Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board
Meeting Transcription
February 17, 2021

[unrelated discussion]

Ginni Buccola: Diane Schwilke?

Diane Schwilke: I'm here. Good morning.

Ginni Buccola: Jordan Storhaug?

Jordan Storhaug: Good morning.

Ginni Buccola: Nancy Lee?

Nancy Lee: Good morning.

Ginni Buccola: Leah Marcotte?

Leah Marcotte: Here. Good morning.

Ginni Buccola: Susan Flatebo?

Susan Flatebo: Here.

Ginni Buccola: Catherine Brown?

Catherine Brown: Here. Good morning.

Ginni Buccola: Morning, everybody. And I believe Connie Huynh was trying to log back in but having some technical difficulties. And Alex Park we'll expect to be joining us.

Leta Evaskus: [indistinct] problems with audio.

Ginni Buccola: Okay. We'll go to the HCA members starting with Leta Evaskus.

Leta Evaskus: Here.

Ginni Buccola: And Donna Sullivan.

Leta Evaskus: I think she's here. She did have audio.

Ginni Buccola: Okay. Ryan Pistoresi?

Ryan Pistoresi: Here.

Ginni Buccola: Luke Dearden? Amy Irwin?

Amy Irwin: Hey, this is Amy. Joey Zarate? Ryan Taketomo? Marissa Tabile?

Marissa Tabile: Here.

Ginni Buccola: Dr. Chris Chen? And Dr. Charissa Fotinos? And I'm sorry. I'm going off the December attendee list. So they may not be present. Our Magellan Medicaid Administration member is Umang Patel.

Umang Patel: Present.

Ginni Buccola: Do we have a DERP presenter today, Leta?

Leta Evaskus: We do not. This is only DUR. No [indistinct].

Ginni Buccola: And then Managed Care Organization representatives, Greg Simas with Molina. Heidi Goodrich with Molina. Petra Eichelsdoerfer.

Petra Eichelsdoerfer: I'm here.

Ginni Buccola: Hi, Petra. And Catherine Vu with Community Health Plan. Okay, if I've missed anyone on the attendee list, let us know. I'm going to hand it over to Leta for meeting details.

Ryan Taketomo: This is Ryan Taketomo. I'm here.

Leta Evaskus: Thanks, Ryan. Okay, I'm Leta Evaskus. The committee and the MCO representatives have been added as organizers. You can mute and unmute yourself. Please mute yourself when you're not speaking to limit the background noise. Please share your camera when you're talking or when you're presenting, otherwise, you can turn your camera off. For stakeholder participation, the chair will first read the list of stakeholder names who pre-registered, I will unmute you, you'll have three minutes. After, the chair will ask if there are any other stakeholders. You can use the raise hand icon and I will call on you and unmute you and you'll have three minutes to speak. The meeting is being recorded so please state your name every time you speak. Thank you. I do have an announcement. This is Connie Huynh's last meeting. So I want to thank you, Connie, for your time as a committee member and we're going to miss working with you.

Ginni Buccola: This is Ginni Buccola. I just want to add, yes, we'll definitely miss working with you Connie. We wish you good luck in your next steps.

Constance Huynh: Oh, thank you I'm going to miss everybody. I've had such a wonderful time on this board. I've learned so much and just being able to collaborate with every one of you has been the highlight of my career thus far. And I really am very sad to leave. It is actually starting to tear up. But yeah, thank you.

Leta Evaskus: Well, keep in touch.

Ginni Buccola: Again, this is Ginni Buccola. And I think we're ready to go then. I see that Umang's slides are up. Our first topic is antibiotics, aminoglycosides-inhaled, and monobactams-inhaled with Umang. So I'll turn it over to you, Umang.

