITRANATAL B-CALM COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
OB COMPLETE ONE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
OB COMPLETE PETITE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NEEVODHA CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VINATE DHA RF GELCAP	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENA1 PEARL SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAPEARL SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRIMACARE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CONCEPT DHA CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
WESCAP-C DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TARON-C DHA CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
DUET DHA 400 COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CVS PRENATAL GUMMIES	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CVS PRENATAL GUMMY VITAMINS	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
COMPLETE NATAL DHA	0	0	$0.00	$0.00	0	0 (0%)	F-AL (max 50 yrs)	No change
WESNATAL DHA COMPLETE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL PLUS-DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
THERANATAL ONE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
STUART ONE CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PREGEN DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
OBTREX DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
BRAINSTRONG PRENATAL COMBO PAC	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL MULTI-DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL MULTI-DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CVS PRENATAL MULTI-DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL MULTIVITAMIN-DHA SFGL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SIMILAC PRENATAL COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CENTRUM SPECIALIST PRENATAL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
THERANATAL COMPLETE COMBO	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATAL + DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CVS WOMEN'S PRENATAL PLUS DHA	0	0	$0.00	$0.00	0	0 (0%)	NF	No change

PRENATAL + DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
EXPECTA PRENATAL COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NEONATAL-DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL-OB+DHA COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CADEAU DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TRISTART DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
WESTGEL DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PNV-DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
WESCAP-PN DHA CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE RESTORE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE ENHANCE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE PIXIE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE DHA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE ESSENTIAL SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL-ONE CAPSULE	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
SELECT-OB + DHA PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ULTRA PRENATAL PLUS DHA SOFTGL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
ULTRA PRENATAL PLUS DHA SOFTGL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENATE MINI SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
CITRANATAL MEDLEY SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL ULTRA SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITAFOL FE PLUS SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
NESTABS ONE SOFTGEL	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
PRENA1 TRUE COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
VITATRUE COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
THERANATAL OVAVITE COMBO PACK	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TOTAL	**12**	**10**	**$0.00**	**$0.00**	**0**	**0 (0%)**		

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary

Recommendation:

- No changes

Oral and Injectable Oncology Medications	
Medications	Oral and Injectable Oncology Medications without medication-specific criteria
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for Healthcare Professional (USP DI), and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age for MCAL
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Up to a 6 month duration depending upon the diagnosis and usual treatment therapies
Maximum Billable Units	Variable
Other Criteria	All of the following criteria must be met: • Requested indication must be supported by NCCN category 1 or 2A level of evidence. If the request is for a category 2B recommendation then the medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication). • Documentation provided of results of genetic testing where required per drug package insert. • Documentation provided of results of all required laboratory values and member specific information (e.g., weight, ALT/AST, creatinine kinase, etc.) when recommended/required per drug package insert. • The medication is being prescribed at a dose that is within FDA approved/NCCN guidelines. • For any medication where a biosimilar is available, when indicated, the member must have documented trial and failure, intolerance, inability to use, or contraindication to the biosimilar medication prior to the brand medication approval **OR** the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested. • For requests for IV medications: attestation medication is administered by a healthcare professional (Medi-Cal only). If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review
Last Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Injectable/Specialty Medications	
Medications	INJECTABLE/SPECIALTY MEDICATIONS WITH NO OTHER DRUG-SPECIFIC OR DIAGNOSIS-SPECIFIC CRITERIA *** The Oral and Injectable Oncology Medications Physician Administered Drug (PAD) medication request guideline will be applied to oncology drugs without drug or class specific criteria***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age for MCAL
Prescriber Restrictions	N/A
Coverage Duration	Up to a 12 month duration depending upon the diagnosis and usual treatment therapies
Maximum Billable Units	Variable
Other Criteria	**Initial Approval** 1. The request for the medication is for an FDA approved indication, and/or is used for a medical condition that is supported by the medical compendium (Micromedex, American Hospital Formulary Service, Drug Points, and Drug Package Insert) as defined in the Social Security Act 1927 and/or per recognized standard of care guidelines. 2. Prescribed dosing of medication is within FDA approved indications and/or is supported by the medical compendium as defined above and/or per recognized standard of care guidelines. 3. For any medication where a biosimilar is available, when indicated, the member must have documented trial and failure, intolerance, inability to use, or contraindication to the biosimilar medication prior to the brand medication approval **OR** the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested. 4. If all of the above conditions are met, the request will be approved for up to 12 months or as recommended per FDA approved indications and/or as defined by the medical compendium as defined above and/or per recognized standard of care guidelines; if all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review. **Reauthorization of Medication** 1. The prescribing physician has provided documentation as to the clinical benefits of the medication supporting continued treatment, **OR** the medication is being continued in accordance with the recommended time as defined by FDA drug package insert, and/or per recommendations of the medical compendium as described above, and/or per recognized standard of care guidelines. 2. Prescribed dosing of medication is within FDA approved indications or per supported by the medical compendium as defined above and/or per recognized standard of care guidelines. 3. For any medication where a biosimilar is available, when indicated, the member must have documented trial and failure, intolerance, inability to use,

	or contraindication to the biosimilar medication prior to the brand medication approval **OR** the currently available biosimilar product does not have the same appropriate use (per the references outlined in “Covered Uses”) as the reference biologic drug being requested. 4. If all of the above conditions are met, the request will be approved for up to 12 months or as recommended per FDA approved indications and/or as defined by medical compendium as defined above and/or per recognized standard of care guidelines; if all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Viltepso	
Medications	Viltepso (viltolarsen)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Concomitant use with another antisense oligonucleotide (e.g. Vyondys 53)
Required Clinical Information	See "other criteria"
Age Restrictions	Age ≤ 20 years Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber must be a neurologist, or a provider who specializes in the treatment of DMD
Coverage Duration	If the criteria are met, the initial request will be approved for up to a 6 month duration; reauthorization requests will be approved for up to 12 months.
Maximum Billable Units	Variable
Other Criteria	**Initial Authorization:** • Member has a confirmed diagnosis of Duchenne's Muscular Dystropy (DMD) and lab test was submitted confirming the mutation of dystrophin gene amenable to exon 53 skipping • Member is ambulatory • Member has stable pulmonary and cardiac function • Attestation of renal function monitoring is provided with request • Baseline dystrophin levels AND results of motor function tests are provided [e.g. 6-Minute Walk Test (6MWT), Time to Stand Test (TTSTAND), Time to Run/Walk Test (TTRW), North Star Ambulatory Assessment (NSAA), Time to Climb 4 Steps Test (TTCLIMB)] • Member must be on a stable corticosteroid regimen for at least 3 months • The request is for an FDA approved dose **Reauthorization:** • Documentation is provided that the member had an increase in dystrophin levels from baseline • Documentation is provided that the member had a positive clinical response (e.g. improvement, stabilization, or reduction of deterioration in 6MWT, TTSTAND, TTRW, NSAA, or TTCLIMB) • Member is ambulatory • Attestation of renal function monitoring is provided with request • The request is for an FDA approved dose If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last Review Date	~~12/2022~~12/2023

Alameda MRGs for Review Q4 2023 P&T CONSENT AGENDA

Recommendation:

- Add new medications Ngenla and Sogroya to policy

Growth Hormone	
Therapeutic Classes (AHFS)	Pituitary
Medications	Formulary, Prior Authorization Required **Omnitrope – preferred agent** Non-formulary: Genotropin, GenotropinMiniQuick Humatrope Norditropin FlexPro Nutropin AQ NuSpin Saizen, SaizenPrep Serostim Zomacton Skytrofa Ngenla Sogroya Any other newly marketed growth hormone product
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO), the American College of Obstetricians and Gynecologists (ACOG), or the American Academy of Pediatrics (AAP) standard of care guidelines.
Exclusion Criteria	Treatment of idiopathic short stature (ISS)-not a covered benefit and will not be approved
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is an endocrinologist or specialist in diagnosis being treated
Coverage Duration	**Initial Approval** CO-GHD, CKD, AO-GHD, Genetic causes: 12 months HIV/AIDS-wasting syndrome: 3 months **Later Approvals** CO-GHD, CKD, AO-GHD, Genetic causes: 12 months HIV/AIDS-wasting syndrome: 3 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	**NOTE: Please defer medication request form to plan as a pass through** **If request is not for Omnitrope, documentation of medical reason, intolerance, inability, or contraindication to use Omnitrope must be provided.** **Initial Authorization** **Childhood-onset growth hormone deficiency (CO-GHD)** • If diagnosis is childhood-onset GH deficiency (CO-GHD) ○ And member is currently **pediatric**, **all** of the following ▪ IGF-1 and insulin-like growth factor binding protein-3 (IGFBP-3) deficiency (< 0 SD below reference range for age and gender)* with prescriber attestation of growth failure

Growth Hormone	
	▪ Provider attests that MRI or CT has been completed to exclude possibility of a pituitary tumor ▪ Provider attests that member's epiphyses are open ○ And member is currently **adult, <u>one</u>** of the following ▪ If diagnosis is idiopathic isolated GHD, documentation was provided that indicates GH therapy is still medically necessary (IGF-1 retesting during the transition period after a minimum 1 month of therapy discontinuation reveals continued GH deficiency) ▪ Diagnosis is GHD associated with multiple (≥3) pituitary hormone deficiencies (MPHD), genetic defect affecting the HPA axes, or member with hypothalamic pituitary structural brain defect **<u>Growth failure due to chronic renal insufficiency (CRI)/ Chronic kidney disease (CKD):</u>** ▪ Documentation of either pretreatment height is < -1.88 standard deviations (SD) below the mean for age or a height velocity–for-age < 3rd percentile that persists beyond 3 months • Provider attests that the member's epiphysis are open **<u>Short stature associated with Prader-Willi Syndrome, Noonan Syndrome, Turner Syndrome, short stature homeobox-containing gene (SHOX) mutation, or other underlying genetic cause</u>** ▪ Documentation of confirmatory genetic test **<u>Adult-onset growth hormone deficiency (AO-GHD)</u>** • If the diagnosis is adult-onset GH deficiency (AO-GHD), documentation of **<u>one</u>** of the following: ○ Insulin Growth Factor (IGF-1) deficiency (< -2 SD below reference range for age and gender)* and multiple (≥3) pituitary hormone deficiencies (MPHD) ○ Evidence of genetic defects affecting the hypothalamic pituitary axes (HPA) (e.g. pituitary disease) ○ Evidence of hypothalamic pituitary structural brain defects (e.g. hypothalamic disease) ○ Positive results of GH stimulatory test (e.g. insulin tolerance test [ITT], glucagon, or macimorelin) **<u>HIV/AIDS-wasting syndrome (Serostim)</u>** • Member is on antiviral therapy • 10% unintentional weight loss over 12 months • Documentation of inadequate response to previous therapy including exercise training, nutritional supplements, appetite stimulants or steroid hormones such as megestrol acetate. **<u>Reauthorization</u>** • Documentation of diagnosis [Note: Idiopathic Short Stature (ISS) is not a covered benefit] • Documented IGF-1 levels do not exceed upper limit of normal (ULN) (> 2 SD above reference range for age and gender)*, or if the IGF-1 levels do not exceed ULN, the dose has been reduced • In CO-GHD, growth response (as demonstrated by length/height and calculated height velocity within previous 6 months).

Growth Hormone	
	• For HIV/AIDs wasting syndrome: documented clinical response including increase in muscle mass and weight *IGF-1 levels are highly age and gender specific. In the event the form provides a value and not the corresponding reference range, refer to published reference ranges for interpretation.
Criteria Statement	• Growth hormone other than Omnitrope is reserved for members who have used (or cannot/should not use) Omnitrope. • For childhood-onset growth deficiency where the member is currently pediatric, growth hormone is reserved for members with growth failure and the epiphysis are open. • For childhood-onset growth deficiency where the member is currently an adult, growth hormone is reserved for members where growth hormone is still medically necessary. • For growth failure due to chronic renal insufficiency, growth hormone is reserved for members with height at least -1.88 standard deviations (SD) below the normal for age and or a height velocity–for-age less than the 3rd percentile that persists beyond 3 months and epiphysis are open. • For short stature in Turner Syndrome, Prader-Willi Syndrome, Noonan Syndrome, short stature homeobox-containing gene (SHOX) mutation, or other underlying genetic cause growth hormone is reserved for members with a confirmatory genetic test. • For adult-onset growth hormone deficiency, growth hormone is reserved for members with pituitary disease and positive results of a growth hormone stimulation test. • For HIV/AIDS wasting syndrome, growth hormone is reserved for members using antiretroviral therapy and have lost at least 10% of initial weight over 12 months and have used (or cannot/should not use) exercise training, nutritional supplements, appetite stimulants or steroid hormones such as megestrol acetate.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Corticotropin	
Therapeutic Classes (AHFS)	Other miscellaneous therapeutic agents
Medications	Formulary, PA required Preferred: Cortrophin (corticotropin) Non-Preferred: Acthar Gel (corticotropin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	**Check AAH active CCS cases for members < 21 years of age**
Prescriber Restrictions	Diagnosis by a neurologist or a specialist in the condition they are treating
Coverage Duration	**Initial Approval** 4 weeks **Later Approval** 4 weeks If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	**Multiple Sclerosis:** • Documentation was submitted that the member is having an acute attack, with neurologic symptoms and increased disability or impairments in vision, strength or cerebellar function, and has failed therapy with IV methylprednisolone, or a medical reason has been submitted why member is unable to use IV methylprednisolone. • If the request is for a non-preferred product, trial and failure of, contraindication to or medical reason for not using the preferred product is required. **All Other FDA Approved Conditions and Indications:** • Documented trial and failure of IV AND oral corticosteroids, or documented medical reason for why the member cannot use these therapies for treatment **AND** • Documentation was provided that ALL other standard therapies have been used to treat the member's condition as described in medical compendia (Micromedex, AHFS, Drug Points, and package insert) as defined in the Social Security Act and/or per recognized standard of care guidelines OR there is a documented medical reason (i.e. medical intolerance, treatment failure, etc.) for why all other standard therapies could not be used to treat the member's condition. **AND** • Prescriber is a specialist in the condition they are treating. • If the request is for a non-preferred product, trial and failure of, contraindication to or medical reason for not using the preferred product is required **Appeals/Reconsiderations:** • Requests for appeals/reconsiderations will be sent out for independent medical review.
Criteria Statement	Cortrophin (corticotropin) is reserved for members with a diagnosis of an acute attack of multiple sclerosis who have used (or cannot/should not use) IV methylprednisolone

	Acthar is reserved for members with a diagnosis of an acute attack of multiple sclerosis who have used (or cannot/should not use) IV methylprednisolone AND Cortrophin.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Testosterone Agents	
Therapeutic Classes (AHFS)	Androgens
Medications	<u>Formulary (first-line)</u> • Testosterone cypionate 100mg/mL (QL #10 ml/30 days), 200mg/mL intramuscular oil (QL #5 ml/30 days) • Testosterone (Vogelxo) 1% gel pump (QL #300gm/30 days) • Testosterone (Androgel) 1.62% gel pump (QL #150gm/30 days) <u>Formulary, PA required (second-line)</u> • Testosterone (Androgel) 1% 50 mg packets • Testosterone (Androgel) 1% 25 mg packets • Testosterone (Testim) 1% gel tube • Testosterone (Axiron) 30mg/1.5ml solution pump • Testosterone enanthate 200mg/mL intramuscular oil (QL #5 ml/30 days) <u>Non-formulary</u> • Testosterone (Fortesta) 2% gel pump • Testosterone (Androgel) 1.62% gel packets • Androderm (testosterone transdermal patch) 2mg/24 hours, 4mg/24 hours • Aveed 750mg/3mL vial • Testopel pellet implant • Testosterone implant pellet • Methyltestosterone (Testred) oral capsules • Methitest (methyltestosterone) oral tablets • Testone CIK (testosterone cypionate) intramuscular injection kit • Natesto (testosterone) nasal gel pump • Xyosted (testosterone enanthate) subcutaneous auto-injector • Jatenzo (testosterone undecanoate) oral capsules • Tlando (testosterone undecanoate) oral capsules • Kyzatrex (testosterone undecanoate) oral capsules Any other newly marketed agents in this class *Requests for greater than indicated Quantity Limits will be reviewed on a case by case basis
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	See "**PA Review Criteria**" below
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	See "**PA Review Criteria**" below
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** If all conditions are met, the request will be approved for up to 3 months. If all criteria are not met, the request is referred to Clinical Reviewer for medical necessity review. **Later Approvals** If all conditions are met, the request will be approved for up to 12 months. If all criteria are not met, the request is referred to Clinical Reviewer for medical necessity review.

Testosterone Agents	

PA Review Criteria	*For GID/gender dysphoria coverage, please refer to the Gender Dysphoria medication guidelines for age less than 21 or greater than or equal to 21 years old.*
	
	INITIAL AUTHORIZATION CRITERIA:
	• Formulary, PA required (second-line) agents are approved if:
	  ○ Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired)
	  ○ Male member
	  ○ Documented testosterone level(s) below 300ng/dL(9.8-10.4 nmol/l) on two separate occasions with levels drawn before 10:00 am
	  ○ Documented trial and failure, contraindication, or intolerance to one formulary first line injectable testosterone AND one formulary first line topical testosterone
	• Non-formulary testosterone products are approved if:
	  ○ Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired)
	  ○ Male member
	  ○ Documented testosterone level(s) below 300ng/dL(9.8-10.4 nmol/l) on two separate occasions with levels drawn before 10:00 am
	  ○ Documented trial and failure, contraindication, or intolerance to one formulary first line injectable testosterone AND one formulary first line topical testosterone AND at least one formulary, PA required (second-line) agent
	REAUTHORIZATION CRITERIA
	• Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired).
	
	<u>For requests over the quantity limit:</u>
	• The member must have a documented treatment failure with the drug prescribed at the health plan's quantity limit **OR** the member requires a dose within prescribing guidelines that exceeds the plan's quantity limit. **AND**
	• The provider has submitted a medical reason why the plan's quantity limit will be inadequate based on the member's condition and treatment history. **AND**
	• The dose requested is supported by the Medical Compendia or current treatment guidelines.

Criteria Statement	(Formulary, PA required (second-line) medications) <INSERT: testosterone packets/tube/solution pump or testosterone enanthate> are reserved for members who have previously used (or cannot/should not take) testosterone cypionate injection AND testosterone (Vogelxo) 1% gel pump or testosterone (Androgel) 1.62% gel pump. Non-formulary testosterone products are reserved for members who have used (or cannot/should not use) testosterone cypionate AND testosterone (Vogelxo) 1% gel pump or testosterone (Androgel) 1.62% gel pump AND testosterone 1% gel packets, tube, or testosterone 30mg/1.5ml solution pump or testosterone enanthate 200mg/mL intramuscular oil. Requests for quantities over the quantity or fill limit are reserved for members who have a documented medical need for quantities in excess of the limits.
Last P&T Review Date	~~12/2022~~<u>12/2023</u>

Recommendation:

- Minor wording update

Self-administered Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)	
Therapeutic Classes (AHFS)	Immunomodulatory agents
Medications	**Preferred:** **glatiramer acetate (COPAXONE)** **dimethyl fumarate (TECFIDERA)** **Non-preferred:** **GILENYA (fingolimod)** **MAYZENT (siponimod)** **AUBAGIO (teriflunomide)** **Vumerity (diroximel fumarate)** **AVONEX, REBIF (Interferon beta-1a)** **BETASERON, EXTAVIA (Interferon beta-1b)** **COPAXONE (glatiramer acetate)** **glatiramer acetate (GLATOPA)** **PLEGRIDY (Peginterferon beta-1a)** **MAVENCLAD (cladribine)** **ZEPOSIA (ozanimod)** **PONVORY (ponesimod)** **BAFIERTAM (monomethyl fumarate)** **KESIMPTA (ofatumumab)** **Any other newly marketed self-administrable DMT for MS indicated for the listed diagnoses**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Members with primary progressive MS (PPMS) Mavenclad • Clinically Isolated Syndrome (CIS)
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Member must be age appropriate per prescribing information (PI) **NOTE: Check AAH active CCS cases for members < 21 years of age**
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	**Initial Approval** — If all of the criteria are met, the request will be approved for 12 months for all agents except Mavenclad (cladribine). If all of the criteria for Mavenclad (cladribine) are met, the request will be approved for 1 course at a time with a lifetime maximum of 2 yearly treatment courses [1 course = (1 cycle per 30 days) two times]. **Later Approval** — 12 months: If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	**Initial Authorization** • For all requests, the medication is being prescribed at a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature. Clinically Isolated Syndrome (CIS) • Diagnosis of CIS

	• If the request is for glatiramer or dimethyl fumarate (Tecfidera) approve. • If the request is for a non-preferred agent, the member must have a documented trial of BOTH preferred agents or have a documented medical reason (e.g. contraindication, intolerance, hypersensitivity, etc.) for not utilizing both of these therapies (exception Gilenya, see bullet below) **AND** o If the request is for Gilenya (fingolimod), documentation of the following ▪ Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination ▪ If the request if for Gilenya (fingolimod) and the member has "highly active" MS, approve <u>WITHOUT</u> requiring trial and failure of both preferred agents o If the request is for Mayzent (siponimod), documentation of the following ▪ Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination ▪ Results of CYP2C9 genotyping AND • Member does not have CYP2C9 *3/*3 (**CONTRAINDICATED)** • If member has CYP2C9 *1/*3 or *2/*3, dose does not exceed 1 mg daily o If the request is for Ponvory (ponesimod) or Zeposia (ozanimod), Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination o If the request is for Kesimpta (ofatumumab), documentation that immunizations are up-to-date. <u>Relapsing Remitting MS (RRMS) and Secondary Progressive MS (SPMS)</u> • Diagnosis of RRMS or SPMS • If the request is for glatiramer or dimethyl fumarate (Tecfidera) approve • If the request is for a non-preferred agent, then the member must have a documented trial of at BOTH preferred agents, or have a documented medical reason (e.g. contraindication, intolerance, hypersensitivity, etc.) for not utilizing both of these therapies (exception Gilenya, see bullet below) **AND** o If the request is for Gilenya (fingolimod), documentation of the following ▪ Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination ▪ If the request if for Gilenya (fingolimod) and the member has "highly active" MS approve <u>WITHOUT</u> requiring trial and failure of both preferred agents o If the request is for Mayzent (siponimod), documentation of the following ▪ Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination ▪ Results of CYP2C9 genotyping AND • Member does not have CYP2C9 *3/*3 (**CONTRAINDICATED)** • If member has CYP2C9 *1/*3 or *2/*3, dose does not exceed 1 mg daily o If the request is for Mavenclad (cladribine), documentation of the following ▪ Member's current weight

	▪ Results of VZV antibody testing and, if negative, documentation of VZV vaccination ▪ If the member has not tried at least one of the preferred therapies listed above but has a documented medical reason for not utilizing these therapies, the member has tried and failed at least one other DMT for MS ○ If the request is for Ponvory (ponesimod) or Zeposia (ozanimod), Healthcare Provider (HCP)-confirmed history of chickenpox, results of varicella zoster virus (VZV) antibody testing and, if negative, documentation of VZV vaccination ○ If the request is for Kesimpta (ofatumumab), documentation that immunizations are up-to-date. **Reauthorization** CIS • The medication is being prescribed at a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature • Documentation was provided that the prescriber has reviewed the risks and benefits of continuing DMT versus stopping. RRMS and SPMS • The medication is being prescribed at a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature • Documentation was provided that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit). AND • If the request is for Mavenclad (cladribine) ○ Member's current weight ○ ****NO MORE THAN 2 COURSES IN TOTAL WILL BE APPROVED.**** **Continuation of Therapy/Grandfathering Provision:** Members with history (within the past 90 days or past 12 months for Mavenclad [cladribine]) of a non-preferred product are not required to try a preferred product prior to receiving the non-preferred product.
Criteria Statement	Dimethyl fumarate (Tecfidera) and glatiramer acetate (Copaxone) are the preferred agents for multiple sclerosis, dependent on the specific sub-type of the disease. Non-preferred agents are reserved for members who have used (or cannot/should not use) the preferred agents.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Remove duplicate medication listing

Fentanyl Citrate	
Therapeutic Classes (AHFS)	Opiate agonists
Medications	**Non-formulary and require prior authorization:** **Fentanyl citrate (Actiq)** lozenge -PREFERRED ~~**Fentora (fentanyl citrate)** buccal tablet~~ **Fentanyl citrate** (**Fentora**) buccal tablet **Lazanda (fentanyl citrate)** nasal spray pump **Subsys (fentanyl citrate)** sublingual spray **Any other short-acting oral/buccal/sublingual/nasal fentanyl formulation**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, hospice/palliative care physician, hematologist, or attestation that the requesting prescriber is working in consultation with one of the aforementioned specialty types.
Coverage Duration	**Initial Approval** 6 months not to exceed #120 per 30 days; Lazanda is limited to 15 bottles per 30 days Subsys is limited to 4 boxes per 30 days **Later Approvals** 6 months not to exceed #120 per 30 days; Lazanda is limited to 15 bottles per 30 days Subsys is limited to 4 boxes per 30 days If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	****All requests for narcotics must be reviewed by a clinical pharmacist.**** **Authorization for Fentanyl Citrate:** • A diagnosis of cancer pain AND • Member is on a maintenance dose of an around-the-clock controlled release pain medication consisting of daily doses of at least morphine 60 mg orally or daily use of an equianalgesic dose of another opioid for a week or longer [e.g. sustained relief morphine, oxycodone ER, fentanyl transdermal patches, morphine ER capsule (Kadian or Avinza)]. AND • Member is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrolled nausea/vomiting OR documentation of trial and failure of at least 2 of the following immediate-release oral pain medications: morphine sulfate, oxycodone/acetaminophen, oxycodone immediate release, hydrocodone/acetaminophen, and hydromorphone. • For requests for (fentanyl citrate) Fentora, Fentora, Subsys, and Lazanda, all criteria listed above must be met AND documentation required of trial and failure, intolerance, contraindication to fentanyl citrate (Actiq) lozenges
Criteria Statement	Fentanyl citrate (Actiq) lozenges are reserved for members with cancer pain who are on maintenance doses of controlled release opioids and who are unable to swallow or has used (or cannot/should not use) at least 2 of the following immediate-release oral pain medications: morphine sulfate, oxycodone/acetaminophen, oxycodone immediate release, hydrocodone/acetaminophen, and hydromorphone.

	(Fentanyl citrate) Fentora, Fentora, Subsys, or Lazanda are reserved for members with cancer pain who are on maintenance doses of controlled release opioids and member is unable to swallow or has used (or cannot/should not use) at least 2 of the following immediate-release oral pain medications: morphine sulfate, oxycodone/acetaminophen, oxycodone immediate release, hydrocodone/acetaminophen, and hydromorphone AND fentanyl citrate (Actiq) lozenges.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Update product listings to align with brand/ generic availability

Proton Pump Inhibitors (PPIs)	
Therapeutic Classes (AHFS)	Proton Pump Inhibitors
Medications	Formulary Omeprazole (Prilosec) capsule Pantoprazole (Protonix) tablet Lansoprazole (Prevacid) DR capsule Formulary, step therapy required Rabeprazole (Aciphex) tablet Esomeprazole (Nexium) capsule Formulary, PA required Dexlansoprazole (Dexilant) capsule Non-Formulary Omeprazole tablet and capsule (Prilosec OTC) Omeprazole/sodium bicarbonate (Zegerid) capsules and packets Lansoprazole (Prevacid) orally disintegrating tablets Esomeprazole (Nexium 24 HR) tablet Nexium DR (esomeprazole) oral granules packet Rabeprazole (Aciphex) sprinkle capsules Pantoprazole (Protonix) packet for oral suspension Prilosec packet for oral suspension Any other non-formulary proton pump inhibitor medication or dosage formulation
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Reauthorization** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	Criteria for approval: Rabeprazole tablets or esomeprazole capsules are approved when the following criteria is met: • Documentation of a trial and failure, or intolerance to omeprazole 40mg capsules AND pantoprazole 40 mg or lansoprazole DR capsule Dexlansoprazole (Dexilant) and non-formulary medications are approved when the following criteria are met: • Documentation of a trial and failure, or intolerance to at least 4 of the following formulary alternatives: omeprazole capsule, pantoprazole tablet, lansoprazole DR capsule, as first line; esomeprazole capsule or rabeprazole tablet as second line
Criteria Statement	Rabeprazole tablets or esomeprazole capsules are reserved for members who have used (or cannot/should not use) omeprazole 40 mg capsules AND pantoprazole 40 mg or lansoprazole DR capsules.

Proton Pump Inhibitors (PPIs)	
	Dexlansoprazole (Dexilant) and non-formulary proton pump inhibitors are reserved for members who have used (or cannot/should not use) at least 4 of the following formulary alternatives: omeprazole capsule, pantoprazole tablet, lansoprazole DR capsule, as first line; esomeprazole tablet DR or rabeprazole tablet as second line.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Gattex (teduglutide)	
Therapeutic Classes (AHFS)	GI DRUGS, MISCELLANEOUS
Medications	Gattex (teduglutide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 month duration with a quantity limit of 1 kit per 30 days **Later Approvals** 12 month duration with a quantity limit of 1 kit per 30 days If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	CRITERIA FOR AUTHORIZATION • Diagnosis of Short Bowel Syndrome (SBS) AND • Dependent on intravenous parenteral nutrition, defined as requiring parenteral nutrition at least three times per week.
Criteria Statement	Gattex is reserved for members with short bowel syndrome and who are dependent on intravenous parenteral nutrition at least 3 times a week.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Butorphanol (Stadol NS)	
Therapeutic Classes (AHFS)	Opiate, partial agonists
Medications	Butorphanol (Stadol NS) 10 mg/ml nasal spray
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Pain specialist: pain management, neurologist, headache/migraine specialist
Coverage Duration	**Initial Approval** 3 months (quantity limit of 1 bottle/30 days) **Later Approvals** 6 months (quantity limit of 1 bottle/30 days) If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	****All requests for narcotics must be reviewed by a clinical pharmacist.**** **INITIAL AUTHORIZATION FOR DIAGNOSIS OF PAIN:** 1. Diagnosis of pain. 2. Documented trial and failure with therapeutic doses or intolerance to at least three oral narcotic medications including: oxycodone, oxycodone/acetaminophen, hydromorphone, hydrocodone/acetaminophen, acetaminophen/codeine, and morphine sulfate (first line therapies) **INITIAL AUTHORIZATION FOR DIAGNOSIS OF PAIN DUE TO MIGRAINE HEADACHE** 1. Diagnosis of pain from migraine headache 2. Documented trial with therapeutic doses of at least one recommended migraine preventative therapy (i.e., topiramate, propranolol, timolol, divalproex sodium, amitriptyline, nortriptyline, Emgality, or verapamil) 3. Documented trial and failure with therapeutic doses or intolerance to at least one triptan (unless contraindicated). **REAUTHORIZATION FOR DIAGNOSIS OF PAIN AND PAIN DUE TO MIGRAINE HEADACHE** 1. Documentation submitted supporting re-evaluation of member OR medical necessity of continued use of medication
Criteria Statement	Butorphanol is reserved for members with a diagnosis of pain who have used (or cannot/should not use) at least three oral narcotic medications including: oxycodone, oxycodone/acetaminophen, hydromorphone, hydrocodone/acetaminophen, acetaminophen/codeine, and morphine sulfate. Butorphanol is reserved for members with diagnosis of migraine headache pain and who have used (or cannot/should not use) at least one recommended migraine preventative therapy (topiramate, propranolol, timolol, divalproex sodium, amitriptyline, nortriptyline, Emgality, or verapamil) and at least one triptan.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Step Therapy Exception	
Therapeutic Classes (AHFS)	N/A
Medications	Drugs on the Alameda Alliance's formulary with a step therapy restriction which do not meet step therapy requirements
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	• The provider has demonstrated knowledge of step therapy requirements. AND • The provider verbally or in writing has submitted a medical reason why required step therapy drug(s) would be ineffective or have the potential to cause harm or deterioration of the member's condition. OR • The provider has submitted a medical reason why the requested drug would be superior to the required prerequisite trial(s) with formulary drug(s).
Criteria Statement	N/A
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Prior Authorization Exception	
Therapeutic Classes (AHFS)	N/A
Medications	Requests for exception to the drug's prior authorization criteria requirements
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert.
Exclusion Criteria	See "PA Review Criteria"
Required Clinical Information	See "PA Review Criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If criteria is not met, request will be sent to a Medical Director/clinical reviewer for medical necessity review.
PA Review Criteria	• The provider either verbally or in writing has submitted a medical or member specific reason why prior authorization criteria all or in part is not applicable to the member. ○ Medical reasons may include but are not limited to: ▪ Criteria requirements are not applicable to the member based on the uniqueness of the member's condition or other physical characteristics of the member's condition. OR ○ Member specific reasons may include but are not limited to: ▪ Psychiatric, intellectual, physical, cultural, and/or linguistic characteristics of the member which may inhibit the provider from obtaining all necessary prior authorization criteria requirements.
Criteria Statement	N/A
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Diclofenac sodium (Solaraze) 3% gel	
Therapeutic Classes (AHFS)	Antineoplastic Agents
Medications	Formulary, PA required Diclofenac sodium (Solaraze) 3% gel
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist
Coverage Duration	**Initial/Re-Approval** If all conditions are met, the request will be approved for up to 3 months. If all criteria are not met, the request is referred to Clinical Reviewer for medical necessity review.
PA Review Criteria	Criteria for approval • Diagnosis of actinic keratosis (AK) • Documented trial and failure of one formulary alternative [i.e. fluorouracil (Efudex) cream or imiquimod (Aldara) cream]
Criteria Statement	Diclofenac sodium 3% gel is reserved for members who have actinic keratosis and have used (or cannot/should not use) one formulary alternative such as fluorouracil (Efudex) or Imiquimod (Aldara) creams.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Hepatitis B Drugs		
Therapeutic Classes (AHFS)	Various	
Medications	Formulary Tenofovir disoproxil fumarate (Viread) 300 mg tablet Formulary - PA required Entecavir (Baraclude) 0.5, 1 mg tablets PREFERRED Baraclude (entecavir) 0.05 mg/ml solution Adefovir (Hepsera) 10 mg tablet Lamivudine (Epivir HBV) 100 mg tablet Lamivudine (Epivir HBV) 25 mg/5 ml solution Viread 150mg, 200mg, 250mg tablet Vemlidy (tenofovir alafenamide fumarate) 25 mg tablet Non-formulary Viread (Tenofovir disoproxil fumarate) 40mg/gm oral powder **Any other newly marketed agent**	
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.	
Exclusion Criteria	N/A	
Required Clinical Information	See "**PA Review Criteria**" below	
Age Restrictions	Check AAH active CCS cases for members < 21 years of age	
Prescriber Restrictions	N/A	
Coverage Duration	**Initial Approval**	For pregnant patients taking prophylaxis therapy for reduction of perinatal transmission of HBV: 6 months All other INITIAL requests: 12 months: Requests can be approved for up to a 90 day supply
	Later Approvals	For RENEWAL requests for patients undergoing chemotherapy: HBV prophylactic treatment is only approved for up to an additional 12 months upon completion of chemotherapy. RENEWAL requests will not be considered for perinatal prophylaxis after 3 months postpartum All other RENEWAL requests:12 months Requests can be approved for up to a 90 day supply Partial approvals - For situations where lab values required for later approvals/ renewals are missing either in full or in part should be granted for 3 months. *If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	**INITIAL CRITERIA for adult population:** • Diagnosis of Hepatitis B; AND	

	• Medication is being prescribed at an appropriate FDA approved dose (for age and weight); AND • Request is for entecavir (Baraclude) tablet OR • Requests for Vemlidy require trial and failure of, intolerance to, or inability to use entecavir (Baraclude) tablet AND • **For Immune-Active chronic hepatitis B (CHB)**: Elevation of ALT ≥2 ULN (above 50 U/L for females or 66 U/L for males) OR evidence of significant histological disease (significant inflammation and/or fibrosis); AND A) Elevated HBV DNA ≥ 2000 IU/mL (HBeAg negative); OR B) Elevated HBV DNA > 20,000 IU/mL (HBeAg positive). • **For Decompensated Cirrhosis:** Presence of decompensated cirrhosis and detectable serum HBV DNA. • **For Compensated Cirrhosis:** Presence of elevated HBV DNA ≥ 2000 IU/mL • **Prophylaxis for Transplant Recipients with Hepatitis B:** A) Patient is HBsAg-positive and undergoing liver transplantation, regardless of HBeAg status or HBV-DNA level pre-transplant; OR B) Patient is HBsAg-negative and received a HBsAg-negative but anti-HBc–positive graft; OR C) Patient has received a HBsAg-positive (non-liver) organ transplant. • **Pregnant Women (for perinatal transmission prophylaxis only; patient does not meet other eligibility categories):** A) Patient is HBsAg-positive pregnant women with an HBV DNA level >200,000 IU/mL; AND B) Patient is in the third trimester of pregnancy • **Undergoing Chemotherapy or Will Be Initiating Cytotoxic Chemotherapy**: A) Patient is HBsAg-positive, anti-HBc–positive regardless of baseline serum HBV DNA levels; OR B) Patient is HBsAg-negative, anti-HBc–positive; AND 1) Receiving anti-CD20 antibody therapy (e.g., rituximab); OR 2) Undergoing stem cell transplantation. • **Acute Symptomatic Hepatitis B** Patient has acute hepatitis B with acute liver failure OR has a protracted, severe course, as indicated by total bilirubin >3 mg/dL (or direct bilirubin >1.5 mg/dL), international normalized ratio >1.5, encephalopathy, or ascites. ***For adults, if request is for adefovir (Hepsera) or lamivudine (Epivir HBV), documentation of treatment failure or contraindication to entecavir (Baraclude) tablet AND tenofovir disoproxil fumarate (Viread) 300 mg tablet must be provided.**

	***If request is for oral solution/oral powder, medical justification for use (i.e. difficulty swallowing) must be provided.** **INITIAL CRITERIA for Treatment of CHB in children (ages 2 to <18 years):** • Diagnosis of Hepatitis B; AND • Medication is being prescribed at an appropriate FDA approved dose (for age and weight); AND • Request is for entecavir (Baraclude) tablet • Patient is HBeAg-positive with both: A) elevated ALT; AND B) measurable HBV-DNA levels ***For children, if request is for adefovir (Hepsera) or lamivudine (Epivir HBV), documentation of treatment failure or contraindication to entecavir (Baraclude) tablet or disoproxil fumarate (Viread) 300 mg tablet must be provided.** **For requests for Viread 150mg, 200mg, or 250mg tablet, documentation of weight required as rationale supporting why tenofovir disoproxil fumarate (Viread) 300 mg tablet cannot be used.** ***If request is for oral solution/oral powder, medical justification for use (i.e. difficulty swallowing) must be provided.** **RENEWAL CRITERIA** • Documented response to treatment shown by reduced HBV DNA levels. • If all other criteria are met but the necessary lab values have not been provided, a partial approval for 3 months may be granted. The partial approval should indicate what information is needed for ongoing approval.
Criteria Statement	N/A
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Blood Glucose Testing Supplies	
Therapeutic Classes (AHFS)	Diabetes mellitus
Medications	Formulary with quantity limits: Members over 21 years on a prenatal vitamin or insulin are allowed 200 strips/30 days, other members allowed 100 strips/30days. Members 0-21 years on a prenatal vitamin are allowed 200 strips/30 days. All other members 0-21, bill CCS **(Check AAH active CCS cases for members < 21 years of age)** FreeStyle InsuLinx Test Strips- 100ct FreeStyle InsuLinx Test Strips- 50ct FreeStyle Lite Test Strips- 100ct FreeStyle Lite Test Strips- 50ct FreeStyle Test Strips- 100ct FreeStyle Test Strips- 50ct Precision Xtra Test Strips- 100ct Precision Xtra Test Strips- 50ct Formulary, limited to 1 meter per 365 days FreeStyle Freedom Lite Meter FreeStyle InsuLinx Meter FreeStyle Lite Meter Precision Xtra Meter ALAMEDA ALLIANCE FOR HEALTH PREFERS USE OF PRECISION OR FREESTYLE BLOOD GLUCOSE TESTING PRODUCTS (MANUFACTURED BY ABBOTT).
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age for members who are not pregnant
Prescriber Restrictions	N/A
Coverage Duration	See "PA Review Criteria". If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	For requests for **Precision or Freestyle preferred test strips**, approve up to 200 strips/30 days for up to 12 months if: • Member is > 21 years of age AND insulin dependent (claims evidence for insulin or documentation from physician if new to plan) OR • Member is any age AND pregnant • For requests for a non-preferred product, documentation or inability to use preferred test strips must be provided. Please consider the preferred alternatives, Precision or Freestyle test strips (with quantity limits). For requests for **Precision or Freestyle preferred test strips**, approve up to a quantity of 100 strips/30 days for up to 12 months if: • Member is > 21 years of age AND no documentation of insulin-dependence or pregnancy • For requests for a non-preferred product, documentation or inability to use preferred test strips must be provided. Please consider the preferred alternatives, Precision or Freestyle test strips (with quantity limits).

Blood Glucose Testing Supplies	
	If member is 0-21 years of age AND no documentation of pregnancy, do not approve. Member is covered by CCS. Check AAH active CCS cases for members < 21 years of age For requests for **Freestyle or Precision Blood Glucose meters**: • Member is allowed 1 meter per year • If request is for a non-preferred product, documentation or inability to use preferred test strips must be provided. Please consider the preferred alternative Freestyle or Precision meters (within fill limits).
Criteria Statement	Freestyle and Precision test strips over a quantity of 100 strips for 30 days are reserved for members who are over 21 years old and insulin dependent OR for members of any age who are pregnant.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Inhaled Corticosteroids/Long-Acting Beta-Agonists (ICS/LABA) Combinations	
Therapeutic Classes (AHFS)	Corticosteroids (respiratory tract)
Medications	**Formulary, PA required** Dulera (mometasone/formoterol) Advair HFA (fluticasone/salmeterol) fluticasone/vilanterol (Breo Ellipta) **Non-Formulary** AirDuo Digihaler (fluticasone/salmeterol) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	Asthma • Documentation of adequate trial and failure, intolerance or inability to use formulary inhaled corticosteroid/long-acting beta agonist combination fluticasone/salmeterol (AirDuo) OR fluticasone/salmeterol (Advair Diskus/ Wixela Inhub) OR budesonide/formoterol (Symbicort) COPD • Documentation of adequate trial and failure, intolerance or inability to use formulary inhaled corticosteroid/long-acting beta agonist combination fluticasone/salmeterol (Advair Diskus/ Wixela Inhub) OR budesonide/formoterol (Symbicort)
Criteria Statement	Dulera, fluticasone/vilanterol (Breo Ellipta), AirDuo Digihaler, or Advair HFA are reserved for members who have used (or cannot/should not use) fluticasone/salmeterol (AirDuo) OR fluticasone/salmeterol (Advair Diskus/ Wixela Inhub) OR budesonide/formoterol (Symbicort), dependent on diagnosis.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Agents for graft versus host disease	
Therapeutic Classes (AHFS)	OTHER MISCELLANEOUS THERAPEUTIC AGENTS, ANTINEOPLASTIC AGENTS
Medications	Rezurock (belumosudil) Imbruvica (ibrutinib) Jakafi (ruxolitinib phosphate) Orencia (abatacept)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for Healthcare Professional (USP DI), and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or other specialist in the treatment of hematopoietic cell transplants
Coverage Duration	Jakafi, Rezurock, and Imbruvica: If all of the conditions are met, the request will be approved for up to a 3 month duration for initial requests and up to a 6 month duration for renewal requests. Orencia: If all of the conditions are met, the request will be approved for 1 month duration (4 total treatments) If criteria is not met, request will be sent to a Medical Director/clinical reviewer for medical necessity review.
PA Review Criteria	****For oncological indications, please refer to the "Oral and Injectable Oncology Medications" policy**** **Initial Authorization:** • Imbruvica o Member has a diagnosis of chronic graft versus host disease o Member has tried and failed or cannot use a systemic corticosteroid or documentation is provided as to why a systemic corticosteroid cannot be used o The drug is prescribed at an FDA-approved dose • Jakafi o Member has a diagnosis of acute graft versus host disease or a diagnosis of chronic graft versus host disease o Member has tried and failed or cannot use a systemic corticosteroid or documentation is provided as to why a systemic corticosteroid cannot be used o The drug is prescribed at an FDA-approved dose • Rezurock o Member has a diagnosis of chronic graft versus-host disease o Member has tried and failed at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, calcineurin inhibitors, mycophenolate mofetil, ibrutinib, ruxolitinib), one of which must be a systemic corticosteroid, or documentation is provided as to why a systemic corticosteroid cannot be used o The drug is prescribed at an FDA-approved dose • Orencia

	○ Orencia is being requested for prophylaxis against acute graft versus host disease ○ Member will be undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor ○ Member will be receiving Orencia in combination with a calcineurin inhibitor (e.g., tacrolimus, cyclosporine) and methotrexate ○ Member will be receiving antiviral prophylactic treatment for Epstein-Barr virus reactivation and will continue for 6 months following HSCT ○ Attestation provider has considered prophylactic antivirals for cytomegalovirus (CMV) infection/reactivation during treatment and for 6 months following HSCT ○ The drug is prescribed at an FDA-approved dose **Re-Authorization:** • Documentation is provided that the member has achieved a clinical benefit from medication (e.g. symptom improvement, reduction in corticosteroid dose) • The drug is prescribed at an FDA-approved dose
Criteria Statement	Imbruvica is reserved for members with a diagnosis of chronic graft versus host disease who have used (or cannot /should not use) a systemic corticosteroid. Jakafi is reserved for members with a diagnosis of acute graft versus host disease or a diagnosis of chronic graft versus host disease who have used (or cannot/should not use) a systemic corticosteroid. Rezurock is reserved for members with a diagnosis of chronic graft versus-host disease who have used (or cannot /should not use) at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, calcineurin inhibitors, mycophenolate mofetil, ibrutinib, ruxolitinib), one of which must be a systemic corticosteroid. Orencia is reserved for members with a need for prophylaxis against acute graft versus host disease who will be undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor, using Orencia in combination with a calcineurin inhibitor (e.g., tacrolimus, cyclosporine) and methotrexate.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Ranolazine (Ranexa, Aspruzyo)	
Therapeutic Classes (AHFS)	CARDIAC DRUGS, MISCELLANEOUS
Medications	Ranolazine ER (Ranexa) Aspruzyo Sprinkle (ranolazine granules)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	CRITERIA FOR AUTHORIZATION Ranolazine ER (Ranexa): • Diagnosis of chronic angina pectoris AND • Documented trial and failure, contraindication, or intolerance to use a beta-blocker, calcium channel blocker AND long-acting nitrate. OR • Documentation member's blood pressure is too low to tolerate additional medications Aspruzyo Sprinkle (ranolazine) • All of the above criteria are met • Documented trial and failure, contraindication, or intolerance to ranolazine ER (Ranexa)
Criteria Statement	Ranolazine ER (Ranexa) is reserved for members who have used (or cannot/should not use) a beta-blocker, calcium channel blocker, and long-acting nitrate. Aspruzyo Sprinkle (ranolazine) is reserved for members who have used (or cannot/should not use) a beta-blocker, calcium channel blocker, and long-acting nitrate AND ranolazine ER (Ranexa).
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Injectable Methotrexate	
Therapeutic Classes (AHFS)	Antineoplastic agents
Medications	RediTrex (methotrexate) Rasuvo (methotrexate) Otrexup (methotrexate) Any other newly approved injectable methotrexate medication
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber is a dermatologist or rheumatologist.
Coverage Duration	**Initial/Re-Approval** If all conditions are met, the request will be approved for up to 12 months. If all criteria are not met, the request is referred to Clinical Reviewer for medical necessity review.

PA Review Criteria	Criteria for approval of RediTrex:
	• For diagnosis of severe, active polyarticular juvenile idiopathic arthritis, approve if:
	  ○ Documented trial and failure, intolerance, contraindication, or inability to use methotrexate tablet AND generic methotrexate injection solution
	• For diagnosis of severe, recalcitrant psoriasis, approve if:
	  ○ Documented trial and failure, intolerance, contraindication, or inability to use one of the following alternatives: topical corticosteroids AND topical vitamin D analogue (e.g., calcipotriene)
	  ○ Documented trial and failure, intolerance, contraindication, or inability to use methotrexate tablet AND generic methotrexate injection solution
	• For diagnosis of severe, active rheumatoid arthritis, approve if:
	  ○ Documented trial and failure, intolerance, contraindication, or inability to use methotrexate tablet AND generic methotrexate injection solution
	Criteria for approval of Rasuvo:
	• Criteria above for RediTrex must be met, per diagnosis AND
	• Documented trial and failure, intolerance, contraindication, or inability to use RediTrex
	
	Criteria for approval of Otrexup:
	• Criteria above for RediTrex must be met, per diagnosis AND
	• Documented trial and failure, intolerance, contraindication, or inability to use RediTrex AND Rasuvo

Criteria Statement	For members with juvenile idiopathic arthritis or severe rheumatoid arthritis, RediTrex is reserved for members who have used (or cannot/should not use) generic methotrexate tablet and injection. Additionally, Rasuvo is reserved for members who have used (or cannot/should not use) RediTrex and Otrexup is reserved for members who have used (or cannot/should not use) RediTrex AND Rasuvo.

	For members with severe psoriasis, RediTrex is reserved for members who have used (or cannot/should not use) topical corticosteroids AND topical vitamin D analogue (e.g., calcipotriene) AND methotrexate tablet AND methotrexate injection. Additionally, Rasuvo is reserved for members who have used (or cannot/should not use) RediTrex and Otrexup is reserved for members who have used (or cannot/should not use) RediTrex AND Rasuvo.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Temazepam (Restoril)	
Therapeutic Classes (AHFS)	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)
Medications	Temazepam (Restoril) 7.5, 22.5 mg
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See “other criteria”
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 6 months **Later Approvals** 12 months If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.

PA Review Criteria	**CRITERIA FOR AUTHORIZATION**
	• Request is for 7.5 mg or 22.5 mg:
	  ○ Diagnosis of insomnia.
	  ○ Documented trial and failure, intolerance, or inability to use 3 of the following: 1) temazepam 15mg or 30mg capsules, 2) zolpidem, 3) eszopiclone, 4) zaleplon for at least 2 weeks (14 days) of therapy each.

Criteria Statement	Temazepam 7.5 mg or 22.5 mg are reserved for members who have used (or cannot/should not use) three of the following medications: temazepam 15mg or 30mg, zolpidem, eszopiclone, or zaleplon for at least 2 weeks (14 days) of therapy each
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Janus Kinase Inhibitors for Nonsegmental Vitiligo	
Therapeutic Classes (AHFS)	SKIN AND MUCOUS MEMBRANE AGENTS, MISC.
Medications	Opzelura (ruxolitinib)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	> 12 years of age
Prescriber Restrictions	Dermatologist, immunologist, or specialist experienced in the treatment of vitiligo
Coverage Duration	**Initial Approval** 6 months **Later Approvals** 12 months If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	**Initial Authorization** ○ Diagnosis of nonsegmental vitiligo ○ Documentation of depigmented lesions including measurements and locations is provided ○ Prescriber attests that the total body vitiligo area (facial and nonfacial) being treated does not exceed 10% BSA ○ Trial and failure of, or intolerance to, ALL of the following: ○ Topical corticosteroids ○ Topical calcineurin inhibitors ○ Targeted phototherapy ○ Prescriber attests that the member will not concomitantly use therapeutic biologics, other Janus kinase inhibitors, potent immunosuppressants, or phototherapy for repigmentation purposes ○ Request is for an FDA-approved dose ****A MAXIMUM OF ONE 60 GRAM TUBE OF OPZELURA PER WEEK OR ONE 100 GRAM TUBE EVERY TWO WEEKS MAY BE APPROVED**** **Reauthorization** ○ Prescriber attests that the member has experienced a clinical benefit (e.g. reduction in size or quantity of or stabilization of existing depigmented lesions; absence of new depigmented lesions) ○ Request is for an FDA-approved dose
Criteria Statement	Opzelura is reserved for members with a diagnosis of nonsegmental vitiligo, with the total body vitiligo area (facial and nonfacial) being treated not exceeding 10% body surface area (BSA), who have used (or cannot/should not use) all of the following: topical corticosteroids, topical calcineurin inhibitors, and targeted phototherapy
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Endari	
Therapeutic Classes (AHFS)	Other Miscellaneous Therapeutic Agents
Medications	Non-formulary Endari (L-Glutamine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert.
Exclusion Criteria	N/A
Required Clinical Information	See "PA Review Criteria" below
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	**Initial/Later Approval** — **If all of the conditions are met, requests will be approved for a 12 months.** If criteria is not met, request will be sent to a Medical Director/clinical reviewer for medical necessity review.
PA Review Criteria	Initial: • Member has diagnosis of sickle cell disease • Documentation was provided that the member had 2 or more crises in the last 12 months • Documentation was provided the member has been on hydroxyurea at the maximum tolerated dose and was compliant within the last 6 months (or a medical reason was provided why member is unable to use hydroxyurea) • Request is for an FDA approved dose Reauthorization: • Prescriber attests member had reduction in number of sickle cell crises • Request is for an FDA approved dose
Criteria Statement	**Endari:** Endari is reserved for members who have unstable sickle cell disease and are taking the highest tolerated dose of hydroxyurea or cannot/should not take hydroxyurea.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Thalomid (thalidomide)	
Therapeutic Classes (AHFS)	IMMUNOMODULATORY AGENTS
Medications	Thalomid (thalidomide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribing physician is infectious disease specialist, oncologist, nephrologist, dermatologist, or hematologist
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	Thalomid is approved if: • Diagnosis of one of the following: ○ erythema nodosum leprosum ○ multiple myeloma ○ chronic graft-versus-host disease (GVHD) in hematopoietic stem cell transplant ○ AIDS-related aphthous stomatitis ○ Waldenstrom's macroglobunemia ○ Systemic light chain amyloidosis
Criteria Statement	Thalomid is reserved for members with erythema nodosum leprosum, multiple myeloma, chronic graft-versus-host disease (GVHD) in hematopoietic stem cell transplant, AIDS-related aphthous stomatitis, Waldenstrom's macroglobunemia, systemic light chain amyloidosis
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Topical Diclofenac	
Therapeutic Classes (AHFS)	Non-steroidal Anti-Inflammatory Agents
Medications	Formulary, Prior Authorization Required Diclofenac epolamine (Flector) 1.3% patch Diclofenac (Pennsaid) 2% pump Diclofenac (Pennsaid) 1.5% solution Non-Formulary Licart (diclofenac) 1.3% patch
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial/Re-auth** If all criteria are met, approve diclofenac (Pennsaid) 2% pump or diclofenac (Pennsaid) 1.5% solution for up to a 12 month duration or diclofenac (Flector) patch or Licart (diclofenac) patch for up to a 3 month duration; if all of the criteria are not met, the request is referred to a clinical reviewer for medical necessity review.
PA Review Criteria	Criteria for approval: • Diagnosis of osteoarthritis [diclofenac (Pennsaid) 1.5% topical solution] or acute pain [diclofenac (Flector) 1.3% patch] AND one of the following conditions are met: ○ Member is over 65 years ○ Member is currently taking oral anticoagulant ○ Documentation of trial and failure or contraindication to one formulary oral NSAID medication. AND ○ For diclofenac (Pennsaid) 1.5% topical solution, trial and failure or contraindication to use diclofenac (Voltaren) gel. OR ○ For diclofenac (Pennsaid) 2% pump, trial and failure or contraindication to use diclofenac (Voltaren) gel AND diclofenac (Pennsaid) 1.5% topical solution OR ○ For Licart (diclofenac) 1.3% patch, trial and failure or contraindication to use diclofenac epolamine (Flector) 1.3% patch
Criteria Statement	Diclofenac (Pennsaid) 1.5% solution is reserved for members with osteoarthritis who are either 65 years of age or currently using an oral anticoagulant and who have used (or cannot/should not use) one oral formulary NSAID AND diclofenac (Voltaren) gel. Diclofenac (Flector) patch is reserved for members with acute pain who are either 65 years of age, currently using an oral anticoagulant, or who have used (or cannot/should not use) one oral formulary NSAID. Diclofenac (Pennsaid) 2% pump is reserved for members with osteoarthritis who are either 65 years of age or currently using an oral anticoagulant and who have used (or cannot/should not use) one oral formulary NSAID AND who have used (or cannot/should not use) diclofenac (Voltaren) gel and diclofenac (Pennsaid) 1.5% topical solution. Licart (diclofenac) 1.3% patch is reserved for members with acute pain who are either 65 years of age or currently using an oral anticoagulant and who have used (or

	cannot/should not use) one oral formulary NSAID AND who have used (or cannot/should not use) diclofenac epolamine (Flector) 1.3% patch.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Otezla (apremilast) for Behcet Disease	
Therapeutic Classes (AHFS)	Disease-Modifying Antirheumatic Agents
Medications	Otezla (apremilast)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert.
Exclusion Criteria	Concurrent use with a biologic DMARD or targeted synthetic DMARD
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber is a rheumatologist or a dermatologist or is working in consultation with a rheumatologist or dermatologist
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer
PA Review Criteria	Criteria for initial authorization: • Drug is being requested at an FDA approved dose. • Documentation of clinical diagnosis of Behcet disease • Documentation of at least one active oral ulcer • Member is not concurrently taking a biologic DMARD (i.e. Orencia, Humira, Stelara, etc.) or a targeted synthetic DMARD (i.e. Olumiant, Xeljanz, etc.) • Documentation that the member has had (consistent with pharmacy claims data OR for new members to the health plan consistent with medical chart history) adequate trial and failure or intolerance to at least one formulary topical steroid and colchicine. Criteria for re-authorization: • Drug is being requested at an FDA approved dose. • Documentation that condition has improved or stabilized with therapy
Criteria Statement	Otezla (apremilast) is reserved for members who have at least one active oral ulcer associated with Behcet disease and have used (or cannot/should not use) at least one formulary topical steroid and colchicine.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Korlym (mifepristone)	
Therapeutic Classes (AHFS)	Cortisol receptor blocker
Medications	Non-formulary, PA required Korlym (mifepristone)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Pregnancy
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	**Initial Approval** 6 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	The following criteria must be met for initial requests: • Diagnosis of hyperglycemia secondary to endogenous Cushing's syndrome with type 2 diabetes mellitus (T2DM) or impaired glucose tolerance (IGT) • Drug is being requested at an FDA approved dose. • Member has failed pituitary surgery or is not a candidate for pituitary surgery • Documented trial and failure of insulin and at least 2 other conventional anti-hyperglycemic medications (ex. metformin, sulfonylurea, DPP-4 inhibitor, etc.) or a documented medical reason for not utilizing these medications. • For females of reproductive age: Must have documentation of a baseline negative pregnancy test within the previous 14 days The following criteria must be met for renewal requests: • Drug is being requested at an FDA approved dose. • Documentation of an improvement in or stabilization of glucose control (ex. reduction in fasting blood glucose, oral glucose tolerance test, or Hemoglobin A1c). • For females of reproductive age: Must have documentation of a recent negative pregnancy test within the previous 14 days
Criteria Statement	Korlym is reserved for members with hyperglycemia from Cushing's syndrome with type 2 diabetes or impaired glucose tolerance who have failed surgery or are not candidates for surgery. The member should have used (or cannot/should not use) other conventional anti-diabetic medications and female members must have a negative pregnancy test.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Rayaldee (calcifediol ER)	
Therapeutic Classes (AHFS)	Vitamin D Analog
Medications	Non-formulary, PA required Rayaldee (calcifediol ER)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber must be a nephrologist or endocrinologist (or working in consultation with a nephrologist or endocrinologist)
Coverage Duration	**Initial Approval** 6 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	The following criteria must be met for initial requests: • Drug is being requested at an FDA approved dose. • Treatment of secondary hyperparathyroidism associated with a diagnosis of stage 3 or 4 chronic kidney disease (CKD) and is not on dialysis • A serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL • Documented trial and failure, contraindication, or documented inability to use a preferred vitamin D analog (ex. calcitriol) The following criteria must be met for renewal requests: • Drug is being requested at an FDA approved dose. • Serum total 25-hydroxyvitamin D levels between 30 and 100 ng/mL • Intact parathyroid hormone (PTH) levels within the desired therapeutic range of 10-65 ng/L • Serum calcium (corrected for low albumin) within the normal range for member • Serum phosphorus below 5.5 mg/dL
Criteria Statement	For the treatment of secondary hyperparathyroidism associated with stage 3 or 4 chronic kidney disease (CKD), Rayaldee is reserved for members who have used (or cannot/should not use) a preferred vitamin D analog (ex. calcitriol). Members must also have a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dl. The request will not be approved for patients with a diagnosis of stage 5 chronic kidney disease or end-stage renal disease on dialysis.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Tetracycline Antibiotics	
Therapeutic Classes (AHFS)	Tetracycline antibiotics
Medications	<u>Formulary</u> Doxycycline monohydrate 50mg, 100mg capsule Doxycycline monohydrate 100mg tablet Tetracycline 250mg, 500mg capsule <u>Formulary, step therapy required</u> Minocycline 100mg capsule
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Minocycline ST and NF Tetracyclines Approval:** 6 months **Approval to Exceed QL:** 3 months If conditions are not met, the request will be sent to a clinical reviewer.

PA Review Criteria	**ALL medications in the tetracycline class are limited to a combined total of 180 days supply per 365 days**
	
	<u>Minocycline capsule step therapy criteria:</u>
	• Dose is appropriate per label or supported by compendia/standard of care guidelines, and is within posted quantity limits
	• Documentation of a trial and failure or intolerance to doxycycline required.
	OR
	• Documentation of culture and sensitivity data, showing minocycline is the only treatment option.
	
	<u>Non-formulary and formulary, prior authorization required tetracyclines</u>
	• Appropriate diagnosis/Indication for requested non-formulary or formulary, prior authorization required medication or meets off-label criteria below AND
	  ○ Off-label criteria:
	  ▪ No other formulary preferred medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
	  ▪ Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources OR
	  ▪ Requested use can be supported by at least two published peer reviewed clinical studies
	• Appropriate dose of medication based on age (i.e. pediatric and elderly populations) and indication AND
	• Documentation of a trial and failure or intolerance with 3 formulary preferred tetracyclines required

	OR • Documentation of culture and sensitivity data, showing the non-formulary/prior authorization required tetracycline is the only treatment option <u>Request for exceeding quantity limit of 180 days per 365 days</u> • The member must have a documented treatment failure with the drug prescribed at the health plan's quantity limit OR the member requires a dose within prescribing guidelines that exceeds the plan's quantity limit. AND • The provider has submitted a medical reason why the plan's quantity limit will be inadequate based on the member's condition and treatment history. AND • The dose requested is supported by the Medical Compendia or current treatment guidelines.
	Minocycline capsule is reserved for members who have used (or cannot/should not use) doxycycline. Medications in the tetracycline class that are non-formulary or formulary, prior authorization required are reserved for members who have used (or cannot/should not use) at least 3 formulary preferred tetracyclines. Medications in the tetracycline class prescribed in quantities over 180 days supply per 365 days are reserved for members who have used (or cannot/should not use) tetracyclines under the quantity limit, whose prescriber has submitted a reason why this is necessary.
Last P&T Review Date	~~12/2022~~<u>12/2023</u>

Recommendation:

- No changes

Budesonide Nebulization Solution (Pulmicort Respules)	
Therapeutic Classes (AHFS)	ORALLY INHALED PREPARATIONS (STEROIDS)
Medications	Budesonide nebulization solution (Pulmicort Respules)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See “other criteria”
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	○ Documentation as to why the member cannot use a preferred formulary corticosteroid via inhaler ○ Total daily dose should not exceed 2 mg. Doses beyond 2 mg/day should be reviewed for medical necessity.
Criteria Statement	Budesonide nebulization solution (Pulmicort Respules) are reserved for members who have used (or cannot/should not use) a preferred formulary corticosteroid via inhaler at doses that do not exceed 2mg per day.
Last P&T Review Date	12/2022

Recommendation:

- No changes

Ophthalmic Anti-Inflammatory Agents	
Therapeutic Classes (AHFS)	EENT Nonsteroidal and Corticosteroid anti-inflammatory agents
Medications	Prolensa (bromfenac) 0.07% Bromsite (bromfenac) 0.075% Ketorolac (Acular LS) 0.4% Acuvail (ketorolac) 0.45% Ilevro (nepafenac) 0.3% Nevanac (nepafenac) 0.1% Bromfenac 0.09% Difluprednate (Durezol) 0.05% (quantity limit)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial/Re-auth** If all criteria are met, approve for up to a 12 month duration with a quantity limit of 1 bottle; if all of the criteria are not met, the request is referred to a clinical reviewer for medical necessity review.
PA Review Criteria	CRITERIA FOR USE: • Documentation of trial and failure, intolerance, contraindication, or inability to use TWO preferred formulary alternatives: diclofenac 0.1%, flurbiprofen 0.03%, ketorolac 0.5% drops, prednisolone 1%, or dexamethasone 0.1% eye drops for at least 30 days each within the last 12 months. • If diagnosis is uveitis: Documentation of trial and failure, intolerance, contraindication, or inability to use both preferred formulary alternatives: prednisolone 1% AND dexamethasone 0.1% eye drops
Criteria Statement	Difluprednate (Durezol), Prolensa, Bromsite, ketorolac (Acular LS), Acuvail, Ilevro, Nevanac, and Bromfenac are reserved for members who have used (or cannot/should not use) TWO preferred formulary alternatives diclofenac 0.1%, flurbiprofen 0.03%, ketorolac 0.5% drops, prednisolone 1%, or dexamethasone 0.1% eye drops for at least 30 days within the last 12 months. For uveitis patients, difluprednate (Durezol) is reserved for members who have used (or cannot/should not use) preferred formulary alternatives prednisolone 1% AND dexamethasone 0.1% eye drops
Last P&T Review Date	~~9/2022~~12/2023

Recommendation:

- No changes

dalfampridine (Ampyra)	
Therapeutic Classes (AHFS)	Other miscellaneous therapeutic agents
Medications	Formulary, PA required **dalfampridine (Ampyra)**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	History of seizures. Moderate or severe renal impairment (creatinine clearance ≤ 50mL/minute)
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Patient must be 18 years of age or older. **NOTE: Check AAH active CCS cases for members < 21 years of age**
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	**Initial Approval** 6 months **Later Approval** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	**Initial Authorization:** • Baseline creatinine clearance (within 6 months of request) • Patient has diagnosis of multiple sclerosis (MS), patient is ambulatory (baseline 25 foot walk was submitted with request), AND patient has walking impairment • Documentation was submitted (consistent with pharmacy claims data, OR for new members to the health plan, consistent with chart notes) that patient is currently being treated for MS (e.g. immunomodulator, interferon, immunosuppressive), or documentation of a medical reason (intolerance, hypersensitivity) as to why patient is unable to use one of these agents to treat their medical condition • Drug is being requested at an FDA approved dose **Re-authorization:** • Documentation of improvement (above baseline) in 25 foot walk was submitted with request • Documentation was submitted patient is on MS treatment (e.g. immunomodulator, interferon, immunosuppressive), or documentation of a medical reason (intolerance, hypersensitivity) as to why patient is unable to use one of these agents to treat their medical condition • Drug is being requested at an FDA approved dose
Criteria Statement	**Dalfampridine (Ampyra)** is reserved for members who are ambulatory, have a walking impairment, and are using (or cannot/should not use) disease modifying oral or injectable treatment for multiple sclerosis.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- No changes

Oral and Injectable Oncology Medications	
Therapeutic Classes (AHFS)	Antineoplastics
Medications	Oral and Injectable Oncology Medications without medication specific criteria
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for Healthcare Professional (USP DI), and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	**Initial requests:** Prescriber must be an oncologist. **Reauthorization requests**: Prescriber must be an oncologist. An exception can be made if the prescriber is in consultation with an oncologist (see Coverage Duration section for approval duration for reauthorizations exceptions).
Coverage Duration	**Initial Approval (for new treatment or dose changes to existing treatment)**: 6 months duration with a day supply limit of up to a 15 day supply for the first fill (for medications that must be stored in the original container, a supply of up to 30 days is allowed). Subsequent fills have a day supply limit of up to 30 days **Later Approvals (with no dose change, given that at least 15 days of therapy are completed)**: Prescribed by an oncologist: 6 months with a day supply limit of up to 30 days Reauthorization exceptions: 1 month with a day supply limit of up to 30 days If criteria is not met, request will be sent to a Medical Director/clinical reviewer for medical necessity review.
PA Review Criteria	All of the following criteria must be met: • Requested indication must be supported by NCCN category 1 or 2A level of evidence. If the request is for a category 2B recommendation then the medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication). • Documentation provided of results of genetic testing where required per drug package insert. • Documentation provided of results of all required laboratory values and member specific information (e.g., weight, ALT/AST, creatinine kinase, etc.) when recommended/required per drug package insert. • The medication is being prescribed at a dose that is within FDA approved/NCCN guidelines. • For any medication where a biosimilar is available (Kanjinti, Zirabev etc), the member must have documented trial and failure, intolerance, inability to use, or contraindication to the biosimilar medication prior to the brand medication approval **OR** the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested.

	• Requests for abiraterone (Zytiga) 500mg tablets should be modified into two abiraterone acetate 250mg tablets. • Requests for Lenvima must be for the most appropriate package size based on the dose requested. Requests for Lenvima should be approved for only the correct daily dosage package size (i.e. for Lenvima 20mg daily, the Lenvima 20mg Daily Dose packaging must be used, and not two packages of Lenvima 10mg Daily Dose)
Criteria Statement	Oral and injectable oncology medications without specific criteria are reserved for indications supported by NCCN category 1 or 2A level of evidence.
Last P&T Review Date	~~12/2022~~12/2023

Alameda Alliance for Health (IHSS)

Q4 2023 INTERIM FORMULARY UPDATES

These changes have been made to the Alliance's formulary recently. The changes were necessary to enhance the formulary.

Medication	Formulary Change
Pradaxa Oral Capsule 150 MG	T2 F-QL (60/30)
Pradaxa Oral Capsule 75 MG	T2 F-QL (60/30)
Mycozyl (tolnaftate) AC External Cream 1 %	NF
Cosentyx Subcutaneous Solution Auto-injector 300 MG/2ML	T2 F-PA
Naloxone 4mg/0.1mL nasal spray OTC	T1 F
COMIRNATY (COVID-19 Vaccine, mRNA, 2023-2024 Formula)	T2 F
COMIRNATY (COVID-19 Vaccine, mRNA, 2023-2024 Formula)	T2 F
Spikevax COVID-19, mRNA, LNP-S, PF, 50 mcg/0.5 mL	T2 F
Spikevax COVID-19, mRNA, LNP-S, PF, 50 mcg/0.5 mL	T2 F
Arexvy Intramuscular Suspension Reconstituted 120 MCG/0.5ML	T2 F-QL (0.5ml per dose, 1 dose per lifetime)
Abrysvo Intramuscular Solution Reconstituted 120 MCG/0.5ML	T2 F-QL (0.5ml per dose, 1 dose per lifetime)
Lagevrio 200 mg capsule	T2 F-AL-QL (40 per 180 days) (18 years and older)
Paxlovid tablet 150/100 mg	T2 F-QL- QL (20 per 180 days) (12 years and older)
Paxlovid tablet 300/100mg	T2 F-QL- QL (30 per 180 days) (12 years and older)

Alameda Alliance for Health Q4 2023 PAD Updates

These changes have been made to the Alliance Physician Administered Drug (PAD) recently.
This list includes summary of changes and is not comprehensive.

HCPCS Code	HCPCS Description Name	Action
J2326	NUSINERSEN	Add PA Requirement
J1301	EDARAVONE	Add PA Requirement
Q5126	BEVACIZUMAB-MALY (ALYMSYS) BIOSIMILAR	Add PA Requirement
Q5127	PEGFILGRASTIM-FPGK (STIMUFEND) BIOSIMILAR	Add PA Requirement
Q5128	RANIBIZUMAB-EQRN (CIMERLI), BIOSIMILAR	Add PA Requirement
Q5129	BEVACIZUMAB-ADCD (VEGZELMA), BIOSIMILAR	Add PA Requirement
Q5130	PEGFILGRASTIM-PBBK (FYLNETRA), BIOSIMILAR	Add PA Requirement
J3399	ONASEMNOGENE ABEPAR (ZOLGENSMA)	Add PA Requirement
J9029	NADOFARAGENE FIRADENOVEC-VNCG	Add PA Requirement
J9259	PACLITAXEL	Add PA Requirement
J9322, J9323	PEMETREXED	Add PA Requirement
J9380	TECLISTAMAB-CGYV (TECVAYLI)	Add PA Requirement
J9350	MOSUNETUZUMAB-AXGB (LUNSUMIO)	Add PA Requirement
J9381	TEPLIZUMAB-MZWV (TZIELD)	Add PA Requirement
Q5131	ADALIMUMAB-AACF (IDACIO)	Add PA Requirement
S0013	ESKETAMINE	Add PA Requirement
J1449	ROLVEDON (EFLAPEGRASTIM-XNST)	Add PA Requirement
J0800	Corticotropin	Replace w/ J0801 and J0802
J1726	MAKENA	Remove PA Requirement
J7639	PULMOZYME (DORNASE ALFA) NON-COMP UNIT	Remove PA Requirement
Q5122	PEGFILGRASTIM-APGF (NYVPERIA) BIOSIMILAR	Update Drug Name
J7191	FACTOR VIII AHF PORCINE PER IU	Update Not carved out to FFS and add PA Requirement for MCAL

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	RX-003
Policy Name	Exception Review Process
Department Name	Pharmacy Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Pharmacy Services
Line(s) of Business	Group Care (IHSS)
Effective Date	6/16/2020
Approval / Revision Date	Pending P&T approval on 12/19/2023~~9/26/2023~~

POLICY STATEMENT

The Alameda Alliance for Health (the "Alliance") has an established process for reviewing and processing medical necessity-based authorization requests for pharmaceutical services that are not on the formulary. The Alliance is committed to ensuring that all eligible Alliance members have timely and efficient access to covered pharmaceutical services that require authorization. The Alliance's pharmaceutical authorization process complies with the standards set by the California Health & Safety Code, Sections 1367.01; the California Code of Regulations (CCR) Title 28, Section 1300.67.241; and the California Welfare & Institutions Code, Section 14185. Prior authorization is not required for the provision of an emergency three (3) day supply of drugs (see RX-009, Pharmaceutical Emergency Supply Provision).

This policy and the associated procedures also pertain to the review process for exceptions to pharmaceutical management procedures, such as Step Therapy, Quantity Limits and Age Limits.

PROCEDURE

I. Exception Process Guidelines

A. Members and their providers are expected to follow pharmaceutical management procedures set forth by the Alliance. However, in some cases a member or provider may opt to seek an exception based on medical necessity. Examples of exception requests include (but are not limited to):

1. A request for coverage of a non-formulary item with no existing Medication Review Guidelines (MRG)
2. A request to bypass an implemented formulary management program, such as step therapy

3. A request to authorize a greater supply than standard quantity limits
4. Any request outside the existing pharmaceutical management procedure and authorization process

B. The Alliance's exception process instructions are available to practitioners and providers through the Alliance's Provider Manual, provider newsletters and on the Alliance's website. Likewise, it is available to members through the Alliance's Evidence of Coverage documents, member newsletters, and on the Alliance's web site. The Alliance mails newsletters to members and providers annually, at minimum. Provider manuals are sent to providers when they join the Alliance and upon request thereafter. Evidence of Coverage documents are sent to members when they join the Alliance, and upon request thereafter. Any change to the exception process will be communicated to providers through mail, e-mail, or fax.

C. The review is based on medical necessity. Specific attention is given to the medical necessity for the situation and whether there is sufficient reason to create an exception to the established procedures.

II. Exception Review Requirements and Process

A. An exception request may originate from a member or a provider. When requested by the member, an Alliance member services representative will contact the provider to initiate the request. Also, the Alliance pharmacy staff may advise a provider to redirect a Prior Authorization request to an exception request if the request falls outside the standard Prior Authorization rules.

B. Providers are responsible for submitting all required information for medical necessity review. A Pharmacy Technician reviews the requests to determine whether all required information has been provided. The Pharmacy Technician pends the request to obtain missing information from the requestor (via phone or fax). The following information may be requested from the pharmacy, provider, member, or family member can include but are not limited to:

1. Reason for the exception request
2. Other medications tried and/or failed
3. Other pertinent history
4. Office and hospital records
5. Drug allergies, resistance, or reactions
6. Ability to reliably self-administer the medication
7. Other medications the member is taking
8. A history of present illness, with treatment plans and progress notes
9. A clinical exam
10. Diagnostic testing results
11. Patient psychosocial history
12. Evaluations from other health care providers and providers
13. Photographs
14. Operative and pathological reports
15. Information regarding benefits for services or procedures
16. Information regarding the local delivery system
17. Patient characteristics and information

C. Types of Exception Requests – All Exception requests must be reviewed by an appropriate healthcare professional and decisions shall be made based on the available clinical evidence in the medical literature as well as any patient-specific

factors. Types of Exceptions include (but are not limited to):

1. **Quantity Limit (QL) Override**
   a) Quantity limits are established through the P&T Committee and are a part of the Medication Request Guidelines for that drug/class.
   b) Providers must provide documentation for why the quantity limit is insufficient for the member and why formulary alternatives or alternate doses cannot be used. Potential QL override requests may involve:
      i. Split dosing for tolerability
      ii. One-time dose titration
      iii. Requirement of a higher dose for efficacy (must be supported by clinical evidence)
2. **Step Therapy (ST) Override**
   a) Step Therapy protocols are established through the P&T Committee and are a part of the Medication Request Guidelines for that drug/class.
   b) Providers must submit necessary justification and supporting clinical documentation(through clinic notes documenting previous medication trials including dose/duration/time frame and/or pharmacy fill history) supporting the provider's determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services to the member, taking into consideration the member's needs and medical history, along with the professional judgment of the member's provider. The basis of the provider's determination may include, but is not limited to, any of the following criteria:
      i. The required prescription drug is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm to the member in comparison to the requested prescription drug, based on the known clinical characteristics of the member and the known characteristics and history of the member's prescription drug regimen.
      ii. The required prescription drug is expected to be ineffective based on the known clinical characteristics of the member and the known characteristics and history of the member's prescription drug regimen.
      iii. The member has tried the required prescription drug while covered by their current or previous health coverage or Medicaid, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. The health care service plan may require the submission of documentation demonstrating that the member tried the required prescription drug before it was discontinued.
      iv. The required prescription drug is not clinically appropriate for the member because the required drug is expected to do any of the following, as determined by the member's prescribing provider:
         (1) Worsen a comorbid condition.
         (2) Decrease the capacity to maintain a reasonable functional ability in performing daily activities.
         (3) Pose a significant barrier to adherence to, or compliance with, the member's drug regimen or plan of care.

v. The member is stable on a prescription drug selected by the member's prescribing provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid.

(1) For non-transitioning members who are already established with Alliance, the Alliance does not consider use of medication samples provided through a physician office as a valid reason for approval/continuation of that medication, or as an acceptable step therapy to another medication.

(2) For non-transitioning members who are already established with Alliance, the Alliance shall allow provider attestation for OTC products that the member has been taking.

(3) For transitioning members until the Beneficiary can be seen by a Plan provider to establish a care plan, as required by Welfare & Institutions (W&I) Code, Section 14185(b), the Alliance will allow for continuation of single-source medications, including medication samples, if provided clinic notes showing all the following:

(a) Patient name

(b) Medication name, dose, and route of administration

(c) Quantity distributed

(d) Date medication was started and date last given/filled

c) The Alliance provides coverage for prescription drugs may require step therapy if there is more than one drug that is clinically appropriate for the treatment of a medical condition.

3. Age Limit (AL) Override

a) Age Limits are established through the P&T Committee and are a part of the Medication Request Guidelines for that drug/class.

b) For override of Age Limits, the provider must submit clinic notes, any relevant labs, and supporting clinical evidence (e.g., national guidelines, primary literature) that the drug being requested is safe and effective for the patient and why formulary alternatives cannot or should not be used.

4. Fill Limit (FL) Override

a) Fill limits (a maximum number of fills over a certain period of time) are established through the P&T Committee and are a part of the Medication Request Guidelines for that drug/class.

b) For override of Fill Limits, the provider must submit documentation for why the member requires additional medication beyond the limit in place, why formulary alternatives cannot or should not be used in the patient, and any relevant labs results and/or other clinical references, national guidelines, or primary literature to support continued use of the drug requested.

5. Maximum Dose Exceeded Override

a) Maximum doses are set by the prescribing information/package insert for

the medication upon FDA approval or by national guidelines for the condition being treated.

b) For use of doses beyond the maximum labeled dose, the provider must submit any relevant labs results, clinical references, national guidelines, and/or primary literature to support the use of a dose beyond the standard dose and justification for why a formulary alternative cannot be used in place of a higher dose of the requested medication.

6. Dose Consolidation Override

a) Quantity limits are established through the P&T Committee and are a part of the Medication Request Guidelines for that drug/class.

b) For approval of a doubling (or higher) of the number of tablets/capsules per prescription for a medication that has a higher strength tablet/capsule available, justification must be submitted for why that higher dose tablet/capsule cannot be used.

7. Partial Fill

a) The Alliance has availability of prescription partial fills of approved medically necessary medications.

8. Lost/Stolen Medication Override

a) Requests for non-controlled medications can be approved by Alliance pharmacy technicians upon request by the member, pharmacy, or provider.

b) For Lost/Stolen controlled medications, the member or provider must submit a police report to the plan that documents which medications were taken and the date the event occurred.

c) For more than one loss of controlled medications per 365 days, future approvals will be authorized only in consultation with the prescriber and your pharmacy.

9. Refill-Too-Soon Override

a) Refill-Too-Soon overrides will be handled on a case-by-case basis and by the medical necessity of the situation.

b) Lost/Stolen medication and vacation overrides will be handled by the corresponding exception policies.

10. Vacation Override

a) Vacation Overrides for up to 3 months (90 days) for travel outside California can be approved by the PBM or by the Alliance pharmacy technicians upon request by the member, pharmacy, or provider when documentation of the departure date, destination, and return date are provided for the following:

i. Non-specialty medications
ii. Non-single-source medications, and/or
iii. Non-controlled medications

b) <u>One vacation override per drug</u> per 365 days can be approved by the PBM and by the Alliance Pharmacy Technicians for medications described in section (C) 10a.

c) For ANY of the following scenarios, providers must submit a standard PA request for review by an Alliance clinical pharmacist with all required information described in section (C) 10a and medical necessity.

i. Vacation overrides over 90 days outside California or over 30

days within California
ii. More than one vacation override per drug per 365 days
iii. Request for specialty, single-source, and/or controlled medications

11. Member Reimbursements
    a) The Alliance will allow member reimbursement of pharmaceutical drugs when required documents are received and appropriate criteria exclusions do not apply. G&A will submit the following required documents to distgrpPharmacy@alamedaalliance.org email:
        i. Member ID Number
        ii. Case Number
        iii. AAH member reimbursement form
        iv. Pharmacy receipt or Pharmacy report print out (must include price paid out of pocket, date, and Rx number)
        v. Pharmacy Leaflet (this includes medication details and member details as well as Rx number).

    b) Reimbursements are not valid and will not be approved when the following criteria exclusions apply:
        i. If the request is made before the 180 days accepted time frame per EOC requirement.
        ii. If the drug was not covered and required a Prior Authorization and Perform PA does not show any active approval for the date paid out of pocket.
        iii. If the required documents are not submitted (Note: re-review can be considered once all documents are received).
        iv. If the request is made for pharmaceutical services received outside of the United States.

    c) The Alliance Pharmacy Services Technician(s) will review each request to ensure that the required documents are available and criteria exclusions do not apply.

    d) Approved requests will be sent to Perform Rx for final review and appropriate reimbursement determination (e.g., check reimbursement mail-out dates, member eligibility and formulary product availability) that will take 7 – 10 business days.

12. Continuation of Therapy Override
    a) The Alliance shall allow continuation of therapy for members using medically necessary drugs when it can be shown through clinic notes/provider attestation for OTC products or prescription fill history that the member has been taking the medication prior to enrollment.
    b) For non-transitioning members who are already established with Alliance, the Alliance does not consider use of medication samples provided through a physician office as a valid reason for

approval/continuation of that medication, or as an acceptable step therapy to another medication.

c) For non-transitioning members who are already established with Alliance, the Alliance shall allow provider attestation for OTC products that the member has been taking.

d) For transitioning members until the Beneficiary can be seen by a Plan provider to establish a care plan, as required by Welfare & Institutions (W&I) Code, Section 14185(b), the Alliance will allow for continuation of medically necessary medications, including medication samples, if provided clinic notes showing all the following:
   i. Patient name
   ii. Medication name, dose, and route of administration
   iii. Quantity distributed
   iv. Date medication was started and date last given/filled

e) For override of the formulary based on continuation of therapy the provider must submit clinical documentation showing the member has previously tried without success or cannot/should not take formulary alternatives, including any relevant labs.

13. Discharge Medication Override

a) Members being discharged on a medication will be approved given a one-time override for up to a 30-day supply. Future approvals will be based on the MRGs and the member's previous use of therapeutic alternatives.

14. Therapeutic Duplication Override

a) If the member is currently taking a medication that is therapeutically equivalent to the medication requested, the reviewing health care provider may deny the request.

b) For approval of a request of a medication that is therapeutically equivalent to a medication the member is already taking requires documentation from the provider that that the member is no longer taking the first medication, or the provider must submit any relevant labs results, clinical references, national guidelines, and/or primary literature to support the use of both medications together.

15. Day Supply Limit

a) The Alliance will cover up to 30 days' worth of medication per prescription, with the exception of the following:
   i. Certain maintenance medications: Up to 90 days per fill
   ii. Certain Specialty medications: Up to 14 days per fill
   iii. Contraceptives: Up to 365 days per fill

D. Exception Requests Based on Medical Necessity:

1. Since exception requests, by definition, do not have a MRG in place, the Pharmacy Technician will not be able to approve the request.
2. The reviewer documents the reason why the request qualifies as an Exception request and refers the case to a pharmacist for review.
3. The pharmacist reviews the case and background materials. The pharmacist can approve Exception Requests when ALL the following criteria are met:
   a) History of failure, contraindication, or intolerance to all formulary

alternatives, or no formulary alternatives exist (if applicable)

b) The treatment plan is:
   i. Safe, effective, and within national standards of practice.
   ii. Not experimental or part of a current clinical trial or study.
   iii. Specific and treats the identified condition.
   iv. Expected to improve health or prevent or delay progression of the condition from getting worse.
   v. Not primarily for convenience.
   vi. Not being used to avoid legal consequences.
   vii. Not contraindicated or have other reasons why use of the drug should not be used.

c) One of the following:
   i. Requested drug is FDA-approved for the condition being treated.
   ii. If requested for an off-label indication, the use is supported in compendia.
   iii. If the off-label use is supported by nationally recognized treatment guidelines or by two (2) peer reviewed articles.

3. The pharmacist will defer cases that cannot be denied based on the above listed denial reasons. These requests and any other highly complicated cases will be sent to an Alliance board-certified Medical Director for review.
   a) The Alliance Medical Director reviews the background of the case and, if needed, contacts the requesting provider for any additional information needed for the review.
   b) The Medical Director may render one of 3 decisions: approve, deny, or modify.
   c) The Medical Director finalizes the review and returns the case to the reviewing pharmacist with documentation of their decision and the rationale.
4. The reviewer documents the criteria and rationale for the decision in the pharmacy authorization system.
5. A pharmacist or a medical director can use nationally recognized treatment guidelines and other clinical information in support of making the decision.
6. Members receive a notice of action (NOA) letter with the outcome of the request and their rights and the process to appeal the decision. The provider also receives an identical copy of the NOA via fax or regular mail. All NOA letters sent to members and providers include their rights and the process to appeal the decision.

E. The qualifications and role of each reviewer in the medication exception review process is consistent with the reviewer roles documented in the *RX- 002 Prior Authorization Review Process*.

E. **External Review**

A request for an external review when the Alliance denies a prior authorization (PA) can be made for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent the filing of a grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care (DMHC). Requests for external review will be made and completed in the Alliance Grievances and Appeals Department.

III. Pain Medication Requests for the Terminally Ill

A. Alameda Alliance shall define a Terminal Illness as an incurable or irreversible condition that has a high probability of causing death within one year or less (Health & Safety Code Section 1373.96 (c)(4)).
B. All prior authorization and exception requests submitted to Alameda Alliance shall be reviewed by clinical pharmacy staff to determine if the patient meets terminally ill status.
C. Terminally ill members shall identify as:
    1. Any member who is currently being treated by a hospice provider
    2. Members with terminal cancer
    3. Any physician directed end-of-life treatment plan that requires the use of the following medications:
        1) morphine 5mg/mL concentrated solution
        2) oxycodone 5mg/mL concentrated solution
        3) sublingual fentanyl formulations
D. Requests from providers for authorization of coverage for a member who has been determined to be terminally ill are approved or denied within 24 hours of the Alliance's receipt of the information requested to make the decision.
E. The requested treatment for a terminally ill member is deemed authorized if the applicable turn-around time has expired.
F. Any medications for pain for members deemed to be terminally ill shall be approved based on medical necessity.
G. The pharmacy department shall keep a log of any requests for pain medication that are deemed to be for a terminally ill member.
    1. The log shall be reviewed on a weekly basis for any denials.
    2. Pain medication requests for terminally ill members shall be tracked monthly and any trends shall be reported on to the Health Care Quality Committee (HCQC) on a quarterly basis.

A. All other medication requests for the terminally ill members

1. Requests from providers for authorization of coverage for a member who has been determined to be terminally ill are approved, modified, or denied **within 24 hours of the Alliance's receipt of the information requested to make the decision.** Only licensed physicians or health care professionals, competent to evaluate the clinical issues, make decisions to deny pain management for terminally ill patients.
2. The requested treatment for a terminally ill member is deemed authorized if the applicable time frame has expired when all the necessary medical information has been provided.
3. For terminally ill members, if a request is denied or more information is required, the Alliance contacts the requesting provider within 24 hours of the determination and provides an explanation of the determination and the reason for the denial or need for more information.

IV. Provision of Drugs during Emergency Circumstances

In emergency circumstances, prior authorization is not required for an emergency three (3) day supply of drugs that would otherwise require authorization. See *RX-009*

Pharmaceutical Emergency Supply Provision

A. Alliance providers are informed of this policy via the Alliance's Provider Manual.
B. Alliance members are informed of this policy via member's Explanation of Coverage.
C. Alliance providers are responsible for following the prior authorization process for the remainder of the prescription.
D. The Alliance allows for payment of the three (3) day supply of the drugs even if the prior authorization request is subsequently denied.
E. Continuity of care requirements do not require the Alliance to continue coverage of drugs dispensed under this provision if they are not found to be medically necessary.

VI. **Non-Specialty Mental Health Services (NSMHS) has various services that will be provided when medically necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice (this includes, but is not limited to):**

A. Outpatient services for the purpose of monitoring drug therapy

~~VI.~~VII. **Monitoring Process**

F. The Alliance provides oversight of its PBM through an annual audit of the PA review process.
G. The Senior Director of Pharmacy Services or designee reviews a monthly authorization report, which provides statistics on all approvals, denials, and modifications to ensure that providers and members have been notified in accordance within the mandated turnaround times.
H. Inter-rater Reliability Review (IRR)
    1. The **Senior Director of** Pharmacy Services **or designee** will conduct IRR annually for clinical pharmacists who review and make determinations for the exceptions requests.
    2. 8 cases will be pulled and reviewed. If 100% clinical pharmacist agreement is not found in all 8 cases then another 22 will be pulled and reviewed for a total of 30 cases.
    3. When a total of 30 cases are reviewed, at least 90% agreement between the clinical pharmacists will be attained. Otherwise, additional sessions will be held until the 90% agreement threshold is reached in a total of 30 cases.
    4. The Alliance will immediately supply remediation if the passing threshold is not met.
    5. New staff require testing prior to conducting utilization review without supervision.
    6. Results of the IRR will be reported to UM Committee.

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DEFINITIONS / ACRONYMS

Pharmaceutical Management Procedures: Formulary drugs that have additional requirements or limits on coverage, such as Step Therapy (ST), Quantity Limits (QL) and Age Limits (AL).

Emergency Circumstances: When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, it is considered an emergency (Health and Safety Code § 1367.01 (h)(2)).

HCQC: Health Care Quality and Compliance Committee

NCQA: National Committee on Quality Assurance

AFFECTED DEPARTMENTS/PARTIES

Pharmacy Services
Pharmacy Benefit Manager (Currently PerformRx)

RELATED POLICIES AND PROCEDURES

RX-002 Prior Authorization Review Process
RX-006 Pharmacy Services Staff Description
RX-008 PBM Delegated Audit Oversight
RX-009 Pharmaceutical Emergency Supply Provision

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Table 1 – Decision & Notification Time Frames
Attachment 1 – Exception Review Process Flow Chart

REVISION HISTORY

9/12/2012, 5/19/2016, 8/30/2018, 12/11/2018, 12/17/2019, 6/16/2020, 3/16/2021, 12/21/2021, 6/21/2022, 3/28/2023, 6/20/2023, 9/26/2023, 12/19/2023

REFERENCES

- California Code of Regulations (CCR), Health & Safety Code, §§1367.01, 1367.21, 1367.22, 1367.24, 1367.206 and 1373.96
- CCR, Welfare & Institutions Code, §14185
- CCR, Title 22, §§51003, 51014.1, 51014.2, 53854 and 53894
- CCR Title 28 §1300.67.24
- MMCD Policy Letter 08-013
- NCQA, 2016 HP Standards & Guidelines, UM 13 (Procedures for Pharmaceutical Management), Element E (Considering Exceptions)
- DHCS All Plan Letter 20-020 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- DMHC APL 18-001 (OPL): Newly Enacted Statutes Impacting Health Plan License Filings
- DHCS Contract #23-30212, Exhibit A – Scope of Work

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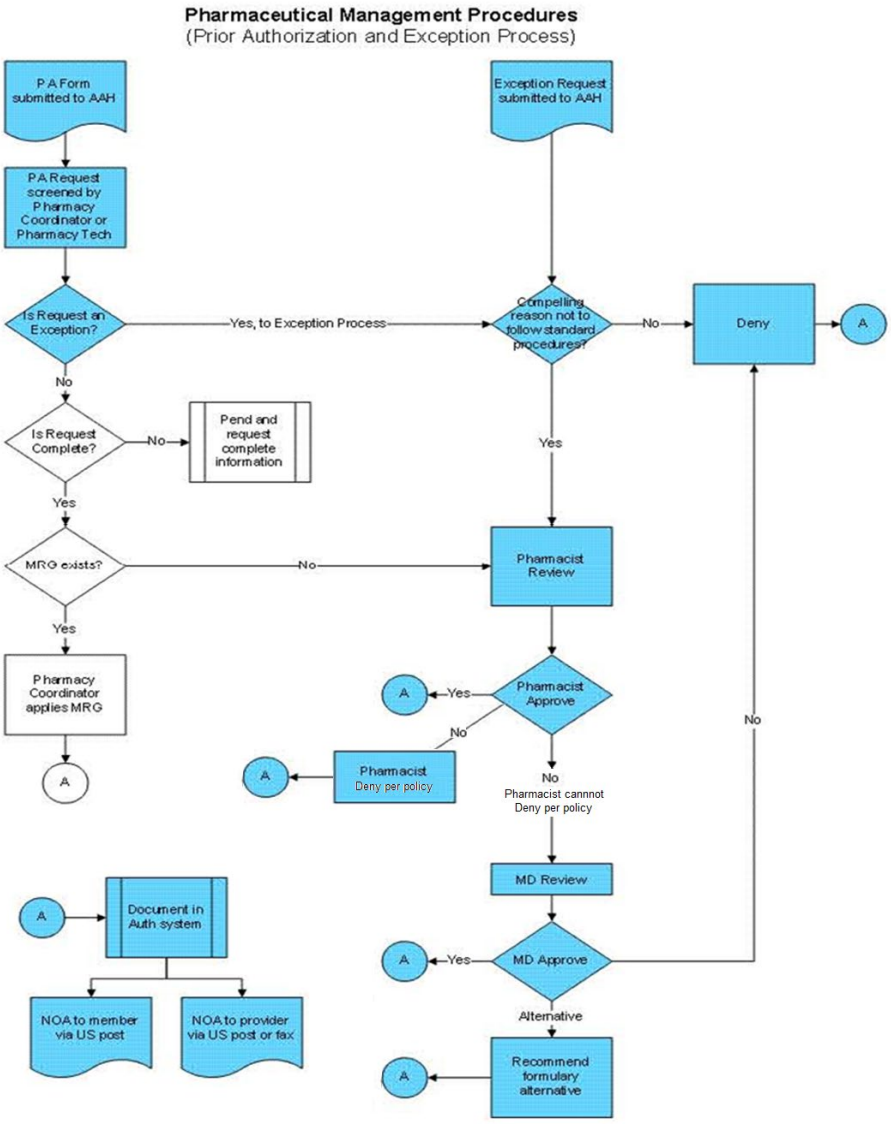
MONITORING

This P&P is reviewed annually to ensure effectiveness.