Umang Patel: Thank you very much. On the next slide here, just to give the committee a quick recap, we do kind of go over the disease states, the new medications or new guidelines that may have come out in the last year or so. Anything prior to that, I try not to keep in the slides. They may be in the appendices for the committee's leisure. On the next slide here, so we'll be going over a little bit over -- there are two different classes, but one topic, so I will kind of bundle them up together. We have antibiotics, inhaled aminoglycosides and monobactams along with cystic fibrosis, respiratory agents as well. On the next slide here, a little background. So cystic fibrosis is a serious autosomal recessive multiorgan disorder that affects approximately 31,000 children and adults in the US and is the most common fatal genetic disease in Caucasians. The median survival in patients is about eight years of age with 80% of patients reaching adulthood. Children are anticipated to live approximately 40 years of age with current treatments, and in 2018, adults comprised approximately 55% of the population, while in 1988, they comprised about 31%. Mutations lead to the disease of the exocrine gland function resulting in the formation of this thick mucus buildup in the lungs, digestive tract, and other parts of the body. So the transmembrane, the CFTR is essentially a regulator that functions as a chloride channel and the mutations in said CFTR cause essentially abnormal chloride transport across the epithelial cells on the mucosal surfaces. So the goals for cystic fibrosis are one, to maintain lung function by controlling infection and clearing mucus in the airway, two, to maintain appropriate growth by providing nutritional support - that can be things such as enzymes, minerals, and multivitamins - and three, to manage disease complications, such as insulin therapy in patients who may develop diabetes. On the next slide here, in terms of guidelines, there are no new changes in

guidelines. This is just here for completeness sake, so I won't go through it in depth. But the guidelines, as I mentioned, the treatments are to maintain lung function by controlling infection, the mucus and nutritional support. And then [indistinct] are the newest, and I say that in a relative term to the entire class, are the newest class of medications available for the disease and improve chloride ion transport abnormalities. And again, the guidelines are from 2013 and 2014 so I will not go over them. They're just here for the committee's reference. On the next slide, so in the last year, some new information that may have come out for Kalydeco. In August 2020, the FDA expanded indications for the treatment of cystic fibrosis in patients aged four to less than six months of age, weighing five kilograms or greater, who have one or more mutations in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data. Previously, this was only six months or greater. So they've expanded the age in the indication. As you can see, the dosage is as I mentioned, weight and age based. And nothing has changed in the availability here as well. Again, to remind the committee, I usually try to bold whatever is new in these new medications, formulations, indications, or guidelines. And so if there's something that is not bolded and others are, that is why. Next slide. And that is all I have for the cystic fibrosis bundle in terms of new information. Any questions from the committee that I can take?

[unrelated discussion]

Ginni Buccola: Okay, any questions committee members? Alright. We have one stakeholder, Daniel Gharbawy with INSMED Incorporated. Are you on the line?

Daniel Gharbawy: How about now?

Ginni Buccola: I can hear you now. Thank you, Daniel. Can you just go ahead and give us your full name and your affiliation? Let us know what your relationship is to your company. And then when you're ready to go, you'll have three minutes to speak with us. Thanks.

Daniel Gharbawy: Certainly. Yeah, thank you. My name is Daniel Gharbawy. I am a pharmacist and medical science liaison at INSMED and I serve the western United States.

Ginni Buccola: You are free to go.

Daniel Gharbawy: Wonderful. So thank you for the opportunity. To just give a brief overview of Arikayce, the proprietary name for amikacin liposome inhalation suspension. Arikayce is the only FDA approved therapy indicated for the treatment of refractory Mycobacterium avium complex or MAC lung disease as part of a combination drug regimen for adults with limited or no alternative treatment options. The use of Arikayce is not recommended for patients with non-refractory MAC lung disease. Arikayce is an inhaled once daily formulation of amikacin and INSMED's advanced liposomal technology is what enables delivery of amikacin directly to the lungs, or it's taken up by lung macrophages where the infective organism resides. This approach is designed to deliver Arikayce to the site of infection while limiting systemic exposure. Arikayce received accelerated approval and its clinical benefit's not yet established. Arikayce has a box warning for increased risk of respiratory adverse reactions, including hypersensitivity pneumonitis, hemoptysis, bronchospasm, and exacerbation of underlying pulmonary disease that have led to hospitalization in some cases. Other warnings include ototoxicity, nephrotoxicity, use in patients with neuromuscular blockade, anaphylaxis and hypersensitivity reactions, and risk for embryo fetal toxicity. Arikayce is contraindicated in patients with a known hypersensitivity to any aminoglycoside. The most common adverse reactions in patients with refractory MAC lung disease include but are not limited to dysphonia, cough, bronchospasm, hemoptysis, musculoskeletal pain, and upper airway irritation. Efficacy was evaluated in the phase three convert trial in which the proportion of patients with refractory MAC lung disease achieved culture conversion, the microbiological goal of therapy and it was significantly greater for Arikayce plus background regimen arm compared with the multi drug background regimen arm alone at a rate of 29% versus 8.9% respectively. Of those receiving Arikayce plus background regimen, in the overall study population 18.3% or 41 of the 224 achieved culture conversion by month six and had sustained sputum culture conversion for up to 12 months of treatment compared to 2.7% or three of the 112 of patients receiving background regimen alone at a p value of less than point 0001. At three months after the completion of treatment, 16.1% of patients, or 36 of the 224 patients in convert who had received Arikayce plus background regimen maintained durable culture conversion compared to no patients who had received background regimen

alone. And again, the p value of less than .0001. Arikayce is administered using only the Lamira nebulizer system at a dose of 590 milligrams once daily and a 28 vile kit of Arikayce along with one Lamira nebulizer kit is provided. Thank you for your consideration.

Ginni Buccola: Thanks very much. Committee members, do you have any questions for Daniel? Okay, I wanted to clarify, I don't see any other stakeholders listed for this topic but I do see a message, Leta, from I don't have any I don't see any other stakeholders listed for this topic, but I do see a message Lita from Siri Vaeth with Cystic Fibrosis Research and I didn't know if --

Leta Evaskus: I have Siri down for the next topic. There's two hands raised. Siri, I'm just going to unmute you really quick to see.

Siri Vaeth: Hi, thank you, Leta. I was not speaking to the antibiotics specifically. So if it's the next group for cystic fibrosis, the modulators, then I'd love to speak.

Ginni Buccola: Great. I see her listed there in the next group.

Leta Evaskus: Okay, so let me get to the hands. We have Helaine Gregory. You are unmuted.

Helaine Gregory: Yes, good afternoon. I also work for him INSMED in the market access group. I hear that there's no further questions for Daniel at the moment. Can we disconnect or would you like us to be available throughout the meeting and/or if any other issue were to come up, a way to communicate with us. How would you like us to manage through that?

Ginni Buccola: That's a good question.

Leta Evaskus: This is Leta Evaskus. If this is the only drug class that you wanted to speak on then you can log off the meeting. If there's any other questions, we could always email you or something. But usually, now would be the time the committee would ask you questions.

Helaine Gregory: Okay, perfect. And then that being the case, unless anybody has any other questions to ask Daniel or myself, then I think we'll proceed to disconnect.

Leta Evaskus: Okay, thank you.

Ginni Buccola: Thank you. Alright, so I think the committee then can move to the motion.

Leta Evaskus: Yes, let me let me bring that up. Let me know if I'm flipping too fast.

Ginni Buccola: This is Ginni. That seems good. If everybody else okay with the speed? Yeah. Okay.

Nancy Lee: This is Nancy. All products listed in the drug class on slide two are considered [indistinct] for their medically accepted [indistinct] status grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of two preferred products with the same indication before nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Constance Huynh: This is Constance Huynh. I second.

Ginni Buccola: This is Ginni Buccola. All those in favor, please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. Thanks, committee. We'll go back to Umang for respiratory agents, specifically cystic fibrosis agents.

Umang Patel: Perfect, great. We should be on anti-coaxial. I did want to ask, cystic fibrosis, since there was two different classes, there was the inhaled antibiotics and the CFTR agents. I covered them both. But I didn't know if the committee needed to make two different motions.

Leta Evaskus: I'm confused. Marissa?

Marissa Tabile: Hey, this is Marissa. Yeah, there's two different motions because they're in two different drug classes. So there's a slide for the cystic fibrosis agents. So there just needs to be a motion for that.

Leta Evaskus: Okay, then we have different stakeholders. So these are listed as two different topics on the agenda, so different stakeholders.

Ginni Buccola: Okay, so we'll go back then. We'll just step down on the agenda to our list of cystic fibrosis stakeholders. Is that correct?

Leta Evaskus: Sounds like it.

Ginni Buccola: Okay. So our cystic fibrosis stakeholders are in the following order: Lisa Allen with Vertex Pharmaceuticals. Lisa is going to be speaking on four products so she'll have 10 minutes. And then after Lisa, we have Devin Wakefield and then we have Siri Vaeth with Cystic Fibrosis research. So, Lisa, are you ready to go?