APPENDIX

Table 1: Decision & Notification Time Frames

Type of Request	Decision	Initial Notification	Written Notification
Prospective, Urgent	Approval	A fax is sent to the requesting provider within 24 hours of receipt of the request	NONE
	Modification		Written notification to the member and provider is generated and deposited with the United States Postal Service in time for pick-up within one business day after the decision
	Denial		
Prospective, Non-Urgent	Approval	A fax is sent to the requesting provider within 24 hours of receipt of the request	NONE
	Modification		Written notification to the member and provider is generated and deposited with the United States Postal Service in time for pick-up within one business day after the decision
	Denial		
Post-service	Approval	A fax is sent to the requesting provider within 24 hours of receipt of the request	NONE
	Modification		Written notification to the member and provider is generated and deposited with the United States Postal Service in time for pick-up within one business day after the decision


Pharmaceutical Management Procedures
(Prior Authorization and Exception Process)
PA Form submitted to AAH
Exception Request submitted to AAH
PA Request screened by Pharmacy Coordinator or Pharmacy Tech
Is Request an Exception?
Yes, to Exception Process
Compelling reason not to follow standard procedures?
No
Deny
A
No
Is Request Complete?
No
Pend and request complete information
Yes
Yes
MRG exists?
No
Pharmacist Review
Yes
Pharmacy Coordinator applies MRG
A
A
Yes
Pharmacist Approve
No
A
Pharmacist Deny per policy
No
Pharmacist cannnot Deny per policy
No
MD Review
A
Document in Auth system
A
Yes
MD Approve
NOA to member via US post
NOA to provider via US post or fax
Alternative
A
Recommend formulary alternative

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	RX-005
Policy Name	P&T Committee Roles and Scope
Department Name	Pharmacy Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Pharmacy Services
Line(s) of Business	Group Care (IHSS)
Effective Date	02/01/2012
Approval / Revision Date	6/20/2023

POLICY STATEMENT

The purpose of this document is to outline the procedure for the structure, operation, functions, and scope of the Alameda Alliance for Health ("the Alliance") Pharmacy and Therapeutics (P&T) Committee.

A committee shall exist within the Alliance that will function as the policy-making body for all matters related to the therapeutic use of drugs and certain medical supplies. The P&T Committee is a subcommittee of the Alliance Board of Governors.

PROCEDURE

To help assure continuing patient access to a quality-driven, cost-effective, rational, drug benefit through the Alliance Drug Formulary, the P&T Committee will complete the following activities and adhere to the following operating procedures.

All pharmacy criteria decisions made by the Committee will be based upon a thorough review of the relevant findings of government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia consulted in pharmaceutical determinations.

The Committee will apply the above findings in adopting the pharmaceutical management procedures, including those used in constructing the formulary or preferred status. Evidenced based guidelines and guidelines will be applied when determining the following:

A. For the non-covered pharmaceuticals, making available an exceptions process to obtain the drugs
B. Considerations regarding limiting access to drugs in certain classes
C. Considerations on whether a pharmaceutical class is covered, not covered, or covered with restrictions and within each class of pharmaceuticals the following considerations are made:
    a. Which pharmaceuticals are preferred or covered at any level
    b. The criteria for prior authorizations of any pharmaceutical not covered
    c. Exceptions process available to members
    d. Substitutions made automatically or with physician permission
    e. Evidence showing how preferred-status pharmaceuticals can produce similar or better results for a majority of the population than other pharmaceuticals in the same class

I. Organization and Operation

A. Membership

1. The Committee shall be comprised of the following members:
    a) Alliance Chief Medical Officer (Co-Chair) or designee
    b) Alliance Senior Director of Pharmacy Services (Co-Chair) or designee
    c) Practicing physician(s) representing Family Practice and/or Internal Medicine
    d) Practicing physician(s) representing Pediatrics
    e) Practicing physician(s) representing a medical specialty as needed in accordance with the agenda
    f) Practicing community pharmacist(s) contracted with Alliance (not to exceed three)
2. Non-voting members:
    a) Alliance Pharmacy Benefit Management Company representative pharmacist(s)
    b) Alliance Director of Provider Relations or designee
    c) Designated personnel (physician, pharmacist, nurse, etc.) representing Quality Assurance.
3. Membership should represent health care providers who serve the Alliance's patient population.
4. All Committee members shall complete a conflict-of-interest form pertaining to any financial or other relationship with pharmaceutical manufacturers. All Committee members' affiliations with outside interests shall not impair the responsible exercise of his or her duties as a P&T Committee member. If they have financial interest with a particular pharmaceutical manufacturer, they will be excluded from discussing and voting on evaluations or policies regarding the manufacturer's product line. (Refer to Appendix 1)
5. Compensation: Voting P&T members who are not Alliance staff are eligible to receive a financial stipend for each attended meeting and e-voting completed

B. Quorum

A quorum, is defined as a simple majority of voting members, must be present to conduct the P&T Committee meeting. A consensus decision will be made on formulary additions, deletions, and drug use/benefit policies. If no consensus is established, the issue will be put to a vote with the decision determined by majority vote of the quorum.

C. Schedule

The P&T Committee shall meet quarterly, at least four times per year. If urgent matters (as determined by the Alliance Chief Medical Officer) pertaining to the selection or utilization of drugs arise between meetings, a telephone or electronic voting will be conducted with the members. All relevant matters discussed between meetings will be presented formally at the next meeting.

D. Materials

An agenda and supplementary materials, including minutes of the previous meeting, shall be prepared, and submitted to the Committee members at least 7 days prior to the meeting to ensure proper review of the material.

1. Minutes of the Committee proceedings shall be prepared and maintained in the permanent records of Alliance.

E. Formulary Change Requests

Alliance providers may request additions, deletions, and modifications to the Alliance Drug Formulary by completing Formulary Request Form found in the Alliance Provider Manual. All requests shall be communicated in writing or by fax to:

Alameda Alliance for Health
Pharmacy Services
1204 South Loop Road
Alameda, CA 94502
Fax: 877-748-4524

F. Pharmaceutical Management Procedures

1. The P&T Committee will review pharmaceutical management procedures including medication guidelines, criteria, and clinical evidence, at least once every 12-month period and update those procedures as necessary as a result of that review.

2. Newly approved and marketed drugs will not be a pharmacy benefit until reviewed for addition to the Drug Formulary. FDA AA or P rated drugs (drug indicated for treatment of AIDS and HIV related illness and drugs with important therapeutic gain over existing therapies) may be an exception to the rule.

3. Addition or deletion to the Drug Formulary will be conducted at least once a year. Exceptions will be a drug product with clinical evidence supporting a significant improvement or decline in reported efficacy,

safety, or cost as determined by the Committee.

4. All decisions by the Committee to add or delete a drug from the Drug Formulary will take effect the first calendar day of the second month after the meeting unless otherwise specified. This is to allow time to notify physicians and other providers and change systems if needed.

5. Appeals to the Committee decisions may be made in writing within one month of the decision notification to the Chair of the Committee. These will be addressed on a case-by-case basis at the discretion of the Committee Chair.

II. Functions and Scope

The functions and scope of this Committee are designed to meet the following goals: to provide quality health care, to manage and control drug costs, and to continue to grow while ensuring the necessary management of resources.

A. Drug Formulary (See RX-004, Formulary Management)

1. Maintain a list of routinely covered drugs acceptable for use in the ambulatory care setting and provide for its constant revision
2. The selection of items to be included in the Drug Formulary shall be based on objective pharmacoeconomic evaluation of their relative therapeutic efficacy, safety, and cost. Therapeutic efficacy, safety, and adverse effects will be considered as the primary reasons for formulary inclusion/exclusion. If those are deemed to be equivalent or similar, the committee will also consider the Pharmacoeconomics of formulary inclusion/exclusion of the drug.
3. The Committee will attempt to minimize duplication of the same basic drug type, drug entity or drug product.

B. Guidelines and Protocols

1. To review drug utilization patterns and establish guidelines, protocols, programs, and procedures that help ensure high quality, cost-effective drug therapy.

C. Drug Use Review (DUR)

1. To recommend, initiate or direct Drug Use Review (DUR) and quality assurance programs. This includes recommending target drug or disease states to review, approving criteria for use before review, reviewing results when completed, making recommendations to appropriate departments, providers, etc., to take corrective action when less than optimal therapy is discovered, and measure for change after corrective action is in place. When recommendations for corrective action involve an individual provider, particularly change in a provider's scope of practice, such recommendation will be reported to the HCQC.

D. Scope of Decisions

1. The committee will make decisions on the following concerns:
2. Classes of pharmaceuticals

3. Classes preferred or covered at any level
4. An exceptions process available to members for obtaining non-covered pharmaceuticals
5. Considerations regarding limiting access to drugs in certain classes Within each class of pharmaceuticals

    (1) The pharmaceuticals preferred or covered at any level
    (2) The criteria for prior authorization of any pharmaceutical
    (3) An exceptions process available to members
    (4) Substitutions made automatically or with physician permission
    (5) This evidence can show how preferred-status pharmaceuticals can produce similar or better results for a majority of the population than other pharmaceuticals in the same class.

E. Evidence-Based Decision Making

These decisions are based on appropriate external evidence to support continued use of revisions of procedures or criteria set forth in section D.

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The following are considered by the P&T Committee when reviewing the formulary:

1. The formulary will contain drugs which represent each mechanism of action sub-class within all major therapeutic categories of prescription drugs.. Drugs newly approved by the Federal Drug Administration (FDA) are reviewed by the P&T Committee within (6) months of FDA approval. The P&T Committee determines whether the newly approved drugs will require prior authorization from the Alliance or be included in the Alliance's formulary.
2. In accordance with the Health and Safety Code, CCR, Section 1367.21, the Alliance allows for the coverage of any drug that is prescribed for use that is different from the use which that drug had been approved for marketing by the FDA, provide that all the following conditions are met.
    a) The drug is prescribed by a participating licensed health care professional for the treatment of:
        (1) A life-threatening condition
        (2) A chronic and seriously debilitating condition, and the drug is medically necessary to treat that condition, and the drug is on the Alliance's formulary. If the drug is not on the Alliance's formulary, the prescriber's request is reviewed in accordance with Health & Safety Code, CCR, Section 1367.24.

    b) The drug has been recognized for the treatment of that condition by one of the following:
        (1) The American Medical Association Drug Evaluations
        (2) The American Hospital Formulary Service Drug Information.

(3) The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional."
(4) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use(s) as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

3. Alliance Provider recommendations for addition or deletion of drugs to the formulary
4. Bioavailability data
5. Cost comparisons against other drugs available to treat the same medical condition(s)
6. Current therapeutic guidelines
7. Dosage ranges by route and age
8. Findings from the following agencies: governmental agencies, medical and pharmaceutical associations, the National Institutes of Health, and regulatory body publications
9. Off-label uses
10. Patient risk factors relative to contraindications, warnings, and precautions
11. Patient utilization and experience
12. Pharmacoeconomic data
13. Pharmacokinetic data
14. Pharmacologic considerations (e.g., drug class, similarity to existing drugs, side effect profile, mechanism of action, therapeutic indication, drug-to- drug interaction potential, and clinical advantages over other products in the specific drug class)
15. Risks versus benefits regarding clinical efficacy clinical efficacy and safety of a particular drug relative to other drugs with the same indication
16. Special monitoring or medication administration requirements

DEFINITIONS / ACRONYMS

Pharmacy and Therapeutics Committee (P&T) - The policy-making body for all matters related to the therapeutic use of drugs and certain medical supplies.

AFFECTED DEPARTMENTS/PARTIES

Pharmacy Services Department
Pharmacy Benefit Manager (Currently – *PerformRx*)

RELATED POLICIES AND PROCEDURES

P&T Charter
Alliance Bylaws – Section 6
RX-002 Prior Authorization Review Process
RX-004 Formulary Management

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

Appendix 1: Confidentiality & Conflict of Interest Form

REVISION HISTORY

[11/13/2020, 3/16/2021, 6/21/2022, 3/28/2023, 6/20/2023]

REFERENCES

- NCQA UM 12.A.1
- NCQA UM 12.D. 1 and 2
- H&SC 1367.24
- H&SC 1367.21
- DHCS All Plan Letter 20-020 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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POLICY AND PROCEDURE

Policy Number	RX-010
Policy Name	Drug Utilization Management
Department Name	Pharmacy Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Pharmacy Services
Line(s) of Business	Medi-Cal~~,~~ Group Care
Effective Date	10/01/2007
Approval / Revision Date	Pending P&T approval on 12/19/2023~~5/1/2023~~

POLICY STATEMENT

The Alameda Alliance for Health's (the "Alliance") Pharmacy Services unit has established Drug Utilization Review (DUR) procedures. The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes. The Alliance's DUR procedures comply with the Alliance's contract with the California Department of Health Care Services (DHCS). The Alliance will provide drug utilization encounter data to DHCS ~~on a monthly basis~~monthly.

Unless otherwise indicated, majority of DUR activities will be applicable to GroupCare only.

PROCEDURE

A. Drug Utilization Review (DUR) Overview:

1. DUR promotes patient safety by ensuring that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes.
2. All retail, specialty and mail service pharmacies are subject to Concurrent Reviews at point-of-sale and periodic Retrospective Reviews after adjudication.

B. Concurrent DUR:

1. This section does not apply to Medi-Cal line of business after the implementation of Medi-Cal Rx.
2. The Alliance's PBM ensures the safety of dispensed medications by notifying dispensing pharmacies of potential adverse events at the point-of-sale. The online messaging process classifies events at different levels of severity.
3. The PBM provides on-line, concurrent DUR messaging to pharmacies and takes appropriate action. Concurrent DUR includes but is not limited to the following

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edits:

(a) Over- and under-utilization
(b) Duplication
(c) Drug-drug or drug-allergy interactions
(d) Drug-disease contraindications
(e) Drug dosage
(f) Drug-age precautions
(g) Drug-gender precaution
(h) Drug-pregnancy precautions

C. Retrospective DUR:

1. The Alliance's PBM will provide a list of on-demand retrospective DUR reports of various topics to monitor fraud, waste, or abuse. These reports are reviewed and may be used by the Alliance to support quality improvement programs (QIPs) and Disease Management programs.
2. The Alliance pharmacy staff or ~~third party~~third-party vendor will run these reports as appropriate.
3. For Medi-Cal line of business, the Alliance will participate in Medi-Cal Global DUR Board and other DHCS organized pharmacy committee meetings.
4. For Medi-Cal line of business, the Alliance will receive comprehensive claims and PA history for their members and can use claims data for their own quality improvement, retrospective DUR activities, and coordination of care if needed including but not limited to identifying patterns of:
   (a) Therapeutic appropriateness
   (b) Adverse events
   (c) Incorrect duration of treatment
   (d) Over or under utilization
   (e) Inappropriate or medically unnecessary prescribing
   (f) Gross overprescribing and use
5. For Medi-Cal line of business, the Alliance will provide active and ongoing outreach to educate providers on common drug therapy problems (e.g., asthma medication ratio monitoring, opioid and naloxone co-prescribing, new prescribing ~~guidelines~~guidelines, and advisories) with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all beneficiary health.
6. For Medi-Cal line of business, the Alliance will be required to submit an annual DUR report to include any descriptions of any retro DUR activities and any innovative practices implemented by the plain in the prior federal fiscal year.
7. ~~6.~~ For Medi-Cal line of business, the Alliance SIU (Special Investigations Unit) monitors and has a process for identifying and addressing fraud and abuse of controlled substances by the Alliance members and the health care Providers who are prescribing these drugs and pharmacies dispensing these drugs to the Alliance members. The Alliance SIU actively investigates any allegations of fraud, waste or abuse regarding the ~~above mentioned~~aforementioned substances.

D. Drug Utilization Data Submission

1. On a regular basis, no less than once monthly, the Alliance's PBM sends the

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encounter data in the mutually agreed-upon format to the Alliance.

2. The Alliance's IT team will prepare the data for monthly submission. (See Policy IT Monthly Encounter Data)

E. Monitoring of DUR Process

1. Concurrent DUR reports and Retrospective DUR reports are reviewed by the Alliance pharmacy staff or third-party vendor and Senior Director, Pharmacy Services or designee and reported to the UM Committee and Quality Improvement Health Equity Committee (QIHEC).
2. Pursuant to 42 CFR 438.3(s)(4) and (5), the Alliance is to operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g)of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities to DHCS.

~~1.~~

F. Preventing Opioid Overutilization

1. This section only applies to Group Care line of business after the implementation of Medi-Cal RX. The Alliance will ensure safe and effective use of opioids which include but are not limited to the following:
   (a) Any ~~long acting~~long-acting opioid will require a prior authorization (PA)
   (b) Short acting opioids will have quantity and day supply limits
   (c) Members who are receiving above 500 MME (morphine milligram equivalent) will require a PA
   (d) Concurrent use of any opioids and benzodiazepines or opioids and antipsychotics
   ~~2.~~(e) The Alliance will ensure that the DUR program meets or exceeds applicable provisions of Section 1004 requirements of the SUPPORT for Patient and Communities Act: A retrospective claims review process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

G. Monitoring Anti-psychotics, Mood stabilizers and Anti-depressants

1. The Alliance will monitor appropriate use of anti-psychotics, mood stabilizers, and anti-depressant medications for all children 18 years of age and under including foster care children enrolled under the California Medicaid State Plan. The Alliance will ensure the following processes:
   (a) Quarterly monitoring of children using anti-psychotics, mood stabilizers and anti-depressants.
   (b) Quarterly monitoring of providers with children using anti-psychotics, mood stabilizers and anti-depressants.

DEFINITIONS / ACRONYMS

- PBM: Pharmacy Benefit Manager (Currently, PerformRx)
- IT: Information Technology Department
- MME: Morphine Milligram Equivalent
- PA: Prior Authorization

AFFECTED DEPARTMENTS/PARTIES

- PBM

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- IT

RELATED POLICIES AND PROCEDURES

- PerformRx P&P: DRUM-3-01 Concurrent Drug Utilization Management Program
- Policy IT Monthly Encounter Data

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REVISION HISTORY

10/7/2007, 8/24/2017, 12/11/2018, 6/25/2019, 3/17/2020, 3/16/2021, 6/15/2021, 6/21/2022, 3/28/2023, 12/19/2023

REFERENCES

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- DHCS All Plan Letter 19-012 Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
- DHCS All Plan Letter 20-020 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to ~~Medi-cal~~Medi-Cal RX
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- DMHC APL 23-026 Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
- DHCS Contract #23-30212, Exhibit A – Scope of Work

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MONITORING

This P&P will be reviewed annually to ensure effectiveness and compliance with regulatory and contractual requirements.

Utilization data is reviewed for trends and analysis, and any identified potential fraud and abuse concerns are reported to the Compliance department. This includes potential fraud and abuse related to controlled substances by members, health care providers prescribing to the member, and pharmacy dispensing the drugs to members.

POLICY AND PROCEDURE

Policy Number	RX-013
Policy Name	Medical Benefit Physician/Facility-Administered Drugs (PAD) Prior Authorization Review Process
Department Name	Pharmacy Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Pharmacy Services
Line(s) of Business	Medi-Cal, Group Care (IHSS)
Effective Date	7/17/2023
Approval / Revision Date	~~6/20/2023~~ Pending P&T approval on 12/19/2023

POLICY STATEMENT

The Alameda Alliance for Health (the "Alliance") has an established process for reviewing and processing medical necessity-based physician/facility-administered drugs (PAD) authorization requests for pharmaceutical services that are on the formulary. The Alliance is committed to ensuring that all eligible Alliance members have timely and efficient access to covered pharmaceutical services that require authorization. The Alliance's pharmaceutical authorization process complies with the standards set by the California Health & Safety Code, Sections 1367.01, 1373.96; the California Code of Regulations (CCR) Title 28, Sections 1363.5, 1367.01, ~~1300.67.241~~; ~~and the California Welfare & Institutions Code, Section 14185 and 42 CFR section 438.900 et seq~~. The Alliance covers medications for treating gender dysphoria or alleviating mental health or substance use. The Alliance ensures parity in coverage of pharmaceuticals used to treat medical/surgical, mental health, and substance abuse disorders.

PROCEDURE

I. Prior Authorization Process Guidelines

A. Prior authorization review and approval hierarchal criteria are utilized and required as outlined in UM-001 (or with PAD Medication Review Guidelines) for the appropriate pharmacy authorizations.

B. The Alliance utilizes evidence-based prior authorization criteria approved by the P&T Committee. Prior authorization criteria are developed and reviewed annually and are based established by organizations such as Medi-Cal guidelines (if for Medi-Cal line of business), Milliman Care Guidelines, Food and Drug Administration (FDA), National Comprehensive Cancer Network (NCCN), UpToDate, and National Institutes of Health (NIH). The Alliance covers pharmaceuticals in accordance with 42 CFR section 438.900 et seq, to ensure parity in

medical/surgical, mental health, and substance abuse benefits and treatment.

II. Prior Authorization Procedures

A. All providers are required to submit prior authorization for Healthcare Common Procedure Coding System (HCPCS) / National Drug Code (NDC) codes that are listed and in alignment with P&T committee approved PA criteria as appropriate.

B. Required information provided on all requests should include:

a) Member demographic information
b) Practitioner demographic information

Requested service/procedure to include specific Current Procedural Terminology

c) (CPT)/Healthcare Common Procedure Coding System (HCPCS) code(s)
d) Member diagnosis (Specific International Classification of Disease (ICD) Code/Description)
e) Clinical indications necessitating service
f) Pertinent medical history, treatment, or clinical data
g) Location of service to be provided
h) Requested/anticipated duration of therapy
i) Proposed date(s) of services

C. Prior authorization requests must be submitted electronically or by fax to the Alliance UM Department.

a) Pharmacy department will manage the end-to-end process when providers send a PAD PA for the Alliance members. This entails some of the following duties below:
   i. Verify eligibility, ~~coverage~~coverage, and network
   ii. Check if there are benefit restrictions
   iii. Generate letter of notifications for approval, partial approval, and denial

A. Retro Requests: The Alliance does not accept post-service or retrospective authorization requests for nonemergent or non-urgent services that would require prior authorization more than 90 days past the date of service.

The exception criteria under which a post service / retrospective request greater than 90 days after the date of service may be considered are:

1. Member eligibility issues, i.e., unable to validate eligibility at time of service, incorrect eligibility information at time of service.

~~1.~~2. In-patient services where the facility is unable to confirm enrollment with the Alliance.

~~A.~~B. Pre-Service/Post-Service Review for Pharmacy Technician (PT)

A. Upon receipt of the authorization request, the PT will review the request for:
   (1) Member eligibility
   (2) Completeness of the request
      (a) Presence of medical codes,
      (b) Presence of medical records
B. Once the authorization request review is complete, the PT enters the authorization request into the clinical information system and routes it to the appropriate UM PT processing queue.
C. Upon selecting authorization request from the queue, the assigned PT reviews the pre-

service/post-service authorization request that includes:

(1) The UM PT reviewer performs a review of the pre-service/post-service/DME or pump associated with PAD authorization request and clinical information presented using the appropriate UM criteria, according to UM-001 Utilization Management Policy or UM Program.

(a) The PT Reviewer documents the decision-making process in the clinical information system.

(b) The PT Reviewer workflow includes:

(i) For authorization requests meeting criteria under the scope of the PT, the PT Reviewer approves the request and generates the Member and Provider approval notification.

(ii) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), or otherwise are outside of PT scope, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the PT Reviewer forwards the request to the Pharmacist Reviewer.

~~B.~~C. Pre-Service/Post-Service Review Pharmacist Reviewer (PR)

A. Pharmacist Reviewer performs a medical necessity review of the authorization request and clinical information presented using the appropriate UM criteria, according to UM-001 Utilization Management Policy or UM Program.

(1) The PR utilizes evidence-based criteria and hierarchical criteria process for approving, modifying, deferring, requested services (as applicable).

(a) The hierarchal criteria process:

(i) Regulatory and contractual requirements

(ii) Evidence based guidelines

(iii) Alliance specific guidelines

(iv) National medical association consensus

(v) Medical necessity/medical judgement

(2) The PT Reviewer documents the clinical decision-making process in the clinical information. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.

(3) For authorization requests not consistent with the request (i.e. conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), not meeting UM Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the PR forwards the request to the UM Medical Director/Physician Reviewer for review.

III. The Alliance's Pharmacy Department processes pharmacy authorization requests in accordance with the procedures described in UM Policy # 001 – Utilization Management and UM Policy #057 (as it may relate to pharmacy services).

a. Outreach calls (up to 3 attempts) may be made to the requesting provider to request reasonably necessary clinical information when needed to make a PA decision or

enter missing required clinical information for medication requests. For each outreach attempt, the reviewer is to document the following:

i. Name and title of person spoken to
ii. Phone number called (if different from one already noted in the PA system)
iii. What specific information was requested

IV. Continuity of Care for Covered Services for Newly Enrolled Medi-Cal and GroupCare Beneficiaries

A. PAD CoC requests are managed using the same mechanisms and processes as UM Policy #036 Continuity of Care for Terminated and Non-Participating Providers, UM Policy #058, Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving A Medical Exemption, and UM Policy#059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care.

~~**B.** Members may request up to 12 months of CoC with an out-of-network/non-participating provider (NPP) if a verifiable fill history exists with that provider as noted below:~~

~~Receiving Treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality~~

~~Taking immunosuppressive medications, immunomodulators, and biologies~~

V. Continuity of Care for Covered Services for Members Receiving Pharmaceutical Treatment

A. Anthem

1. Member may request up to 6 months for continuity of care service to continue an active course of treatment.
2. Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to January 1, ~~2024~~2024, and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition as in DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

B. Medi-Cal Beneficiaries who newly enroll in Medi-Cal managed care from Medi-Cal fee-for service, on or after January 1, 2023~~3~~4 (~~ie~~i.e.. Adult Expansion)

1. Member may request up to 90 days for continuity of care service following AAH enrollment and until reassessment as in APL 23-022.

C. LTC Members

1. ICF-DD
   A. Member may request up to 90 days for continuity of care service following AAH enrollment and until reassessment as in APL 23-023.
2. Subacute
   A. Member may request up to 6 months for continuity of care service following AAH enrollment and or duration of TAR (which ever duration is shorter) as in APL 23-027.
3. LTC-SNF
   A. Member may request up to 90 days for continuity of care service following AAH enrollment and until reassessment as in APL 23-004.

V. Continuation of Therapy

A. The Alliance shall allow continuation of therapy for members using medically necessary

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drugs when it can be shown through clinic notes or medication fill history that the member has been taking the medication prior to enrollment.

B. For transitioning members until the Beneficiary can be seen by a Plan provider to establish a care plan, as required by Welfare & Institutions (W&I) Code, Section 14185(b), the Alliance will allow for continuation of medically necessary medications if provided clinic notes showing all of the following:
   1. Patient name
   2. Medication name, ~~dose~~dose, and route of administration
   3. Quantity distributed
   4. Date medication was started and date last given/filled

~~IV.~~VI. Annual Review of PAD Prior Authorization and UM Criteria

a. All PAD utilization management criteria undergo annual evaluation for appropriateness and effectiveness. Criteria are updated when necessary. The P&T committee reviews the pharmacy UM program, including delegated elements. The review encompasses scope, policies and procedures, and criteria as appropriate.

~~V.~~VII. Monitoring of the PA process

a. Inter-rater Reliability- the Alliance evaluates the consistency of decision making for those health care professionals involved in applying PAD Criteria.

~~VI.~~VIII. Pharmacy Department will communicate with Utilization Management (UM), Communications & Outreach, Medical Directors, Provider Services (PR), Member Services (MSR), Claims and Benefit Configuration Departments to implement prior authorization restriction requirements in Heath Suite and outreach to providers and members.

~~VII.~~IX. Pharmacy Services will comply with appropriate UM policies as they relate to pharmacy supported authorizations, NOA letters and regulatory requirements (see related policies section for reference).

DEFINITIONS / ACRONYMS

- PAD: Physician/Facility-Administered Drugs
- NCQA: National Committee on Quality Assurance
- UM: Utilization Management

AFFECTED DEPARTMENTS/PARTIES

Pharmacy Services
Utilization Management
Claims
Benefit Configuration
Member Services
Provider Relations
Communications and Outreach

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management

UM-036 Continuity of Care for Terminated and Non-Participating Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-051 Attachment A UM Timeliness Standards for Medi-Cal and Group Care
UM-054 Notice of Action
UM-057 Authorization Service Request
UM-058 Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving A Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care

REVISION HISTORY

6/20/2023, 12/19/2023

REFERENCES

- NCQA UM 12, Element A, B, D
- Alliance Provider Manual
- Health & Safety Code, Sections 1363.5, 1367.01, 1367.21, 1367.215, 1373.96
- ~~CCR, Title 28, Section 1300.67.241~~
- ~~Welfare & Institutions Code, Section 14185~~
- ~~42 CFR section 438.900 et seq.~~
- Senate Bill 855 – Mental Health as a Medical Necessity
- DHCS All Plan Letter 22-012 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- DHCS All Plan Letter 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal FFS, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023
- DHCS APL 23-004 Skilled Nursing Facilities -- Long Term Care Benefit Standardization And Transition Of Members To Managed Care
- DHCS APL 23-027, Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- DHCS APL 23-023 – Intermediate Care Facilities for Individuals with Developments Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- DHCS Contract #23-30212, Exhibit A – Scope of Work
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide

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MONITORING

This policy will be reviewed annually to ensure effectiveness.

APPENDIX

Table 1: Medical Benefit Determination Turnaround Timetable of Different Regulatory Bodies

Type of Request	NCQA	DHCS	DMHC	**Alliance**
Prospective, Urgent	72 hours	72 hours	72 hours	**72 hours**

Prospective, Non-Urgent	Medi-Cal: 14 calendar days Group Care: 15 calendar days	5 business days	5 business days	**5 business days**
Post-service	30 calendar days	30 calendar days	30 calendar days	**30 calendar days**

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE TEMPLATE

Policy Number	RX-014
Policy Name	Physician/Facility-Administered Drugs (PAD) Prior Authorization List Management
Department Name	Pharmacy Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Pharmacy Services
Line(s) of Business	Medi-Cal, Group Care (IHSS)
Effective Date	12/19/2023
Approval / Revision Date	Pending P&T approval on 12/19/2023

POLICY STATEMENT

The Alameda Alliance for Health ("Alliance") has an established mechanism for maintaining, reviewing, and updating its physician/facility-administered drug prior authorization list. The Alliance is committed to ensuring that all eligible Alliance members have access to high quality and cost-effective pharmaceutical care. The Alliance's Physician/Facility-Administered Drugs (PAD) Prior Authorization List Management process complies with the standards set by the Health and Safety Code, CCR, Section 1363.5, 1367.01, 1367.21, 1367.215. The Alliance covers medications for treating gender dysphoria or alleviating mental health or substance use.

PROCEDURE

A. Physician/Facility-Administered Drugs Prior Authorization List Management

1. The Alliance's PAD PA List Management is managed by the Pharmacy and Therapeutics (P&T) Committee with consultation support from PBM and third-party vendor.
2. The P&T Committee objectively appraises, evaluates, and selects physician administered drugs pharmaceutical products for prior authorization requirements inclusion or exclusion. Products are evaluated based on efficacy, safety, ease of use, and cost. This is an ongoing process to ensure the optimal use of therapeutic agents.
3. The Alliance's PAD PA List Management is updated on a continuing basis after each meeting of the P&T Committee as well as between P&T Committee meetings when interim changes are implemented by Alliance pharmacy services. Alliance

Providers are notified of all prior authorization changes in a timely manner, using Alliance's website and fax.

4. Drugs newly approved by the Food and Drug Administration (FDA) are reviewed by the P&T Committee within six (6) months of FDA approval. The P&T Committee determines whether the newly approved drugs will require prior authorization from the Alliance to be included on the Alliance's PAD PA List for review of medical necessity.
5. In accordance with Health & Safety Code, CCR, Section 1367.21, the Alliance allows for the coverage of any drug that is prescribed for use that is different from the FDA-approved use(s), provided that **all of the following conditions** are met to show medical necessity:
   a. The drug is prescribed by a participating licensed health care professional for the treatment of:
      i. A life-threatening condition; or
      ii. A chronic and seriously debilitating condition, and the drug is medically necessary to treat that condition, and the drug is on the Alliance's PAD PA List.
   c. The drug has been recognized for the treatment of that condition by any of the following:
      i. The American Medical Association Drug Evaluations
      ii. The American Hospital Formulary Service Drug Information
      iii. The United States Pharmacopoeia Dispensing Information, Volume I, "Drug Information for Health Care Professionals"
      iv. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use(s) as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
      v. It is the prescriber's responsibility to submit the supporting documentation.

6. The Alliance covers pharmaceuticals in accordance with 42 CFR section 438.900 et seq, to ensure parity in medical/surgical, mental health, and substance abuse benefits and treatment.

B. Pharmacy and Therapeutics (P&T) Committee:

1. The P&T Committee's voting membership consists of the Alliance's Chief Medical Officer or designee, the Alliance Senior Director of Pharmacy Services or designee, (4) four licensed practicing physicians and practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater). The non-voting membership may include a clinical pharmacist from the Alliance's Pharmacy Benefit Manager (PBM), a representative from the Alliance's Quality Improvement Unit, Alliance Operations Unit, and practicing physicians representing a medical specialty as needed in accordance with the agenda and the specific medications or subjects being reviewed.
2. Per the P&T Charter, the P&T Committee is responsible for the following:
   a. Develop and implement effective drug utilization review

treatment outcome systems to optimize the quality of the pharmacy services
   b. Review the list on a quarterly basis
   c. Ensuring that the PAD PA List review considers all drugs approved by the Federal Drug Administration (FDA)
   d. Ensuring that deletions from the PAD PA List are documented and justified.
3. The following are considered by the P&T Committee when reviewing the PAD PA List:
   a. Alliance Provider recommendations for additions or deletion of drugs to the PAD PA List
   b. Bioavailability data
   c. Cost comparisons against other drugs available to treat the same medical condition(s)
   d. Current therapeutic guidelines
   e. Dosage ranges by route and age
   f. Findings from the following agencies: governmental agencies, medical and pharmaceutical associations, the National Institute of Health, and regulatory body publications
   g. Medical literature and clinical trials
   h. Off-label uses
   i. Patient risk factors relative to contraindications, warnings, and precautions
   j. Patient utilization and experience
   k. Pharmacokinetic data
   l. Pharmacologic considerations (e.g., drug class, similarity to existing drugs, side effect profile, mechanism of action, therapeutic indication, drug-to-drug interaction potential, and clinical advantages over other products in the specific drug class)
   m. Risks versus benefits regarding clinical efficacy and safety of a particular drug relative to other drugs with the same indication
   n. Special monitoring or medication administration requirements

C. Notification of PAD PA List Changes

1. The Alliance notifies its Providers about PAD PA List additions, deletions, and modifications and after each quarterly P&T Committee meeting, or more frequently as needed. Providers are notified through the Alliance website update and provider fax.
2. Utilization Management (UM), Community Outreach Medical Director, Provider Services (PR), Member Services (MSR), Claims and Benefit Configuration Departments are also notified of PAD PA List changes. A copy of the Summary of Prior Authorization Updates will be emailed to the Director of UM, PR, MSR, C &O once available. The Director of UM, PR, and MSR will disseminate the information to UM Medical Director, UM Managers, UM coordinator, Provider Services Representatives, and Member Services Representatives as of the effective date of the change. In addition, any interim changes will be communicated to the Director on an as-needed basis.

DEFINITIONS / ACRONYMS

- PAD: Physician/Facility-Administered Drugs
- Formulary: list of drugs covered by the Alliance
- NCQA: National Committee on Quality Assurance
- UM: Utilization Management
- PR: Provider Relations
- MSR: Member Services
- C&O: Communications and Outreach

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Pharmacy Services
Member Services
Provider Relations
Communications and Outreach

RELATED POLICIES AND PROCEDURES

RX-002 Prior Authorization Review Process
RX-005 P&T Committee Roles and Scope P&T Charter
UM-001 Utilization Management
UM-036 Continuity of Care for Terminated and Non-Participating Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-051 Attachment A UM Timeliness Standards for Medi-Cal and Group Care
UM-054 Notice of Action
UM-057 Authorization Service Request
UM-058 Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving A Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care

REVISION HISTORY

REFERENCES

- NCQA UM 12, Element A**,** B, D
- Alliance Provider Manual
- Health & Safety Code, Sections 1363.5, 1367.01, 1367.21, 1367.215
- Senate Bill 855 – Mental Health as a Medical Necessity
- DHCS All Plan Letter 22-012 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx

This policy will be reviewed annually to ensure effectiveness.

Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

PHARMACY & THERAPEUTICS COMMITTEE

Record of Committee Meeting Minutes

Tuesday, September 26, 2023 | 5:00pm – 7:00pm

Status	Voting Committee Members	Organization	Initials	Officer / Notes
P	Steve O'Brien, MD	CMO - Alliance	SO	Chairman
P	Helen Lee, PharmD	Senior Director of Pharmacy Services – Alliance	HL	Co-Chair
P	Aaron Basrai, PharmD	Haller's Pharmacy	AB	BOG
P	Paul Bayard, MD	La Clinica de la Raza (CHCN)	PB	
P	Pamela Gumbs, PharmD	United Pharmacy	PG	
P	Ivan Lee, MD	Private Practice	IL	
P	Bao Dao, MD	Epic Care	BD	
P	Donna Carey, MD	Medical Director of Case Management- Alliance	DC	

P=Present; PH=Call-in; A=Absent; CMO = Chief Medical Officer; DOPS=Director of Pharmacy Services; BOG = Board of Governors Representative

Status	Regular Guests	Organization	Role / Department
P	Natalee Felten	PerformRx	Formulary Management & Drug Utilization Review
P	Pat DeHoratius	PerformRx	Manager Formulary/DUR
	Barrie Cheung	PerformRx	Regional Pharmacy Director
P	Rahel Negash, PharmD	Alameda Alliance	Pharmacy Supervisor
P	Ramon Tran Tang, PharmD	Alameda Alliance	Clinical Pharmacist
P	Jefferey Bencini, Pharm D	Alameda Alliance	Clinical Pharmacist
P	Timothy Tong, Pharm D	Alameda Alliance	Clinical Pharmacist
A	Beverly Juan, MD	Alameda Alliance	Medical Director
A	Sanjay Bhatt, MD	Alameda Alliance	Medical Director
A	Darryl Crowder	Alameda Alliance	Provider Relations
A	Bibek Sandhu, PharmD, MBA	PillarRX	Consulting Pharmacist

Other Guests	

Follow-up Items:

Clerk of the Committee: Benita Ochoa

<table>
<tr><th>Agenda Item</th><th>Discussion Leader</th><th>Discussion Summary</th><th>Action</th><th>Notes</th></tr>
<tr><td>I) Call to Order</td><td>S. O'Brien</td><td>• Agenda Overview</td><td>Called to order at 5:00PM</td><td></td></tr>
<tr><td>II) Informational Updates</td><td>S. O'Brien
H. Lee</td><td>Informational Updates
• Anthem
• ICF-DD
• DMHC Audit
• PAD PA list
Medi-Cal Rx MCDAC Drugs
<table>
<tr><th>MCDAC Drug</th><th>Indication</th><th>CDL Status</th><th>Recommendation
Based on - Safety, Efficacy, Essential Need, Misuse Potential, etc.</th></tr>
<tr><td>Accrufer (ferric maltol) 30mg capsules</td><td>Adult iron deficiency</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Konvomep (omeprazole and sodium bicarbonate) oral suspension</td><td>Short-term treatment (4 to 8 weeks) of active benign gastic ulcer; Reduction of risk of upper gastrointestinal (GI) bleeding in critically ill adult patients</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Triptodur (triptorelin) 22.5mg single-use kit</td><td>Pediatric (2 years and older) central precocious puberty</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Lyvispah (baclofen) oral granules 5mg, 10mg and 20mg</td><td>Spasticity from multiple sclerosis</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Tremfya (guselkumab) 100mg/mL prefilled syringe and 100mg/mL one-press patient-controlled injector</td><td>Plaque Psoriasis; Adult Psoriatic arthritis</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Veozah (fezolinetant) 45mg tablets</td><td>Vasomotor symptoms due to menopause</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Vowst (fecal microbiota spores, live-brpk) capsules</td><td>Recurrent Clostridium Difficile infection (CDI) following bacterial treatment of recurrent CDI</td><td>F-PA</td><td>Keep F-PA</td></tr>
<tr><td>Zonisade (zonisade) 100mg/5mL oral suspension</td><td>Adjuntive therapy for partial-onset seizures</td><td>F-PA</td><td>Keep F-PA</td></tr>
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Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
III) **Pharmacy Utilization Reports (Quarter 3, 2023)**	H. Lee	(All matters listed on the Consent Calendar are to be approved with one motion unless a member of the P&T Committee removes an item for separate action. Any consent calendar item for which separate action is requested shall be heard as the next Agenda item in closed session.) • Top 50 Drugs by Cost (IHSS) o The top 50 drugs accounted for 964 claims for 488 members and cost $1,227,621, which is an increase of $76,992 in spend from the previous quarter. o Cabometyx has risen from number 5 to number 1, with 4 claims for one member. Requests for these medications are reviewed via the oncology MRG. o Biktarvy is now at number 2, with an increase of 2 claims since the previous quarter. o Skyrizi is at number 3 with 4 claims for 2 members. This medication is currently preferred in the biologic DMARD PA policies. o Vemlidy is down to number 4 with 49 claims for 21 members. This is an increase of one claim since last quarter. This medication is managed via the Hepatitis B MRG, which was loosened during Q4 2022 P&T to require trial and failure of, or reason not to use, entecavir (previously generic Viread and entecavir). o Revlimid is at 5 and Jakafi at number 6, both with 3 claims for one member. These are managed via the oncology MRG and the non-oncology indication of Revlimid is reviewed via the Agents for graft versus host disease MRG. • Medi-Cal Top 50 Drugs by Cost for 2nd Quarter 2023 o The top 50 drugs accounted for 28,648 claims for 24,488 members and cost $39,740,857.16, which is an increase of $2,732,910.41 in spend from the previous quarter and $12,026,834.98 in spend compared to a quarter before Medi-Cal Rx conversion. o Ozempic has risen from the number 6 to number 5, with 1181 claims for 1001 members. o Vemlidy is down to number 7 with 346 claims for 307 members. This is a decrease of 8 claims since last quarter. • Top 50 PA Reviewed Drugs (IHSS) o Reviewed and discussed the top 50 drugs by cost o Top 50 PA requests = 162. There were 251 total PA requests for quarter 2. - 55 requests (34%) were approved. This approval rate is lower, by 19%, than what was observed last quarter. - 107 requests (66%) were denied or partially approved. o Wegovy 0.25mg/0.5ml is new at number one and had a total of 21 requests for that strength, which is the starting dose. - There were 35 total requests for this medication in the top 50, for the various strengths. - There were 26 denials and 4 partial approvals. - Wegovy requires a diagnosis of obesity or history of heart attack, despite diet and exercise, and requires trial and failure of, or reason not to use Qsymia and Contrave. o Jardiance 10mg is at number 2 with 13 requests (along with the 25mg tablet, in total it had 18 requests) with 2 approvals. - The formulary alternative is Steglatro, with trial and failure of metformin.		

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Ozempic 0.25-0.5mg/dose pen is at number 3 with 10 requests for that strength, which is the starting dose.

Ozempic requires a trial and failure of metformin.

Vemlidy is at number 4, with 9 requests. Five of those were approved.

Vemlidy requires trial and failure of entecavir.

Lidocaine 5% patch is at number 5 and had 8 requests with 3 approvals.

This medication requires a diagnosis of neuropathic pain and a trial and failure of gabapentin or pregabalin and one other formulary alternative used for neuropathic pain or morphine MME < 50 for 3 months.

Medi-Cal Top 50 Prior Authorization Requests by Volume for 2nd Quarter 2023

The top 50 drugs accounted for 175,083 claims for 155,526 members and cost $3,805,809.48.
Ibuprofen moved down to number 4 from number 2 with 7642 claims for 6897 members. This is a decrease of 33 claims from last quarter.
Fluticasone has risen to number 2 from number 3 with 9506 claims for 8741 members. This is an increase of 1,985 claims from last quarter.
Aspirin has risen from number 4 to number 3 with 7650 claims for 7063 members. This is an increase of 344 claims from last quarter.
Loratadine remains at the number 5 spot with 7642 claims for 6897 members. This is an increase of 1,322 claims from last quarter.

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<tr><td>IV) E-Voting Material/Consent Agenda</td><td>H. Lee/B. Ochoa</td><td>
<table>
<tr><th>Monographs/Class Reviews</th><th>Changes</th></tr>
<tr><td>Macrolides</td><td>• No change</td></tr>
<tr><td>Bowel Prep</td><td>• No change</td></tr>
<tr><th>Medication Request Guidelines</th><th>Changes</th></tr>
<tr><td>Moxifloxacin Oral Tablet</td><td>• Minor wording update</td></tr>
<tr><td>Physician Administered Medication (PAD)/ Medical Benefit Guidelines</td><td>• Minor clarification update</td></tr>
<tr><td>Off-label uses</td><td>• Minor clarification update</td></tr>
<tr><td>Non-Formulary and PA Required Medications without Drug-Specific</td><td>• Minor clarification update</td></tr>
<tr><td>Erythropoiesis-Stimulating Agents</td><td>• Retacrit availability is no longer an issue, update preferred agents.
• Minor zidovudine clarification</td></tr>
<tr><td>Vancomycin</td><td>• Minor wording clarifications</td></tr>
</table>
</td><td>Approved via e-voting:
Yes: 7
No: 0
Abstained: 1</td><td></td></tr>
</table>

Agenda Item	Discussion Leader	Discussion Summary		Action	Notes
		Scabicides and Pediculicides	• Minor wording clarifications		
		Dronabinol	• Minor spelling update		
		Constipation agents	• No change		
		Multaq (dronedarone)	• No change		
		Safety Edit Exception	• No change		
		Quantity Limit Exception	• No change		
		Atovaquone-proguanil (Malarone)	• No change		
		Santyl Ointment	• No change		
		Spravato (esketamine) Intranasal	• No change		
		Topical Acne Agents	• No change		
		Memantine ER (Namenda XR)	• No change		
		Tranexamic acid (Lysteda)	• No change		
		Biologic Agents for Nasal Polyposis	• No change		
		Rapid-Acting Insulin	• No change		
		Antiemetics	• No change		
		Rifabutin (Mycobutin)	• No change		
		Topical Antibiotics	• No change		
		Fertility Agents	• No change		
		Erectile Dysfunction Medications	• No change		
		Physician Administered Drug (PAD) Guidelines	**Changes**		
		Exondys 51	• Minor wording update		
		Erythropoiesis-Stimulating Agents	• Remove duplicate Procrit Minor zidovudine clarification		
		Adakveo	• No change		
		Interim Formulary Updates			
		• See p. 105 in packet			
		Pharmacy Policy & Procedure Updates			
		• RX-002 – PA Review Process	• DMHC Contraceptive language addition		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes

- RX-003 – Exception Review Process
- DMHC Step Therapy language addition

ED Oversight

- None

90 Day Maintenance List updates

- 365-day contraceptive coverage language

P&T Meeting Minutes

- P&T Meeting Minutes Q2 June 20, 2023

Interim Formulary Changes

These changes have been made to the Alliance's formulary recently. The changes were necessary to enhance the formulary.