Lisa Allen: Can you hear me okay?

Ginni Buccola: I can hear you. Just go ahead and to start yourself off, give us your name and your affiliation and then you'll have 10 minutes.

Lisa Allen: Thank you. Good morning. My name is Lisa Allen. I'm with medical affairs at Vertex Pharmaceuticals. Thank you for this opportunity to provide public testimony on behalf of our cystic fibrosis transmembrane conductance regulator modulators. CFTR modulators are the only cystic fibrosis medicines that work by targeting the underlying cause of CF, which is the defect in the CFTR protein as Umang described. There are currently four CFTR modulators approved for treatment of CF based on age and phenotype: Trikafta, Symdeko, Orkambi, and Kalydeco. Today I will be focusing on the recent label expansions for Trikafta, Symdeko, and Kalydeco. As Umang mentioned, on September 25th of last year, the FDA expanded the age indication for Kalydeco to include eligible patients with CF to four months to less than six months to the label. With this approval, up to approximately 50 patients between four months to less than six months old were newly eligible for Kalydeco in the United States. Most recently, on December 21st of last year, the FDA approved additional CFTR mutations to the labels for three of our medicines:

Trikafta, Symdeko, and Kalydeco. These additional mutations were approved based on in vitro data from an established cell model systems that we use to test rare mutations for responsiveness to CFTR modulators when clinical trials are not feasible due to low patient numbers. With the addition of these newly indicated mutations, an estimated 650 additional patients with CF are now eligible for CFTR modulator. To summarize the updated indications, Trikafta is a combination of ivacaftor, a CFTR potentiator, tezacaftor, and elexacaftor, now indicated for the treatment of CF and patients 12 years of age and older who have at least one F508del mutation in the CFTR gene, or a mutation in the CFTR gene that's response is based on the invitro data. And the full list of eligible mutations can now be found in table four of the Trikafta USPI. Symdeko is indicated for the treatment of patients with CF age six years and older who are homozygous for the F508del mutation or who had at least one mutation that's responsive to tezacaftor/ivacaftor based on invitro data and or clinical evidence. And the full list of eligible mutations for Symdeko can be found in table six of the USPI. Kalydeco is a CFTR potentiator indicated for the treatment of CF in patients four months and older who have one mutation that is responsive to ivacaftor based on clinical and/or invitro assay data. And the full list of Kalydeco eligible mutations can be found in table three of the Kalydeco USPI. The warnings and precautions associated with Kalydeco, Symdeko, and Orkambi have been shared with this committee previously. They are in the USPI and include important information on liver function test elevations, drug interactions with CYP3a inducer inhibitors and cataracts. Additionally, for Orkambi, the warnings and precautions include information on use in patients with advanced liver disease, respiratory events, and the effects on blood pressure. Please refer to the full USPI for a complete list of warnings and precautions as well as additional safety data. I would like to thank the committee for maintaining preferred access to Kalydeco, Symdeko, and Orkambi. During my final few minutes of testimony, I would like to highlight the head to head clinical data that support the addition of Trikafta to the preferred drug list. Trikafta has demonstrated superiority over Symdeko and Kalydeco in phase three randomized controlled clinical trial. Trial two in the Trikafta USPI was a Symdeko active controlled trial conducted in patients aged 12 years and older homozygous for f508del, which met its primary endpoint of absolute change from baseline at week four in percent predicted FEV1 by ten percentage