Medication	Formulary Change
Trikafta 80-40-60 mg (d)/59.6 mg (n) granule pack, Trikafta 100-50-75 mg (d)/75 mg (n) granule pack	NF to F-PA
Lupron Depot-Ped 45 mg intramuscular syringe kit	NF to F-PA
Abilify Asimtufii 720 mg/2.4 mL suspension, extend .rel. IM syringe, Abilify Asimtufii 960 mg/3.2 mL suspension, extend. rel. IM syringe	NF to F-PA
Kalydeco 13.4 mg oral granules in packet	NF to F-PA
Udenyca Autoinjector 6 mg/0.6 mL subcutaneous auto-injector	NF to F-PA

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Liqrev 10 mg/mL oral suspension — NF to F-PA Zeposia Starter Kit (28-day) 0.23 mg-0.46 mg-0.92 mg capsules dosepack — NF to F-PA Flucelvax Quad 2023-2024 — NF to F-AL-QL (12 years and up) (1 fill per 270 days) Fluad Quad 2023-2024 — NF to F-AL-QL (65 years and up) (1 fill per 270 days) Afluria Quad 2023-2024 — NF to F-AL-QL (12 years and up) (1 fill per 270 days) Flublok Quad 2023-2024 — NF to F-AL-QL (18 years and up) (1 fill per 270 days) Fluzone Quad 2023-2024 — NF to F-AL-QL (12 years and up) (1 fill per 270 days) Fluzone High-Dose Quad 2023-2024 — NF to F-AL-QL (65 years and up) (1 fill per 270 days) Flumist Quad 2023-2024 — NF to F-AL-QL (12-49 years) (1 fill per 270 days) Flulaval Quad 2023-2024 — NF to F-AL-QL (12 years and up) (1 fill per 270 days) Fluarix Quad 2023-2024 — NF to F-AL-QL (12 years and up) (1 fill per 270 days) Afluria Quad 2023-2024 — NF to F-AL-QL (12 years and up) (1 fill per 270 days) Mycozyl (tolnaftate) AC External Cream 1 % — F to NF (no past 6 month utilization) FaStep COVID-19 Antigen Test In Vitro Kit — NF to F-QL (8 per 30 days)		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Physician Administered Drug (PAD) Prior authorization (PA) list Updates **HCPCS Code** / **Product Name (Generic Name, Brand Name)** / **PA Action** **J9160** ONTAK (DENILEUKIN DIFTITOX) 300 MCG Addition **J2503** MACUGEN (PEGAPTANIB SODIUM) 0.3 MG Addition **J2504** ADAGEN (PEGADEMASE BOVINE) 25 IU Addition **J0135** HUMIRA (ADALIMUMAB) 20MG Addition **J3490** UNCLASSIFIED Drug Addition The following changes have been made to the Alliance 's PAD PA list recently. These changes were necessary to evaluate medical necessity based on medical guidelines, utilization, and other information.		
V) New Business	N. Felten	**New MRGs** **Specialty Biologic Agents** - Step 1 preferred pays at point of sale - Hadlima (adalimumab-bwwd) and adalimunmab-fkjp (Hulio) **Transthyretin-mediated amyloidosis agents** - Preferred: Amvuttra (vutrisiran) - Cardiomyopathy-Vyndaquel (tafamidis meglumine), Vyndamax (tafamidis) - Presriber must be neurologist, cardiologist, or specialist in the treatment of amyloidosis. **Vowst** - Vowst (fecal microbata spores, live-brpk) - Vowst is reserved for members who have a diagnosis of at least 1 recurrent episode of CDI (≥2 total CDI episodes), with the current episode of CDI being controlled (<3 unformed/loose stools/day for 2 consecutive days) and a positive stool test for C. - difficile within 30 days before prior authorization request. - Administration must be24–72 hours following completion of antibiotic course for CDI treatment and the member must bowel cleanse using magnesium citrate or polyethylene glycol electrolyte solution the day before the first dose of Vowst. **Vyjuvek (beremagene geperpavec-svdt)** - Should be administered by a health professional once weekly. - Wound presentation must be appropriate in appearance.	Move to approve: 1st:PG 2nd:BD	

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		- All require specialist prescribers. **New PADs** **Omisirge (omidubicel-onlv)** - IV medication indicated for use in adults and pediatric patients. 12 years or older. - Patient has a hematologic malignancy planned for umbilical cord blood transplantation following myeloablative conditioning. - Treatment is modified allogeneic hematopoietic stem cell donor source. - Represents a new option for patients who are eligible for transplants but are unable to find a donor source. - Patients must have the appropriate diagnosis, not have an available donor and have no prior stem cell transplant. - Indicated as a one-time treatment. **Qalsody (tofersen)** - New policy for Oalsody, indicated for the treatment of ALS in adults who have a mutation of the SOD1 gene. - The first agent approved specifically for this population. - We are looking for the correct diagnosis with the correct genetic mutation. Patients should not be dependent on ventilation or tracheostomy. **Lamzede (velmanase alfa)** - New policy newer IV medication indicated for treatment of non-central nervous system manifestations of alpha mannosidosis in adults and pediatric patients. - This drug provides alpha mannosidase enzyme. - We are looking for the correct diagnosis, attestation of non-central nervous system manifestations, patient weight, and the ability to walk without support. **Enzyme Replacement Therapies for Fabry Disease** - Enzyme replacement therapies for Fabry disease. - This policy covers two medications Fabrazyme and Elfabrio - Fabry disease is a rare progressive genetic disorder caused by the deficient alpha-galactosidase. - Requesting correct diagnosis by enzyme level or pathogenic mutation for males. For females' genetic detection of the gene and clinical manifestations. Should not be using Galafold and need weight.		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Vyjuvek (beremagene geperpavec-svdt) - Same as corresponding pharmacy policy just reviewed. - This medication may be billed either through pharmacy claim or medical benefit. **Elevidys (delandistrogene moxeparvovec-rokl)** - Gene therapy IV product indicated for the treatment of ambulatory pediatric patients aged 2-5 years with DMD with a confirmed mutation and DMD gene. - This is the first gene therapy for DMD designed to target the underlying cause of the disease. - We are looking for the correct dose confirmed by genetic testing, correct diagnosis, correct dose and attestation that patient is still ambulatory. And the patient has been on a stable dose of corticosteroids for at least 3 months. Also, we need documentation of the baseline micro-dystrophin protein level. - Cost is 3.2 million dollars per treatment **Specialty Biologic Agents for FDA approved indications** - Will discuss with Humira. **Leqembi (lecanemab-irmb)** - This treatment should be initiated in treatment in Alzheimer's Disease for patients with mild cognitive impairment or mild dementia. That is the population that was initiated in the clinical trial. - CMS has indicated Medicare will cover the Alzheimer's Disease drugs with traditional approval and appropriate setting and support the collection or real-world data that will be through participation in a registry. - We are requiring evidence of the diagnosis if stage 3 or stage 4 Alzheimer's Disease as evidenced by documented by one of the three rating scales with a dose that is FDA approved. - We are looking for in the past year results of history of positive results for te presence of beta amyloid plaques on a PET scan or cerebrospinal fluid testing as well as recent within the past year MRI scan. - Asking for a baseline disease severity documentation, as well as no recent history of stroke, CIA or seizure in the past year for safety. **Gene Therapy for Regular Red Blood Cell (RBC) Transfusion Dependent Beta-Thalassemia** - Zynteglo is the first gene therapy to be approved by the FDA for the treatment of transfusion dependent beta-thalassemia. - This is a rare and inherited blood disorder caused by mutations in the beta globulin gene. - It is another one-time treatment with a high cost of 2.8 million per treatment - For this policy we are looking for appropriate dose and diagnosis as well as member requiring regular red blood cell transfusions with one of the two definitions listed in the sub bullet point and the prescriber attestation that there is no family match HSCT and a negative pregnancy test.		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Roctavian (valoctocogene roxaparvovec) - The first gene therapy approved for treatment of adults with severe hemophilia A without antibodies AAV2 as well as detected by an FDA approved anti-AAV2 antibody test showing the patient is negative for anti -AAV5 antibodies. - Roctavian is a viral vector carrying the FVIII gene that encodes factor eight and is administered IV as a one-time dose treatment - It is intended to be alternative treatment to chronic prophylaxis therapy with factor VIII or hemlibra products 2.9 million dollars per treatment. - For this policy we are looking for diagnosis of severe hemophilia A, documentation that they are taking a current prophylactic regime of Factor VIII infusions or bispecific monoclonal antibodies. - Documented anti-AAV5 antibody test showing the patient is negative for anti-AAV5 antibodies. - Documented Factor VIII inhibitor titer test showing the patient is negative for Factor VIII inhibitors. - Attestation that the prescriber performed liver health assessments, pt. weight. **Enzyme replacement therapy for acid sphingomyelinase deficiency (ASMD)** - This is IV medication Xenpozyme indicated for the treatment of non-central nervous system manifestations of ASMD in adult and pediatric patients. - The mutation results in damage to the liver, spleen, lungs, bone marrow, lymph nodes and neurons. - We require a correct diagnosis confirmed by one of the two bullet point methods. - The clinical presentation consistent with type B or type A/B - Documentation of baseline ALT and AST withing 1 month prior to initiation of treatment. **Generalized Pustular Psoriasis (GPP) Agents** - Spevigo is the first FDA approved IL 36 receptor antagonist indicated for the treatment of GPP flares in adults. This is a chronic systemic inflammable disease that is accompanied by a high fever and general malaise. - One time dose, two doses may be given if symptoms remain. - Requires appropriate diagnosis with a moderate to severe acute flare. If a member has taken Spevigo in the past they must have achieved a significant clinical response for the second dose.		
VI) Class Reviews, Monographs, and Recommendations	N. Felten	**Humira Biosimilar Comparative Review and Strategy**		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Recommendation: - Humira has increased in cost year after year. On July 1st of this year many biosimilar drugs launched. - The competition has led to significant price reductions. - The chart in comparative review is on page 190. - Both bio similar are seeking interchangeable status and Hadlima does have the high concentration dosage form. - The previous authorization volume we see high approval rates of about 86%. Humira was being prescribed regularly and appropriately. To eliminate provider and member burden with the new cost effective biosimilars we are recommending adding unbranded Hulio and Hadlima to formulary with a quantity limit and removing prior authorization requirement. - We also recommend transitioning members to these two products. - This would lead to considerable savings at over $134.000 per year if all members converted to the biosimilar who are currently on brand Humira. - To align with the recommendation, we are also recommending updating the prior authorization criteria. - We are going to retire the indications specific policies and approve a newly developed policy for all FDA approved indications. - The new policy Specialty Biologic Agents will take the place of all of our previous disease state specific policy. - Step 1: Prefeerred pays at point of sale (POS) Hadlima and Hulio - The rest of the biologic's demurs are stratified into two steps selected based on clinical characteristics and cost. - To have a step two drug is the indication and dose must be appropriate is to have and member must have tried and failed or have a reason why they cannot use one of the biosimilars. - Step 3 agents the member must have tried both step 1 and step 2 drugs and if side effects are cited as a reason not to use a biosimilar the FDA MedWatch form must be filled out and a copy submitted along with the request. - We do have exceptions where requests for the lower concentration used in pediatric patients may be approved without trying step 1 or step 2 agents and we have removed our previous preferred agents. **Comments:** SO: Its complicated and a different way to organize the construct around the new products.		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Abrysvo Monograph **Recommendation:** - New RSV vaccine indicated for 16 years or older as well as pregnant individuals at 32 to 36 weeks gestational age for the prevention of RSV in infants from birth through 6 months of age. - Given as a single IM shot. - We are recommending addition to the formulary with a limit of one dose per lifetime. **Comments:**		
		Arexvy Monograph **Recommendation:** - Indicated in patients with active immunization for the prevention of lower respiratory tract disease caused by respiratory syncytial virus in individuals 60 years of age or older. Not in pregnant individuals. **Comments:** BD: Is the RSV indicated for patients use with immuno depressive therapy? NF: This one is only aged based for 60 and older for both. Abrysvo and Arexvy, Abysvo is for pregnant individuals no lower ages if they have immune compromised. HL: Starting October 1st all RSV vaccine will be also covered without PA. Can be found on the Medi-Cal Rx website. SO: That is important, there will be no criteria and can be given at the clinic. HL: No criteria.		
		Ophthalmic Antibiotics & Ophthalmic Antibiotics -Steroid Combinations Class Review **Recommendation:** - Change brand Tobradex to formulary – PA 2-fills per 365 days. - The cost is over $257 per tube. - Adding in the formulary ointment **Comments:**		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Ulcerative Colitis Class Review **Recommendation:** - No formulary changes recommended. - Prior authorization policy as shown for mesalamine change is to remove Crohn's disease as an indication as these formularies are only specifically indicated for ulcerative colitis. - Corticosteroids for ulcerative colitis and Crohn's disease policy where we changed brand and generic status added new medication Orikos as well as criteria for its use. **Comments:**		
		Chelating agents Class Review **Recommendation:** - No formulary change recommendations - MRG for farriprox we are recommend a trial and failure for deferasirox - Policy for Wilsons disease adding new medication Cuvior to the policy and the criteria for review. **Comments:**		
		Respiratory Aids and Devices Class Review **Recommendation:** - We are looking to align all formulary peak flow meter and nebulizers to allow QL 1 per 365 days. - Align formulary spacers to have 2 QL per 365 days. - Would like to retire this policy as there are various spacers and any non-formulary items can be reviewed via the general non-formulary policy. **Comments:**		

VII) Medication Request Guidelines	R. Negash	The committee has reviewed and discussed the following updates and additions to the Medication Review Guidelines (MRG) Guideline (Changes): **Nuedexta (dextromethorphan/quinidine)** - Updating the indication since it is now for Pseudobulbar Affect not secondary to ALS or MS. We are making that update to reflect the new indication. - No other changes Guideline (Changes): **Cartilaginous Repair Agents** - We are removing the Sodium hyaluronate since its no longer on the market. - No other changes Guideline (Changes): **Ophthalmic Anti-inflammatory Immunomodulators** - First change in the medication section, spelling updates and adding the new Miebo drops to our criteria - In the PA review criteria we will see updates for indication - We are including dry eye and treatment of dry eye symptoms and dry eye disease - Instead of keratoconjuctivitis sicca alone - We will also remove the diagnosis of ocular graft and host disease or corneal transplant rejections prophylaxis since these are off label uses - We are updating products that require PA by listing a general statement instead of medication so that it will address new products that will enter the market. - Spelling updates as well. - No other content change. Guideline (Changes): **Desvenlafaxine succinate (Pristiq) – RETIRE** - Generic Pristiq. - Recommendation is to retire the policy - Each tablet is 60 cents about $18 dollars a month - We will actually recommend to have this on formulary instead of formulary AA. this will pay at POS - Other products for this are less expensive but we would like to expand formulary for this item. Guideline (Changes): **White Blood Cell Stimulators** - Changes in the medication section most of them we are just rearranging the order of preferred agents and adding agents that came to market. - Stimufend and Fylnetra are getting added - And we also have the Rolvedon adding in formulary section and grouping together appropriately. - No other changes.		

Guideline (Changes): **Drugs for Gender Dysphoria For Less Than 21 Years Old**

- We are getting formulary alignment.
- Removing 40yr old age limit requirement for estradiol patches. This will help to allow access for those under 40years old at POS.
- All age limit language is getting removed from the policy.
- We are also removing products that are no longer available, in this case its Vantas
- In our covered uses we are updating guidelines for accuracy
- No other changes.

Guideline (Changes): **Drugs for Gender Dysphoria For At Least 21 Years Old**

- Same changes as previous guideline but for at least 21 years old
- Removing age limits, removing Vantas and guideline updates.
- No other changes

Guideline (Changes): **Intranasal Steroids**

- Updates include the addition of Flonase Sensimist formulary alignment with budesonide (Rhinocort) suspension. This already pays at POS we are just adding it to our criteria so its clear.
- It is repeated in its non-formulary agent requests
- No other changes

Guideline (Changes): **Opioid Use Disorder (OUD) Agents**

- Medications section we are adding a new product Brixadi
- This is going to be non-formulary status.
- We have prescriber restrictions that we are lifting since the data 200 also known as the x waiver is discontinued. We want to make sure that there is no barrier to accessing the product.
- We are rearranging the review criteria section. We have requests for medication that are formulary PA and non-formulary. For example, suboxone film we are looking for appropriate dosing and they are trying the preferred product which is the Subtext tablet and the Suboxone tablet.
- We see for Brixadi the same structure and criteria, appropriate diagnosis and preferred agents
- The reauthorization criteria we want to see that appropriate dosing is being utilized
- No other changes

Guideline (Changes): **Alosetron (Lotronex)**

- The first stange is for the inclusion criteria we are going to remove the gender restrictions since we don’t have that in our formulary.
- We also going to remove soluble fiber as a preferred agent. We are doing this based on guidelines since they point ot IBS-D and global IBS for the use of the soluble fiber. Since technically Alosetron is indicated for IBS_D specific to diarrhea
- No other changes.

		Guideline (Changes): **Viberzi (eluxadoline)** - Changes are in the review criteria; we are adding contra indications here and this is consistent with the AGA guidelines. - We are looking to see that the member has gallbladder and also, they are not drinking more than 3 alcoholic beverages per day. - You see again the removal of soluble fiber since this is a IBS-D specific policy - No other changes Guideline (Changes): **Rifamycin Antibiotics** - The same soluble fiber update we are removing that as preferred with the similar logic of the previous policy - No other changes Guideline (Changes): **Injectable/Infusible Bone-Modifying Agents for Oncology Indications** - One simple change we are removing the requirement for baseline renal function since these requests are coming from specialists and monitoring is likely inferred here. - No other changes Guideline (Changes): **Medications for the treatment of Multi-Drug Resistant Tuberculosis** - We are removing pacer as a obsolete option here and updating the coverage duration for Sirturo and Pretomanid and this is based on the pivotal trials and guidance. - The PA review Criteria we are getting rid of the one bullet point that is referencing limitation to pulmonary since it is already mentioned in the diagnosis bullet point above - No other changes. Guideline (Changes): **Adenosine Triphosphate-Citrate Lyase (ACL) inhibitors** - The change is we are adding the congenital heart disease (CHD) criteria option - For those who have hyperlipidemia and atherosclerotic cardiovascular disease this is one of the options for one of the following that would meet criteria of use for these agents. - Also, format update for the reauthorization criteria with the addition of OR - No other changes Guideline (Changes): **Vaginal Progesterone** - First change is in the coverage duration. - Adding Endometrin so that its available with a 30-day supply - In PA review criteria we are showing that short cervix is a requirement for use, and this is based on the guidelines that show that there is no benefit for patients if they don't have this condition. - No other changes Guideline (Changes): **Injectable/Infusible Agents for Osteoporosis and Paget's Disease** - In the Glucocorticoid-Induced Osteoporosis section we are updating to include high to very high risk of fracture - We are removing the element the 10year probability of hip or combined major osteoporosis facture between 1 to 3 percent and 10 to 19 percent respectively. - Since this parameter does not call for injectable osteoporosis treatment		

		- No other changes Guideline (Changes): **Synagis – RETIRE** - Indicated for those 24 months and younger and for IHSS the population for group care members is at least 12 - Guideline (Changes): **Specialty Biological Agents Preferred Products – RETIRE** - Falls in line with the humira biosimiliar conversion strategy. The beginning of the criteria that is specific to each indication. Guideline (Changes): **Specialty biologics for Chron's – RETIRE** Guideline (Changes): **Specialty Biological Agents for Ulcerative Colitis – RETIRE** Guideline (Changes): **Specialty Biological Agents for Rheumatoid Arthritis – RETIRE** Guideline (Changes): **Specialty Biological Agents for Adult Psoriatic Arthritis (PsA) – RETIRE** Guideline (Changes): **Specialty Biological Agents for Psoriasis – RETIRE** Guideline (Changes): **Specialty Biological Agents for Juvenile Idiopathic Arthritis – RETIRE** Guideline (Changes): **Specialty Biological Agents for Ankylosing Spondylitis – RETIRE** Guideline (Changes): **Specialty Biological Agents for Non-radiographic Axial Spondyloarthritis (nr-axSpA) – RETIRE** Guideline (Changes): **Specialty Biological Agents for Hidradenitis Suppurativa – RETIRE** Guideline (Changes): **Specialty Biological Agents for Giant Cell Arteritis – RETIRE** Guideline (Changes): **Specialty Biological Agents for Uveitis- RETIRE** **Comments/Questions:**		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
VIII) Physician Administered Drug (PAD) Policies	N. Felten	**Aduhelm** - Rearranging the bullet points and requirements to standardize the language and format between this policy. - We want to require only one evidence score for diagnosis vs previously all. - Update the documentation requirement confirmation of beta amyloid to align with the package insert and trial. - For reauthorization in place of outlining all safety parameters we would like to require prescriber attestation that safety monitoring and management of amyloid related imaging abnormalities also know as ARIA and intra cerebral hemorrhage is being conducted vs attesting to all the different parts of that. **Rebyota** - Adding in the new medication Vowst the fecal transplant capsule adding to the medical policy as well with the same criteria because this could potentially be given to inpatient as well. **Injectable/Infusible Agents for Osteoporosis and Paget's Disease** - Making the same changes that Rahel described in the corresponding MRG for Glucocorticoid-Induced Osteoporosis therapy the very high-risk category and omission of the FRAX 10 - **White Blood Cell Stimulators** - Changes mirror what was presented by Rahel **Iron-containing Products** - Recommending updating the policy for injectors newly obtained indication for treatment in iron deficiency of adult patients with heart failure - Want to allow approval with diagnosis of NYHA class II/III only - Update coverage durations to be inclusive with both possible dosing schedules for iron deficiency anemia for Injectafer **Tepezza** - Newly gained expanded indication for in active thyroid disease previously it was just active. - We are recommending removing the CAS requirement and we are also inserting some bullet points to differentiate the pre-requisite therapies based on disease activity **Specialty biologics for Chron's – RETIRE** **Specialty Biological Agents for Ulcerative Colitis – RETIRE**		

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Specialty Biological Agents for Rheumatoid Arthritis – RETIRE **Specialty Biological Agents for Adult Psoriatic Arthritis (PsA) – RETIRE** **Specialty Biological Agents for Psoriasis – RETIRE** **Specialty Biological Agents for Ankylosing Spondylitis – RETIRE** **Specialty Biological Agents for Non-radiographic Axial Spondyloarthritis (nr-axSpA) -RETIRE** **Specialty Biological Agents for Juvenile Idiopathic Arthritis – RETIRE** **Specialty Biological Agents for Hidradenitis Suppurativa – RETIRE** **Specialty Biological Agents for Giant Cell Arteritis – RETIRE** **Specialty Biological Agents for Uveitis – RETIRE**		
IX) Informational Updates on New Developments in Pharmacy	N. Felten	New Product Review - New Products were discussed.		

BRAND NAME	GENERIC NAME/DOSAGE FORM	RECOMMENDATION
Trikafta	elexacaftor/tezacaftor/ivacaft 80-40-60 mg (d)/59.5 mg (n) granule pack, and 100-50-75 mg (d)/75 mg (n) granule pack	F-PA (already added via CRF)
Gralise	Gabapentin 900mg, 750mg, 450mg extended release tablet	Non-formulary
Qalsody	Tofersen 100 mg/15 mL (6.7 mg/mL) intrathecal solution	Non-formulary (see new PAD policy)
Lupron Depot-Ped 45 mg intramuscular syringe kit	leuprolide acetate 45 mg intramuscular syringe kit	F-PA (already added via CRF)
Vowst	fecal microbio spore,live-brpk capsule	Non-formulary (see new PAD & MRG policy)
Abilify Asimtufii	720 mg/2.4 mL suspension, extend.rel. IM syringe, 960 mg/3.2 mL suspension, extend.rel. IM syringe	F-PA (already added via CRF)
Lumryz	Sodium oxybate 4.5 gram, 6 gram, 7.5 gram, 9 gram granules extended release in packet	Non-formulary
Kalydeco	Ivacaftor 13.4 mg oral granules in packet	F-PA (already added via CRF)
Zolpidem	Zolpidem 7.5 mg capsule	Non-formulary

			Uzedy	Risperidone 50 mg/ 0.14 mL, 75 mg/ 0.21 mL, 100 mg/ 0.28 mL, 125 mg/ 0.35 mL, 150 mg/ 0.42 mL, 200 mg/ 0.56 mL, 250 mg/ 0.7 mL subcut extended-release suspension syringe	Non-formulary			
			Udenyca	Pegfilgrastim-cbqv 6 mg/ 0.6 mL subcutaneous auto-injector	F-PA (already added via CRF)			
			Sogroya	somapacitan-beco 5 mg/1.5 mL (3.3 mg/mL), 10 mg/1.5 mL (6.7 mg/mL), 15 mg/1.5 mL (10 mg/mL) subcutaneous pen injector	Non-formulary			
			Liqrev	sildenafil citrate 10 mg/mL oral suspension	F-PA (already added via CRF)			
			Veozah	Fezolinetant 45mg tablet	Non-formulary			
			Amjevita	adalimumab-atto (CF) 10 mg/0.2 mL subcutaneous syringe	Non-formulary			
			Tafinlar	dabrafenib mesylate 10 mg tablet for oral suspension	Non-formulary			
			Mekinist	trametinib dimethyl sulfoxide 0.05 mg/mL oral solution	Non-formulary			
			Elfabrio	pegunigalsidase alfa-iwxj 2 mg/mL intravenous solution	Non-formulary (see new PAD policy)			

			Omnipod Go	Omnipod Go pods 10 units, 15 units, 20 units, 25 units, 30 units, 35 units, 40 units/day subcutaneous	Non-formulary			
			Bigfoot Unity	Bigfoot Unity pen cap-Novolog device, Humalog device, lispro device, Lyumjev device, Admelog device, Apidra device, aspart device, Tresiba device, Lantus device, Fiasp device, Basaglar device, Toujeo device, Toujeo Max device, Bigfoot Unity program kit	Non-formulary			
			Kalydeco	Ivacaftor 5.8 mg oral granules in packet	F-PA (already added via CRF)			
			Epkinly	Epcoritamab-bysp 48 mg/0.8 mL subcutaneous solution, 4 mg/0.8 mL subcutaneous solution (MUST DILUTE)	Non-formulary			
			Brixadi	Buprenorphine Weekly 8 mg/0.16 mL, 16 mg/0.32 mL, 24 mg/0.48 mL, 32 mg/0.64 extended release subcutaneous syringe Buprenorphine Monthly 64 mg/0.18mL, 96 mg/0.27 mL, 128 mg/0.36 mL extended release subcutaneous syringe	Non-formulary			

			Zavzpret	zavegepant hcl 10 mg/actuation nasal spray	Non-formulary			
			Inpefa	sotagliflozin 200mg tablet	Non-formulary			
			Olpruva	Sodium phenylbutyrate 2 gram, 3 gram, 4 gram, 5 gram, 6 gram, 6.67 gram oral pellets in packet	Non-formulary			
			Zeposia	Ozanimod hydrochloride starter Kit (28-day) 0.23 mg-0.46 mg-0.92 mg capsules dosepack	Non-formulary			
			Vyjuvek	beremagene geperpavec-svdt 5 x 10exp9 PFU/2.5 mL topical gel	Non-formulary (see new PAD policy)			
			Miebo 100 % eye drops	perfluorohexyloctane/ pf 100 % eye drops	F-PA (see MRG review)			
			Zejula	niraparib tosylate 100mg, 200mg, 300mg tablets	Non-formulary			
			Columvi	glofitamab-gxbm 1 mg/mL intravenous solution	Non-formulary			
			Talzenna	talazoparib tosylate 0.1mg, 0.35mg capsules	Non-formulary			
			Vyvgart Hytrulo	efgartigimod-hyaluronidas-qvfc 1,008 mg-11,200	Non-formulary			

				unit/5.6 mL subcutaneous solution				
			Hulio	adalimumab-fkjp 20 mg/0.4 mL, 40 mg/0.8 mL subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	Non-formulary			
			Adalimumab-fkjp	adalimumab-fkjp 20 mg/0.4 mL, 40 mg/0.8 mL subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	F-QL (see Humira document)			
			Idacio	adalimumab-aacf 40 mg/0.8 mL subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	Non-formulary			
			Rezzayo	rezafungin 200 mg intravenous vial	Non-formulary			
			Cyltezo	adalimumab-adbm 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml, subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	Non-formulary			
			Rystiggo	rozanolixizumab-noli 280 mg/2 ml subcutaneous vial	Non-formulary			
			Suflave	polyethylene glycol 3350/sodium sulfate/potassium chloride/magnesium sulfate/sodium chloride 178.7 g-7.3 g-	Non-formulary			

				1.12 g-0.9 g-0.5 g oral solution				
			Elevidys	delandistrogene moxeparvovec-rokl 1.33 x 10^{13} intravenous suspension	Non-formulary (see new PAD policy)			
			Adalimumab-adaz	adalimumab-adaz 40 mg/0.4 ml subcutaneous syringe; 40 mg/0.4 mL subcutaneous auto-injector	Non-formulary			
			Hyrimoz	adalimumab-adaz 10 mg/0.1 ml, 20 mg/0.2 ml, 40 mg/0.4 ml, 80 mg/0.8 ml subcutaneous syringe; 40 mg/0.4 mL, 80 mg/0.8 ml subcutaneous auto-injector	Non-formulary			
			Yusimry	adalimumab-aqvh 40 mg/0.8 mL subcutaneous pen injector	Non-formulary			
			Yuflyma	adalimumab-aaty 40 mg/0.4 mL subcutaneous pen injector	Non-formulary			
			Hadlima	adalimumab-bwwd 40 mg/0.4 ml, 40 mg/0.8 ml subcutaneous syringe; 40 mg/0.4 mL, 40 mg/0.8 ml subcutaneous auto-injector	F-QL (see Humira document)			
			Litfulo	ritlecitinib 50 mg oral tablet	Non-formulary			

			Austedo XR	deutetrabenazine 6 mg-12mg-24mg ER tablet titration pack	Non-formulary			
			Abrysvo	respiratory syncytial virus vaccine	F-QL (see monograph)			
			Adstiladrin	nadofaragene firadenovec-vncg	Non-formulary			
			Arexvy	respiratory syncytial virus vaccine, adjuvanted	F-QL (see monograph)			
			Roctavian	valoctocogene roxaparvovec-rvox	Non-formulary (see new PAD policy)			
			Brenzavvy	bexagliflozin 20 mg oral tablet	Non-formulary			
			Xenpozyme	olipudase alfa-rpcp 4 mg intravenous vial	Non-formulary (see new PAD policy)			
			Vanflyta	quizartinib 17.7 mg, 26.5 mg oral tablets	Non-formulary			
			Ngenla	somatrogon-ghla 24 mg/1.2 ml, 60 mg/1.2 ml subcutaneous pen injector	Non-formulary			
			Cosentyx	Secukinumab 300 mg/2 ml subcutaneous auto-injector	F-PA (already added via CRF)			
			Yuflyma	adalimumab-aaty 40 mg/0.4 mL subcutaneous prefilled syringe	Non-formulary			

Agenda Item	Discussion Leader	Discussion Summary	Action	Notes
		Xdemvy — lotilaner 0.25% ophthalmic solution — Non-formulary Beyfortus — nirsevimab-alip 50 mg/0.5 ml, 100 mg/ml intramuscular syringe — Non-formulary Xacduro — sulbactam/durlobactam 1 g-1 g intravenous vial — Non-formulary Izervay — avacincaptad pegol 2 mg/0.1 ml intravitreal vial — Non-formulary		
X) Old Business	N. Felten	- None		
XI) Public Comment	N. Felten	- No public comment		
XII) Adjournment	S. O'Brien	- Meeting adjourned at 6:34PM	None	

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10/24/2023
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Steve O'Brien, MD
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10/26/2023
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Helen Lee, PharmD, MBA
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Alameda Alliance for Health

10/26/2023
Date

Alameda IHSS Benchmark Analysis and Recommendations: Q4 2023 P&T

USP Category: Dermatological Agents

USP Class: Dermatitis and Pruritus Agents

Benchmark Count	Formulary Count	Recommended Formulary Additions	Status	Rationale
16	15	• Eucrisa External Ointment 2 % (DDID 196328)	F-PA	• There are already review criteria for Eucrisa in the Agents for Atopic Dermatitis. This is a commonly used medication.

USP Category: Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)

USP Class: Anabolic Steroids

Benchmark Count	Formulary Count	Recommended Formulary Additions	Status	Rationale
1	0	• None	N/A	• The only member of this class, oxandrolone, is no longer available in either brand or generic form, so cannot be added to the formulary to meet this benchmark drug count.

New Physician Administered Drug (PAD) Guidelines Alameda Q4 2023 P&T

New PAD:

Myasthenia Gravis Agents	
Medications	Vyvgart (efgartigimod) Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase) Rystiggo (rozanolixizumab) Soliris (eculizumab) Ultomiris (ravulizumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**Other Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age ≥ 18 years
Prescriber Restrictions	Prescribed by a neurologist or rheumatologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Diagnosis of generalized myasthenia gravis (gMG) • Patient has a positive serological test for one of the following: o Anti-AChR antibodies o Anti-muscle-specific tyrosine kinase (MuSK) antibodies (Rystiggo only) • Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II, III or IV • Patient has tried and failed, or has contraindication, to one of the following: o Two (2) or more conventional therapies (i.e. acetylcholinesterase inhibitors, corticosteroids, non-steroidal immunosuppressive therapies) o Failed at least 1 conventional therapy and required chronic plasmapheresis or plasma exchange or intravenous immunoglobulin • Medication is prescribed at an FDA approved dose • Patient is not using agents covered by this policy concurrently (i.e. no concurrent use of Vyvgart, Vyvgart Hytrulo, Rystiggo, Soliris, or Ultomiris) • Requests for Soliris (eculizumab) and Ultomiris (ravulizumab) will also require all of the following: o Documentation of vaccination against meningococcal disease or a documented medical reason why the patient cannot receive vaccination or vaccination needs to be delayed o Antimicrobial prophylaxis with oral antibiotics (penicillin, or macrolides if penicillin-allergic) for two weeks will be administered if the meningococcal vaccine is administered less than two weeks before starting therapy or a documented medical reason why the patient cannot receive oral antibiotic prophylaxis **Re-Authorization:** • Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality-of-life scores, MG-ADL scores, etc). • Medication is prescribed at an FDA approved dose.

	If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last P&T Review Date	12/2023

New PAD:

Veopoz	
Medications	Veopoz (pozelimab-bbfg)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	• Patients with unresolved Neisseria meningitidis infection • Concurrent use of another complement inhibitor (i.e. Soliris)
Required Clinical Information	See "**Other Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber must have experience in treating complement related disorders (i.e., gastroenterologist, immunologist, cardiologist, etc.)
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria	**Initial Authorization:** • Medication is prescribed at an FDA approved dose • Diagnosis of CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease • Documentation of hypoalbuminemia (serum albumin <3.5 g/dL) • Documentation of patient weight **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e. symptom improvement, normalization of labs such as serum albumin (3.5-5.5 g/dL) and IgG concentrations, reduced hospitalizations and severe adverse events, increased quality of life, etc.) • Documentation of patient weight • Medication is prescribed at an FDA approved dose If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last P&T Review Date	12/2023

New PAD:

Lantidra	
Medications	Lantidra (donislecel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**Other Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age 18 years of age and older
Prescriber Restrictions	Prescriber must be an endocrinologist
Coverage Duration	If all criteria are met, the request will be approved for one infusion. A member may only receive a maximum of 3 infusions per lifetime as there is no data regarding the efficacy or safety for treatment with more than 3 infusions.

Other Criteria	**Initial Authorization**
	
	• Documentation of Type 1 Diabetes diagnosis for more than 5 years
	• Documentation of blood glycated hemoglobin (HbA1c) above target goal
	• Documentation of intensive insulin management efforts (i.e., adjusting insulin regimen to multiple daily injections, frequently monitoring blood glucose levels daily, the use of devices such as a continuous glucose monitor, etc.)
	• Member has at least one of the following, despite intensive insulin management efforts:
	  ○ Inability to sense hypoglycemia until the blood glucose falls to less than 54 mg/dL
	  ○ At least 1 or more episodes of severe hypoglycemia (blood glucose below 50 mg/dL) in the past 3 years
	• Provider must confirm the following:
	  ○ Blood glycosylated hemoglobin (HbA1c) is not higher than 12%
	  ○ Member has an insulin requirement of no more than 0.7 International Units (IU)/kilogram/day
	  ○ Member has a Body Mass Index (BMI) less than 27 kg/m^2
	  ○ Member is not diagnosed with a psychiatric disorder (i.e., schizophrenia, bipolar disorder, or major depression)
	  ○ Member does not have severe cardiac disease as defined by: Recent myocardial infarction within the past 6 months, angiographic evidence of non-correctable coronary artery disease, or evidence of ischemia on a functional cardiac exam
	• Provider attests that member will be receiving concomitant immunosuppression therapy
	• Drug is being requested at an FDA-approved dose
	• Member's weight
	
	Reauthorization
	
	• Member has not achieved independence from exogenous insulin within one year of infusion OR member has lost independence from exogenous insulin within one year after a previous infusion
	• Provider attests that member will be receiving concomitant immunosuppression therapy

	• Drug is being requested at an FDA-approved dose • Member's weight If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last P&T Review Date	12/2023

New PAD:

Bleeding Disorder Products	
Therapeutic Classes (AHFS)	Hemostatics
Medications	Advate, Adynovate, Afstyla, Alphanate, Alphanine SD, Alprolix, Altuviiio, Benefix, Eloctate, Esperoct, Hemlibra, Hemofil M, Humate-P, Idelvion, Ixinity, Jivi, Koate, Koate-DVI, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Profilnine, Rebinyn, Recombinate, Rixubis, Wilate, Xyntha, Xyntha Solofuse, Obizur, Vonvendi, Coagadex, Corifact, Feiba, NovoSeven RT, Tretten, Sevenfact, Fibryga RiaStap, and any newly marketed blood product indicated for a bleeding disorder
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**Other Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age Patient must be age appropriate per package insert
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	If all of the criteria are met, the request will be approved for 1 month. If the provider states that the requested medication is for a chronic or long-term condition for which the medication may be necessary for the life of the patient, the request will be approved for 12 months.
Other Criteria	• Patient has a diagnosis of a bleeding disorder and the type of deficiency has been provided • Product is being used for an FDA-approved indication at an FDA approved dose or the indication/dose are otherwise supported by treatment guidelines or compendia If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last P&T Review Date	12/2023

New Medication Request Guidelines (MRGs) Alameda Q4 2023 P&T

New MRG:

Ocaliva	
Therapeutic Classes (AHFS)	GI Drugs, Miscellaneous
Medications	Ocaliva (obeticholic acid)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age Member must be 18 years of age or older
Prescriber Restrictions	Prescriber must be a hepatologist or gastroenterologist
Coverage Duration	If the criteria are met, the request will be approved for 5 mg once daily for a 3 month duration for initial authorization and up to 10 mg once daily for up to a 12 month duration for reauthorization
PA Review Criteria	**Initial Authorization**: • Diagnosis of primary biliary cholangitis (PBC) with confirmation of diagnosis by the following tests: a) Positive antimitochondrial antibody test b) Elevated serum alkaline phosphatase (ALP) level • Ocaliva is being requested in addition to ursodeoxycholic acid (UDCA) due to patient having an inadequate response to UDCA monotherapy for at least 1 year, OR member has a documented medical reason (e.g. contraindication, intolerance, hypersensitivity) why UDCA cannot be used and is taking Ocaliva as monotherapy • Prescriber attests the patient does not have complete biliary obstruction, decompensated cirrhosis (e.g., Child-Pugh Class B or C), or compensated cirrhosis (Child-Pugh Class A) with evidence of portal hypertension • Submission of the following test results within 30 days of request: a) Serum ALP b) Total bilirubin **Re-authorization**: • Provider attests that the patient has not developed complete biliary obstruction, decompensated cirrhosis (e.g., Child-Pugh Class B or C), or compensated cirrhosis (Child-Pugh Class A) with evidence of portal hypertension • Submission of lab tests confirming each of the following: o A decrease in ALP of ≥ 15% from baseline o ALP is less than 1.67 times the upper limit normal (ULN); defined as 118 U/L for females and 124 U/L for males o Total bilirubin ≤ ULN defined as 1.1 mg/dL for females and 1.5 mg/dL for males
Criteria Statement	Ocaliva is reserved for members with a diagnosis of primary biliary cholangitis (PBC) with confirmation of the diagnosis by the following tests: positive antimitochondrial antibody test and an elevated serum alkaline phosphatase (ALP) level, who have used (or cannot/should not use) to ursodeoxycholic acid (UDCA), Members should not have a diagnosis of complete biliary obstruction, decompensated cirrhosis (e.g., Child-Pugh Class B or C), or compensated cirrhosis (Child-Pugh Class A) with evidence of

	portal hypertension. Recent (within 30 days of the request) serum ALP and total bilirubin lab test results must be submitted.
Last P&T Review Date	12/2023

New MRG:

- Implement new combined Non-Formulary/Prior Authorization Required Medications MRG
  - Replaces the following retired MRG policies:
    - Injectable/Specialty Medications
    - Non-Formulary and PA Required Medications without Drug-Specific Criteria
    - Brand Medications When a Generic or Biosimilar is Available

Non-Formulary/Prior Authorization Required Medications	
Therapeutic Classes (AHFS)	N/A
Medications	• Non-formulary/ PA Required Medications and/or specialty drugs without drug or class specific prior authorization criteria • Brand drugs and reference biologics when a therapeutic equivalent generic drug or biosimilar/interchangeable biologic is available *** The Oral and Injectable Oncology Medications prior authorization criteria will be applied to oncology drugs without drug or class specific criteria***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	According to package insert Check AAH active CCS cases for members < 21 years of age **unless** the medication is being requested for one of the following conditions: • Asthma • Acne • Atopic Dermatitis/Eczema • Psoriasis (except disfiguring condition) • Turner's syndrome • Migraine (not as a result of a CCS coverable condition) • Autism • ADHD • Depression • Failure to thrive • Exogenous obesity • Contraception (Birth control) • Smoking cessation
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, requests will be approved for up to 12 months (depending on the diagnosis and usual treatment duration).
PA Review Criteria	**If request is for a brand name medication with a generic or biosimilar available send to plan for review** ****The use of medications for cosmetic purposes is NOT a covered benefit, unless used to treat gender dysphoria, mental health, or substance use disorder. Medications for cosmetic purposes ARE a covered benefit when used to treat gender dysphoria, mental health, or substance use disorder, when other formulary alternatives are not available**** **Authorization:**

	• The drug is requested for an appropriate use (per the references outlined in "Covered Uses" • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • Patient meets one of the four following criteria: o Documented trial and failure or intolerance with up to two formulary/preferred medications appropriate for the requested use (per the references outlined in "Covered Uses" or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication). For medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. o No other preferred medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia. o All other preferred medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. o The member has tried and failed the 2 separate formulary components of the combination medication OR 2 separate therapeutic equivalents to the components of the combination medication, if available on formulary OR the provider has submitted a medical reason why the requested combination medication would be superior to the required prerequisite trial(s) with formulary drug(s) [e.g. Yosprala (aspirin/omeprazole), the 2 separate components would need to be tried and failed] **AND, if applicable**: o The dose should be consolidated if clinically appropriate (ex: if a request is for Trintellix 10mg tablet, take 2 tablets (=20mg) once daily, a 20mg tablet should be approved, dosed once daily.) • If the request is for a brand drug with a therapeutically equivalent (A-rated) generic drug currently available, documentation of the following: o The provider either verbally or in writing has submitted a medical or member specific reason why the brand name drug is required based on the member's condition or treatment history; **AND** if the member had side effects or a reaction to the generic drug, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. The MedWatch form must be included with the prior authorization request • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available, documentation of one of the following: o The prescriber has verbally or in writing submitted a medical or member specific reason why the reference biologic is required based on the member's condition or treatment history; **AND** if the member had side effects or a reaction to all biosimilar or interchangeable biologics, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. The MedWatch form must be included with the prior authorization o The currently available biosimilar product(s) does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested
Criteria Statement	N/A
Last P&T Review Date	12/2023

New MRG:

Sohonos	
Therapeutic Classes (AHFS)	Other Miscellaneous Therapeutic Agents
Medications	Sohonos (palovarotene)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	• Pregnancy • Use in patients younger than 8 years of age for females and 10 years of age for males
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age Per package insert
Prescriber Restrictions	Prescribed by an orthopedic specialist or provider who specializes in rare connective tissue diseases
Coverage Duration	If all of the criteria are met, the initial or reauthorization request will be approved for up to 6 months taking into account patient specific scenarios
PA Review Criteria	**Initial Authorization:** • Documented diagnosis of fibrodysplasia ossificans progressiva (FOP) • Documented genetic testing of ACVR1 R206H mutation • Attestation that patient is not pregnant and appropriate contraception methods will be used at least 1 month before treatment, during treatment, and 1 month after the last dose (if applicable) • Documentation of weight for patients younger than 14 years old • Medication is prescribed at an FDA approved dose **Re-Authorization:** • Documentation or provider attestation of clinical benefit (i.e. volume reduction of heterotopic ossification) or worsening (i.e. flare-up presence and/or worsening of flare-ups) • Attestation that patient is not pregnant and appropriate contraception methods will be used at least 1 month before treatment, during treatment, and 1 month after the last dose (if applicable) • Documentation of weight for patients younger than 14 years old • Medication is prescribed at an FDA approved dose
Criteria Statement	Sohonos is reserved for members with a diagnosis of fibrodysplasia ossificans progressiva (FOP) with documented genetic testing of ACVR1 R206H mutation, who is not pregnant and appropriate contraception methods will be used at least 1 month before treatment, during treatment, and 1 month after the last dose (if applicable), with a weight documentation for those members younger than 14 years old.
Last P&T Review Date	12/2023

Drug Name: Jesduvroq (daprodustat)

Manufacturer: GlaxoSmithKline

Approval Date: 2/1/2023

Marketing Date: 9/13/2023

Recommendation

- Change from NF to F-PA. Implement new MRG below.
  - There was no utilization of this medication from 7/1/2023 - 9/30/2023

Prescribing Information

Indication

For the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least four months.

Mechanism of Action

Daprodustat is a reversible inhibitor of hypoxia inducible factor prolyl hydroxylase-1 (HIF-PH1), PH2 and PH3 (IC50 in the low nM range). This activity results in the stabilization and nuclear accumulation of HIF-1α and HIF-2α transcription factors, leading to increased transcription of the HIF-responsive genes, including erythropoietin.

Dosage and Administration

Administer orally once daily, with or without food.

Black Box Warning

Increased risk of death, myocardial infarction, stokre, venous thromboembolism, and thrombosis of vascular access:

- Jesduvroq increases the risk of thrombotic vascular events, including major adverse cardiovascular events (MACE).
- Targeting a hemoglobin (Hb) level greater than 11 g/dL is expected to further increase the risk of death and arterial venous thrombotic events, as occurs with erythropoietin stimulating agents (ESAs), which also increase erythropoietin levels.
- No trial has identified a Hb target level, dose of Jesduvroq, or dosing strategy that does not increase these risks.
- Use the lowest dose of Jesduvroq sufficient to reduce the need for red blood cell transfusions.

Adverse Reactions

Most common (incidence ≥10%): hypertension, thrombotic vascular events, and abdominal pain.

Serious: increased risk of death, myocardial infarction, stroke, venous thromboembolism, thrombosis of vascular access, risk of hospitalization for heart failure, hypertension, and gastrointestinal erosion.

Use in Specific Populations, Pregnancy

Available data with Jesduvroq use in pregnant women are insufficient to establish a drug associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. There are risks to the mother and the fetus associated with CKD. Daprodustat administered orally to pregnant rats and rabbits during the period of organogenesis was associated with adverse fetal outcomes, including embryonic and fetal loss and reduced fetal weight, at doses that caused maternal toxicity and polycythemia. Advise pregnant women of the potential risk to the fetus.

Drug Interactions

CYP2C8 Inhibitors: Concomitant administration of strong CYP2C8 inhibitors (e.g., gemfibrozil) with Jesduvroq is contraindicated due to a marked increase in daprodustat exposure. Concomitant administration of moderate CYP2C8 inhibitors (e.g., clopidogrel) increases daprodustat exposure. Reduce the starting dose of Jesduvroq by half when initiating treatment in patients on clopidogrel or a moderate CYP2C8 inhibitor except in patients whose starting dose is already 1 mg. Monitor hemoglobin and adjust the dose of Jesduvroq when initiating or stopping therapy with clopidogrel or a moderate CYP2C8 inhibitor during treatment with Jesduvroq.

CYP2C8 Inducers: CYP2C8 inducers (e.g., rifampin) may decrease daprodustat exposure, which may result in loss of efficacy. Monitor hemoglobin and adjust the dose of Jesduvroq when initiating or stopping therapy with CYP2C8 inducers during treatment with Jesduvroq.

How Supplied

1 mg, 2 mg, 4 mg, 6 mg or 8 mg tablets

Price

$117 - $2,815

(Per month depending on severity of anemia, based on WAC.)

Clinical Studies

Completed

Title	Anemia Studies in Chronic Kidney Disease: Erythropoiesis Via a Novel Prolyl Hydroxylase Inhibitor Daprodustat-Dialysis (ASCEND-D) NCT: 02879305
Design	Randomized, phase 3, sponsor-blind, active-controlled, global, multicenter, event-driven clinical trial
Population	N= 2964 The mean age was 57 years (range 18-95), 57% were males, 67% were Caucasian, 16% were Black, and 12% were Asian. In the US region, 39% of patients were Black. Approximately 25% of the population was Hispanic or Latino. The largest regions of enrollment were the US (29%) and Eastern Europe/South Africa (28%). Common comorbid conditions included hypertension (92%), hyperlipidemia (50%) and diabetes mellitus (42%).

Arms	Patients on hemodialysis (HD) randomized 1:1 to receive: • Oral hypoxia-inducible factor prolyl hydroxylase inhibitor (HIF-PHI, daprodustat) or • Intravenous epoetin alfa Patients on peritoneal dialysis (PD) randomized 1:1 to receive: • Oral daprodustat or • Subcutanrous darbepoetin alfa
Endpoint(s)	Primary: • Mean change in the Hb level from baseline to weeks 28 through 52 (noninferiority margin, −0.75 g per deciliter) • First occurrence of a major adverse cardiovascular event (a composite of death from any cause, nonfatal myocardial infarction, or nonfatal stroke), with a noninferiority margin of 1.25

Inclusion Criteria	• Age: 18 to 99 years of age (inclusive)
	• Use of any approved ESA for at least the 6 weeks prior to screening and between screening and randomization
	• Hb concentration:
	  ○ On Week -8: Hb 8 to 12 grams per deciliter (g/dL)
	  ○ On randomization (Day 1):
	  ▪ Hb 8 to 11 g/dL and receiving at least the minimum ESA dose
	  ▪ Hb >11 g/dL to 11.5 g/dL and receiving greater than the minimum ESA dose
	• Dialysis: On dialysis >90 days prior to screening and continuing on the same mode of dialysis from screening (Week -8) through to randomization (Day 1)
	• Frequency of Dialysis:
	  ○ Hemodialysis (HD) $\geq$ 2 times/week
	  ○ Peritoneal dialysis (PD) $\geq$ 5 times/week
	  ○ Home hemodialysis $\geq$ 2 times/week

Exclusion Criteria	• Ferritin ≤100 ng/ml (≤100 mcg/L), transferrin saturation ≤20% at screening • Evidence of non-renal anemia • Cardiovascular abnormalities (including myocardial infarction, acute coronary syndrome, stroke or transient ischemic attack within 4 weeks of screening) • New York Heart Association (NYHA) Class IV heart failure • Uncontrolled hypertension • Liver disease • History of malignancy within 2 years of screening • Current treatment of cancer • Complex kidney cyst
Results	Primary:

Table 6. Change in Hemoglobin in Adults with Anemia Due to Chronic Kidney Disease Receiving Dialysis: ASCEND-D Trial (ITT Analysis)[a]

Assessment	JESDUVROQ (n = 1,487)	rhEPO[b] (n = 1,477)
Primary endpoint: change in Hgb[c]		
Mean baseline Hgb, g/dL (SD)	10.4 (1.0)	10.4 (1.0)
Hgb change, g/dL (SE)[d,e]	0.3 (0.02)	0.1 (0.02)
Mean treatment difference (95% CI)[c]	0.2 (0.1, 0.2)	
Change in Hgb - hemodialysis patients[f]		
Number of patients	1,316	1,308
Mean baseline Hgb, g/dL (SD)	10.4 (1.0)	10.4 (1.0)
Hgb change, g/dL (SE)[d,e]	0.3 (0.02)	0.1 (0.02)
Mean treatment difference (95% CI)[c]	0.2 (0.1, 0.3)	
Change in Hgb - peritoneal dialysis patients[f]		
Number of patients	171	169
Mean baseline Hgb, g/dL (SD)	10.3 (1.0)	10.2 (1.0)
Hgb change, g/dL (SE)[d,e]	0.4 (0.1)	0.2 (0.1)
Mean treatment difference (95% CI)[c]	0.2 (-0.04, 0.3)	

CI = Confidence interval; Hgb = Hemoglobin; ITT = Intent to treat; rhEPO = Recombinant human erythropoietin; SD = Standard deviation; SE = Standard error.

[a] Intent to Treat (ITT) analyses included observed and imputed values on and off treatment after randomization. Eight percent of patients had no observed hemoglobin during Weeks 28 to 52.

[b] Hemodialysis patients received epoetin alfa and peritoneal dialysis patients received darbepoetin alfa.

[c] Adjusted for multiplicity.

[d] Mean Hgb change from baseline to Evaluation Period (EP): Weeks 28 to 52.

- Primary efficacy outcome of mean (±SE) change in the Hb level from baseline to weeks 28 through 52 was 0.28±0.02 g per deciliter with daprodustat and 0.10±0.02 g per deciliter with ESA therapy, for a difference of 0.18 g per deciliter (95% CI, 0.12 to 0.24), which met the prespecified noninferiority margin for daprodustat.

Table 7. Major Adverse Cardiovascular Events in the ASCEND-D Trial (ITT Analysis)[a]

Co-primary composite endpoint	JESDUVROQ (n = 1,487)	rhEPO[b] (n = 1,477)
First occurrence of MACE[c], n	374	394
All-cause mortality[d], n	244	233
Non-fatal myocardial infarction[d], n	101	126
Non-fatal stroke[d], n	29	35
Hazard ratio (95% CI)[c]	0.93 (0.81, 1.07)	
Incidence rate per 100 PY	11.1	11.9

CI = Confidence interval; ITT = Intent to treat; MACE = Major adverse cardiovascular events; PY = Person Years; rhEPO = Recombinant human erythropoietin.

[a] ITT analyses included events on and off treatment after randomization.

[b] Hemodialysis patients received epoetin alfa; peritoneal dialysis patients received darbepoetin alfa.

[c] Co-primary endpoint.

[d] Component of composite endpoint.

[e] Adjusted for baseline covariates.

- Primary safety outcome of first MACE occurred in 374 of 1487 patients (25.2%) in the daprodustat group and in 394 of 1477 patients (26.7%) in the ESA group (hazard ratio, 0.93; 95% CI, 0.81 to 1.07), results that met the prespecified noninferiority margin of 1.25.

Conclusion	Among patients with CKD undergoing dialysis, daprodustat was noninferior to ESAs regarding the change in the Hb level from baseline and cardiovascular outcomes.
Interpretation	Daprodustat's efficacy and safety offers a novel, oral treatment for patients with anemia who are undergoing dialysis for CKD. Unlike previous trials of other HIF-PHIs, vadadustat and roxadustat, this trial included an observation and evaluation of a rapid rise in the Hb level (> 2 g/dL during a 4-week period). However, this could be explained by the dosing protocol used. A major limitation of this trial was its length, as HIF does activate transcription of some cytokines that have oncogenic long-term side effects. Furthermore, the open-label design among patients and investigators may have biased reporting of adverse events. Additionally, the only ESA evaluated in the trial was epoetin alfa; therefore, generalizability of conclusions about noninferiority of daprodustat to other ESAs was lacking. Larger and longer trials comparing daprodustat to epoetin alfa as well as other ESAs will be needed to evaluate the efficacy and safety of daprodustat in the treatment for anemia in patients undergoing dialysis.

Ongoing

Title	Anemia Studies in CKD: Erythropoiesis Via a Novel PHI Daprodustat - Pediatric (ASCEND-P) NCT: 05682326

Design	Phase 3, multicenter, open-label single arm trial
Completion Date	August 2026

Guidelines

Note guidelines have not been updated to include Jesduvroq (daprodustat).

KDIGO Clinical Practice Guideline for Anemia in Chronic Kideny Disease (2012). Available from: https://kdigo.org/wp-content/uploads/2016/10/KDIGO-2012-Anemia-Guideline-English.pdf

Use of ESAs and Other Agents to Treat Anemia in CKD

ESA Initiation

3.1: Address all correctable causes of anemia (including iron deficiency and inflammatory states) prior to initiation of ESA therapy. (Not Graded)

3.2: In initiating and maintaining ESA therapy, we recommend balancing the potential benefits of reducing blood transfusions and anemia-related symptoms against the risks of harm in individual patients (e.g., stroke, vascular access loss, hypertension). (1B)

3.3: We recommend using ESA therapy with great caution, if at all, in CKD patients with active malignancy—in particular when cure is the anticipated outcome—(1B), a history of stroke (1B), or a history of malignancy (2C).

3.4.1: For adult CKD ND patients with Hb concentration Z10.0 g/dl (Z100 g/l), we suggest that ESA therapy not be initiated. (2D)

3.4.2: For adult CKD ND patients with Hb concentration o10.0 g/dl (o100 g/l) we suggest that the decision whether to initiate ESA therapy be individualized based on the rate of fall of Hb concentration, prior response to iron therapy, the risk of needing a transfusion, the risks related to ESA therapy and the presence of symptoms attributable to anemia. (2C)

3.4.3: For adult CKD 5D patients, we suggest that ESA therapy be used to avoid having the Hb concentration fall below 9.0 g/dl (90 g/l) by starting ESA therapy when the hemoglobin is between 9.0–10.0 g/dl (90–100 g/l). (2B)

3.4.4: Individualization of therapy is reasonable as some patients may have improvements in quality of life at higher Hb concentration and ESA therapy may be started above 10.0 g/dl (100 g/l). (Not Graded)

3.4.5: For all pediatric CKD patients, we suggest that the selection of Hb concentration at which ESA therapy is initiated in the individual patient includes consideration of potential benefits (e.g., improvement in quality of life, school attendance/performance, and avoidance of transfusion) and potential harms. (2D)

ESA Maintenance Therapy

3.5.1: In general, we suggest that ESAs not be used to maintain Hb concentration above 11.5 g/dl (115 g/l) in adult patients with CKD. (2C)

3.5.2: Individualization of therapy will be necessary as some patients may have improvements in quality of life at Hb concentration above 11.5 g/dl (115 g/l) and will be prepared to accept the risks. (Not Graded)

3.6: In all adult patients, we recommend that ESAs not be used to intentionally increase the Hb concentration above 13 g/dl (130 g/l). (1A)

3.7: In all pediatric CKD patients receiving ESA therapy, we suggest that the selected Hb concentration be in the range of 11.0 to 12.0 g/dl (110 to 120 g/l). (2D)

ESA Dosing

3.8.1: We recommend determining the initial ESA dose using the patient's Hb concentration, body weight, and clinical circumstances. (1D)
3.8.2: We recommend that ESA dose adjustments be made based on the patient's Hb concentration, rate of change in Hb concentration, current ESA dose and clinical circumstances. (1B)
3.8.3: We suggest decreasing ESA dose in preference to withholding ESA when a downward adjustment of Hb concentration is needed. (2C)
3.8.4: Re-evaluate ESA dose if (Not Graded): K The patient suffers an ESA-related adverse event K The patient has an acute or progressive illness that may cause ESA hyporesponsiveness (See Recommendations 3.13.1–3.13.2)
ESA Administration
3.9.1: For CKD 5HD patients and those on hemofiltration or hemodiafiltration therapy, we suggest either intravenous or subcutaneous administration of ESA. (2C)
3.9.2: For CKD ND and CKD 5PD patients, we suggest subcutaneous administration of ESA. (2C)
Frequency of administration
3.10: We suggest determining the frequency of ESA administration based on CKD stage, treatment setting, efficacy considerations, patient tolerance and preference, and type of ESA. (2C)
Type of ESA
3.11.1: We recommend choosing an ESA based on the balance of pharmacodynamics, safety information, clinical outcome data, costs, and availability. (1D)
3.11.2: We suggest using only ESAs that have been approved by an independent regulatory agency. Specifically, for 'copy' versions of ESAs, true biosimilar products should be used. (2D)
Evaluating and Correcting Persistent Failure to Reach or Maintain Intended Hemoglobin Concentration
Frequency of monitoring
3.12.1: During the initiation phase of ESA therapy, measure Hb concentration at least monthly. (Not Graded) 3.12.2: For CKD ND patients, during the maintenance phase of ESA therapy measure Hb concentration at least every 3 months. (Not Graded) 3.12.3: For CKD 5D patients, during the maintenance phase of ESA therapy measure Hb concentration at least monthly. (Not Graded) Initial ESA hyporesponsiveness 3.13.1: Classify patients as having ESA hyporesponsiveness if they have no increase in Hb concentration from baseline after the first month of ESA treatment on appropriate weight-based dosing. (Not Graded) 3.13.2: In patients with ESA hyporesponsiveness, we suggest avoiding repeated escalations in ESA dose beyond double the initial weight-based dose. (2D)
Subsequent ESA Hyporesponsiveness
3.14.1: Classify patients as having acquired ESA hyporesponsiveness if after treatment with stable doses of ESA, they require 2 increases in ESA doses up to 50% beyond the dose at which they had been stable in an effort to maintain a stable Hb concentration. (Not Graded)
3.14.2: In patients with acquired ESA hyporesponsiveness, we suggest avoiding repeated escalations in ESA dose beyond double the dose at which they had been stable. (2D)
Management of Poor ESA Responsiveness
3.15.1: Evaluate patients with either initial or acquired ESA hyporesponsiveness and treat for specific causes of poor ESA response. (Not Graded)
3.15.2: For patients who remain hyporesponsive despite correcting treatable causes, we suggest individualization of therapy, accounting for relative risks and benefits of (2D):

- decline in Hb concentration
- continuing ESA, if needed to maintain Hb concentration, with due consideration of the doses required, and
- blood transfusions

Recommendation Definitions

Class/Level	Definition
1	Good-quality patient-oriented evidence (ie, evidence measuring outcomes that matter to patients: morbidity, mortality, symptom improvement, cost reduction, and quality of life)
2	Limited-quality patient-oriented evidence
A	We are confident that the true effect lies close to that of the estimate of the effect
B	The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
C	The true effect may be substantially different from the estimate of the effect
D	The estimate of effect is very uncertain, and often will be far from the truth

Clinical Opinions

Anemia, a common complication of CKD, is defined by the World Health Organization as a hemoglobin concentration of <13 g/dL for adult males and postmenopausal females and <12 g/dL for premenopausal females. The anemia in CKD occurs as normocytic anemia, and is associated with increased morbidity and mortality related to cardiovascular disease. Patients with CKD cannot make enough erythropoietin; therefore, low erythropoietin levels cause a low red blood cell count, leading to chronic anemia. ESAs are the current standard of care for treating anemia in CKD, but they are largely reserved for the dialysis dependent patient population, given their parenteral administration, storage requirements, and cardiovascular safety concerns. HIF-PHIs have been highly anticipated over the past few years as the first oral therapy for treating anemia in CKD.

Jesduvroq is the first and only HIF-PHI approved in the United States; however, its labeling restricts its use to patients who have been dialysis depdenent for at least 4 months. Jesduvroq works by stimulating the transcription of the erythropoietin gene, leading to increased levels of endogenous erythropoietin. There are two other HIF-PHIs undergoing investigation, vadadustat and roxadustat, but the future of these products remain unclear.

The promising results of the ASCEND-D trial demonstrate a potential convenient and efficacious alternative to injectable ESAs for adult CKD patients on dialysis. However, since HIF pathways regulate numerous biological processes, there is a risk for nonerythropoeitic adverse events such as cancer, thrombosis, and cardiovascular disease. ESAs have similar safety concerns but are still considered standard of care. Note that neither Jesduvroq nor ESAs have been shown to improve quality of life or well-being or reduce fatigue. Operationally, Jesduvroq's once daily dosing may make it difficult for dialysis centers to incorporate the drug into practice. Additionally, an oral, self administered drug may lower compliance, leading to worse outcomes. Without longer studies to definitively demonstrate safety, Jesduvroq's oral dosing and novel mechanism of action may not be enough of a draw to disrupt the market for its injectable ESA competitors.

Alternatives

There are no other FDA-approved HIF-PHIs at this time.

Prior Authorization Criteria

New:

Jesduvroq	
Therapeutic Classes (AHFS)	Hematopoietic Agents
Medications	Jesduvroq (daprodustat)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Diagnosis of uncontrolled hypertension Concomitant use of strong CYP2C8 inhibitors (e.g., gemfibrozil
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Member must be at least 18 years of age
Prescriber Restrictions	Prescriber must be a hematologist or nephrologist
Coverage Duration	If all conditions are met, the request will be approved with a 6 month duration. If conditions are not met, the request will be sent to a clinical reviewer.

PA Review Criteria	**Initial Authorization:**
	• Member has a diagnosis of chronic kidney disease (CKD) and has been undergoing dialysis for at least four months
	• Member has a documented hemoglobin between 8.0 and 11.5 g/dL
	• Member has documentation of trial and failure, intolerance, contraindication, or inability to use erythropoietin stimulating agents (ESA)
	• Documentation of the current ESA product (e.g., Procrit, Aranesp, etc.) and dose.
	• The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning therapy, to correct the deficiency:
	  ○ Serum ferritin level (> 100ng/mL)
	  ○ Transferrin saturation (TSAT) (> 20%)
	• Provider attests that member has no history of myocardial infarction, cerebrovascular event, or acute coronary syndrome in the past 3 months
	• Member will not be receiving concurrent treatment with an ESA
	• Request is for an FDA-approved dose
	• All submitted lab results have been drawn within 30 days of the request
	
	Reauthorization:
	• All submitted lab results have been drawn within 30 days of the reauthorization request.
	• Member has a documented increase in hemoglobin from baseline
	• The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning therapy, to correct the deficiency:
	  ○ Serum ferritin level (> 100ng/mL)
	  ○ Transferrin saturation (TSAT) (> 20%)
	• Member will not be receiving concurrent treatment with an ESA
	• Request is for an FDA-approved dose

Criteria Statement	Jesduvroq is reserved for members with a diagnosis of chronic kidney disease (CKD) who have been undergoing dialysis for at least four months, with a documented hemoglobin between 8.0 and 11.5 g/dL, with normal serum ferritin and transferrin

	saturation lab values (or the member MUST be receiving, or is beginning therapy, to correct the deficiency), with no history of myocardial infarction, cerebrovascular event, or acute coronary syndrome in the past 3 months who have used (or cannot should not use) erythropoietin stimulating agents (ESA).
Last P&T Review Date	12/2023

References

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Drug Name: Lodoco (colchicine)

Manufacturer: AGEPHA Pharma

Approval Date: 6/20/2023

Marketing Date: 9/1/2023

Recommendation

- Change from NF to F-PA. See new MRG policy below.
    - There was no utilization of this medication from 7/1/2023 - 9/30/2023

Prescribing Information

Indication

To reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular disease.

Mechanism of Action

The mechanism of action of colchicine in the prevention of major cardiovascular events is not understood. However, it is known that colchicine disrupts cytoskeletal functions through inhibition of β-tubulin polymerization into microtubules and consequently prevents the activation, degranulation, and migration of neutrophils. Colchicine may also interfere with the intracellular assembly of the inflammasome complex in neutrophils and monocytes that mediates activation of interleukin-1β. These anti-inflammatory effects are consistent with clinical data demonstrating that colchicine reduces high sensitivity C- reactive protein (hs-CRP).

Dosage and Administration

0.5 mg orally once daily

Black Box Warning

None

Adverse Reactions

Most common: Gastrointestinal symptoms (diarrhea; vomiting; abdominal cramping) and myalgia

Serious: Blood dyscrasias and neuromuscular toxicity

Use in Specific Populations, Pregnancy

Available human data from published literature on colchicine use in pregnancy over several decades have not identified any drug associated risks for major birth defects, miscarriage, or adverse maternal or fetal outcomes. Colchicine crosses the human placenta. Although animal reproduction and developmental studies were not conducted with Lodoco®, published animal reproduction and development studies indicate that colchicine causes embryofetal toxicity and altered postnatal development at exposures within or above the clinical therapeutic range.

Drug Interactions

Coadministration of P-gp and/or CYP3A4 inhibitors (e.g., cyclosporine or clarithromycin) have been demonstrated to alter the concentration of colchicine. The potential for drug-drug interactions must be considered prior to and during therapy.

How Supplied

0.5 mg tablets

Price

$495

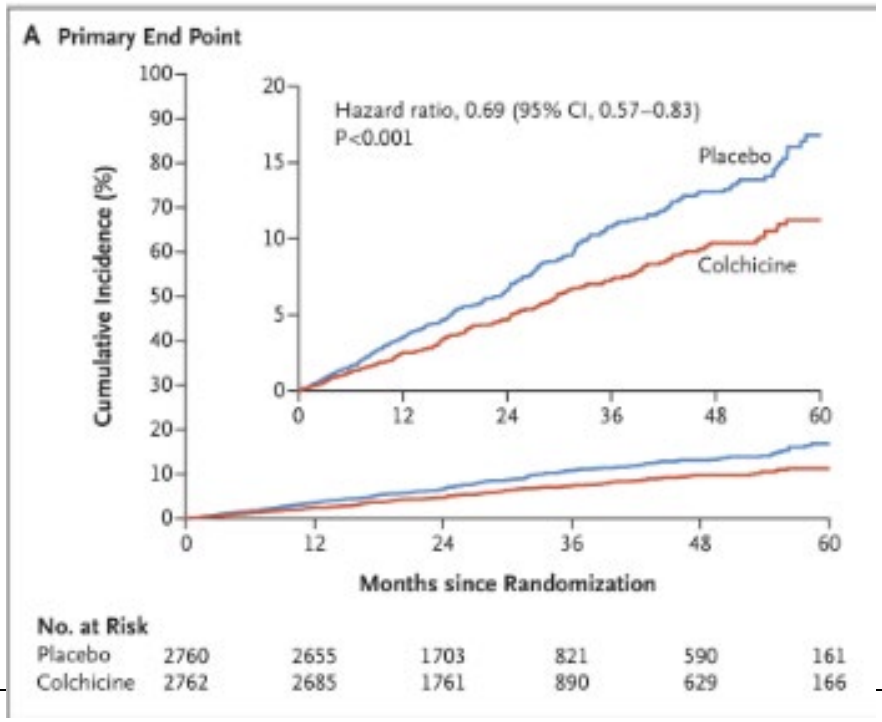
(Per month, based on WAC.)

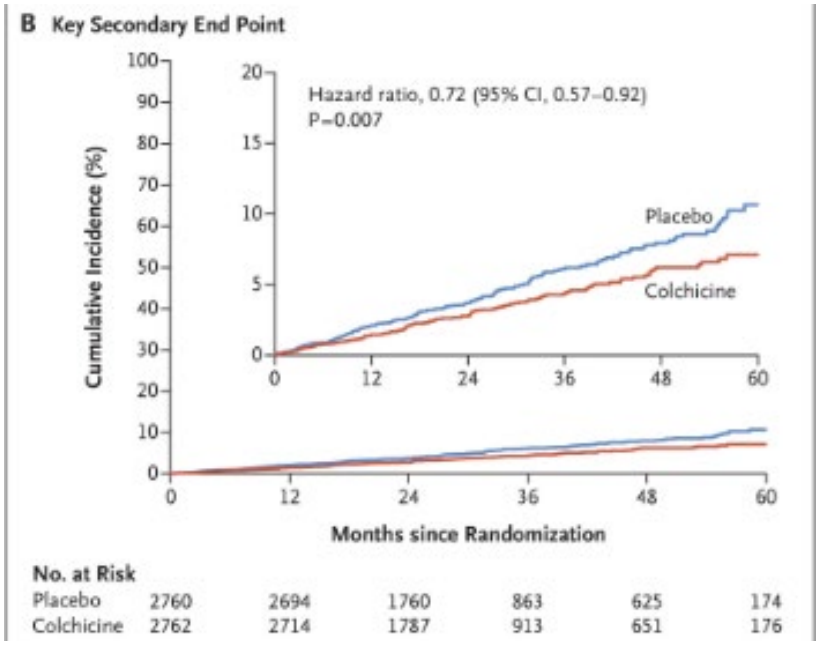
Clinical Studies

Completed

Title	Colchicine in Patients with Chronic Coronary Disease (LoDoCo2) NCT: ACTRN12614000093684 PMID: 32865380
Design	Randomized, controlled, double-blind trial
Population	N=5522 Participants ranged from 35 to 82 years of age, 34.48% were from Australia, 65.52% were from the Netherlands, 15.3% of patients were female, 11.7% of patients were current tobacco users, and 18.2% of patients were diabetic. Patients were treated for chronic coronary disease, with 99.7% taking an antiplatelet agent or an anticoagulant, 96.6% a lipid-lowering agent, 97.3% of which were statins, 62.1% a beta-blocker, and 71.7% an inhibitor of the renin–angiotensin system.
Arms	Participants were randomized in a 1:1 ratio to receive one of the following with a median duration follow-up of 28.6 months: • 0.5 mg colchicine tablet once daily (N=2762) • Placebo once daily (N=2760)
Endpoint(s)	Primary: • Composite of cardiovascular death, myocardial infarction, ischemic stroke or ischemia-driven coronary revascularization Secondary: • Composite of cardiovascular death, myocardial infarction or ischemic stroke • Composite of myocardial infarction or ischemia-driven coronary revascularization

	• Composite of cardiovascular death or myocardial infarction • Ischemia-driven coronary revascularization • Myocardial infarction • Ischemic stroke • Death from any cause • Cardiovascular death
Inclusion Criteria	• Participant age >35 and ≤85 years old • Proven coronary artery disease by coronary angiography, CT coronary angiography, or Coronary Artery Calcium Score (>400) • Patients with history of bypass surgery are included if surgery occurred more than 10 years prior, or indicated angiographic evidence of graft failure or have had undergone percutaneous intervention • Clinically stable for at least 6 months
Exclusion Criteria	• Pregnancy, breast feeding, or planning/considering pregnancy throughout study period • Renal impairment (estimated glomerular filtration rate [eGFR] <50 mL/min/1.73m^2) • Severe heart failure (New York Heart Association Functional class 3 or 4) • Moderate or severe valvular heart disease likely requiring intervention • Dependency or frailty or life expectancy < 5 years • Peripheral neuritis, myositis, or marked myo-sensitivity to statins • Required long term colchicine therapy for other reasons
Results	Primary: • A primary end-point event occurred in 6.8% of patients in the colchicine group and in 9.6% of patients in the placebo group, resulting in a 31% lower relative risk (RRR) with colchicine compared to placebo (hazard ratio [HR], 0.69; 95% confidence interval [CI], 0.57 to 0.83; p<0.001)



	Secondary: • A secondary endpoint occurred in 4.2% of patients in the colchicine group and in 5.7% of patients in the placebo group, with incidence rates of 1.5 and 2.1 events (respectively), per 100 person-years (HR, 0.72; 95% CI, 0.57 to 0.92; p=0.007) 
Conclusion	In a randomized trial involving patients with chronic coronary disease, the risk of cardiovascular events was significantly lower among those who received 0.5 mg of colchicine once daily than among those who received placebo.
Interpretation	Lodoco® was approved by the FDA to reduce the risk of future cardiovascular events in patients with established cardiovascular disease. Lodoco® 0.5mg once daily demonstrated statistical significance in both primary and secondary outcomes after 28.6 months. There were several limitations discussed in the study. First, the percentage of women participation in the trial raises concern since it was low. This is concerning due the percentage of women diagnosed with chronic coronary disease within the general population. Blood pressure and lipid panels were not measured at baseline or throughout the trial, limiting the reporting of outcomes based on risk factor control. Inflammation indicators such as C-reactive protein levels were not measured at baseline, so the effects of treatment according to the anti-inflammatory state at baseline could not be measured.

Ongoing

Title	Colchicine Protective Effect in Patients Undergoing Percutaneous Coronary Intervention (COLCHICINE-PROTECT) NCT: 05739929

Design	Randomized, placebo controlled, double blinded
Completion Date	August, 30, 2024

Guidelines

Note guidelines have not been updated since the approval of Lodoco®

Arnett DK, Blumenthal RS, Albert MA, Buroker AB, Goldberger ZD, Hahn EJ, Himmelfarb CD, Khera A, Lloyd-Jones D, McEvoy JW, Michos ED, Miedema MD, Muñoz D, Smith SC Jr, Virani SS, Williams KA Sr, Yeboah J, Ziaeian B. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019 Sep 10;140(11):e596-e646. doi: 10.1161/CIR.0000000000000678.

According to the 2019 American College of Cardiology (ACC)/American Heart Association guidelines on cardiovascular disease prevention in clinical practice, primary and secondary prevention of cardiovascular disease includes lifestyle modifications, such as a heart-healthy diet, regular aerobic exercises, maintenance of desirable body weight, and avoidance of tobacco products. Guideline-directed medical therapies are used to optimize treatment of cardiovascular risk factors, such as:

- Dyslipidemia: statins, non-statin lipid-lowering agents (ezetimibe, PCSK9 inhibitors, bempedoic acid)
- Type 2 diabetes mellitus: metformin, sodium-glucose transport protein 2 (SGLT2) inhibitors, and glucagon-like peptide-1 (GLP-1) receptor agonists
- Hypertension: beta blockers, angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), aldosterone blockers
- Atherosclerotic cardiovascular disease (ASCVD): aspirin

Other adjunctive therapies that may be of benefit in some patients include, antiplatelet therapy with P2Y12 receptor blockers such as clopidogrel, oral anticoagulants such as factor Xa inhibitors, and marine omega-3 fatty acids such as icosapent ethyl.

Clinical Opinions

According to the Centers for Disease Control and Prevention (CDC), coronary artery disease is labeled as the most common heart disease in the United States of America, affecting about 18 million people. Coronary artery disease is diagnosed due to plaque buildup within the walls of the coronary arteries and other areas of the body. The buildup of plaque results in narrowing of the arteries, affecting blood flow (atherosclerosis). The narrowness of the arteries may lead to chest pain (angina) which is the most common symptom of CAD. However, for many, the first sign of CAD may be a heart attack.

Coronary artery disease may be fatal if appropriate treatment is not followed. According to the CDC, a step-by-step approach should be taken for the treatment of CAD. Lifestyle changes such as healthy diet (low fat and sodium), increased physical activity, and smoking cessation are essential as additions to medication therapy. Pharmacologic therapies include aspirin/clopidogrel, statins, ACE inhibitors/ARBs, beta blockers, and aldosterone blockers. Lodoco® is an anti-inflammatory atheroprotective cardiovascular treatment. It was approved as “low-dose colchicine” at a dose of

0.5 mg once daily, after proven benefit for cardiovascular disease was in clinical trials. In the LoDoCO2, treatment of Lodoco® 0.5 mg once daily demonstrated statistical significance versus placebo treatment in the outcomes of: cardiovascular death, ischemic stroke, spontaneous myocardial infarction, and coronary revascularization driven by ischemia. Lodoco® was approved with a broad indication for use in cardiovascular disease and represents a new approach to treatment by targeting inflammation as a driver of atherosclerotic risk. Given the availability of other proven low-cost generic standard-of-care therapies, the potential risk for severe drug interactions in patients who use Lodoco®, and the high cost of Lodoco®, providers and payers are likely to reserve Lodoco® only for patients who remain at high risk of recurrent cardiovascular events after treatment with alternative standard-of-care medications.

Alternatives

Drug Name^	Formulary Status	Dosage Form	Price*
Atorvastatin (Lipitor®)	F	10mg, 20mg, 40 mg, 80 mg oral tablet	$2
Jardiance® (empagliflozin)	F-PA	10 mg, 25mg oral tablet	$593
Nexletol® (bempedoic acid)	F-PA	180 mg oral tablets	$396

**Price per month unless otherwise noted. Pricing for multi-source generic medications based on National Average Drug Acquisition Cost (NADAC). Pricing for single-source branded medications and generic drugs without NADAC data based on Wholesale Acquisition Cost (WAC).*

New PA Criteria

Lodoco	
Therapeutic Classes (AHFS)	OTHER MISCELLANEOUS THERAPEUTIC AGENTS
Medications	Lodoco (colchicine) tablets
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber must be a cardiologist
Coverage Duration	If all the criteria are met, the initial request will be approved for 12 months.

PA Review Criteria	**Initial Authorization**:
	• Patient has established atherosclerotic disease or multiple risk factors for cardiovascular disease
	• Patient is currently receiving statin therapy, or documentation has been provided that the member has a medical reason statin therapy is not appropriate
	• Documentation is provided that guideline directed medical therapies targeted to patient's specific risk factors are being maximized, such as medications targeted at reduction in cholesterol, blood pressure, antiplatelet therapies, and diabetes
	• Patient does not have pre-existing blood dyscrasias (ex. leukopenia, thrombocytopenia)
	• Patient does not have renal failure (CrCl less than 15 ml/min) or severe hepatic impairment
	• Patient is not currently taking medications contraindicated for concurrent use with Lodoco
	  ○ Strong CYP3A4 inhibitors (ex. atazanavir, clarithromycin, darunavir/ritonavir, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, tipranavir/ritonavir)
	  ○ P-glycoprotein inhibitors (ex. cyclosporine, ranolazine)

Criteria Statement	Lodoco is reserved for members with a diagnosis of established atherosclerotic disease or multiple risk factors for cardiovascular disease who are currently taking a statin (or cannot/should not take a statin) and does not have pre-existing blood dyscrasias or renal failure (CrCl less than 15 ml/min) or severe hepatic impairment.
Last P&T Review Date	12/2023

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Insulins

Executive Summary

CLASS OVERVIEW

Insulin products are FDA-approved to improve glycemic control in patients with diabetes mellitus (DM). DM is a group of metabolic disorders that includes type 1, type 2, and gestational diabetes. This presents as hyperglycemia, with etiologies varying based on type but including reduced insulin secretion, increased glucose production, or decreased glucose utilization. Secondary pathophysiological changes also occur in these patients due to the dysregulation involved with diabetes, including renal disease, neuropathy, visual impairment, hearing loss, and cardiac complications.

Insulin is a key component of diabetes management by providing glycemic control and preventing irreversible pathophysiological complications. There are many insulin products, and they are grouped by type: ultra-long acting, long-acting, intermediate, rapid-acting, short-acting, premixed, and biosimilar. Although all insulin products have a similar mechanism of action, their roles in therapy differ due to their various time to onset, peak time, and duration of action. Insulin therapy is most commonly administered by subcutaneous injection, which allows for prolonged absorption.

According to the 2023 American Diabetes Association Clinical Guidelines, individuals with type 1 diabetes (T1DM) need to be treated with insulin as a first-line therapy. This is an essential part of therapy for T1DM due to the hallmark pathophysiology of the disorder, which is complete absence or near-absence of beta cell function. Without insulin therapy, the patient's blood glucose could cause irreparable and even fatal consequences. Insulin replacement regimens often consist of basal and prandial insulin. Basal insulin – intermediate or long-acting insulin, is used to maintain blood sugar levels steady throughout meals and overnight. While prandial insulin – short or rapid-acting insulin is often taken at or before meals to control blood sugar levels. For individuals with type 2 diabetes (T2DM), there is still some level of beta cell functioning and some degree of insulin production, so insulin therapy is not a first-line recommendation. Even so, the guidelines recommend early addition of basal insulin to oral therapy to extend the time to treatment failure. For both conditions, treatment is patient-centered and depends on multiple external factors.

UTILIZATION FINDINGS

There were 155 claims for 86 members, for a total cost of $35,437, and an average cost per claim of $228. The most highly utilized medication was insulin glargine-yfgn (U-100) 100 unit/mL (3 mL) subcutaneous pen with 64 claims, followed by Admelog SoloStar U-100 Insulin lispro 100 unit/mL subcutaneous pen, with 22 claims, and finally insulin lispro (U-100) 100 unit/mL subcutaneous pen, with 12 claims. There were 3 prior authorization requests, which were all approved.

Manufacturers Sanofi, Lilly, and Novo Nordisk have announced upcoming price reductions in their insulin products, which will go into effect sometime in Q4 2023 (Lilly and Novo) and 1/1/2024 (Sanofi) notably on several of their branded products. Biocon/Mylan recently announced price cuts to insulin glargine-yfgn products that would take effect 1/1/2024. Novo also recently announced that they would be permanently discontinuing Levemir products in 2024. Other manufacturers may announce additional changes and/or price cuts on brand and/or generic products in response to these manufacturers price cuts and discontinuations.

RECOMMENDATIONS

- Change from NF to F-QL (30/30) due to new favorable pricing reductions comparative to other similar formulations.
    - Lantus Solostar U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen
        - Lantus Solostar will be similar in price to generic insulin glargine-yfgn pen and Rezvoglar KwikPen ($92-96 per 15ml).
    - Lantus U-100 Insulin 100 unit/mL subcutaneous solution
        - Lantus vial will be similar in pricing to generic insulin glargine-yfgn vial ($63-64 per 10ml)

CLINICAL SUMMARY

Insulin products are FDA-approved to improve glycemic control in patients with diabetes mellitus (DM). DM is a group of chronic metabolic disorders that predominantly are known as type 1 (T1DM) or type 2 (T2DM). Diabetes is prevalent in approximately 37 million adults in the USA, and 1 in 5 people are undiagnosed. When uncontrolled, it leads to hyperglycemia, which is defined as blood glucose greater than 125 mg/dL while fasting and greater than 180 mg/dL 2 hours postprandial. This commonly presents as blurred vision, fatigue, polydipsia, polyuria, and polyphagia. The etiologies for diabetes vary depending on type. T1DM is an autoimmune reaction that completely halts the body's ability to produce insulin. These individuals are diagnosed in early childhood and account for 5-10% of diabetes diagnoses. On the other hand, T2DM can be triggered by a variety of processes, including insulin resistance, genetic markers, and lifestyle factors. These individuals are usually diagnosed later in life and account for 90-95% of all diabetes diagnoses. Secondary pathophysiological changes associated with diabetes occur in these patients including renal disease, neuropathy, visual impairment, hearing loss, and cardiac complications. Diabetes is the leading cause of kidney failure, lower-limb amputations, and adult blindness, if left untreated.

According to the 2023 American Diabetes Association (ADA) Clinical Guidelines, pharmacologic therapy should be guided by patient-centered treatment factors, including comorbidities and treatment goals. Insulin is a key component of diabetes management for both type 1 and 2 diabetes, by providing glycemic control and preventing irreversible pathophysiological complications. Insulin is the first-line therapy for patients with T1D and should be initiated immediately upon diagnosis. Pharmacologic therapy in T2D should be initiated after the consideration of healthy lifestyle habits, diabetes self-management, education, and social determinants of the person. Pharmacologic approaches including combination therapy with agents such as metformin, glucagon-like peptide 1 receptor agonists, sodium-glucose cotransporter 2 inhibitors and other agents should be considered prior. Insulin should be considered as part of any combination regimen when hyperglycemia is severe. Common practice is to initiate insulin therapy for people who present with blood glucose levels ≥ 300 mg/dL or A1C > 10% or if the individual has symptoms of hyperglycemia (i.e., polyuria or polydipsia) or evidence of catabolism (weight loss).There are many insulin products, and they are grouped by type: ultra-long acting, long-acting, intermediate, rapid-acting, short-acting, premixed, and biosimilar. Although all insulin products have a similar mechanism of action, their roles in therapy vary due to time to onset, peak time, and duration of action.

There are two broad categories that these types of insulin fall under: basal insulin and prandial insulin. Basal insulin provides a constant level of insulin that is absorbed slowly and works to allow the body to use it throughout the day whenever needed, similarly to the way an individual's pancreas would produce insulin. This term refers to three types of insulin: intermediate, long-acting, and ultra-long-acting. Intermediate insulin, such as NPH, has an onset of 1-2 hours, a peak effect around 4-12 hours, and ultimately lasts over 12 hours of the day. Long-acting insulins, such as glargine and detemir, has an onset of 1 ½ - 2 hours and then exhibits a stable plateau effect that lasts 24 hours. Ultra-long-acting insulin, such as degludec begins to work in 1-6 hours and then can last 36 hours or more. The main role in therapy for basal insulin is to control blood sugars overnight, while fasting, and between meals. Prandial insulin, also known as meal-time insulin, acts rapidly within the body to manage the elevation of glucose that occurs following meals. It is commonly

taken three times a day with breakfast, lunch, and dinner. This term refers to two types of insulin: short-acting and rapid-acting. Short-acting insulin, such as regular human, has an onset of 30-60 minutes, a peak effect around 2-3 hours, and works for an additional 3-6 hours after that. Rapid-acting insulin, such as aspart and lispro, has an onset of about 3-20 minutes, a peak of about 1-3 hours, and will last for 5 hours. The main role in therapy for prandial insulin is to control the blood glucose spikes that occur after meals, as well as to correct any unintentional spikes that occur between meals or during the night.

Additional insulin options include pre-mixed combination insulins and biosimilars. Combination insulins are formulated with rapid or short-acting insulin plus intermediate or long-acting insulin. Their pharmacokinetics favor both 24-hour efficacy and patient convenience. Their primary role in therapy is to provide a simple insulin treatment plan by combining a basal and prandial insulin. This is preferred for patients who may need the ease of therapy such as senior citizens or those with disabilities. Furthermore, biosimilars are biological products that are very similar to products already approved by the FDA, with no true meaningful differences outside of the way they are produced. They offer the same safety and effectiveness at potentially lower costs. There have been two recent approvals for biosimilars in the US, Semglee® and Rezvoglar™. Both of these are available as biosimilars for insulin glargine (Lantus®). They are both long-acting insulins and offer the same efficacy and safety that Lantus does. Semglee® came to market in 2021 at a 65% discount from Lantus® as the first interchangeable biological product. Rezvoglar™ came to market in 2023 with a 78% discount to Lantus®.

With regards to future advancements, there are no trials due to be completed in the next 6 months. However, there is a new insulin product, insulin icodec, that is currently undergoing phase 3 testing that is potentially going to be approved in early 2024. This is formulated to be a once-weekly basal insulin injection, a large striation from the current daily dosed insulin regimens.

American Diabetes Association, 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes-2023. Diabetes Care 1 January 2023.

Pharmacologic Therapy for Adults with Type 1 Diabetes

- Most individuals with type 1 diabetes should be treated with multiple daily injections of prandial and basal insulin, or continuous subcutaneous insulin infusion. (Recommendation category A)
- Most individuals with type 1 diabetes should use rapid-acting insulin analogs to reduce hypoglycemia risk. (Recommendation category A)
- Individuals with type 1 diabetes should receive education on how to match mealtime insulin doses to carbohydrate intake, fat, and protein content, and anticipated physical activity. (Recommendation category B)

Pharmacologic Therapy for Adults with Type 2 Diabetes

- Early combination therapy can be considered in some individuals at treatment initiation to extend the time to treatment failure. (Recommendation category A)
- The early introduction of insulin should be considered if there is evidence of ongoing catabolism, if symptoms of hyperglycemia are present, or when A1C levels (>10%) or blood glucose levels (>300 mg/dL) are very high. (Recommendation category E)
- If insulin is used, combination therapy with a glucagon-like peptide 1 receptor agonist is recommended for greater efficacy, durability of treatment effect, and weight and hypoglycemia benefit. (Recommendation category A)
- Medication regimen and medication-taking behavior should be reevaluated at regular intervals (every 3-6 months) and adjusted as needed to incorporate specific factors that impact choice of treatment. (Recommendation category E)
- Clinicians should be aware of the potential for overbasalization with insulin therapy. Clinical signals that may prompt evaluation of overbasalization include basal dose more than 0.5 units/kg/day, high bedtime-morning or postprandial glucose differential, hypoglycemia (aware or unaware), and high glycemic variability. Indication of overbasalization should prompt reevaluation to further individualize therapy. (Recommendation category E)

Pharmacologic Therapy Goals

- Assess glycemic status (A1C or other glycemic measurement such as time in range or glucose management indicator) at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). (Recommendation category E)
- Assess glycemic status at least quarterly and as needed in patients whose therapy has recently changed and/or who are not meeting glycemic goals. (Recommendation category E)
- An A1C goal for many nonpregnant adults of <7% without significant hypoglycemia is appropriate. (Recommendation category A)
- On the basis of provider judgment and patient preference, achievement of lower A1C levels than the goal of 7% may be acceptable and even beneficial if it can be achieved safely without significant hypoglycemia or other adverse effects of treatment. (Recommendation category B)
- Less stringent A1C goals (such as <8%) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits. (Recommendation category B)

Recommendation Definitions

Class/Level	Definition
A	• Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including

Class/Level	Definition
	○ Evidence from a well-conducted multicenter trial ○ Evidence from a meta-analysis that incorporated quality ratings in the analysis • Compelling nonexperimental evidence • Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including ○ Evidence from a well-conducted trial at one or more institutions ○ Evidence from a meta-analysis that incorporated quality ratings in the analysis
B	• Supportive evidence from well-conducted cohort studies ○ Evidence from a well-conducted prospective cohort study or registry ○ Evidence from a well-conducted meta-analysis of cohort studies • Supportive evidence from a well-conducted case-control study
C	• Supportive evidence from poorly controlled or uncontrolled studies ○ Evidence from randomized clinical trials with one or more major OR three or more minor methodological flaws that could invalidate the results ○ Evidence from observational studies with high potential for bias (case series with comparison with historical controls) ○ Evidence from case series or case reports • Conflicting evidence with the weight of evidence supporting the recommendation
E	• Expert consensus or clinical experience

FORMULARY PLACEMENT, UTILIZATION AND COST EXPERIENCE (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST			Manufacturer	PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	Rx	Mbrs	Total	Avg/Rx	Cost^		Total	Approved (%)	Current	Recommend
Long-acting Insulin										
Basaglar KwikPen® U-100 Insulin 100 unit/mL (3 mL) subcutaneous	3	1	$538.87	$179.62	$326.25	Lilly	0	0 (0%)	NF	No change
Basaglar Tempo Pen® (U-100) Insulin 100 unit/mL (3 mL) subcutaneous	0	0	$0.00	$0.00	$326.25	Lilly	0	0 (0%)	NF	No change
insulin glargine (U-100) 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$159.75	Winthrop/ Sanofi	0	0 (0%)	NF	No change
Lantus Solostar® U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	**$96.36***	Sanofi-Aventis	0	0 (0%)	NF	→ **F-QL (30/30)**
insulin glargine (U-100) 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$106.50	Novo Nordisk	0	0 (0%)	NF	No change
Lantus® U-100 Insulin 100 unit/mL subcutaneous solution	3	1	$812.01	$270.67	**$64.26***	Sanofi-Aventis	0	0 (0%)	NF	→ **F-QL (30/30)**
Rezvoglar™ KwikPen (insulin glargine - aglr) 100 unit/mL (3 mL) subcutaneous	0	0	$0.00	$0.00	$92.00	Lilly	0	0 (0%)	F-QL (30/30)	No change
insulin glargine-yfgn (U-100) 100 unit/mL subcutaneous solution	1	1	$85.60	$85.60	**$62.97***	Mylan	0	0 (0%)	F-QL (30/30)	No change
Semglee® (insulin glargine-yfgn) 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$269.30	Mylan	0	0 (0%)	NF	No change
insulin glargine-yfgn (U-100) 100 unit/mL (3 mL) subcutaneous pen	64	38	$8,382.48	$130.98	**$92.00***	Mylan	1	1 (100%)	F-QL (30/30)	No change
Semglee® (insulin glargine-yfgn) Pen 100 unit/mL (3 mL) subcutaneous	0	0	$0.00	$0.00	$403.95	Mylan	0	0 (0%)	NF	No change
Toujeo SoloStar® U-300 Insulin 300 unit/mL (1.5 mL) subcutaneous pen	0	0	$0.00	$0.00	$408.00	Sanofi	0	0 (0%)	NF	No change
Toujeo Max® U-300 SoloStar 300 unit/mL (3 mL) subcutaneous insulin pen	7	2	$3,673.39	$524.77	$544.22	Sanofi	0	0 (0%)	NF	No change
Levemir FlexTouch® U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	**$161.77***	Novo Nordisk	0	0 (0%)	NF	No change
Levemir FlexPen® 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	**$161.77***	Novo Nordisk	0	0 (0%)	NF	No change

Levemir® U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	**$107.85***	Novo Nordisk	0	0 (0%)	NF	No change
insulin degludec (U-100) 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$166.95	Novo Nordisk	0	0 (0%)	NF	No change
Tresiba FlexTouch® U-100 insulin 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$508.35	Novo Nordisk	1	1 (100%)	NF	No change
insulin degludec (U-100) 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$110.40	Novo Nordisk	0	0 (0%)	NF	No change
Tresiba® U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$338.90	Novo Nordisk	0	0 (0%)	NF	No change
insulin degludec (U-200) 200 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$334.80	Novo Nordisk	0	0 (0%)	NF	No change
Tresiba FlexTouch® U-200 insulin 200 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$1,016.85	Novo Nordisk	0	0 (0%)	NF	No change
Rapid-acting Insulin										
Humalog Junior KwikPen®(U-100) 100 unit/mL subcutaneous half-unit pen	0	0	$0.00	$0.00	$530.40	Lilly	0	0 (0%)	NF	No change
insulin lispro (U-100) 100 unit/mL subcutaneous half-unit pen	0	0	$0.00	$0.00	$149.55	Lilly	0	0 (0%)	F-QL (30/30)	No change
Humalog® U-100 Insulin 100 unit/mL subcutaneous cartridge	0	0	$0.00	$0.00	$510.00	Lilly	0	0 (0%)	NF	No change
Admelog U-100 Insulin lispro 100 unit/mL subcutaneous solution	1	1	$83.09	$83.09	$98.00	Sanofi	0	0 (0%)	F-QL (30/30)	No change
Humalog U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	**$82.41***	Lilly	0	0 (0%)	NF	No change
insulin lispro (U-100) 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$23.50	Lilly	0	0 (0%)	F-QL (30/30)	No change
Humalog KwikPen® U-200 Insulin 200 unit/mL (3 mL) subcutaneous	0	0	$0.00	$0.00	**$159.12***	Lilly	0	0 (0%)	NF	No change
Admelog® SoloStar U-100 Insulin lispro 100 unit/mL subcutaneous pen	35	22	$5,903.66	$168.68	$189.30	Sanofi	0	0 (0%)	F-QL (30/30)	No change
Humalog KwikPen® (U-100) Insulin 100 unit/mL subcutaneous	0	0	$0.00	$0.00	**$159.12***	Lilly	0	0 (0%)	NF	No change
Humalog Tempo Pen® (U-100) Insulin 100 unit/mL subcutaneous	0	0	$0.00	$0.00	$530.40	Lilly	0	0 (0%)	NF	No change
insulin lispro (U-100) 100 unit/mL subcutaneous pen	12	7	$1,847.00	$153.92	$149.40	Lilly	0	0 (0%)	F-QL (30/30)	No change
Lyumjev™ U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$275.00	Lilly	0	0 (0%)	NF	No change

Lyumjev KwikPen™ U-100 Insulin 100 unit/mL subcutaneous	0	0	$0.00	$0.00	$530.40	Lilly	0	0 (0%)	NF	No change
Lyumjev Tempo Pen™ (U-100) Insulin 100 unit/mL subcutaneous	0	0	$0.00	$0.00	$530.40	Lilly	0	0 (0%)	NF	No change
Lyumjev KwikPen™ U-200 Insulin 200 unit/mL (3 mL) subcutaneous	0	0	$0.00	$0.00	$424.00	Lilly	0	0 (0%)	NF	No change
Fiasp® Penfill U-100 Insulin 100 unit/mL (3 mL) subcutaneous cartridge	0	0	$0.00	$0.00	$537.00	Novo Nordisk	0	0 (0%)	NF	No change
Fiasp FlexTouch® (insulin aspart) U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$559.00	Novo Nordisk	0	0 (0%)	NF	No change
Fiasp® (insulin aspart) U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$289.00	Novo Nordisk	0	0 (0%)	NF	No change
insulin aspart U-100 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$135.80	Novo Nordisk	0	0 (0%)	NF	No change
Novolog® U-100 Insulin aspart 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	**$72.34***	Novo Nordisk	0	0 (0%)	NF	No change
insulin aspart (U-100) 100 unit/mL (3 mL) subcutaneous pen	0	0	$0.00	$0.00	$262.35	Novo Nordisk	0	0 (0%)	NF	No change
Novolog Flexpen® U-100 Insulin aspart 100 unit/mL (3 mL) subcutaneous	0	0	$0.00	$0.00	**$91.09***	Novo Nordisk	0	0 (0%)	NF	No change
insulin aspart U-100 100 unit/mL subcutaneous cartridge	0	0	$0.00	$0.00	$252.45	Novo Nordisk	0	0 (0%)	NF	No change
Novolog PenFill® U-100 Insulin aspart 100 unit/mL subcutaneous cartridg	0	0	$0.00	$0.00	$252.00	Novo Nordisk	0	0 (0%)	NF	No change
Afrezza® 4 unit cartridge with inhaler	0	0	$0.00	$0.00	$450+	Mannkind	0	0 (0%)	NF	No change
Afrezza® 8 unit cartridge with inhaler	0	0	$0.00	$0.00	$450+	Mannkind	0	0 (0%)	NF	No change
Afrezza® 12 unit cartridge with inhaler	0	0	$0.00	$0.00	$450+	Mannkind	0	0 (0%)	NF	No change
Afrezza® 4 unit (90)/8 unit (90) cartridge with inhaler	0	0	$0.00	$0.00	$450+	Mannkind	0	0 (0%)	NF	No change
Afrezza® 4 unit (60)/8 unit (60)/12 unit (60) cartridge with inhaler	0	0	$0.00	$0.00	$450+	Mannkind	0	0 (0%)	NF	No change
Afrezza® (regular insulin) 8 unit (90)/12 unit (90) cartridge,inhaler	0	0	$0.00	$0.00	$450+	Mannkind	0	0 (0%)	NF	No change
Apidra® U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	**$85.17***	Sanofi-Aventis	0	0 (0%)	NF	No change
Apidra® SoloStar U-100 Insulin 100 unit/mL subcutaneous pen	0	0	$0.00	$0.00	**$164.57***	Sanofi-Aventis	0	0 (0%)	NF	No change
Short-acting Insulin										
Novolin® R Flexpen 100 unit/mL (3 mL) subcutaneous insulin pen	0	0	$0.00	$0.00	**$91.09***	Novo Nordisk	0	0 (0%)	NF	No change

Humulin® R Regular U-100 Insulin 100 unit/mL injection solution	0	0	$0.00	$0.00	**$44.61***	Lilly	0	0 (0%)	F-QL (30/30)	No change
Novolin® R Regular U-100 Insulin 100 unit/mL injection solution	0	0	$0.00	$0.00	**$48.20***	Novo Nordisk	0	0 (0%)	NF	No change
Humulin® R U-500 (Conc) Insulin Kwikpen 500 unit/mL (3 mL) subcutaneous	4	3	$2,689.54	$672.38	$574 (6 mL)	Lilly	0	0 (0%)	F-QL (15/30)	No change
Humulin® R U-500 (Concentrated) Insulin 500 unit/mL subcutaneous soln	0	0	$0.00	$0.00	$1,487 (20 mL)	Lilly	0	0 (0%)	F-QL (20/30)	No change
Intermediate Acting										
Humulin® N NPH U-100 Insulin (isophane susp) 100 unit/mL subcutaneous	9	2	$1,181.12	$131.24	**$44.61***	Lilly	0	0 (0%)	F-QL (30/30)	No change
Novolin® N NPH U-100 Insulin isophane 100 unit/mL subcutaneous susp	0	0	$0.00	$0.00	**$48.20***	Novo Nordisk	0	0 (0%)	NF	No change
Humulin® N NPH U-100 Insulin KwikPen 100 unit/mL (3 mL) subcutaneous	2	1	$1,809.92	$904.96	**$141.39***	Lilly	0	0 (0%)	F-QL (30/30)	No change
Novolin® N Flexpen 100 unit/mL (3 mL) subcutaneous insulin pen	1	1	$498.17	$498.17	**$91.09***	Novo Nordisk	0	0 (0%)	NF	No change
Combination Insulin										
Humulin® 70/30 U-100 Insulin 100 unit/mL subcutaneous suspension	2	1	$261.81	$130.91	**$44.61***	Lilly	0	0 (0%)	F-QL (30/30)	No change
Novolin® 70/30 U-100 Insulin 100 unit/mL subcutaneous suspension	0	0	$0.00	$0.00	**$48.20***	Novo Nordisk	0	0 (0%)	NF	No change
Humulin® 70/30 U-100 Insulin KwikPen 100 unit/mL subcutaneous	3	2	$2,731.98	$910.66	**$141.39***	Lilly	0	0 (0%)	F-QL (30/30)	No change
Novolin® 70-30 FlexPen U-100 Insulin 100 unit/mL (70-30) subcutaneous	0	0	$0.00	$0.00	**$91.09***	Novo Nordisk	0	0 (0%)	NF	No change
Humalog® Mix 50-50 KwikPen U-100 Insulin 100 unit/mL subcutaneous pen	0	0	$0.00	$0.00	$530.00	Lilly	0	0 (0%)	F-QL (30/30)	No change
Humalog® Mix 50-50 (U-100) Insulin 100 unit/mL subcutaneous suspension	0	0	$0.00	$0.00	$285.00	Lilly	0	0 (0%)	F-QL (30/30)	No change
Humalog® Mix 75-25 (U-100) Insulin 100 unit/mL subcutaneous suspension	4	1	$4,385.02	$1,096.26	$285.00	Lilly	1	1 (100%)	F-QL (30/30)	No change
Humalog® Mix 75-25 KwikPen U-100 insulin 100 unit/mL subcutaneous pen	0	0	$0.00	$0.00	$530.40	Lilly	0	0 (0%)	NF	No change
insulin lispro protamine-lispro 100 unit/mL (75-25) subcutaneous pen	0	0	$0.00	$0.00	$149.25	Lilly	0	0 (0%)	F-QL (30/30)	No change
insulin aspar prot-insulin aspart 100 unit/mL (70-30) subcutaneous pen	4	2	$553.66	$138.41	**139.71***	Novo Nordisk	0	0 (0%)	F-QL (30/30)	No change
Novolog® Mix 70-30 FlexPen U-100 Insulin 100 unit/mL subcutaneous pen	0	0	$0.00	$0.00	**139.71***	Novo Nordisk	0	0 (0%)	NF	No change

insulin aspar prt-insulin aspart 100 unit/mL (70-30) subcutaneous soln	0	0	$0.00	$0.00	$141.30	Novo Nordisk	0	0 (0%)	F-QL (30/30)	No change
Novolog® Mix 70-30 U-100 Insulin 100 unit/mL subcutaneous solution	0	0	$0.00	$0.00	$300.10	Novo Nordisk	0	0 (0%)	NF	No change
TOTAL	**155**	**86**	**$35,437.32**	**$228.63**			**3**	**3 (100%)**		

^ WAC for brand products and PAC for generic products as of October 2023. Cost listed is for 1 vial (10 mL) or 1 package of pens (15 mL) unless otherwise noted.
* Pricing effective Q4 2023 for noted Lilly products and 1/1/2024 for noted Novo Nordisk and Sanofi products
Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary

PRIOR AUTHORIZATION CRITERIA

Recommendation:

- Change Lantus to preferred status

Long-Acting Basal Insulin	
Therapeutic Classes (AHFS)	Insulins
Medications	Formulary with quantity limit (30/30): Insulin glargine-yfgn solution 100 unit/ml vial and pen injector **PREFERRED** Rezvoglar (insulin glargine-aglr) 100unit/ml KwikPen **PREFERRED** Lantus Solostar (insulin glargine) 100 unit/ml, Lantus (insulin glargine) 100 unit/ml vial **PREFERRED** Non-formulary Semglee (YFGN) (insulin glargine) 100 unit/ml vial and pen Insulin glargine (Winthrop) 100 unit/ml vial, Solostar Levemir FlexTouch (insulin detemir), Levemir (insulin detemir) vial Toujeo Solostar (insulin glargine) 300 unit/ml pen Tresiba (insulin degludec) 100 unit/ml vial and pen, 200 unit/ml pen ~~Lantus Solostar (insulin glargine) 100 unit/ml, Lantus (insulin glargine) 100 unit/ml vial~~ Basaglar (insulin glargine) KwikPen 100 unit/ml Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	For requests for non-formulary basal insulin, approve if: • Diagnosis of Type I or Type II Diabetes • Documentation of trial and failure, inability to use, intolerance, or contraindication to one formulary preferred long-acting insulin For requests above the quantity limit • The provider has submitted a medical reason why the plan's quantity limit will be inadequate based on the member's condition and treatment history.
Criteria Statement	Non-formulary basal insulins are reserved for members with diabetes who have used (or cannot/should not use) one preferred formulary basal insulin: insulin glargine-yfgn solution 100 unit/ml vial / pen injector, Lantus Solostar/ vial, or Rezvoglar KwikPen.
Last P&T Review Date	~~5/2022~~12/2023

Recommendation:

- Add missing medication insulin aspart to policy under non-formulary medications
- Minor wording update

Rapid-Acting Insulin	
Therapeutic Classes (AHFS)	Insulins
Medications	Formulary with quantity limits: Admelog U-100 vial and Admelog Solostar Insulin Lispro 100 units/ml vial, pen Non-formulary Apidra 100 units/ml vial Apidra Solostar 100 units/ml Humalog KwikPen 100 units/ml, 200 units/ml Humalog 100 units/ml vial, cartridge Novolog 100 units/ml vial Novolog FlexPen100 units/ml Fiasp vial, FlexTouch, penfill Lyumjev KwikPen (insulin lispro-aabc) 100units/ml, 200units/ml Insulin aspart 100 units/ml Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 12 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	For requests for non-formulary rapid acting insulin, approve if: • Diagnosis of Type I or Type II Diabetes • Documentation of trial and failure, inability to use, intolerance, or contraindication to one of the formulary rapid acting insulins. If request is for pen formulation, documentation of trial and failure, inability to use, intolerance, or contraindication to using Admelog Solostar or Insulin Lispro 100 units/ml vial or pen must be provided.
Criteria Statement	Non-formulary rapid acting insulins are reserved for members with diabetes who have used (or cannot/should not use) Admelog vial, Admelog Solostar, Insulin Lispro 100 units/ml vial, or pen.
Last P&T Review Date	~~6/2023~~12/2023

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Pneumococcal Vaccines

Proprietary Name	Non-proprietary Name
Prevnar 13®	pneumococcal vaccine
Prevnar 20®	pneumococcal 20-valent conjugate vaccine
Pneumovax-23®	pneumococcal vaccine polyvalent
Vaxneuvance®	pneumococcal 15-valent conjugate vaccine

UTILIZATION FINDINGS

There were 17 claims for 17 members, for a total of $4,100, and an average cost per claim of $241. The most highly utilized medication was Prevnar 20, with 15 claims. There were no prior authorization requests.

RECOMMENDATIONS

- Remove the age limit minimum of 19 years from all applicable vaccines. This was previously to account for Vaccines For Children (VFC) however not all IHSS Group Care members qualify for VHC. All pneumococcal vaccines are indicated from early childhood and up, thus no age limit is indicated.

Clinical Summary

Pharmacologic Classification

For prevention of pneumococcal disease, either pneumococcal polysaccharide (PPSV) or conjugate-type (PCV) vaccines are currently available. These inactivated bacterial vaccines stimulate an immune response to the polysaccharide capsular "shell" of the bacteria. PPSV contains partially purified pneumococcal capsular polysaccharides only, whereas PCV contains capsular polysaccharides attached to a protein very similar to diphtheria toxin. Generally, PCV vaccines produce a more robust and durable immune response. The PCV form is more appropriate for young children (under 2 years of age) because their immature immune systems do not recognize and build immunity to the capsular polysaccharides when presented alone, and the protein-conjugate helps elicit a T cell-dependent memory response. Currently PCV products Prevnar and Vaxneuvance are FDA-approved for use in children, and PPSV (Pneumovax 23) is approved for children 2 years of age and older. Prevnar 20 was recently granted FDA approval in pediatric populations for prevention of pneumococcal disease in patients 6 weeks and older, and for the prevention of otitis media in patients 6 weeks through 5 years old.

Disease and Treatment Overview

Streptococcus pneumoniae infection can cause severe disease in both adult and pediatric populations and is the leading cause of bacterial pneumonia in the world. Other serious complications include meningitis, bacteremia, and otitis media. Elderly individuals, young children, those with certain chronic conditions, and the immune-compromised are especially at risk. More than 90 pneumococcal serotypes are known, and vaccine developers focus efforts on including serotypes in the vaccines most commonly causing invasive or drug-resistant disease. CDC recommends routine vaccination against pneumococcal disease for all children under 2 years of age, and adults 65 years and older. Older children and adults deemed at higher risk for pneumococcal disease should also be vaccinated, and complete recommendations can be found on the CDC's website.

The most recent ACIP recommended vaccination schedule for children under 18 years was updated to include a choice of either Prevnar 13 or Vaxneuvance where vaccination with a pneumococcal conjugate vaccine was recommended, with no preference given to the choice of agent. Pneumococcal conjugate vaccines are recommended as a series of four doses for all children younger than 2 years old, beginning at 2 months of age. Additional vaccination recommendations for children with certain medical conditions are also available, and usually include the addition of Pneumovax 23 at defined intervals post-PCV vaccination.

The CDC approved updates to guidelines and recommendations for pneumococcal vaccine use for the adult population in early 2022 based off Advisory Committee on Immunizations Practices (ACIP) recommendations, which address the use of newer products Prevnar 20 and Vaxneuvance. Recommendations took a more streamlined approach compared to previous iterations:

- Adults 65 years of age or older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine [either PCV 20 (Prevnar 20) or PCV 15 (Vaxneuvance)]. If PCV 15 is used, this should be followed by a dose of Merck's PPSV 23 (Pneumovax-23) ≥ 1 year later. Adults with immunocompromising conditions, cochlear implant, or CSF leak might benefit from shorter intervals such as ≥8 weeks. These vaccine doses do not need to be repeated if given before age 65 years.
- Adults 19 years of age or older with certain underlying medical conditions or other risk factors who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive 1 dose of a pneumococcal conjugate vaccine (either PCV 20 or PCV 15). If PCV 15 is used, this should be followed by a dose of PPSV 23 ≥ 1 year later. Adults with immunocompromising conditions, cochlear implant, or CSF leak might benefit from shorter intervals such as ≥8 weeks.
    - Risk factors: alcoholism, chronic heart/liver/lung disease, cigarette smoking, diabetes mellitus, chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease or other hemoglobinopathies, cerebrospinal fluid leak, or cochlear implant.

Future Landscape

It is predicted products such as Vaxneuvance and Prevnar 20 will likely replace Prevnar 13, given enhanced coverage against pneumococcal serotypes. With the newest approval for Prevnar 20 in children, the ACIP is likely to review and update guidance relating to immunization practices in the near future. Prevnar 20 is likely to be an appealing option to providers for several reasons, including the enhanced serotype coverage compared to Vaxneuvance and additional indication for prevention of otitis media.

Prescribing Information

INDICATIONS, DOSING and ADMINISTRATION

Medication	Indications	Dosing/Administration
Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	In children 6 weeks through 5 years of age (prior to the 6th birthday), Prevnar 13 is indicated for: • active immunization for the prevention of invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F • active immunization for the prevention of otitis media caused by *S. pneumoniae* serotypes 4, 6B, 9V, 14, 18C, 19F, and 23F. No otitis media efficacy data are available for serotypes 1, 3, 5, 6A, 7F, and 19A In children 6 years through 17 years of age (prior to the 18th birthday), Prevnar 13 is indicated for: • active immunization for the prevention of invasive disease caused by *S. pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F In adults 18 years of age and older, Prevnar 13 is indicated for: • active immunization for the prevention of pneumonia and invasive disease caused by *S. pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F	Intramuscular: Children 6 weeks through 5 years: The four-dose immunization series consists of a 0.5 mL injection administered at 2, 4, 6, and 12–15 months of age. Children 6 through 17 years of age: a single dose Adults 18 years and older: a single dose
Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	In individuals 6 weeks of age and older Prevnar 20 is a vaccine indicated for: • active immunization for the prevention of invasive disease caused by Streptococcus pneumoniae serotypes 1, 3, 4, 5, 6A, 6B, 7F, 8, 9V, 10A, 11A, 12F, 14, 15B, 18C, 19A, 19F, 22F, 23F, and 33F In individuals 6 weeks through 5 years of age, Prevnar 20 is a vaccine indicated for: • active immunization for the prevention of otitis media caused by S. pneumoniae serotypes 4, 6B, 9V, 14, 18C, 19F, and 23F In individuals 18 years of age and older, Prevnar 20 is a vaccine indicated for: • active immunization for the prevention of pneumonia and invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B,	Intramuscular: Children: 0.5 mL as a 4-dose immunization series at 2, 4, 6, and 12 through 15 months of age Adults 18 years of age and older: 0.5 mL as a single dose

	7F, 8, 9V, 10A, 11A, 12F, 14, 15B, 18C, 19A, 19F, 22F, 23F, and 33F **This indication for the prevention of pneumonia caused by S. pneumoniae serotypes 8, 10A, 11A, 12F, 15B, 22F, and 33F in individuals 18 years of age and older is approved under accelerated approval based on immune responses as measured by opsonophagocytic activity (OPA) assay. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.*	
Pneumovax-23® (pneumococcal vaccine polyvalent)	In persons 50 years of age or older and persons aged ≥2 years who are at increased risk for pneumococcal disease, Pneumovax 23 is a vaccine indicated for: • active immunization for the prevention of pneumococcal disease caused by the 23 serotypes contained in the vaccine (1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19F, 19A, 20, 22F, 23F, and 33F)	Intramuscular or subcutaneous: Adults: 0.5 mL as a single dose Children aged ≥2 years who are at increased risk for pneumococcal disease: 0.5 mL as a single dose
Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)	In individuals 6 weeks of age and older, Vaxneuvance is indicated for: • active immunization for the prevention of invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, 22F, 23F and 33F	Intramuscular: Children: a 4-dose series at 2, 4, 6 and 12 through 15 months of age (and at least 2 months after the third dose) Adults: 0.5 mL as a single dose

BOXED WARNINGS and CONTRAINDICATIONS

Medication	Boxed Warnings	Contraindications
Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	N/A	Severe allergic reaction (eg, anaphylaxis) to pneumococcal vaccine, any component of the formulation, or any diphtheria toxoid-containing vaccine
Prevnar 20® (pneumococcal 20-valent conjugate vaccine)		
Pneumovax-23® (pneumococcal vaccine polyvalent)		Severe allergic reaction (eg, anaphylactic/ anaphylactoid reaction) to pneumococcal vaccine or any component of the formulation
Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)		Severe hypersensitivity (eg, anaphylaxis) to pneumococcal conjugate vaccine, any component of the formulation, or to diphtheria toxoid.

WARNINGS/PRECAUTIONS

Medication	Warnings/Precautions
Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	***Concerns related to adverse effects:*** • Anaphylactoid/hypersensitivity reactions: Immediate treatment (including epinephrine 1 mg/mL) for anaphylactoid and/or hypersensitivity reactions should be available during vaccine use • Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection

	• Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in adolescents and young adults and within 15 minutes after vaccination ***Disease-related concerns:*** • Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness (with or without fever) • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months of age with asplenia • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months of age with chronic illness • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months with HIV infection • Not to be used to treat pneumococcal infections or to provide immunity against diphtheria • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months with sickle cell disease ***Concurrent drug therapy issues:*** • Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • Receipt of PPSV23 within 1 year prior to pneumococcal conjugate vaccine (PCV13) diminishes response to PCV13 when compared to response in PPSV23 naïve individuals • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist ***Dosage form specific issues:*** • Some dosage forms may contain polysorbate 80 (also known as Tweens). Hypersensitivity reactions, usually a delayed reaction, have been reported following exposure to pharmaceutical products containing polysorbate 80 in certain individuals ***Special populations:*** • Consider deferring vaccination during periods of severe immunosuppression (eg, patients receiving chemo-/radiation therapy or other immunosuppressive therapy including high-dose corticosteroids); may have a reduced response to vaccination • Antibody responses were lower in older adults >65 years compared to adults 50 to 59 years • Antibody responses were lower in preterm infants (<37 weeks gestational age) compared to term infants (≥37 weeks gestational age). Apnea following IM vaccination has been observed in some preterm infants ***Additional pediatric considerations:*** • Febrile seizures have been reported; CDC reports indicate that young children appear to be at increased risk of febrile seizures when given the pneumococcal conjugate vaccine (PCV13) at the same time as the inactivated influenza virus vaccine (TIV); the risk appears to be greatest from ages 12 to 23 months. Because febrile seizures are typically benign and occur in 2% to 5% of all young children, the ACIP does not recommend a delay in administration of either vaccine or altering the vaccine schedule in any manner due to the potential risk of infection
Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	***Concerns related to adverse effects:*** • Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection

	• Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in adolescents and young adults and within 15 minutes after vaccination ***Disease-related concerns:*** • Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness (with or without fever) • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration ***Concurrent drug therapy issues:*** • Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • Receipt of PPSV23 1 to 5 years prior to pneumococcal conjugate vaccine (PCV20) diminishes response to PCV20 when compared to response in PPSV23 naive individuals • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist ***Special populations:*** • Consider deferring immunization during periods of severe immunosuppression (eg, patients receiving chemo-/radiation therapy or other immunosuppressive therapy including high-dose corticosteroids); may have a reduced response to vaccination • Antibody responses were lower in adults ≥70 years of age compared to adults 18 to 64 years of age ***Dosage form specific issues:*** • Some dosage forms may contain polysorbate 80 (also known as Tweens). Hypersensitivity reactions, usually a delayed reaction, have been reported following exposure to pharmaceutical products containing polysorbate 80 in certain individuals
Pneumovax-23® (pneumococcal vaccine polyvalent)	***Concerns related to adverse effects:*** • Anaphylactoid/hypersensitivity reactions: Immediate treatment (including epinephrine 1 mg/mL) for anaphylactoid and/or hypersensitivity reactions should be available during vaccine use • Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection • Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in adolescents and young adults and within 15 minutes after vaccination ***Disease-related concerns:*** • Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration • Use with caution in patients with severely compromised cardiovascular function where a systemic reaction may pose a significant risk • Patients with HIV should be vaccinated as soon as possible following confirmation of the diagnosis • Vaccination may not be as effective in patients with chronic CSF leaks due to congenital lesions, skull fractures, or neurosurgical procedures

	• Use with caution in patients with severe pulmonary disease where a systemic reaction may pose a significant risk • Patients who will undergo splenectomy should also be vaccinated at least 2 weeks prior to surgery, if possible • May cause relapse in patients with stable idiopathic thrombocytopenia purpura ***Concurrent drug therapy issues:*** • Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist • This vaccine does not replace the need for penicillin (or other antibiotic) prophylaxis against pneumococcal infection. In persons who require penicillin (or other antibiotic) prophylaxis against pneumococcal infection, such prophylaxis should not be discontinued after vaccination with pneumococcal vaccine ***Special populations:*** • Consider deferring immunization during periods of severe immunosuppression (eg, patients receiving chemo/radiation therapy or other immunosuppressive therapy [including high-dose corticosteroids]); may have a reduced response to vaccination • Pneumococcal vaccine is not approved for use in children <2 years. Children in this age group do not develop an effective immune response to the capsular types contained in this polysaccharide vaccine • Patients who will undergo cochlear implant placement should be vaccinated at least 2 weeks prior to surgery, if possible • Postmarketing reports of adverse effects in elderly patients, especially those with comorbidities, have been significant enough to require hospitalization
Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)	***Concerns related to adverse effects:*** • Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection • Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in adolescents and young adults and within 15 minutes after vaccination ***Disease-related concerns:*** • Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness (with or without fever) • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration ***Concurrent drug therapy issues:*** • Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist ***Special populations:*** • Consider deferring vaccination during periods of severe immunosuppression (eg, patients receiving chemo-/radiation therapy or other immunosuppressive therapy including high-dose corticosteroids); may have a reduced response to vaccination

Price

	Prevnar 13®	Prevnar 20®	Pneumovax-23®	Vaxneuvance®
Formulary Status	F-QL (0.5ml per one dose)	F-QL-AL (0.5ml per one dose, 1 fill per lifetime) (min age 19 years)	F-QL-AL (0.5ml per one dose, 2 fills per lifetime) (min age 19 years)	F-QL-AL (0.5ml per one dose, 1 fill per lifetime) (min age 19 years)
Price Per Dose^	$233	$261	$117	$222

^Proprietary drug pricing is based on wholesale acquisition cost (WAC) and non-proprietary drug pricing is based on National Average Drug Acquisition Cost (NADAC) for 1 month supply unless otherwise noted.

Prescribing Information (alternate layout)

	Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
Indications	In children 6 weeks through 5 years of age (prior to the 6th birthday), Prevnar 13 is indicated for: • active immunization for the prevention of invasive disease caused by Streptococcus pneumoniae serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F • active immunization for the prevention of otitis media caused by S. pneumoniae serotypes 4, 6B, 9V, 14, 18C, 19F, and 23F. No otitis media efficacy data are available for serotypes 1, 3, 5, 6A, 7F, and 19A In children 6 years through 17 years of age (prior to the 18th birthday), Prevnar 13 is indicated for: • active immunization for the prevention of invasive disease caused by S. pneumoniae serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F In adults 18 years of age and older, Prevnar 13 is indicated for: • active immunization for the prevention of pneumonia and invasive disease caused by S. pneumoniae serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F	In individuals 6 weeks of age and older Prevnar 20 is a vaccine indicated for: • active immunization for the prevention of invasive disease caused by Streptococcus pneumoniae serotypes 1, 3, 4, 5, 6A, 6B, 7F, 8, 9V, 10A, 11A, 12F, 14, 15B, 18C, 19A, 19F, 22F, 23F, and 33F In individuals 6 weeks through 5 years of age, Prevnar 20 is a vaccine indicated for: • active immunization for the prevention of otitis media caused by S. pneumoniae serotypes 4, 6B, 9V, 14, 18C, 19F, and 23F In individuals 18 years of age and older, Prevnar 20 is a vaccine indicated for: • active immunization for the prevention of pneumonia and invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 8, 9V, 10A, 11A, 12F, 14, 15B, 18C, 19A, 19F, 22F, 23F, and 33F **This indication for the prevention of pneumonia caused by S. pneumoniae serotypes 8, 10A,*	In persons 50 years of age or older and persons aged ≥2 years who are at increased risk for pneumococcal disease, Pneumovax 23 is a vaccine indicated for: • active immunization for the prevention of pneumococcal disease caused by the 23 serotypes contained in the vaccine (1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19F, 19A, 20, 22F, 23F, and 33F)	In individuals 6 weeks of age and older, Vaxneuvance is indicated for: • active immunization for the prevention of invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, 22F, 23F and 33F

	Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
		11A, 12F, 15B, 22F, and 33F in individuals 18 years of age and older is approved under accelerated approval based on immune responses as measured by opsonophagocytic activity (OPA) assay. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.		

		Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
Dosing (adults)		Intramuscular: 0.5 mL as a single dose	Intramuscular: 0.5 mL as a single dose	Intramuscular or subcutaneous: 0.5 mL as a single dose	Intramuscular: 0.5 mL as a single dose
Dosing (pediatrics)		Intramuscular: • Children 6 weeks through 5 years: The four-dose immunization series consists of a 0.5 mL injection administered at 2, 4, 6, and 12–15 months of age. • Children 6 through 17 years of age: a single dose	Intramuscular: 0.5 mL as a 4-dose immunization series at 2, 4, 6, and 12 through 15 months of age	Intramuscular or subcutaneous: Children aged ≥2 years who are at increased risk for pneumococcal disease: 0.5 mL as a single dose	Intramuscular: a 4-dose series at 2, 4, 6 and 12 through 15 months of age (and at least 2 months after the third dose)
Boxed Warnings		N/A	N/A	N/A	N/A
Contraindications		Severe allergic reaction (eg, anaphylaxis) to pneumococcal vaccine, any component of the formulation, or any diphtheria toxoid-containing vaccine	Severe allergic reaction (eg, anaphylaxis) to pneumococcal vaccine, any component of the formulation, or any diphtheria toxoid-containing vaccine	Severe allergic reaction (eg, anaphylactic/anaphylactoid reaction) to pneumococcal vaccine or any component of the formulation	Severe hypersensitivity (eg, anaphylaxis) to pneumococcal conjugate vaccine, any component of the formulation, or to diphtheria toxoid
Warnings & Precautions	**Concerns related to adverse effects:**	• Anaphylactoid/hypersensitivity reactions: Immediate treatment (including epinephrine 1 mg/mL) for anaphylactoid and/or hypersensitivity reactions should be available during vaccine use • Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection • Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in	• Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection • Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in adolescents	• Anaphylactoid/hypersensitivity reactions: Immediate treatment (including epinephrine 1 mg/mL) for anaphylactoid and/or hypersensitivity reactions should be available during vaccine use • Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection • Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in	• Vaccine administration that is too high on the upper arm may cause shoulder injury (eg, shoulder bursitis, tendinopathy) resulting in shoulder pain and reduced range of motion following injection • Syncope has been reported with use of injectable vaccines and may result in serious secondary injury (eg, skull fracture, cerebral hemorrhage); typically reported in adolescents

		Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
		adolescents and young adults and within 15 minutes after vaccination	and young adults and within 15 minutes after vaccination	adolescents and young adults and within 15 minutes after vaccination	and young adults and within 15 minutes after vaccination
	Disease-related concerns:	• Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness (with or without fever) • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months of age with asplenia • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months of age with chronic illness • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months with HIV infection • Not to be used to treat pneumococcal infections or to provide immunity against diphtheria • Use of pneumococcal conjugate vaccine does not replace use of the 23-valent pneumococcal polysaccharide vaccine in children ≥24 months with sickle cell disease	• Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness (with or without fever) • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration	• Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration • Use with caution in patients with severely compromised cardiovascular function where a systemic reaction may pose a significant risk • Patients with HIV should be vaccinated as soon as possible following confirmation of the diagnosis • Vaccination may not be as effective in patients with chronic CSF leaks due to congenital lesions, skull fractures, or neurosurgical procedures • Use with caution in patients with severe pulmonary disease where a systemic reaction may pose a significant risk • Patients who will undergo splenectomy should also be vaccinated at least 2 weeks prior to surgery, if possible • May cause relapse in patients with stable idiopathic thrombocytopenia purpura	• Defer administration in patients with moderate or severe acute illness (with or without fever); vaccination should not be delayed for patients with mild acute illness (with or without fever) • Use with caution in patients with bleeding disorders (including thrombocytopenia); bleeding/hematoma may occur from IM administration

		Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
	Concurrent drug therapy issues:	• Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • Receipt of PPSV23 within 1 year prior to pneumococcal conjugate vaccine (PCV13) diminishes response to PCV13 when compared to response in PPSV23 naïve individuals • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist	• Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • Receipt of PPSV23 1 to 5 years prior to pneumococcal conjugate vaccine (PCV20) diminishes response to PCV20 when compared to response in PPSV23 naive individuals • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist	• Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist • This vaccine does not replace the need for penicillin (or other antibiotic) prophylaxis against pneumococcal infection. In persons who require penicillin (or other antibiotic) prophylaxis against pneumococcal infection, such prophylaxis should not be discontinued after vaccination with pneumococcal vaccine	• Use with caution in patients receiving anticoagulant therapy; bleeding/hematoma may occur from IM administration • To maximize vaccination rates, the Advisory Committee on Immunization Practices (ACIP) recommends simultaneous administration (ie, >1 vaccine on the same day at different anatomic sites) of all age-appropriate vaccines (live or inactivated) for which a person is eligible at a single clinic visit, unless contraindications exist
	Dosage form specific issues:	• Some dosage forms may contain polysorbate 80 (also known as Tweens). Hypersensitivity reactions, usually a delayed reaction, have been reported following exposure to pharmaceutical products containing polysorbate 80 in certain individuals	• Some dosage forms may contain polysorbate 80 (also known as Tweens). Hypersensitivity reactions, usually a delayed reaction, have been reported following exposure to pharmaceutical products containing polysorbate 80 in certain individuals		

	Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
Special populations:	• Consider deferring vaccination during periods of severe immunosuppression (eg, patients receiving chemo-/radiation therapy or other immunosuppressive therapy including high-dose corticosteroids); may have a reduced response to vaccination • Antibody responses were lower in older adults >65 years compared to adults 50 to 59 years • Antibody responses were lower in preterm infants (<37 weeks gestational age) compared to term infants (≥37 weeks gestational age). Apnea following IM vaccination has been observed in some preterm infants	• Consider deferring immunization during periods of severe immunosuppression (eg, patients receiving chemo-/radiation therapy or other immunosuppressive therapy including high-dose corticosteroids); may have a reduced response to vaccination • Antibody responses were lower in adults ≥70 years of age compared to adults 18 to 64 years of age	• Consider deferring immunization during periods of severe immunosuppression (eg, patients receiving chemo/radiation therapy or other immunosuppressive therapy [including high-dose corticosteroids]); may have a reduced response to vaccination • Pneumococcal vaccine is not approved for use in children <2 years. Children in this age group do not develop an effective immune response to the capsular types contained in this polysaccharide vaccine • Patients who will undergo cochlear implant placement should be vaccinated at least 2 weeks prior to surgery, if possible • Postmarketing reports of adverse effects in elderly patients, especially those with comorbidities, have been significant enough to require hospitalization	• Consider deferring vaccination during periods of severe immunosuppression (eg, patients receiving chemo-/radiation therapy or other immunosuppressive therapy including high-dose corticosteroids); may have a reduced response to vaccination
Additional pediatric considerations:	• Febrile seizures have been reported; CDC reports indicate that young children appear to be at increased risk of febrile seizures when given the pneumococcal conjugate vaccine (PCV13) at the same time as the inactivated influenza virus vaccine (TIV); the risk appears to be greatest from ages 12 to 23 months. Because febrile seizures are typically benign and occur in 2% to 5% of all young children, the ACIP does not recommend a delay in			

		Prevnar 13® (pneumococcal 13-valent conjugate vaccine)	Prevnar 20® (pneumococcal 20-valent conjugate vaccine)	Pneumovax-23® (pneumococcal vaccine polyvalent)	Vaxneuvance® (pneumococcal 15-valent conjugate vaccine)
		administration of either vaccine or altering the vaccine schedule in any manner due to the potential risk of infection			
Cost per dose (WAC):		$233	$261	$117	$222

Pneumococcal Serotypes in FDA-Approved Vaccines

Serotype	Prevnar 13®	Prevnar 20®	Pneumovax 23®	Vaxneuvance®
1	X	X	X	X
2			X	
3	X	X	X	X
4	X	X	X	X
5	X	X	X	X
6A	X	X		X
6B	X	X	X	X
7F	X	X	X	X
8		X	X	
9N			X	
9V	X	X	X	X
10A		X	X	
11A		X	X	
12F		X	X	
14	X	X	X	X
15B		X	X	
17F			X	
18C	X	X	X	X
19F	X	X	X	X
19A	X	X	X	X
20			X	
22F		X	X	X
23F	X	X	X	X
33F		X	X	X

Formulary Placement, Utilization and Cost Experience (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST		PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	**Rx**	**Mbrs**	**Total Plan Paid**	**Avg/Rx Plan Paid**	**Total**	**Approved (%)**	**Current**	**Recommend**
Pneumococcal Vaccines								
Prevnar 13® (pneumococcal 13-valent conjugate vaccine) (PF) 0.5 mL intramuscular syringe	0	0	$0.00	$0.00	0	0 (0%)	F-QL (0.5ml per one dose, 1 fill per lifetime)	No change
Prevnar 20® (pneumococcal 20-valent conjugate vaccine) (PF) 0.5 mL intramuscular syringe	15	15	$3,761.18	$250.75	0	0 (0%)	F-QL-AL (0.5ml per one dose, 1 fill per lifetime) (min age 19 yrs)	→ **F-QL (0.5ml per one dose, 1 fill per lifetime)**
Pneumovax-23® (pneumococcal vaccine polyvalent) 25 mcg/0.5 mL injection solution	0	0	$0.00	$0.00	0	0 (0%)	F-QL-AL (0.5ml per one dose, 2 fills per lifetime) (min age 19 yrs)	→ **F-QL (0.5ml per one dose, 2 fills per lifetime)**
Pneumovax-23® (pneumococcal vaccine polyvalent) 25 mcg/0.5 mL injection syringe	1	1	$124.55	$124.55	0	0 (0%)	F-QL-AL (0.5ml per one dose, 2 fills per lifetime) (min age 19 yrs)	→ **F-QL (0.5ml per one dose, 1 fill per lifetime)**
Vaxneuvance® (pneumococcal 15-valent conjugate vaccine crm197 protein adsorbed)/0.5 mL injection suspension	1	1	$215.15	$215.15	0	0 (0%)	F-QL-AL (0.5ml per one dose, 1 fill per lifetime) (min age 19 yrs)	→ **F-QL (0.5ml per one dose, 1 fill per lifetime)**
TOTAL	**17**	**17**	**$4,100.88**	**$241.23**	**0**	**0 (0%)**		

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary

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Neurotoxins (select)

Proprietary Name	Non-proprietary Name
Dysport®	abobotulinumtoxinA
Xeomin®	incobotulinumtoxinA
Botox®	onabotulinumtoxinA
Myobloc®	rimabotulinumtoxinB
Daxxify®	daxibotulinumtoxinA-lanm

UTILIZATION FINDINGS

There were no claims and no prior authorization requests.

RECOMMENDATIONS

- No changes

Clinical Summary

Pharmacologic Classification

Neurotoxins, or botulinum toxins, are produced by Clostridium botulinum that causes regional muscle weakness through its action as a zinc endopeptidase cleaving specific proteins involved in vesicular fusion. Disruption of these fusion proteins interferes with the release of acetylcholine at the neuromuscular junction, resulting in localized muscle weakness.

Disease and Treatment Overview

Botulinum toxins has been in use since the 1970s. Over the last decade, the utilization of botulinum toxin has expanded due to a broader range of approved indications. There are currently four preparations of botulinum toxin type A (Botox®, Xeomin®, and Dysport®, Daxxify®) and one preparation of botulinum toxin type B (Myobloc®) that is commercially available. Indications for these products include treatment of blepharospasm, cervical dystonia, adult spasticity, and headache. Botox® is the oldest product, has the most indications, and holds a high degree of market share control in this class. Daxxify® (daxibotulinumtoxinA-lanm) is the newest product on the market, with its only therapeutic indication being for cervical dystonia, which was approved in August 2023. Neurotoxins are also routinely used for wrinkles, however, this indication is for cosmetic use and is not covered by most plans.

Future Landscape

Dysport® is currently being studied in phase 3 clinical trials for urinary incontinence in individuals with neurologic conditions. There is also a new formulation of Dysport® currently in phase 3 clinical trials. Additionally, a molecule called ABP-450 is in phase 2 trials being studied for migraine and cervical dystonia. Biosimilars for Botox® are also currently in development, but it is unclear when they may receive approval and hit the market.

Prescribing Information

Indication

Indication	Dysport®	Xeomin®	Botox®	Myobloc®	Daxxify®
Blepharospasm		x	x		
Cervical dystonia	x	x	x	x	x
Chronic sialorrhea		x		x	
Upper limb spasticity	x	x	x		
Lower limb spasticity	x		x		
Wrinkled face	x	x	x		x
Bladder muscle dysfunction-overactive			x		
Chronic migraine prophylaxis			x		
Axillary hyperhidrosis			x		
Strabismus			x		
Incontinence due to detrusor instability			x		
Overactive bladder			x		

The following is a cost comparison for comparable indications between the four botulinum toxin type A products (Dysport®, Xeomin®, Daxxify®, and Botox®)

Blepharospasm:

	Dysport®	Xeomin® (adults only)	Botox® (age 12 and up)
Dosing	N/A	50 Units (25 Units per eye) into the lateral and medial orbicularis oculi muscle of the upper lid and into the lateral canthus and the lateral orbicularis oculi muscle of the lower lid; repeat treatment based on clinical response, but no	1.25 to 2.5 units (0.05 to 0.1 mL) injected into medial and lateral pretarsal orbicularis oculi muscle of upper lid and into lateral pretarsal orbicularis oculi muscle of lower lid; treatment may be repeated every 3 months; repeat dose may be increased 2-fold for inadequate responses; there appears to be little

		more frequently than every 12 weeks	benefit obtainable from injecting more than 5 Units per site-cumulative MAX, 200 units/30 days
WAC pricing	N/A	$5.20/unit (50 U) $4.96/unit (100 U/200 U)	$6.34/unit (100 U/200 U)
Rebated pricing	N/A	$4.84 /unit (50 U) $4.61/unit (100 U/200 U)	N/A
Pricing per month	N/A	16.7 U WAC: $83 Rebated: $77	15 U WAC: $95
Pricing favors Xeomin®			

Cervical Dystonia (only indicated for adult patients for all four products):

	Dysport®	**Xeomin®**	**Daxxify®**	**Botox®**
Dosing	The recommended initial dose is 500 Units given intramuscularly as a divided dose. For dose modification, studies suggest that the total dose administered in a single treatment should be between 250 Units and 1000 Units no more frequently than every 12 weeks	Initial total dose, 120 units divided and injected among affected muscles, no more frequently than every 12 weeks	125 Units to 250 Units given intramuscularly as a divided dose among affected muscles. Product labeling prohibits re-treatment intervals shorter than every 12 weeks.	198 to 300 units (mean, 236 units) divided among affected muscles. Limit total dose administered into sternocleidomastoid muscles to 100 units or less to decrease dysphagia occurrence
WAC pricing	$1.71/unit (300 U/500 U)	$5.20/unit (50 U) $4.96/unit (100 U/200 U)	$4.20/unit (100 U)	$6.34/unit (100 U/200 U)

Rebated pricing	$1.60/unit (300 U/500 U)	$4.84 /unit (50 U) $4.61/unit (100 U/200 U)	N/A	N/A
Pricing per indication	1000 U (rec. max) WAC: $1,710 Rebated: $1,600	120 U (initial dose) WAC: $595 Rebated: $553	250 U (max) $1,050	300 U (max) $1,902
Pricing favors Xeomin®				

Upper limb spasticity (all indicated for patients 2 years of age and older):

	Dysport®	**Xeomin®**	**Botox®**
Dosing	In the clinical trial that assessed the efficacy and safety of Dysport® for treatment of upper limb spasticity in adults, doses of 500 units and 1000 units were divided among selected muscles at a given treatment session; maximum recommended total dose (upper and lower limb combined) of Dysport® for the treatment of spasticity in adults is 1500 Units	Varies from 25 to 200 units depending on the area/muscle(s) being treated; MAX 400 units/treatment session and no sooner than every 12 weeks	Start with lowest dose; usual dosage ranged from 75 to 400 units (using a 5 units/0.1 mL reconstituted solution) per treatment session
WAC pricing	$1.71/unit (300 U/500 U)	$5.20/unit (50 U) $4.96/unit (100 U/200 U)	$6.34/unit (100 U/200 U)
Rebated pricing	$1.60/unit (300 U/500 U)	$4.84 /unit (50 U) $4.61/unit (100 U/200 U)	N/A
Pricing per indication	1500 U (max combined upper/lower limb dose) WAC: $2,565	400 U (max dose) WAC: $1,984 Rebated: $1,844	400 U (max dose) $2,536

	Rebated: $2,400		
Pricing favors Xeomin®			

Lower limb spasticity:

	Dysport® (ages 2+)	Xeomin®	Botox® (ages 2+)
Dosing	Doses of 1000 units and 1500 units were divided among selected muscles at a given treatment session per clinical trials; maximum recommended total dose (upper and lower limb combined) of Dysport® for the treatment of spasticity in adults is 1500 Units	N/A	300 to 400 units divided among 5 muscles; maximum cumulative dose should not exceed 400 units
WAC pricing	$1.71/unit (300 U/500 U)	N/A	$6.34/unit (100 U/200 U)
Rebated pricing	$1.60/unit (300 U/500 U)	N/A	N/A
Pricing per indication	1500 U (max combined upper/lower limb dose) WAC: $2,565 Rebated: $ 2,400	N/A	400 U (max cumulative dose) $2,536
Pricing favors Xeomin® (with preferred pricing)			

Other Comparative Information

	Dysport®	Xeomin®	Daxxify®	Botox®
Route of Administration	Intramuscular	Intramuscular	Intramuscular	Intramuscular Intradermal Intradetrusor
Dose conversion ratio to Botox®*	3:1	1:1	2:1	N/A
Vial size	300u, 500u	50u, 100u, 200u	50u, 100u	100u, 200u

Amount of drug migration from injection site	some	most	some	least
Duration of action†	12 weeks	12 weeks	12 weeks	12 weeks
Contraindications	Allergy to any of the components Infection at injection site Contains lactose-not for patients with cow's milk protein allergy	Allergy to any of the components Infection at injection site	Allergy to any of the components Infection at injection site	Allergy to any of the components Infection at injection site

* The molecules and pharmacokinetics of the three botulinum toxin A products differ, making a straight conversion ratio of equivalent therapeutic doses more difficult. The comparisons are approximate.

†Duration of Action: Botulinum toxins have a significantly longer effect on autonomic neurons in smooth muscle (6–9 months), for indications such as hyperhidrosis or overactive bladder, compared to the 3 to 4 months observed for striated skeletal muscle (face, limb, etc.). Differences in duration of action between Botox®, Dysport®, Xeomin®, and Daxxify® is unclear. Package inserts for each of the products references dosing every 12 weeks. The Dysport® package insert describes dosing intervals longer than every 12 weeks in the most detail, although all package inserts describe longer dosing intervals. Daxxify® has shown the potential for a longer duration of effect as it utilizes a different excipient compared to all other neurotoxin products. The product with the overall longest duration of action is not known.

Black Box Warning

All botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects.

Adverse Reactions

Most common: Injection site pain, bruising, edema, flu-like symptoms

Guidelines

Simpson DM, Hallett M, Ashman EJ, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2016;86(19):1818-1826.

Blepharospasm

- OnabotulinumtoxinA and incobotulinumtoxinA injections should be considered (Level B), and abobotulinumtoxinA may be considered (Level C), as treatment options for blepharospasm

- Botulinum toxin is considered the first-line treatment of blepharospasm by most movement disorder specialists; all type A toxins appear to have similar efficacy and can continue to be efficacious over long periods

Cervical Dystonia

- AbobotulinumtoxinA and rimabotulinumtoxinB should be offered (Level A), and onabotulinumtoxinA and incobotulinumtoxinA should be considered (Level B), as options for the treatment of cervical dystonia
  - Botulinum toxin is accepted as first-line treatment for cervical dystonia. Although the evidence levels may differ across botulinum toxinserotypes and brands, all formulations have regulatory approval and are commonly used. There is an extensive clinical history of onabotulinumtoxinA and incobotulinumtoxinA use, but the lack of additional class I studies led to only a Level B recommendation. Comparative trials indicate similar efficacy for rimabotulinumtoxinB and onabotulinumtoxinA, and for abobotulinumtoxinA and onabotulinumtoxinA, in the treatment of cervical dystonia.

Spasticity

- For focal manifestations of adult spasticity involving the upper limb, abobotulinumtoxinA, incobotulinumtoxinA, and onabotulinumtoxinA, should be offered (Level A), and rimabotulinumtoxinB should be considered (Level B), as treatment options
- For focal manifestations of adult spasticity involving the lower limb that warrant treatment, onabotulinumtoxinA and abobotulinumtoxinA should be offered (Level A) as treatment options
  - There is insufficient evidence to support or refute a benefit of incobotulinumtoxinA, or rimabotulinumtoxinB for treatment of adult lower limb spasticity
- OnabotulinumtoxinA should be considered as a treatment option before tizanidine for treating adult upper extremity spasticity (Level B)
- Both high-volume, low-potency injections of onabotulinumtoxinA and endplate targeting of onabotulinumtoxinA into proximal upper extremity muscles should be considered to enhance tone reduction in spasticity (Level B)

Headache

- OnabotulinumtoxinA should be offered as a treatment option to patients with chronic migraine to increase the number of headache-free days (Level A) and should be considered to reduce headache impact on health-related quality of life (Level B)
- OnabotulinumtoxinA should not be offered as a treatment for episodic migraine

Recommendation Definitions

Level of Recommendation	Phrasing	Definition
Level A	"Must"	Strongest recommendation level; these recommendations are rare, as they are based on high confidence in the evidence and require both a high magnitude of benefit and low risk.
Level B	"Should"	More common recommendations, as the requirements are less stringent but still based on the evidence and benefit–risk profile.
Level C	"May"	Represents the lowest allowable recommendation level the AAN considers useful within the scope of clinical practice and can accommodate the highest degree of practice variation.

Ailani J, Burch RC, Robbins MS, Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. Headache. 2021;61(7):1021-1039.

The following are medications with evidence of efficacy in migraine:

- Established efficacy (two or more class I trials based on American Academy of Neurology [AAN] evidence classification):
    - Oral:
        - Candesartan
        - Divalproex sodium
        - Frovatriptan (for short-term prevention of menstrual-related migraine)
        - Metoprolol
        - Propranolol
        - Timolol
        - Topiramate
    - Parenteral:
        - Eptinezumab
        - Erenumab
        - Fremanezumab
        - Galcanezumab
        - OnabotulinumtoxinA
- Probably effective (one class I or two class II trials based on AAN evidence classification):
    - Oral:
        - Amitriptyline
        - Atenolol
        - Lisinopril
        - Memantine
        - Nadolol
        - Venlafaxine
    - Parenteral: OnabotulinumtoxinA + calcitonin gene-related peptide (CGRP) monoclonal antibodies

Lightner DJ, Gomelsky A, Souter L, Vasavada SP. Diagnosis and treatment of overactive bladder (Non-neurogenic) in adults: AUA/SUFU guideline amendment 2019. J Urol. 2019;202(3):558-563.

First-Line Treatments:

- Clinicians should offer behavioral therapies (e.g., bladder training, bladder control strategies, pelvic floor muscle training, fluid management) as first line therapy to all patients with overactive bladder (Standard; Evidence strength: Grade B)
- Behavioral therapies may be combined with pharmacologic management (Recommendation; Evidence strength: Grade C)

Second-Line Treatments:

- Clinicians should offer oral anti-muscarinics or oral β3-adrenoceptor agonists as second-line therapy (Standard; Evidence strength: Grade B)
- If an immediate release (IR) and an extended release (ER) formulation are available, then ER formulations should preferentially be prescribed over IR formulations because of lower rates of dry mouth (Standard; Evidence strength: Grade B)
- Clinicians may consider combination therapy with an anti-muscarinic and β3-adrenoceptor agonist for patients refractory to monotherapy with either antimuscarinics or β3-adrenoceptor agonists. (Option; Evidence strength: Grade B)
- Transdermal oxybutynin (patch or gel) may be offered (Recommendation; Evidence strength: Grade C)
- If a patient experiences inadequate symptom control and/or unacceptable adverse drug events with one antimuscarinic medication, then a dose modification or a different anti-muscarinic medication or a β3-adrenoceptor agonist may be tried (Clinical Principle)

Third-line Treatments:

- Clinicians may offer intradetrusor onabotulinumtoxinA as third-line treatment in the carefully-selected and thoroughly-counseled patient who has been refractory to first- and second-line overactive bladder treatments.

The patient must be able and willing to return for frequent post-void residual evaluation and able and willing to perform self-catheterization if necessary (Option; Evidence strength: Grade C)

- Clinicians may offer peripheral tibial nerve stimulation (PTNS) as third line treatment in a carefully selected patient population (Option; Evidence strength: Grade C)
- Clinicians may offer sacral neuromodulation (SNS) as third line treatment in a carefully selected patient population characterized by severe refractory overactive bladder symptoms or patients who are not candidates for second-line therapy and are willing to undergo a surgical procedure (Recommendation; Evidence strength: Grade C)

Recommendation Definitions

Statement Type	Definition
Standard	Directive statement that an action should (benefits outweigh risks/burdens) or should not (risks/burdens outweigh benefits) be taken based on Grade A (high quality; high certainty) or B (moderate quality; moderate certainty) evidence.
Recommendation	Directive statement that an action should (benefits outweigh risks/burdens) or should not (risks/burdens outweigh benefits) be taken based on Grade C (low quality; low certainty) evidence.
Option	Non-directive statement that leaves the decision regarding an action up to the individual clinician and patient because the balance between benefits and risks/burdens appears equal or appears uncertain based on Grade A (high quality; high certainty), B (moderate quality; moderate certainty), or C (low quality; low certainty) evidence.
Clinical Principle	A statement about a component of clinical care that is widely agreed upon by urologists or other clinicians for which there may or may not be evidence in the medical literature.
Expert Opinion	A statement, achieved by consensus of the Panel, that is based on members' clinical training, experience, knowledge, and judgment for which there is no evidence.

Evidence Grade	Definition
Grade A	Well-conducted randomized controlled trials (RCT) or exceptionally strong observational studies.
Grade B	RCTs with some weaknesses of procedure or generalizability or generally strong observational studies.
Grade C	Observational studies that are inconsistent, have small sample sizes or have other problems that potentially confound interpretation of data.

McConaghy JR, Fosselman D. Hyperhidrosis: management options. Am Fam Physician. 2018;97(11):729-734.

- Topical 20% aluminum chloride should be used as first-line treatment in most cases of primary hyperhidrosis, regardless of severity and location (Evidence rating: C)
- Iontophoresis may be effective as first- or second-line treatment for primary hyperhidrosis of the palms or soles (Evidence rating: C)
- Intradermal onabotulinumtoxinA injections may be considered first- or second-line treatments for many cases of primary hyperhidrosis involving the axillae, palms, soles, or face (Evidence rating: C)
- Oral anticholinergics are recommended if treatment with topical aluminum chloride, onabotulinumtoxinA injection, and iontophoresis is ineffective (Evidence rating: C)
- Local surgery and endoscopic thoracic sympathectomy should be considered only after topical and medical treatments have failed (Evidence rating: C).

Recommendation Definitions

Evidence Rating	Definition
A	Consistent, good-quality patient-oriented evidence.
B	Inconsistent or limited-quality patient-oriented evidence.
C	Consensus, disease-oriented evidence, usual practice, expert opinion, or case series.

Clinical Opinions

- For the largest segment of the Botox business, migraine headache, AbbVie does not have competition from the other botulinum toxins.

Approximate Botulinum Toxin Utilization by Diagnosis

%	Indication	Drug(s)
50%	Migraine	Botox
13%	Cervical Dystonia	Botox, Xeomin, Dysport, Myobloc
12%	Spasticity	Botox, Xeomin, Dysport
9%	Blepharospasm	Botox, Xeomin
6%	OAB / Incontinence	Botox
5%	Hyperhidrosis	Botox
<1%	Strabismus	Botox

- The recent approvals of CGRP inhibitors for migraine may impact overall Botox® market share in addition to competition from competitor neurotoxin products.
- Xeomin® has the smaller 50-unit vial that may reduce waste when a larger vial size is not required, or in indications or patients who require less than 50 unit per therapy.
- Daxxify® is formulated with a 35 amino acid peptide excipient (RTP004) to prevent surface adsorption and thermal stability, whereas all other neurotoxin products utilize human serum albumin (HSA) as an excipient to limit loss of activity and their adsorption to glass surfaces. Preclinical research suggests that the RTP004 protein in Daxxify® adheres the product to the nerves close to the injection site, potentially making its effect last longer.

Formulary Placement, Utilization and Cost Experience (7/1/2023 - 9/30/2023)

UTILIZATION HISTORY			COST		PRIOR AUTH HISTORY		FORMULARY PLACEMENT	
Medication	**Rx**	**Mbrs**	**Total**	**Avg/Rx**	**Total**	**Approved (%)**	**Current**	**Recommend**
Botulinum Toxins								
Botox® (onabotulinumtoxinA) 100 unit, 200 unit vials for injection	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Dysport® (abobotulinumtoxinA) 300 unit, 500 unit vials for injection	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Myobloc® (rimabotulinumtoxinB) 2,500 unit/0.5 mL, 5,000 unit/1 mL, 10,000 unit/2 mL vials for injection	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
Xeomin® (incobotulinumtoxinA) 50 unit, 100 unit, 200 unit vials for injection	0	0	$0.00	$0.00	0	0 (0%)	F-PA	No change
Daxxify® (daxibotulinumtoxinA-lanm) 100 unit vial for injection	0	0	$0.00	$0.00	0	0 (0%)	NF	No change
TOTAL	**0**	**0**	**$0.00**	**$0.00**	**0**	**0 (0%)**		

Key (as applicable) F = Formulary, no restrictions; F-QL = Formulary, quantity limit applies; F-AL = Formulary, age limit applies; F-ST = Formulary, step therapy applies; F-PA = Formulary, PA required; NF = Non-formulary;

Prior Authorization Criteria

Recommendation:

- Add new medication Daxxify to policy.

Botulinum Toxins A&B	
Therapeutic Classes (AHFS)	OTHER MISCELLANEOUS THERAPEUTIC AGENTS
Medications	PA required Xeomin (incobotulinumtoxinA) - Preferred Non-Formulary Botox (onabotulinumtoxinA) Myobloc (RimabotulinumtoxinB) Dysport (ibobotulinumtoxinA) Daxxify (daxibotulinumtoxinA) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Cosmetic use
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial/Re-Approval** If all of the conditions are met, the request will be approved for 12 month duration. If the conditions are not met, the request will be sent to a Medical Director/clinical reviewer for medical necessity review.

PA Review Criteria	***The use of these medications for cosmetic purposes is NOT a covered benefit***
	Xeomin is the preferred product for all FDA approved indications
	
	The following criteria must be met for initial requests:
	• Dose is appropriate per label or supported by compendia/standard of care guidelines
	• Documentation was submitted, that the member had an adequate trial (consistent with pharmacy claims) standard first line therapy for their condition and/or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not taking first line therapy to treat their medical condition.
	• If the diagnosis is **chronic migraine** (≥15 days per month with headache lasting 4 hours a day or longer), the member has a documented adequate trial, for at least 4 weeks EACH, at minimum effective doses (consistent with pharmacy claims data) of two of the following classes of drugs:
	  ○ Beta blockers (e.g. propranolol, timolol, etc.)
	  ○ Amitriptyline or venlafaxine
	  ○ Divalproex ER or DR, valproic acid or topiramate
	  ○ Or a medical reason was submitted (intolerance, hypersensitivity, contraindication, etc) why the member is not able to utilize these therapies.
	• If the diagnosis is **overactive bladder**, the member has a documented adequate trial (consistent with pharmacy claims data) of at least 2 formulary medications (e.g. oxybutynin)
	• If the diagnosis is **Hyperhidrosis,** the member has tried and failed a prescription strength antiperspirant (e.g. 20% aluminum chloride hexahydrate)
	• If the diagnosis is **Chronic Sialorrhea**,

	○ Documentation is provided that the member has had sialorrhea lasting at least 3 months ○ The member has tried and failed at least two anticholinergic medications (e.g. glycopyrrolate, hyoscyamine, benztropine) • For all FDA-approved indications, if the medication request is for a botulinum toxin other than Xeomin, the member has a documented medical reason (intolerance, hypersensitivity, contraindication, treatment failure etc) for not using to treat their medical condition. The following criteria must be met for re-authorization requests: • Dose and indication continue to be appropriate per label or supported by compendia/standard of care guidelines • Documentation submitted indicates a clinical benefit was observed and rationale for continuation of treatment
Criteria Statement	Xeomin is reserved for members with medical conditions which these medications are approved for use in. The member should have used (or cannot/should not use) other preferred treatments for the condition prior to the approval of Xeomin. Non-formulary botulinum toxin medications are reserved for members with medical conditions which these medications are approved for use in and who have used (or cannot/should not use) other preferred treatments for the condition and who have used (or cannot/should not use) Xeomin.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Add new medication Daxxify to policy.
- Remove language indicating that Xeomin is the preferred medication

Botulinum Toxins A&B	
Medications	Xeomin (incobotulinumtoxinA) ~~- Preferred~~ Botox (onabotulinumtoxinA) Myobloc (rimabotulinumtoxinB) Dysport (ibobotulinumtoxinA) Daxxify (daxibotulinumtoxinA) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Cosmetic use
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, the initial request will be approved for up to a 12 month duration; reauthorization requests will be approved for up to 12 months.
Maximum Billable Units	Variable

Other Criteria	***The use of these medications for cosmetic purposes is NOT a covered benefit***
	~~**Xeomin is the preferred product for all FDA approved indications**~~
	
	The following criteria must be met for initial requests:
	• Dose is appropriate per label or supported by compendia/standard of care guidelines
	• Documentation was submitted, that the member had an adequate trial (consistent with pharmacy claims) standard first line therapy for their disease state and/or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc.) for not taking first line therapy to treat their medical condition.
	• If the diagnosis is **chronic migraine** (≥15 days per month with headache lasting 4 hours a day or longer), the member has a documented adequate trial, for at least 4 weeks EACH, at minimum effective doses (consistent with pharmacy claims data) of two of the following classes of drugs:
	  ○ Beta blockers (e.g. propranolol, timolol, etc.)
	  ○ Amitriptyline or venlafaxine
	  ○ Divalproex ER or DR, valproic acid or topiramate
	  ○ Or a medical reason was submitted (intolerance, hypersensitivity, contraindication, etc.) why member is not able to utilize these therapies.
	• If the diagnosis is **overactive bladder**, the member has a documented adequate trial (consistent with pharmacy claims data) of at least 2 formulary medications (e.g. oxybutynin)
	• If the diagnosis is **Hyperhidrosis,** the member has tried and failed a prescription strength antiperspirant (e.g. 20% aluminum chloride hexahydrate)
	• If the diagnosis is **Chronic Sialorrhea**,
	  ○ Documentation is provided that the member has had sialorrhea lasting at least 3 months
	  ○ The member has tried and failed at least two anticholinergic medications (e.g. glycopyrrolate, hyoscyamine, benztropine)
	• ~~For all FDA-approved indications, if the medication request is for a botulinum toxin other than Xeomin, the member has a documented medical reason~~

	~~(intolerance, hypersensitivity, contraindication, treatment failure etc) for not using to treat their medical condition.~~ The following criteria must be met for re-authorization requests: • Dose and indication continue to be appropriate per label or supported by compendia/standard of care guidelines • Documentation submitted indicates a clinical benefit was observed and rationale for continuation of treatment If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review
Last Review Date	~~12/2022~~12/2023

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3. UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com. Accessed on September 25, 2023.
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7. Ailani J, Burch RC, Robbins MS, Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. Headache. 2021;61(7):1021-1039.
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9. McConaghy JR, Fosselman D. Hyperhidrosis: management options. Am Fam Physician. 2018;97(11):729-734.

Recommendation:

- Retire. Combine with new Non-Formulary/Prior Authorization Required Medications policy

Injectable/Specialty Medications	
Therapeutic Classes (AHFS)	N/A
Medications	NON-FORMULARY & PA REQUIRED INJECTABLE/SPECIALTY MEDICATIONS WITH NO SPECIFIC PRIOR AUTHORIZATION CRITERIA *** The Oral and Injectable Oncology Medications prior authorization criteria will be applied to oncology drugs without drug or class specific criteria***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age **unless** the medication is being requested for one of the following conditions: • Asthma • Acne • Atopic Dermatitis/Eczema • Psoriasis (except disfiguring condition) • Turner's syndrome • Migraine (not as a result of a CCS coverable condition) • Autism • ADHD • Depression • Failure to thrive • Exogenous obesity • Contraception (Birth control) • Smoking cessation
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** Up to 12 month duration depending upon the diagnosis and usual treatment therapies **Later Approvals** Up to 12 month duration depending upon the diagnosis and usual treatment therapies If criteria is not met, request will be sent to a clinical reviewer for medical necessity review.
PA Review Criteria	**Initial Approval** 1. The request for the medication is for an FDA approved indication, and/or is used for a medical condition that is supported by the medical compendium (Micromedex, American Hospital Formulary Service, Drug Points, and Drug Package Insert) as defined in the Social Security Act 1927 and/or per recognized standard of care guidelines. 2. There is no formulary or plan preferred medication alternatives, **OR** there is a documented medical reason (i.e. medical intolerance, treatment failure, etc.) for why a formulary or plan preferred medication couldn't be used to treat the member's condition 3. For any medication where a biosimilar is available (e.g. rituximab), the member must have documented trial and failure, intolerance, inability to use,

	or contraindication to the biosimilar medication prior to the brand medication approval OR the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested. 4. Prescribed dosing of medication is within FDA approved indications and/or is supported by the medical compendium as defined above and/or per recognized standard of care guidelines. 5. If all of the above conditions are met, the request will be approved for up to 12 months or as recommended per FDA approved indications and/or as defined by the medical compendium as defined above and/or per recognized standard of care guidelines; if all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review. **Reauthorization of Medication** 1. The prescribing physician has provided documentation as to the clinical benefits of the medication supporting continued treatment, **OR** the medication is being continued in accordance with the recommended time as defined by FDA drug package insert, and/or per recommendations of the medical compendium as described above, and/or per recognized standard of care guidelines. 2. Prescribed dosing of medication is within FDA approved indications or per supported by the medical compendium as defined above and/or per recognized standard of care guidelines. 3. If all of the above conditions are met, the request will be approved for up to 12 months or as recommended per FDA approved indications and/or as defined by medical compendium as defined above and/or per recognized standard of care guidelines; if all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Criteria Statement	N/A
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Retire. Combine with new Non-Formulary/Prior Authorization Required Medications policy

Brand Medications When a Generic or Biosimilar is Available	
Therapeutic Classes (AHFS)	N/A
Medications	Oral and injectable brand drugs and reference biologics when a therapeutic equivalent generic drug or biosimilar/interchangeable biologic is available *** The Oral and Injectable Oncology Medications prior authorization criteria will be applied to oncology drugs without drug or class specific criteria*** *** The Injectable/Specialty Medications prior authorization criteria will be applied to specialty drugs without drug or class specific criteria***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age **unless** the medication is being requested for one of the following conditions: - Asthma - Acne - Atopic Dermatitis/Eczema - Psoriasis (except disfiguring condition) - Turner's syndrome - Migraine (not as a result of a CCS coverable condition) - Autism - ADHD - Depression - Failure to thrive - Exogenous obesity - Contraception (Birth control) - Smoking cessation
Prescriber Restrictions	N/A
Coverage Duration	**Approval** Up to 12 months depending on diagnosis and usual treatment therapies If the criteria is not met, the request will be referred to a clinical reviewer for medical necessity review.
PA Review Criteria	**If request is for a brand name medication with a generic or biosimilar available send to plan for review** • If the medication requested is a BRAND NAME medication with generic or biosimilar available, the following must be met: ○ Member must use the authorized generic (if available), if made by the maker of the brand-name product OR ○ Member must use the biosimilar product when available, unless the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested, prior to the approval of the brand OR ○ Member must use generic formulation with the same inactive ingredients as the brand name product (if available)

	• AND, member must try and have documented adverse reaction to three (3) different generic formulations. If there are fewer than 3 formulations available, the member must try all available generic formulations before the brand name product will be approved. **Criteria for re-authorization:** • Member is stable and continuing the medication
Criteria Statement	Brand name medications with a generic or biosimilar available are reserved for members who have used (or cannot/should not use) the generic (if available) or authorized generic (if available) or the biosimilar or generic formulation with the same inactive ingredients as brand name (if available) and who have had adverse reactions to three different generic formulations.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Retire. Combine with new Non-Formulary/Prior Authorization Required Medications policy

Non-Formulary and PA Required Medications without Drug-Specific Criteria	
Therapeutic Classes (AHFS)	N/A
Medications	Non-Formulary and PA Required Medications without Drug Specific Criteria ****Please Note: If the request is for a non-formulary brand with a generic, refer to Criteria for Brand Medications When Generic is Available*****
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Cosmetic purposes/ indications (unless related to gender dysphoria, mental health, or substance use disorder)
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age **unless** the medication is being requested for one of the following conditions: - Asthma - Acne - Atopic Dermatitis/Eczema - Psoriasis (except disfiguring condition) - Turner's syndrome - Migraine (not as a result of a CCS coverable condition) - Autism - ADHD - Depression - Failure to thrive - Exogenous obesity - Contraception (Birth control) - Smoking cessation
Prescriber Restrictions	N/A
Coverage Duration	**Approval** Up to 12 months depending on diagnosis and usual treatment therapies If the criteria is not met, the request will be referred to a clinical reviewer for medical necessity review.
PA Review Criteria	****The use of medications for cosmetic purposes is NOT a covered benefit, unless used to treat gender dysphoria, mental health, or substance use disorder. Medications for cosmetic purposes ARE a covered benefit when used to treat gender dysphoria, mental health, or substance use disorder, when other formulary alternatives are not available**** **Criteria for approval:** • Appropriate diagnosis/Indication for requested non-formulary medication or meets off-label criteria below AND *Off-label criteria:* ○ One of the following: ▪ Patient has had a documented trial and or intolerance with up to two preferred medications used to treat the documented diagnosis, or for medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. ▪ No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia **AND**

	○ One of the following: ▪ Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Covered Uses section above) ▪ Requested use can be supported by at least two published peer reviewed clinical studies which must be submitted along with request • Appropriate dose of medication based on age (i.e. pediatric and elderly populations) and indication AND • In the absence of evidence supporting the use of the requested medication compared to the preferred agents, documented trial and failure or intolerance with at least three formulary medications (if available) that are used to treat the documented diagnosis (consideration will also be given to the route of administration, mechanism of action, and potency of the requested medication and the alternatives tried). For medications where there is only one formulary agent, only that agent must have been ineffective or not tolerated OR • No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia. OR • All other formulary medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. OR • The member has tried and failed the 2 separate formulary components of the combination medication OR 2 separate therapeutic equivalents to the components of the combination medication, if available on formulary OR the provider has submitted a medical reason why the requested combination medication would be superior to the required prerequisite trial(s) with formulary drug(s) [e.g. Yosprala (aspirin/omeprazole), the 2 separate components would need to be tried and failed] • The dose should be consolidated if clinically appropriate (ex: if a request is for Trintellix 10mg tablet, take 2 tablets (=20mg) once daily, a 20mg tablet should be used approved, dosed once daily.)
Criteria Statement	Non-formulary and prior authorization required medications are reserved for members who have used (or cannot/should not use) up to three formulary three formulary that are used to treat the documented diagnosis OR meet off-label criteria OR has tried and failed or is unable to use separate components (or therapeutic equivalents) of a combination medication or is unable to use a consolidated dose form.
Last P&T Review Date	~~9/2023~~12/2023

Recommendation:

- Update policy for recent new approval of Ingrezza for the indication of Huntington's disease.
- Add safety exclusion for concurrent MAOI use
- For tardive dyskinesia no longer require the use of Ingrezza prior to Austedo as pricing varies between patients
- Reformat and rearrange sections of policy for ease of use

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors~~Movement Disorders~~	
Therapeutic Classes (AHFS)	Vesicular Monoamine Transport 2 Inhibitor
Medications	Non-formulary, PA required: Ingrezza (valbenazine) capsules Austedo (deutetrabenazine) tablets Tetrabenazine (Xenazine) tablets Any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Concurrent use of monoamine oxidase inhibitors (MAOIs)~~N/A~~
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist or psychiatrist.
Coverage Duration	**Initial Approval** 6 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	**Initial Authorization:** • Dose is within FDA-approved limits • Prescriber attests patient will not be receiving treatment with any other VMAT2 inhibitor ~~**Initial criteria for**~~**For approval for use in** ~~**diagnosis of**~~ **tardive dyskinesia** (TD):~~, for Austedo or Ingrezza approve if:~~ • Member must have clinical diagnosis of tardive dyskinesia that has persisted for the last 90 days, with documented baseline evaluation (e.g., Abnormal Involuntary Movement Scale (AIMS), the Tardive Dyskinesia Rating Scale (TDRS), etc.) • For members on antipsychotics, the antipsychotic dose(s) must have been stable for a continuous 90 day period at some point prior to the request • Prescriber has attempted at least ONE of the following strategies to manage the patient's condition, or has provided a clinical reason why NONE of the following are possible: ○ Reducing the dose of the drug responsible for causing dyskinesia ○ Discontinuing the drug responsible for causing dyskinesia ○ For members on first generation antipsychotics, switching to a second generation antipsychotic ○ Trial of benzodiazepines • For VMAT2 inhibitors other than tetrabenazine, member has a documented medical reason (e.g., treatment failure, intolerance, hypersensitivity, contraindication) for not using tetrabenazine AND ○ For Austedo requests: ▪ Prescriber attests patient has no signs of hepatic impairment ▪ For patients at risk for QT prolongation, prescriber attests a baseline ECG has been obtained

- For Ingrezza requests:
  - Must be dosed at one capsule per day

- ~~Patient must have diagnosis of moderate to severe tardive dyskinesia, with documented baseline evaluation using a scoring tool: [e.g. Abnormal Involuntary Movement Scale (AIMS) > 10 OR Extrapyramidal Symptom Rating Scale (ESRI) > 20, Schooler and Kane's Research Diagnoses for Tardive Dyskinesia (RD-TD]~~
- ~~MD attests that patient has had a baseline electrocardiogram (EKG) and is aware of the possible risk of QT prolongation~~
- ~~Dose is within FDA approved limits~~
- ~~Ingrezza must be dosed at one capsule per day~~
- ~~Patient is not receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors~~
- ~~If request is for Austedo, approve if documentation is provided (provider attestation or claims history) of trial and failure, intolerance of, contraindication to, or inability to use Ingrezza.~~

~~**Reauthorization for diagnosis of tardive dyskinesia:**~~
- ~~Documentation was provided that demonstrates stabilization or improvement in average score on the previously-submitted symptom rating scale~~
- ~~Dose is within FDA approved limits~~
- ~~Ingrezza must be dosed at one capsule per day~~

~~**Initial criteria for diagnosis of moderate to severe**~~**For approval for use in chorea associated with Huntington's Disease (HD)~~with chorea, for tetrabenzine or Austedo~~:**
- Patient must have diagnosis of moderate to severe Huntington's with chorea, with documented baseline Total Maximal Chorea (TMC) score provided
- For VMAT2 inhibitors other than tetrabenazine, member has a documented medical reason (e.g., treatment failure, intolerance, hypersensitivity, contraindication) for not using tetrabenazine AND
  - For Austedo requests:
    - Prescriber attests patient has no signs of hepatic impairment
    - For patients at risk for QT prolongation, prescriber attests a baseline ECG has been obtained
  - For Ingrezza requests:
    - Must be dosed at one capsule per day

- ~~Patient must have diagnosis of moderate to severe Huntington's with chorea, with documented baseline evaluation with one of the following scoring tools: Total Maximal Chorea (TMC) score ≥ 8, or Total Functional Capacity (TFC) score ≥ 5.~~
- ~~MD attests that patient has had a baseline electrocardiogram (EKG) and is aware of the possible risk of QT prolongation~~
- ~~Dose is within FDA approved limits~~
- ~~Patient is not receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors~~
- ~~If request is for Austedo, approve if documentation is provided (provider attestation or claims history) of trial and failure, intolerance of, contraindication to, or inability to use tetrabenazine.~~

Reauthorization ~~for diagnosis of moderate to severe Huntington's with chorea~~:
- Documentation or provider attestation of positive clinical response (e.g., improvement from baseline in average scores on the previously submitted symptom rating scale, decrease in symptoms, etc.)

	~~• Documentation was provided that demonstrates stabilization or improvement in TMC or TFC scores~~ • Dose is within FDA approved limits
Criteria Statement	For a diagnosis of chorea with Huntington's disease, Austedo and Ingrezza are ~~is~~ reserved for members who have used (or cannot/should not use) tetrabenazine. For a diagnosis of tardive dyskinesia, Austedo and Ingrezza are ~~is~~ reserved for members who have used (or cannot/should not use) ~~Ingrezza~~tetrabenazine.
Last P&T Review Date	~~6/2023~~12/2023

Recommendation:

- Expand timeframe for trial and failure of prerequisite drugs to be 365 days, as 180 days may be too restrictive
- Wording update

Isotretinoin capsules	
Therapeutic Classes (AHFS)	Skin and mucous membrane agents, miscellaneous
Medications	Formulary, PA required PREFERRED • Claravis (isotretinoin) • Myorisan (isotretinoin) • Zenatane (isotretinoin) • Amnesteem (isotretinoin) • Accutane (isotretinoin) • Isotretinoin Formulary, PA required NON-PREFERRED • Isotretinoin (Absorica) • Absorica LD (isotretinoin) Or any newly marketed oral retinoid product
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	**Initial/Re-Approval** 6 months **Later Approvals** If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	All of the following conditions must be met for approval: • Diagnosis of moderate to severe recalcitrant nodular acne. • Documented treatment with a therapeutic trial and failure or intolerance to one or more first line topical therapies (e.g. topical antibiotics or topical retinoids) IN COMBINATION WITH one or more first line oral therapies (e.g. doxycycline, tetracycline, or minocycline) for at least 4 weeks (28 days) of therapy of each drug in the previous ~~180~~ 365days • If the request is for a non-preferred drug, documentation has been provided that the member has tried and failed two preferred drugs or has a medical reason why these drugs cannot be used
Criteria Statement	Preferred generic isotretinoin medications (e.g., Claravis, Myorisan, Zenatane, Amnesteem, Accutane) are reserved for members with moderate to severe recalcitrant nodular acne who have used (or cannot/should not use) oral antibiotics. Isotretinoin (Absorica) or Absorica LD (isotretinoin) are reserved for members who have severe acne, who have used (or cannot/should not use) topical therapies (e.g. topical antibiotics or topical retinoids) AND oral antibiotics. Non-preferred agents are reserved for members with moderate to severe recalcitrant nodular acne who have used (or cannot/should not use) oral antibiotics. Isotretinoin (Absorica) 25mg or 35mg capsules or Absorica LD (isotretinoin) are reserved for members who have severe acne, who have used (or cannot/should not use) topical

Isotretinoin capsules	
	therapies (e.g. topical antibiotics or topical retinoids) AND oral antibiotics AND at least two ~~first line~~preferred agents.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Correct “IU” notation
- Add Myfembree as a trial and failure option under the endometriosis section for completeness

Gonadotropin Releasing Hormone (GNRH) Agonists	
Therapeutic Classes (AHFS)	Gonadotropins
Medications	**Preferred GnRH Agonist(s) for their respective indications:** Lupron Depot (leuprolide acetate) Lupron Depot-Ped (leuprolide acetate) Zoladex (goserelin acetate) **Non-Preferred GnRH Agonist(s):** Fensolvi (leuprolide acetate) Supprelin LA (histrelin acetate) Synarel (nafarelin acetate) Triptodur (triptorelin pamoate) Any newly marketed GnRH agonist
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert.
Exclusion Criteria	N/A
Required Clinical Information	See “PA Review Criteria” below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescriber must be a specialist in the field to treat the member’s condition.
Coverage Duration	**Initial Approval** For central precocious puberty: the request will be approved for up to 12 months. If all of the conditions are met, the request will be approved for up to 3-6 months as indicated below for other indications as recommended per FDA approved indications and/or as defined by the medical compendium or standard of care guidelines. **Later Approvals** See Initial Approvals If criteria is not met, request will be sent to a Medical Director/clinical reviewer for medical necessity review
PA Review Criteria	****IF DIAGNOSIS IS CANCER, USE Oral and Injectable Oncology Medications CRITERIA**** **PEDIATRIC POPULATION** *For GID/gender dysphoria coverage, please refer to the Gender Dysphoria medication guidelines for age less than 21.* **ADULT POPULATION** *For GID/gender dysphoria coverage, please refer to the Gender Dysphoria medication guidelines for age 21 years of age or older.* **INITIAL AUTHORIZATION for ALL REQUESTS:** • The medication is being prescribed for an FDA approved/standard of care guideline indication and within FDA approved/standard of care dosing guidelines. AND the member meets the following for the respective diagnosis:

Criteria for central precocious puberty:

- Onset of secondary sexual characteristics occurred when member was aged less than 8 years for females or aged less than 9 years for males
- Diagnosis of central precocious puberty as defined by one of the following
    - Pubertal response to a GnRH stimulation test and/or measurement of gonadotropins (FSH/LH)
    - Bone age advanced one year beyond the chronological age
        - Members with low or intermediate basal levels of LH should have a GnRH stimulation test to clarify the diagnosis.
            - If basal levels of ultrasensitive LH are markedly elevated [e.g. more than 0.3ml IU/L (where IU-International units)] in a child with precocious puberty, then a diagnosis of CPP can be made without proceeding to a GnRH stimulation test.
- Brain magnetic resonance imaging (MRI) has been performed for all boys with CPP and for girls with onset of secondary sexual characteristics before the age of six years of age to rule out a tumor.
- If the request is for any agent other than Lupron Depot-Ped the member has had a documented trial and failure with Lupron Depot-Ped or a documented medical reason (e.g. intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use Lupron Depot-Ped

Endometriosis:

- Member has a confirmed diagnosis (e.g. laparoscopy, etc.) of endometriosis
- Documented contraindication to or trial and failure of the use of a combined oral estrogen-progestin contraceptive OR a progestin only AND non-steroidal anti-inflammatory agents.
    - If one of the following drugs has been tried previously, a trial of OCPs is not required: Orilissa (elagolix), Myfembree, danazol, or aromatase inhibitors (e.g. anastrozole, letrozole)
- Member is receiving “add back” hormonal therapy (e.g. norethindrone acetate, conjugated estrogen or progestin therapy, etc.)
- If the request is for a non-preferred agent, the member has had a documented trial and failure with one of the preferred agents or a documented medical reason (e.g. intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use these medications
- Approval is 6 months

Leiomyomata/fibroids:

- Member has a confirmed diagnosis (e.g. pelvic examination, etc.)
- If the request is for any agent other than Lupron Depot the member has had a documented trial and failure with Lupron Depot or a documented medical reason (e.g. intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use Lupron Depot
- Approval is 3 months

Endometrial thinning

- Documentation indicates member is scheduled for endometrial ablation for dysfunctional uterine bleeding.
- If the request is for any agent other than Zoladex the member has had a documented trial and failure with Zoladex or a documented medical reason (e.g. intolerance, hypersensitivity, contraindication) was submitted why the member is not able to use Zoladex
- Approval is 3 months

	REAUTHORIZATION for all requests: • The medication is being prescribed for an FDA approved indication and within FDA approved dosing guidelines. • Documentation was provided supporting continued treatment (e.g. member still has symptoms), and medication is being continued as recommended in package insert or standard of care guidelines. AND meets the following per diagnosis: Central precocious puberty (CPP) • If the medication reauthorization is for central precocious puberty, the child is male and < 12 years or female and < 11 years of age OR a documented medical reason to continue treatment was provided with request, and includes current height and bone age Endometriosis • Prescriber has evaluated member for osteoporosis (e.g. Dexascan), and member is receiving "add back" hormonal therapy (e.g. norethindrone acetate, conjugated estrogen or progestin therapy, etc., AND calcium and vitamin D supplementation. • The member has not received cumulative doses of the GnRH agonist greater than 12 months of therapy. Fibroids • The member has not received cumulative doses of the GnRH agonist greater than 6 months of therapy
Criteria Statement	**Central Precocious Puberty:** Lupron Depot-Ped is reserved for members who have met the criteria for the diagnosis and treatment of central precocious puberty. **Endometriosis**: Zoladex and Lupron Depot/Ped are reserved for members who have met the criteria for the diagnosis and treatment of endometriosis. **Uterine leiomyomas (Fibroids):** Lupron Depot is reserved for members who have met the criteria for the diagnosis and treatment of uterine leiomyomas (fibroids). **Endometrial thinning:** Zoladex is reserved for members who have met the criteria for the diagnosis and treatment of endometrial thinning. **Non-preferred agents:** <Insert agent> is reserved for members who have met the criteria for the diagnosis and treatment of <insert indication> and have used (or cannot/ should not use) the preferred agent for the diagnosis <Insert agent(s)>.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Add in additional oral antifungal medications for completeness, along with review criteria for each
- Under itraconazole onchomycosis section, allow for trial and failure of terbinafine or fluconazole
- Reformat and rearrange sections for clarity
- Add in reauthorization criteria

Oral Anti-Fungals	
Therapeutic Classes (AHFS)	Azoles; antifungals miscellaneous
Medications	Formulary fluconazole 50, 100, 150, 200 mg tablet and 10, 40 mg/ml suspension terbinafine 250 mg tablet Formulary, with age restriction: limited to members ≤ 12 years griseofulvin microsize 125 mg/5 ml suspension Formulary, step therapy griseofulvin microsized 500 mg and ultramicrosized 125, 250 mg tablet Formulary, prior authorization required /Non-formulary voriconazole (Vfend) 50, 200 mg tablet and 200 mg/5 ml suspension itraconazole 100 mg capsules and 10 mg/ml suspension posaconazole delayed release-tablet Noxafil (posaconazole) oral suspension Cresemba (isavuconazonium) capsule Flucytosine capsule
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	**Initial Approval** 6 months **Later Approvals** 12 months If conditions are not met, the request will be sent to a clinical reviewer.

PA Review Criteria	For **voriconazole**, approve if one of the following:
	• Diagnosis of one of the following:
	  • Iinvasive pulmonary aspergillus infections ~~aspergillosis~~ ~~OR~~
	  • Aa~~a~~ serious fungal infection caused by Scedosporium apiospermum ~~and~~ or Fusarium species~~.~~
	  ~~**OR**~~
	  • Treatment of invasive candidiasis in critically ill patients
	  • Primary prophylaxis for aspergillus infections for special populations such as lung transplant, acute myeloid leukemia (AML), allo-stem cell transplant with prolonged neutropenia from chemotherapy AND high risk for infection
	• For esophageal candidiasis or candidemia in nonneutropenic patients: documentation of trial and failure, intolerance, or contraindication to fluconazole or nystatin
	• For blastomycosis or histoplasmosis: documentation of trial and failure, intolerance, or contraindication to itraconazole

Oral Anti-Fungals	
	~~• Diagnosis of esophageal candidiasis, candidemia (nonneutropenics), or disseminated candidiasis of the skin, abdomen, kidney, bladder wall or wounds; AND~~ ~~○ Documented trial and failure with a formulary treatment option (i.e. fluconazole or nystatin) or documented medical reason (e.g., recent discharge from hospital on oral voriconazole, intolerance, hypersensitivity, contraindication) for not using a formulary treatment option for relevant indications~~ ~~• If request is for oral suspension, above criteria must be met and documentation of difficulty or inability to swallow must be provided~~ For **itraconazole** capsules, approve if one of the following: • Diagnosis of aspergillosis and documentation of intolerance or disease refractory to voriconazole capsules ~~OR~~ • Diagnosis of blastomycosis, histoplasmosis ~~OR~~ • Diagnosis of coccidioidal infections and documentation of trial and failure, intolerance, contraindication, or inability to use fluconazole ~~OR~~ • Diagnosis of oropharyngeal or esophageal candidiasis and the member is immunocompromised. If the member is not immunocompromised, documentation of trial and failure, intolerance, contraindication, or inability to use oral fluconazole ~~OR~~ ~~○ NOTE: Requests for itraconazole oral solution will be approved if the oral solution is being requested for a diagnosis of oropharyngeal or esophageal candidiasis~~ ~~•~~ Diagnosis of onchomycosis and documentation of trial and failure, intolerance, contraindication, or inability to use terbinafine ~~250 mg once daily for 12 weeks~~or fluconazole ~~OR~~ ~~• If request is for itraconazole oral solution and diagnosis of onchomycosis and documentation of trial and failure, intolerance, contraindication, or inability to use terbinafine 250 mg once daily for 12 weeks and documentation of difficulty or inability to swallow itraconazole capsules must be provided~~ For **griseofulvin** tablets, approve if: • Diagnosis of dermatophyte infections of the skin, hair, and nails: tinea barbae, capitis, corporis, cruris, pedis, unguium (onchomycosis) and documentation of trial and failure, intolerance, inability to use, or contraindication to use terbinafine 250 mg or topical therapy (e.g. ciclopirox 8% solution, terbinafine cream, gel, or solution) • If request is for oral solution, the above criteria must be met and documentation of inability or difficulty swallowing must be provided For **posaconazole tablets**, approve if one of the following: • For prophylaxis of invasive aspergillus or candida in patients at high risk of developing invasive aspergillus or candida due to being severely immunocompromised: trial and failure or inability to use voriconazole • For the treatment of invasive aspergillosis: trial and failure or inability to use voriconazole For **Noxafil suspension,** approve if: • For oropharyngeal candidiasis, there is documentation of trial and failure, intolerance, or contraindication to fluconazole For **Cresemba**, approve if one of the following: • Diagnosis of invasive mucormycosis in adults

Oral Anti-Fungals	
	• For invasive aspergillosis in adults, there is documentation of trial and failure, intolerance, or contraindication to voriconazole For **flucytosine**, approve if one of the following: • Diagnosis of cryptococcal meningitis or cryptococcosis • Diagnosis of candidiasis with CNS involvement, symptomatic urinary tract infections (e.g. cystitis, pyelonephritis, or fungal masses), endocarditis or infected cardiac devices, endophthalmitis, septicemia, or pulmonary infections **Reauthorization** • Documentation is provided that the member has responded to therapy • Additional therapy is medically necessary and clinically appropriate **NOTE**: ○ Requests for itraconazole solution require a documented trial and failure, or intolerance to itraconazole oral capsules unless the oral solution is being requested for diagnosis of oropharyngeal or esophageal candidiasis. ○ Requests for voriconazole suspension require a documented trial and failure, or intolerance to voriconazole tablets ○ Requests for flucytosine require combination therapy with amphotericin B for systemic candidiasis, cryptococcal meningitis, or cryptococcosis
Criteria Statement	**Voriconazole** tablets are reserved for members who have used (or cannot/should not use) a formulary medication (i.e. fluconazole or nystatin). For blastomycosis or histoplasmosis, voriconazole tablets are reserved for members who have used (or cannot/should not use) itraconazole. **Voriconazole** oral suspension is reserved for members who have used (or cannot/should not use) voriconazole tablets. **Itraconazole** ~~tablets~~ capsules are reserved for members who have used (or cannot/should not use) fluconazole or terbinafine ~~250 mg~~ tablets~~,~~. **Itraconazole** oral solution is reserved for members who have used (or cannot/should not use) itraconazole capsules unless the oral solution is being requested for diagnosis of oropharyngeal or esophageal candidiasis. **Griseofulvin** tablets are reserved for members who have used (or cannot/should not use) terbinafine 250 mg tablet or topical medications. **Griseofulvin** oral solution is reserved for members who have used (or cannot/should not use) griseofulvin tablets. Posacoazole tablets are reserved for members who have used (or cannot/should not use) voriconazole. Noxafil suspension is reserved for members who have used (or cannot/should not use) fluconazole. Cresemba is reserved for members who have used (or cannot/should not use) voriconazole. Flucytosine is reserved for members who have a diagnosis of cryptococcal meningitis or cryptococcosis, candidiasis with CNS involvement, symptomatic urinary tract infections (e.g. cystitis, pyelonephritis, or fungal masses), endocarditis or infected cardiac devices, endophthalmitis, septicemia, or pulmonary infection.
Last P&T Review Date	~~12/2022~~12/2023

Recommendation:

- Add Hiberix to policy, this is already coded.
- Havrix & Vaqta – remove age limit of minimum 19 years, can be used starting at 12 months
- Twinrix – change to 4 fills per lifetime to accommodate accelerated schedule. Change age limit to minimum 18 years. Not indicated for pediatrics
- Engerix-B – 20mcg/ml formulations: Change to 4 fills per lifetime to accommodate for those on hemodialysis. Change maximum per dose to 2ml to accommodate for those on hemodialysis. Remove age limit of minimum 19 years, can be used starting at birth.
    - Add Engerix-B Injection Suspension Prefilled Syringe 10 MCG/0.5ML DDID 219956 to formulary at the same formulary status as above.
- Recombivax - Remove age limit of minimum 19 years, can be used starting at birth.
- Heplisav-B - Change age limit to minimum 18 years. Not indicated for pediatrics
- PreHevbrio - Change age limit to minimum 18 years. Not indicated for pediatrics
- Gardasil-9 – Remove age limit of minimum 19 years, can be used starting at 9 years. Add age maximum of 45 years.
- IPOL - Remove age limit of minimum 19 years, can be used starting at 6 weeks.
- M-M-R II - Remove age limit of minimum 19 years, can be used starting at 12 months
- Add Proquad to formulary. DDID 204200. F-QL (0.5ml per dose, 2 fills per lifetime)
- Priorix - Remove age limit of minimum 19 years, can be used starting at 12 months
- Menactra & Menveo - Remove age limit of minimum 19 years, can be used starting at 2 years. Add age maximum of 55 years.
- MenQuadfi - Remove age limit of minimum 19 years, can be used starting at 2 years.
- Bexsero - Remove age limit of minimum 19 years, can be used starting at 10 years. Add age maximum of 25 years.
- Trumenba - Remove age limit of minimum 19 years, can be used starting at 10 years. Add age maximum of 25 years.
- Prevnar-13, Prevnar-20, Pneumovax-23, and Vaxneuvance - Remove age limit of minimum 19 years, can be used starting at 6 months or 2 years (Pneumovax-23)
- Tenivac and TDVax - Remove age limit of minimum 19 years, can be used starting at 7 years.
- Boostrix and Adacel - Remove age limit of minimum 19 years, can be used starting at 10 years.
- Add Pentacel to policy, this is already coded.
- Add Vaxelis to formulary. DDIDs 213061; 213062. F-QL (0.5ml per dose, 3 fills per lifetime)
- Varivax - Remove age limit of minimum 19 years, can be used starting at 12 months
- Shingrix – Remove age limit of minimum 19 years, can be used starting at 18 years if increased risk
- Vivotif – add coded quantity limit of 4 capsules per fill to policy language. Remove age limit of 6 years. This is correct however there are no members on AAH IHSS under 12 years of age.
- Add new vaccines Abrysvo and Arexvy

Immunizations	
Therapeutic Classes (AHFS)	Toxoids;vaccines
Medications	Formulary, 1st line (fill limits indicated if applicable) Influenza vaccine (only most recent strain is on formulary) – 1 fill per 270 days ActHib (Haemophilus influenzae type b) ~~(Hib)~~ – 3 fills per lifetime Hiberix (Haemophilus influenzae type b) – 3 fills per lifetime Havrix, Vaqta (Hepatitis A) – 2 fills per lifetime~~; age minimum 19 years~~ Twinrix (Hepatitis A and B) – ~~3~~ 4 fills per lifetime; age minimum ~~19~~ 18 years ~~Engerix-B, Recombivax HB (Hepatitis B) – 3 fills per lifetime; age minimum 19 years~~

Immunizations	
	Engerix-B (Hepatitis B) – 4 fills per lifetime Recombivax HB (Hepatitis B) – 3 fills per lifetime Heplisav-B (Hepatitis B) – 2 fills per lifetime; age minimum ~~19~~ 18 years PreHevbrio (Hepatitis B trivalent) - 3 fills per lifetime; age minimum ~~19~~ 18 years Gardasil-9 (HPV) – 3 fills per lifetime; age ~~minimum 19~~maximum 45 years IPOL (Polio) – 5 fills per lifetime~~; age minimum 19 years~~ M-M-R II (Measles, Mumps, Rubella) – 2 fills per lifetime~~; age minimum 19 years~~ Proquad (Measles, Mumps, Rubella) – 2 fills per lifetime Priorix (Measles, Mumps, Rubella) – 2 fills per lifetime~~; age minimum 19 years~~ Menactra, Menveo A-C-Y-W (Meningococcal) – 2 fills per lifetime; age ~~minimum 19~~ maximum 55 years MenQuadfi (Meningococcal) – 2 fills per lifetime~~; age minimum 19 years~~ Bexsero (Meningococcal) – 2 fills per lifetime~~; age minimum 19 years~~; age maximum 25 years Trumenba (Meningococcal) – 3 fills per lifetime~~; age minimum 19 years~~; age maximum 25 years Prevnar-13 (Pneumococcal) – 1 fill per lifetime~~; age minimum 19 years~~ Prevnar 20 (Pneumococcal) – 1 fill per lifetime~~; age minimum 19 years~~ Pneumovax 23 (Pneumococcal) – 2 fills per lifetime~~; age minimum 19 years~~ Vaxneuvance (Pneumococcal) – 1 fill per lifetime~~; age minimum 19 years~~ Imovax Rabies and Rabavert (Rabies) Tenivac, TDVax ~~and Tetanus/diphtheria toxoids~~ (Tetanus/diphtheria)~~; age minimum 19 years~~ Boostrix and Adacel (Tetanus, diphtheria, pertussis)~~; age minimum 19 years~~ Pentacel (Tetanus, diphtheria, pertussis, polio, Haemophilus influenzae type b) – 4 fills per lifetime Vaxelis (Tetanus, diphtheria, pertussis, polio, Haemophilus influenzae type b) – 3 fills per lifetime Varivax (Chicken pox) – 2 fills per lifetime~~; age minimum 19 years~~ Shingrix (Shingles) – 2 fills per lifetime; age minimum ~~19~~ 18 years Vivotif oral capsules (Typhoid) – 4 capsules per 1 fill; age 6 years and older Abrysvo (RSV) – 1 fill per lifetime Arexvy (RSV) – 1 fill per lifetime Non-Formulary, with PA required Biothrax (Anthrax) Ixiaro (Japanese encephalitis) Typhim Vi (Typhoid) YF-Vax (Yellow Fever) Dengvaxia (dengue) Ticovac (tick-borne encephalitis) Any other newly marketed vaccine ~~*Note: Any immunization requests for members less than 19 years of age should be covered under the VFC program unless otherwise noted.~~
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See “**PA Review Criteria**” below
Age Restrictions	N/A
Prescriber Restrictions	See “Medication/Fill limits” above

Immunizations		
Coverage Duration	**Initial Approval** **Later Approvals**	As defined based on guidelines for covered uses As defined based on guidelines for covered uses If conditions are not met, the request will be sent to a clinical reviewer.
PA Review Criteria	For Biothrax, Ixiaro, Typhim Vi, Dengvaxia, Ticovac, and YF-Vax, approve if: • Documentation showing destination of travel where vaccines are recommended per ACIP and CDC: ACIP Vaccine Recommendations and CDC Travel Vaccine Recommendations • Documentation showing departure and return dates of travel. • Dosage and frequency are appropriate according to the FDA and manufacturer package inserts For formulary vaccines above the fill limit, approve if: Dosage and frequency are appropriate according to the FDA and manufacturer package inserts For all other non-formulary vaccines, approve if: • Documentation of trial and failure, inability to use, contraindication, or intolerance to formulary alternatives. • Dosage and frequency are appropriate according to the FDA and manufacturer package inserts.	
Criteria Statement	Biothrax, Ixiaro, Typhim Vi, Dengvaxia, Ticovac, and YF-Vax are reserved for members who are traveling to destinations that require vaccines recommended by the CDC and/or ACIP.	
Last P&T Review Date	~~12/2022~~12/2023	

Recommendation:

- Add new medication Zepbound to policy at parity with the other GLP1 products and change formulary status from NF to F-PA (DDIDs 225118, 225119, 225120, 225121, 225122, 225123)

Anti-Obesity Medications	
Therapeutic Classes (AHFS)	GI drugs, miscellaneous; anorexigenic agents
Medications	Alli (orlistat) Xenical (orlistat) Phentermine (phentermine hcl) (Adipex-P) Phentermine (phentermine hcl) (Lomaira) Qsymia (phentermine/topiramate) Contrave (naltrexone/bupropion) Saxenda (liraglutide) Wegovy (semaglutide) Zepbound (tirzepatide) Any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "**PA Review Criteria**" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	**Initial/Re-Approval** If all conditions are met, the request will be approved for up to 6 months. If all criteria are not met, the request is referred to Clinical Reviewer for medical necessity review.

PA Review Criteria	**INITIAL CRITERIA FOR APPROVAL**
	Phentermine HCL (Adipex-P)
	• Diagnosis of obesity (including documentation of BMI ≥ 30) OR BMI ≥27 and at least one weight-related-comorbidity (such as diabetes, controlled hypertension, hyperlipidemia etc) or history of heart attack, despite diet and exercise.
	• For phentermine (Lomaira): trial and failure or medical reason for not using generic phentermine (Adipex-P)
	Alli:
	• Diagnosis of obesity (including documentation of BMI ≥ 30) OR BMI ≥27 and at least one weight-related comorbidity (such as diabetes, controlled hypertension, hyperlipidemia etc.) or history of heart attack despite diet and exercise.
	
	Qsymia
	• **For adults:** Diagnosis of obesity (including documentation of BMI ≥ 30) OR BMI ≥27 and at least one weight-related comorbidity (such as diabetes, controlled hypertension, hyperlipidemia etc.) or history of heart attack, despite diet and exercise. **OR**
	  ○ **For pediatrics**: BMI in the ≥95th percentile standardized for age and sex
	  ▪ https://www.cdc.gov/healthyweight/bmi/calculator.html
	• Documented trial and failure, contraindication, or intolerance to use phentermine HCL (Adipex-P) and topiramate as separate ingredients

	Contrave • Diagnosis of obesity (including documentation of BMI ≥ 30) OR BMI ≥27 and at least one weight-related comorbidity (such as diabetes, controlled hypertension, hyperlipidemia etc.) or history of heart attack, despite diet and exercise. • Documented trial and failure, contraindication, or intolerance to use Qsymia Saxenda, ~~and~~ Wegovy, and Zepbound • Diagnosis of obesity (including documentation of BMI ≥ 30) OR BMI ≥27 and at least one weight-related comorbidity (such as diabetes, controlled hypertension, hyperlipidemia etc.) or history of heart attack, despite diet and exercise • Documented trial and failure, contraindication, or intolerance to use Qsymia AND Contrave Xenical: • Diagnosis of obesity (including documentation of BMI ≥ 30) OR BMI ≥27 and at least one cardiovascular comorbidity (such as diabetes, controlled hypertension, history of heart attack, etc.) despite diet and exercise. • Documented trial and failure, contraindication, or intolerance to Alli dosed at 120 mg (2 capsules) three times daily. **REAUTHORIZATION CRITERIA FOR APPROVAL** • Documented weight loss of 5% of body weight or more, compared with baseline • If a weight-related comorbidity was previously noted, an objective improvement compared with baseline is documented (e.g. reduction in blood pressure, cholesterol, hemoglobin A1c, etc.)
Criteria Statement	Phentermine is reserved for members who are obese with body mass index of ≥ 30 or ≥ 27 with a comorbidity such as diabetes or hypertension. Generic Lomaira is reserved for members who have used (or cannot/should not use) generic Adipex-P. Alli is reserved for members who are obese with a body mass index of ≥ 30 or ≥ 27 with a comorbidity such as diabetes, hypertension, or heart attack. Qsymia is reserved for adult members who are obese with a body mass index of ≥ 30 or ≥ 27 with a comorbidity such as diabetes, hypertension, or heart attack or pediatric members who are obese with a BMI in the ≥95th percentile standardized for age and sex and who have used (or cannot/should not use) phentermine and topiramate as separate ingredients. Contrave is reserved for members who are obese with a body mass index of ≥ 30 or ≥ 27 with a comorbidity such as diabetes, hypertension, or heart attack and who have used (or cannot/should not use) Qsymia. Saxenda, ~~and~~ Wegovy, and Zepbound are reserved for members who are obese with a body mass index of ≥ 30 or ≥ 27 with a comorbidity such as diabetes, hypertension, or heart attack and who have used (or cannot/should not use) Qsymia and Contrave. Xenical is reserved for obese members with a body mass index of ≥ 30 or ≥ 27 with a comorbidity such as diabetes, hypertension, or heart attack and who have used (or cannot/should not use) Alli.
Last P&T Review Date	~~12/2022~~12/2023

Alameda PADs for Review Q4 2023 P&T

Recommendation:

- Add new medication Izervay and criteria for review
- Update the myasthenia gravis section to refer requests to the new myasthenia gravis specific policy

Complement Inhibitors	
Medications	Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan), Syfovre (pegcetacoplan injection), Izervay (avacincaptad pegol injection)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age for MCAL
Prescriber Restrictions	Prescriber must be a hematologist, nephrologist, neurologist, oncologist, ophthalmologist, or other appropriate specialist.
Coverage Duration	If the criteria are met, the initial request will be approved as follows: For Soliris (eculizumab), Ultomiris (ravulizumab), and Empaveli (pegcetacoplan): initial request will be approved for up to a 3 month duration; reauthorization requests will be approved for up to 6 months. For Syfovre (pegcetacoplan injection): initial and reauthorization requests will be approved for up to 12 months. For Izervay (avacincaptad pegol injection): initial request will be approved for up to 12 month duration with no reauthorization.
Maximum Billable Units	Variable

Other Criteria	**Initial Authorization:**
	• The request is age appropriate according to FDA approved package labeling or nationally recognized compendia; AND
	• The request is for a dose that is FDA approved or in nationally recognized compendia in accordance with the patient's diagnosis, age and concomitant medical conditions; AND
	• For Soliris (eculizumab), Ultomiris (ravulizumab), and Empaveli (pegcetacoplan)
	  ○ Documentation of vaccination against meningococcal disease or a documented medical reason why the patient cannot receive vaccination or vaccination needs to be delayed AND
	  ○ Antimicrobial prophylaxis with oral antibiotics (penicillin, or macrolides if penicillin-allergic) for two weeks will be administered if the meningococcal vaccine is administered less than 2 weeks before starting therapy or a documented medical reason why the patient cannot receive oral antibiotic prophylaxis.
	
	For Generalized Myasthenia Gravis (gMG):
	• Refer to the "Myasthenia Gravis Agents" policy
	~~• The request is for Soliris (eculizumab) or Ultomiris (ravulizumab)~~
	~~• Patient has a positive serologic test for anti-AChR antibodies~~
	~~• Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical~~

~~classification of class II,III or IV at initiation of therapy~~

- ~~Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy~~
- ~~One of the following:~~
  - ~~Failed treatment over total of 1 year or more with 2 or more immunosuppressive therapies (ISTs) either in combination or as monotherapy; **OR**~~
  - ~~Failed at least 1 IST and required chronic plasmapheresis or plasma exchange or intravenous immunoglobulin; **OR**~~
  - ~~Has a documented history of contraindications or intolerance to ISTs~~

For Neuromyelitis Optica Spectrum Disorders (NMOSD):

- Refer to the: **"Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents"** policy

For paroxysmal nocturnal hemoglobinuria (PNH):

- Documentation of Type III PNH red blood cell (RBC) clone by flow cytometry greater than 10%
- Hemoglobin (Hgb) < 10.5 g/dL
- If the request is for Empaveli (pegcetacoplan), documented trial and failure of, contraindication to, or medical reason for not using Soliris (eculizumab) or Ultomiris (ravulizumab)

Atypical Hemolytic Uremic Syndrome (aHUS)/Complement-Mediated HUS)

- Documentation of confirmed diagnosis as evidenced by complement genotyping and complement antibodies; **OR**
- Provider attestation treatment is being used empirically and delay in therapy will lead to unacceptable risk to the patient

Geographic Atrophy (GA):

- If the request is for Syfovre (pegcetacoplan injection), member must be ≥ 60 years of age
- If the request is for Izervay (avacincaptad pegol injection), member must be ≥ 50 years of age
- ~~Greater than or equal to 60 years of age~~
- Diagnosis of GA secondary to age-related macular degeneration (AMD)
- Absence of choroidal neovascularization (CNV) in treated eye
- Best-corrected visual acuity (BCVA) ~~≥~~ 24 letters (approximately 20/320) or better using Early Treatment Diabetic Retinopathy Study (ETDRS)
- GA lesion size ≥2.5 and ≤17.5 mm2 with at least 1 lesion ≥1.25 mm2

Re-Authorization:

- Re-authorization may be considered for all agents included in these criteria with the exception of Izervay (avacincaptad pegol injection), which is only indicated for a 12 month duration
- Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality of life scores, increased Hgb, reduced need for blood transfusions, slowing of growth rate of GA lesions, etc.); **AND**
- The request is for a dose that is FDA approved or in nationally recognized compendia in accordance with the patient's diagnosis, age, and concomitant medical condition~~The request is for an FDA approved dose~~

If the request is for atypical hemolytic uremic syndrome (aHUS)/ complement-mediated HUS:

	• Documentation of confirmed diagnosis as evidenced by:
	  ○ Complement genotyping
	  ○ Complement antibodies
	
	If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.

Last Review Date	~~6/2023~~12/2023

Recommendation

- Update language so that preferred agents are no longer required

Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents	
Medications	~~Step 1:~~ Rituximab (Rituxan, Truxima - biosimilar , Ruxience - biosimilar, Riabni - biosimilar) ~~Step 2:~~ Enspryng (satralizumab-mwge) Uplizna (inebilizumab-cdon) ~~Step 3:~~ Soliris (eculizumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	For Enspryng, Uplizna, Soliris: Anti-aquaporin-4 (AQP4) antibody **negative** neuromyelitis optica spectrum disorder (NMOSD)
Required Clinical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an immunologist, neurologist or hematologist
Coverage Duration	If all of the conditions are met, requests will be approved for 12 months.
Maximum Billable Units	Variable

Other Criteria	**** When the biosimilar is indicated, the member must have documented dates of trial and failure, intolerance, inability to use, or contraindication to the biosimilar medication prior to the brand medication approval OR the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested, in addition to meeting all applicable criteria below.**
	
	Initial Authorization:
	For rituximab:
	• Member has a diagnosis of NMOSD
	• Documentation indicating that the member has been screened for HBV (hepatitis B virus) prior to initiation of treatment
	• Dosing is supported by compendia or standard of care guidelines
	
	For Enspryng:
	• Member has a diagnosis of anti-aquaporin-4 (AQP4) antibody **positive** NMOSD
	• Provider attests to completion of the following assessments prior to the first dose of Enspryng as outlined in the prescribing information:
	  ○ Hepatitis B virus screening
	  ○ Tuberculosis screening
	  ○ Liver transaminase screening
	  ○ Member has not received live or attenuated-live virus vaccines within 4 weeks before the start of Enspryng therapy
	• Documented ~~trial and failure or~~ medical contraindication to rituximab, azathioprine, or mycophenolate mofetil
	• Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines
	
	~~Exceptions:~~

	~~Requests for drugs in step 2 (Enspryng, Uplizna) may be approved without a trial and failure of rituximab, azathioprine, or mycophenolate if the member has been using Soliris~~ For Uplizna: • Member has a diagnosis of anti-aquaporin-4 (AQP4) antibody **positive** NMOSD • Provider attests to completion of appropriate assessments prior to the first dose of Uplizna as outlined in the prescribing information: o Hepatitis B virus screening o Quantitative serum immunoglobulins o Tuberculosis screening o Member has not received live or attenuated-live virus vaccines within 4 weeks before the start of Uplizna therapy • Documented ~~trial and failure or~~ medical contraindication to ~~a~~ rituximab, azathioprine, or mycophenolate mofetil • Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines ~~Exceptions:~~ ~~Requests for drugs in step 2 (Enspryng, Uplizna) may be approved without a trial and failure of rituximab, azathioprine, or mycophenolate if the member has been using Soliris~~ For Soliris: • Member has a diagnosis of anti-aquaporin-4 (AQP4) antibody **positive** NMOSD ~~•~~ Documented ~~trial and failure or~~ medical contraindication to ~~(one from each bullet below):~~ • ~~R~~rituximab, azathioprine, or mycophenolate mofetil ~~o Enspryng~~ ~~o Uplizna~~ • Documentation of vaccination against meningococcal disease or a documented medical reason why the member cannot receive vaccination or vaccination needs to be delayed • Antimicrobial prophylaxis with oral antibiotics (penicillin, or macrolides if penicillin-allergic) for two weeks if the meningococcal vaccine is administered < 2 weeks before starting therapy or a documented medical reason why the member cannot receive oral antibiotic prophylaxis. • Dosing is consistent with FDA-approved labeling or is supported by compendia or standard of care guidelines **Reauthorization:** • Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit) • Request is for an FDA approved/medically accepted dose If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last Review Date	~~12/2022~~12/2023

Recommendation

- Update language so that preferred agents are no longer required
- Minor language changes/ removals

Healthcare professional (HCP) administered/IV Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)	
Medications	**Ocrevus (ocrelizumab)** **Ruxience (rituximab-pvvr) - biosimilar** **Truxima (rituximab-abbs) - biosimilar** **Rituxan (rituximab)** **Riabni (rituximab-arrx) - biosimilar** **Rituxan Hycela (rituximab/hyaluronidase)** **Lemtrada (alemtuzumab)** **Tysabri (natalizumab)** **Briumvi (ublituximab-xiiy)** **Any other newly marketed healthcare professional administrable DMT for MS indicated for the listed diagnoses**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), and/or per standard of care guidelines.
Exclusion Criteria	Tysabri or Briumvi: • Primary Progressive MS (PPMS) Lemtrada: • Primary Progressive MS (PPMS) • Clinically Isolated Syndrome (CIS)
Required Clinical Information	See "Other Criteria" below
Age Restrictions	Check AAH active CCS cases for members < 21 years of age for MCAL
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	12 months
Maximum Billable Units	Variable
Other Criteria	For requests for Tysabri for the indication of Crohn's disease, please see the Injectable/Specialty Medications ~~Specialty Biological Agents for Crohn's Disease~~ policy **** When the biosimilar is indicated, the member must have documented dates of trial and failure, intolerance, inability to use, or contraindication to the biosimilar medication prior to the brand medication approval, OR the currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested, in addition to meeting all applicable criteria below.** **Initial Authorization** Clinically Isolated Syndrome (CIS), Relapsing Remitting MS (RRMS), Secondary Progressive MS (SPMS) ○ Diagnosis of CIS, RRMS, or SPMS ○ The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature ~~○ Documented trial of BOTH preferred agents or a documented medical reason (e.g. contraindication, intolerance, hypersensitivity, etc.) for not utilizing these therapies.~~ ~~○ Preferred agents: glatiramer and dimethyl fumarate (Tecfidera)~~

~~OR~~

~~For members with "highly active" MS requesting Lemtrada (alemtuzumab), Tysabri (natalizumab) or rituximab, a trial with Gilenya (fingolimod) alone will be acceptable.~~

- If the request is for Ocrevus (ocrelizumab), Briumvi (ublituximab-xiiy), or rituximab, documentation of the following:
  - Attestation that the member has been screened for and does not have active hepatitis B virus (HBV)
  - Attestation that the member has received all non-live immunizations for rituximab according to immunization guidelines or has a documented medical reason for not receiving recommended immunizations
  - If the request is for Rituxan Hycela (rituximab/hyaluronidase) or brand Rituxan, all of the above AND documented medical reason why the member cannot use a rituximab biosimilar product.
- If the request is for Tysabri (natalizumab), documentation of the following
  - Member does not have a history of progressive multifocal leukoencephalopathy (PML)
  - Documentation consistent with pharmacy claims data indicating the member is not currently using any antineoplastic, immunosuppressant, or immunomodulating medications

Primary Progressive Multiple Sclerosis (PPMS)

- Diagnosis of PPMS
- The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- If the request is for Ocrevus (ocrelizumab) or rituximab, documentation of the following has been submitted
  - Attestation that the member has been screened for and does not have active HBV
  - Member has received all non-live immunizations for rituximab, according to immunization guidelines or has a documented medical reason for not receiving recommended immunizations
  - If the request is for Rituxan Hycela (rituximab/hyaluronidase) or brand Rituxan, all of the above AND documented medical reason why the member cannot use a rituximab biosimilar product.

Reauthorization

CIS

- The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Documentation was provided that the prescriber has reviewed the risks and benefits of continuing DMT versus stopping.

PPMS, RRMS, or SPMS

- Documentation was provided that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit)
- The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- If the request is for Lemtrada (alemtuzumab), documentation of the following
  - At least 12 months has or will have elapsed since previous treatment

	○ If the request is for Tysabri (natalizumab), documentation of the following has been submitted ○ Member does not have a history of PML ○ Documentation consistent with pharmacy claims data was submitted indicating the member is not currently using any antineoplastic, immunosuppressant, or immunomodulating medications ~~**Continuation of Therapy/Grandfathering Provision**~~: ~~Members with history (within the past 90 days) of a non-formulary product (or the past 12 months for Lemtrada) are not required to try a preferred agent prior to receiving the non-preferred product.~~ If all of the above criteria are not met for initial or re-authorization, the request is referred to a Clinical Reviewer for medical necessity review
Last Review Date	~~6/2023~~12/2023

Recommendation

- Update language so that preferred agents are no longer required

Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention	
Medications	Emgality (galcanezumab-gnlm) ~~- PREFERRED~~ Aimovig (erenumab-aooe) Ajovy (fremanezumab-vfrm) Vyepti (eptinezumab-jjmr) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See "other criteria"
Age Restrictions	Check AAH active CCS cases for members < 21 years of age for MCAL
Prescriber Restrictions	N/A
Coverage Duration	If the criteria are met, the initial request will be approved for up to a 6 month duration; reauthorization requests will be approved for up to 6 months.
Maximum Billable Units	Variable
Other Criteria	**Criteria for Initial Authorization:** **Cluster Headache:** • Request for Emgality (galcanezumab) for diagnosis of episodic cluster headache • Requested dose is within FDA approved dosing guidelines **Migraine Headache Prophylaxis:** • Requested dose is within FDA approved dosing guidelines • Provider should note on the prior authorization request the number of headache days per month • Trial and failure (or a medical justification for not using e.g. hypersensitivity, baseline bradycardia or hypotension, adverse events experienced from previous trial, etc.) with at least one of the following:: 1. Beta-adrenergic blockers 2. Topiramate or divalproex ER or DR 3. A tricyclic antidepressant (TCA) (e.g. amitriptyline or nortriptyline) OR a serotonin norepinephrine reuptake inhibitor (SNRI) (e.g. venlafaxine or duloxetine) 4. Frovatriptan, zolmitriptan or naratriptan (for menstrual migraine prophylaxis) ~~• If the medication request is for a Calcitonin Gene-Related Peptide Antagonist other than Emgality, the patient has a documented medical reason (intolerance, hypersensitivity, contraindication, treatment failure etc) for not using Emgality to treat their medical condition.~~ **Criteria for Re-Authorization:** **Episodic Cluster Headache:** Documented reduction in the frequency of headaches (clinical benefit). **Migraine:**

	• Greater than or equal to a 50% reduction in the number of headache days per month relative to pre-treatment baseline (clinical benefit) • The provider should note on the prior authorization request the number of headache days per month If all of the above criteria are not met, the request is referred to a Clinical Reviewer for medical necessity review.
Last Review Date	~~6/2023~~12/2023

Recommendation

- Retire policy, as it refers to order of therapy. Review requests for these medications via the Injectable/Specialty Medications PAD policy

Specialty Biologic Agents for FDA approved indications	
Medications	Step 1: Hadlima (adalimumab-bwwd) Adalimumab-fkjp (Hulio) Step 2: Enbrel (etanercept) Simponi, Simponi Aria (golimumab) Infliximab Inflectra (infliximab-dyyb) Avsola (infliximab-axxq) Renflexis (infliximab-abda) Orencia (abatacept) Xeljanz, Xeljanz XR (tofacitinib) Kineret (anakinra) Otezla (Apremilast) Siliq (brodalumab) Kevzara (sarilumab) Actemra (tocilizumab) Olumiant (baricitinib) Entyvio (Vedolizumab) Step 3: Humira (adalimumab) Stelara (ustekinumab) Skyrizi (risankizumab) Arcalyst (rilonacept) Ilaris (canakinumab) Tremfya (guselkumab) Remicade (infliximab) Cosentyx (secukinumab) Zeposia (ozanimod) Taltz (ixekizumab) Tysabri (natalizumab) Cimzia (certolizumab) Rinvoq (upadacitinib) Ilumya (tildrakizumab-asmn) Sotyktu (deucravacitinib) All adalimumab biosimilar agents not listed in step 1(ex. Amjevita, Cyltezo, Hyrimoz, Yuflyma, etc.) Litfulo (ritlecitinib) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Clinical Information	See “other criteria”

Age Restrictions	Check AAH active CCS cases for members < 21 years of age
Prescriber Restrictions	Prescribed by a specialist in the field to treat the member's respective medical condition
Coverage Duration	If all of the conditions are met, requests will be approved for 12 months.
Maximum Billable Units	Variable

Other Criteria	**Initial authorization:**
	• The drug is being requested for an appropriate use (per the references outlined in "Covered Uses")
	• The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses")
	• If the request is for a preferred Step 2 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use a preferred Step 1 agent appropriate for the requested use (per the references outlined in "Covered Uses")
	• If the request is for a non-preferred Step 3 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use one preferred step 1 agent and one preferred step 2 agent appropriate for the requested use (per the references outlined in covered uses)
	AND:
	• If the request is for a reference biologic drug with a biosimilar or interchangeable biologic drug (ex. Humira, Remicade), documentation of one of the following:
	  • The provider has verbally, or in writing, submitted a member-specific reason why the reference biologic is required based on the member's condition or treatment history; AND if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. MedWatch form must also be included with the prior authorization request.
	Form FDA 3500 – Voluntary Reporting
	  • The currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested
	*NOTE:
	• Requests for 80mg/0.8mL dose presentations of Humira or non-preferred biosimilar adalimumab agents:
	  ○ Documentation that member has tried 40mg dose presentations to achieve desired dose, or a medical reason must be provided why this cannot be used.
	• Requests for Humira 10 mg/0.1 mL in pediatric patients may be approved without a trial of a step 1 or step 2 agent, when requested for an appropriate use (per the references outlined in "Covered Uses")
	
	Reauthorization:
	• Documentation submitted indicates that the member has obtained clinical benefit from the medication.
	• The drug is being requested for an appropriate use and dose (per the references outlined in "Covered Uses")

Last Review Date	~~9/2023~~12/2023

ALAMEDA NEW PRODUCT REVIEW Q4 2023 P&T

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
8/21/2023	Ycanth	cantharidin 0.7% topical solution	Verrica Pharmaceuticals	• Topical treatment of molluscum contagiosum in adult and pediatric patients 2 years of age and older	$1,370 per 3-week treatment course	Podofilox, Tretinoin	Non-formulary
8/21/2023	Elrexfio	elranatamab-bcmm 44 mg/1.1 ml, 76 mg/1.9 ml SQ vial	Pfizer	• Treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody	$41,500 (average monthly price)	Tecvayli, Abecma, Carvykti, Talvey	Non-formulary
8/21/2023	Opvee	nalmefene 2.7 mg/0.1 ml nasal spray	Opiant Pharmaceuticals	• For the emergency treatment of known or suspected overdose induced by natural or synthetic opioids in adults and pediatric patients aged 12 years and older, as manifested by respiratory and/or central nervous system depression	$49 per dose	Naloxone, Narcan, Kloxxado	Non-formulary
8/21/2023	Talvey	talquetamab-tgvs 3 mg/1.5 ml, 40 mg/ml subcutaneous vial	Janssen Biotech	• Treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody	$45,000 (average monthly price)	Tecvayli, Abecma, Carvykti, Elrexfio	Non-formulary
8/21/2023	Iyuzeh	latanoprost 0.005% ophthalmic solution	Thea Pharma	• For the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension	$300	Latanoprost, Bimatoprost, Brimonidine, Brinzolamide	Non-formulary
8/28/2023	Airsupra	albuterol-budesonide inhalation aerosol 90-80 mcg/act	AstraZeneca	• As-needed treatment or prevention of bronchoconstriction and to reduce the risk of exacerbations in patients with asthma 18 years of age and older	$475/unit	Albuterol inhalers, Pulmicort Flexhaler	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
8/28/2023	Veopoz	pozelimab-bbfg 400 mg/2mL injection solution	Regeneron	• Treatment of adult and pediatric patients 1 year of age and older with CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease.	$300,000 (maintenance dosing, 70 kg adult)	None	Non-formulary (See new PAD policy)
8/28/2023	Eylea HD	aflibercept 8 mg/0.07 mL intravitreal solution	Regeneron	• Neovascular (Wet) Age-Related Macular Degeneration (nAMD) • Diabetic Macular Edema (DME) • Diabetic Retinopathy (DR)	$2,625/dose (maintenance dosing every 8-12 weeks)	Eylea, Vabysmo, Lucentis	Non-formulary
9/4/2023	Sohonos	palovarotene 1 mg, 1.5 mg, 2.5 mg, 5 mg, 10 mg oral capsules	Ipsen Biopharmaceuticals	• For reduction in the volume of new heterotopic ossification in adults and children aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressiva (FOP)	$51,300 for maintenance dose	None	Non-formulary (See new PAD policy)
9/4/2023	Nitrofurantoin	nitrofurantoin 50 mg/5 mL oral suspension	Rising Pharmaceuticals	• Treatment of urinary tract infections when due to susceptible strains of Escherichia coli, enterococci, Staphylococcus aureus, and certain susceptible strains of Klebsiella and Enterobacter species	$2,198 per 60 mL bottle	Sulfamethoxazole/ trimethoprim	Non-formulary
9/4/2023	Balfaxar	prothrombin complex concentrate, human-lans 500 unit, 1000 unit intravenous vials	Octapharma	• For the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (e.g., warfarin) therapy in adult patients with need for an urgent surgery/invasive procedure	$7,875-$15,750 per treatment course	Kcentra	Non-formulary
9/4/2023	Rykindo	risperidone 25 mg, 37.5 mg, 50 mg extended release intramuscular vials	Shandong Luye Pharmaceutical Co.	• For the treatment of schizophrenia in adults • Monotherapy or as adjunctive therapy to lithium or valproate for the maintenance treatment of bipolar I disorder in adults.	$2,346 for max dose	Risperdal Consta, Abilify Maintena, Aristada, Zyprexa Relprevv, Perseris	Non-formulary
9/11/2023	Daxxify	daxibotulinumtoxinA-lanm 100 unit intramuscular vial	Revance Therapeutics	• Temporary improvement in the appearance of moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity in adult patients • Treatment of cervical dystonia in adult patients.	$1,050 for max dose per treatment	Botox, Dysport, Myobloc, Xeomin	Non-formulary (See class review)

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
9/11/2023	Lodoco	colchicine 0.5 mg oral tablets	AGEPHA Pharma	• To reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular disease	$495	Atorvastatin, Rosuvastatin, Ezetimibe, Nexletol, Jardiance	F-PA (See monograph)
9/18/2023	Jesduvroq	daprodustat 1 mg, 2 mg, 4 mg, 6 mg, 8 mg oral tablets	GlaxoSmithKline	• Treatment of anemia due to chronic kidney disease in adults who have been receiving dialysis for at least four months	$117 - $2,815 depending on severity of anemia	Aranesp, Epogen, Procrit, Retacrit	F-PA (See monograph)
9/18/2023	Cresemba	isavuconazonium 74.5 mg oral capsule	Astellas Pharma	• Treatment of invasive aspergillosis • Treatment of invasive mucormycosis	$6,435 for one month maintenance dose	Voriconazole, Isavuconazole, Amphotericin B	NF (See MRG policy)
9/18/2023	Akeega	niraparib/abiraterone 50 mg-500 mg, 100 mg-500 mg oral tablets	Janssen Biotech	• Treatment of adult patients with deleterious or suspected deleterious BRCAmutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) with prednisone	$18,750	Lynparza + Abiraterone Xtandi + Talzenna	Non-formulary
9/18/2023	Lantidra	donislecel-jujn intravenous cellular suspension	CellTrans Inc.	• Treatment of adults with Type 1 diabetes who are unable to approach target HbA1c because of current repeated episodes of severe hypoglycemia despite intensive diabetes management and education	$105,000 per dose	None	Non-formulary (See new PAD policy)
9/25/2023	Breo Ellipta	fluticasone furoate-vilanterol 50-25 mcg/inhalation	GlaxoSmithKline	• Maintenance treatment of patients with chronic obstructive pulmonary disease (COPD) • Maintenance treatment of asthma in patients aged 5 years and older	$395	Symbicort, Dulera, Advair	Non-formulary
9/25/2023	Ojjaara	momelotinib 100 mg, 150 mg, 200 mg tablet	GlaxoSmithKline	• Treatment of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [postpolycythemia vera (PV) and post-essential thrombocythemia (ET)], in adults with anemia	$26,900	Jakafi	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
9/25/2023	Aphexda	motixafortide 62 mg SC solution reconstituted	BiolineRx USA	• To be used in combination with filgrastim (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma	$11,800/dose (2 vials)	Mozobil	Non-formulary
9/25/2023	Adalimumab-adbm	adalimumab-adbm 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml, subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	Boehringer Ingelheim	• Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Crohn's Disease, Ulcerative Colitis, Plaque Psoriasis, Hidradenitis Suppurativa	$658 per dose	Humira, Amjevita, Hulio, Idacio, Hyrimoz, Yusimry, Yuflyma, Hadlima	Non-formulary
10/2/2023	Pokonza	potassium chloride 10 mEQ oral packet	Carwin Associates	• Treatment and prophylaxis of hypokalemia with or without metabolic alkalosis, in patients for whom dietary management with potassium-rich foods or diuretic dose reduction is insufficient.	$1,640	Potassium chloride tablets & oral solution	Non-formulary
10/2/2023	Hyrimoz	adalimumab-adaz 40 mg/0.8 ml subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	Sandoz	• Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Crohn's Disease, Ulcerative Colitis, Plaque Psoriasis, Hidradenitis Suppurativa	$650 per dose	Humira, Amjevita, Hulio, Idacio, Cyltezo, Yusimry, Yuflyma, Hadlima	Non-formulary
10/9/2023	Trientine	trientine 500 mg oral capsules	Rising Pharmaceuticals	• Treatment of patients with Wilson's disease who are intolerant of penicillamine.	$46,000 (max dose)	Syprine, Galzin	Non-formulary
10/9/2023	Kepivance	palifermin 5.16 mg intravenous vial	Swedish Orphan Biovitrum	• To decrease the incidence and duration of severe oral mucositis in patients with hematologic malignancies receiving myelotoxic therapy in the setting of autologous hematopoietic stem cell support. Kepivance is indicated as supportive care for preparative regimens predicted to result in ≥ WHO Grade 3 mucositis in the majority of patients	$19,882 per treatment course (for a 70 kg adult)	None	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
10/9/2023	Pombiliti	cipaglucosidase alfa-atga 105 mg intravenous vial	Amicus Therapeutics	• To be used in combination with Opfolda, an enzyme stabilizer, for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy	$49,980 (for a 70 kg adult)	Lumizyme, Nexviazyme	Non-formulary
10/9/2023	Opfolda	miglustat 65 mg oral capsules	Amicus Therapeutics	• To be used in combination with Pombiliti, a hydrolytic lysosomal glycogen-specific enzyme, for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy	$260	Miglustat	Non-formulary
10/9/2023	Motpoly XR	lacosamide 100 mg, 150 mg, 200 mg extended-release oral capsules	Aucta Pharmaceuticals	• Treatment of partial-onset seizures in adults and in pediatric patients weighing at least 50 kg	$1,250 (max dose)	Lacosamide	Non-formulary
10/16/2023	Cosentyx	secukinumab 125 mg/5 ml intravenous vial	Novartis	• Treatment of adults with active psoriatic arthritis (PsA) • Treatment of adults with active ankylosing spondylitis (AS) • Treatment of adults with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation	$6,345 (max dose)	Taltz, Infliximab, Adalimumab, Skyrizi, Siliq	Non-formulary
10/16/2023	Kalydeco	ivacaftor 5.8 mg oral granules in packet	Vertex	• Treatment of cystic fibrosis (CF) in patients age 1 month and older who have at least one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data	$26,857	Orkambi, Symdeko, Trikafta	Add to T2 F-PA (line extension)
10/16/2023	Entyvio	vedolizumab 108 mg/0.68 ml subcutaneous auto-injector	Takeda Pharmaceuticals	• Treatment of moderately to severely active ulcerative colitis (UC)	$5,886	Adalimumab, Stelara, Rinvoq, Xeljanz, Simponi	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
10/16/2023	First Pantoprazole	pantoprazole 4 mg/ml oral suspension kit	Azurity Pharmaceuticals	• Treatment of erosive esophagitis associated with gastroesophageal reflux disease (GERD)	$175 per kit	Omeprazole oral suspension kit	Non-formulary
10/23/2023	Glipizide	glipizide 2.5 mg oral tablet	TruPharma	• To be used as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.	$41	Glyburide, Glimepiride	Non-formulary
10/23/2023	Likmez	metronidazole 500 mg/5 ml oral suspension	Kesin Pharma	• Trichomoniasis in adults • Amebiasis in adults and pediatric patients • Anaerobic bacterial infections in adults	$545 per 10-day treatment course (for a 70 kg adult)	Metronidazole, Clindamycin, Levofloxacin,	Non-formulary
10/30/2023	Velsipity	etrasimod 2 mg oral tablets	Pfizer	• Treatment of moderately to severely active ulcerative colitis in adults	$6,164	Zeposia, Rinvoq, Adalimumab, Xeljanz, Stelara, Entyvio	Non-formulary
10/30/2023	Abrilada	adalimumab-afzb 20 mg/0.4 ml, 40 mg/0.8 ml subcutaneous syringe; 40 mg/0.8 mL subcutaneous auto-injector	Pfizer	Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Crohn's Disease, Ulcerative Colitis, Plaque Psoriasis, Hidradenitis Suppurativa, Uveitis	$3,288 per dose	Humira, Amjevita, Hulio, Idacio, Cyltezo, Hyrimoz, Yusimry, Yuflyma, Hadlima	Non-formulary
10/30/2023	Bimzelx	bimekizumab-bkzx 160 mg/ml subcutaneous syringe; 160 mg/mL subcutaneous auto-injector	UCB	• Treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy	$7,200	Cosentyx, Taltz, Skyrizi, Stelara, Tremfya, Adalimumab,	Non-formulary
10/30/2023	Ozobax DS	baclofen 10 mg/5 ml oral solution	Metacel Pharmaceuticals	• Treatment of spasticity resulting from multiple sclerosis, particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity • May also be of some value in patients with spinal cord injuries and other spinal cord diseases	$816 per bottle	Baclofen, Tizanidine, Gabapentin, Dantrolene	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
10/30/2023	Altuviiio	antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl 750-unit intravenous vial	Bioverativ Therapeutics Inc.	• For use in adults and children with hemophilia A (congenital factor VIII deficiency) for: o Routine prophylaxis to reduce the frequency of bleeding episodes o On-demand treatment & control of bleeding episodes o Perioperative management of bleeding	$71,540 for a 70 kg adult	Novoeight, Advate, Afstyla, Kogenate FS, Kovaltry, Nuwiq, Recombinate, Xyntha/Solofuse, Adynovate, Esperoct, Jivi, Alphanate, Humate P, Wilate, Eloctate, Obizur, Hemofil M, Koate	Non-formulary (see new PAD policy)
11/7/2023	Omvoh	mirikizumab-mrkz 300 mg/15 ml intravenous via	Eli Lilly and Company	• Treatment of moderately to severely active ulcerative colitis in adults	$9,593	Adalimumab, Infliximab, Rinvoq, Stelara, Entyvio, Zeposia	Non-formulary
11/7/2023	Omvoh	mirikizumab-mrkz 100 mg/ml subcutaneous auto-injector	Eli Lilly and Company	• Treatment of moderately to severely active ulcerative colitis in adults	$10,361	Adalimumab, Infliximab, Rinvoq, Stelara, Entyvio, Zeposia	Non-formulary
11/14/2023	Zepbound	tirzepatide	Eli Lilly and Company	• To be used as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of: o 30 kg/m2 or greater (obesity) or o 27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes mellitus, obstructive sleep apnea or cardiovascular disease	$1,060	Wegovy, Saxenda, Contrave, Qsymia, Xenical	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
11/14/2023	Rozlytrek	entrectinib 50 mg oral pellet packet	Genentech	• Treatment of adult patients with *ROS1*-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test • Treatment of adult and pediatric patients older than 1 month of age with solid tumors that: o Have a neurotrophic tyrosine receptor kinase *(NTRK)* gene fusion, as detected by an FDA-approved test without a known acquired resistance mutation, o Are metastatic or where surgical resection is likely to result in severe morbidity, and o Have progressed following treatment or have no satisfactory alternative therapy. This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.	$19,087 for a child with a BSA of 1.1 m^2	Vitrakvi, Xalkori	Non-formulary
11/14/2023	Fruzaqla	fruquintinib 1 mg, 5 mg oral capsules	Takeda Pharmaceuticals	• Treatment of adult patients with metastatic colorectal cancer (mCRC) who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type and medically appropriate, an anti-EGFR therapy	$25,200	Lonsurf, Stivarga	Non-formulary
11/14/2023	Zurzuvae	zuranolone 20 mg, 25 mg, 30 mg oral capsules	Sage Therapeutics, Inc.	• Treatment of postpartum depression (PPD) in adults	$15,900 per 14-day treatment course	Escitalopram, Sertraline, Venlafaxine, Zulresso	Non-formulary

DATE ADDED	BRAND NAME	GENERIC NAME/ DOSAGE FORM	MANUFACTURER	INDICATION	PRICING*	FORMULARY ALTERNATIVES	RECOMMENDATION^
11/14/2023	Inpefa	sotagliflozin 400 mg oral tablets	Lexicon Pharmaceuticals	• To reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with: o Heart failure or o Type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors	$598	Farxiga, Jardiance	Non-formulary
11/14/2023	Xphozah	tenapanor 20 mg, 30 mg oral tablets	Ardelyx	• To reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy	$2,960		Non-formulary
11/14/2023	Voquezna	vonoprazan 10 mg, 20 mg tablets	Phathom Pharmaceuticals, Inc.	• For healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults • To maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults • In combination with amoxicillin and clarithromycin for the treatment of *Helicobacter pylori (H. pylori)* infection in adults • In combination with amoxicillin for the treatment of *H. pylori* infection in adults.	$650	Lansoprazole, Pantoprazole, Omeprazole, Esomeprazole	Non-formulary

*	Pricing reflects Wholesale Acquisition Cost (WAC) per month unless otherwise noted.
†	Pricing based on standard twice-monthly dosing for most indications.
‡	Pricing is per each kit on items listed as a kit.