points between Trikafta compared to Symdeko. This ten percentage point change in FEV1 reflects the treatment effects of Trikafta on top of Symdeko treatment. Additional analyses showed improvements in lung function were consistent across all the patients subgroups analyzed. This study also met all key secondary endpoints including a significant reduction in sweat chloride and a significant clinically meaningful increase in the CFTR respiratory domain score, which is the tool used to measure CF specific respiratory related patient reported outcomes. In addition, top line results of a phase three randomized control [indistinct] patient and either a gating mutation or residual function mutation were publicly announced on July 20 of last year. This study met its primary endpoint of a mean absolute within group change of 3.7 percentage points in FEV1 from baseline through week eight. This was statistically significant with a p value of less than .001. This 3.7 percentage point change in FPV1 reflects the treatment effect of Trikafta on top of Kalydeco or Symdeko. This study also met all secondary endpoints including a statistically significant mean within group reduction in sweat chloride. The regimen was well tolerated in general and safety data were consistent with those that have been observed in previous phase three studies with Trikafta. The safety profile of Trikafta is based on data from all 510 patients from two pivotal phase three studies. A total of 257 patients aged 12 and older received at least one dose to Trikafta. The warnings and precautions associated with Trikafta are provided in the full USPI and include important information on liver function test elevations, drug interactions with CYP3 inducers inhibitors, and cataracts. Elevated [indistinct] and bilirubin have been observed in Trikafta treated patients with CF, so guidance around monitoring of LFTs are also recommended in the USPI. If patients experience significant elevations of their liver function test, there's also guidance for interrupting Trikafta. Coadministration with strong CYP3 inducers is not recommended. And the dose of Trikafta should be reduced when you use concomitantly with moderate or strong CYP3a inhibitors. And lastly, cases of cataracts have been reported in pediatric patients treated with ivacaftor containing regimens. Therefore, baseline and follow-up eye exams are recommended. Based on these data, I would like to respectfully ask the committee to add Trikafta to the preferred drug list. Thank you very much for your time. I'm happy to answer any questions you may have.

Ginna Buccola: Thank you, Lisa. Committee members, do you have any questions for Lisa?

Alex Park: Alex Park here. Can I ask a question of Umang and Lisa?

Lisa Allen: Of course.

Alex Park: Umang, in the materials we received from Magellan, there was a head to head trial of Trikafta and Symdeko and I'm thinking that's the one Lisa was talking about. Lisa, is that the four week trial you're talking about?

Lisa Allen: That's correct, yes.

Alex Park: Okay, thank you.

Ginni Buccola: Any other questions, committee members? Okay, thank you very much, Lisa. Next we have Devin Wakefield, a person living with cystic fibrosis. Devin, are you available?

Devin Wakefield: Yes. Hi, can you hear me?

Ginni Buccola: Yes, I can. Devin, just go ahead and give us your full name. And if you have any affiliations or ties to pharmaceutical companies, let us know. And then you'll have three minutes to talk.

Devin Wakefield: Hi, yeah, my name is Devin Wakefield. I am not affiliated with any drug companies. But I do take Trikafta and I just wanted to be here today to advocate for protecting the patient's relationship with their health care team and also give some more context on the value of Trikafta and other modulators in cystic fibrosis. So I just wanted to start by saying the patient and doctor should be the ones to decide if Trikafta and other modulator drugs are right for the patient. I fear certain parts of the access policy may force unwarranted decisions. The patient and medical care should be at the forefront of making these decisions, as they understand best the complex reality of CF care. In my experience I have had with cystic fibrosis, I've had a lot of issues with my Gi system, my lungs and sinuses, and endocrine system. And I've been on tons of medications and at times, I've had to spend three hours or more each day on my health, including inhaled

medication, exercise, a heck of a lot of pills to take, and keeping close watch on my diet. So with the introduction of Trikafta into my daily regimen, I've seen a lot of benefits, especially valuable during this pandemic. Pre-Trikafta, each winter, I would get sick, requiring IV antibiotics and hospitalization to recover. And during the late winters of 2018 and 2019, I had severe episodes of hemoptysis, where I would be constantly coughing up blood during the day. And if I tried to lay down, it would trigger more blood that I'd have to cough up. Trikafta. since its introduction in late 2019 in my care has helped prevent this, which keeps me out of a hospital bed that someone with Covid may need. Furthermore, it also means I'm much more able to take care of myself at home, requiring less doctor visits, and less risk of catching any respiratory viruses out there. So obviously, Trikafta's been really helpful for maintaining my health. So the current cystic fibrosis DUR policy requires patients to meet certain metrics before access on Trikafta. And I think some of these add a burden to CF patients that are unwarranted. For example, the requirement that a patient must not have severe hepatic impairment, [indistinct] Trikafta is not worth it if the patient has poor liver function. And while Trikafta can have some negative impacts on liver function, this is not certain. And in fact, some patients have reported improved liver function over time. I am one of those patients. Another issue I have with the policy is the requirement that the patient --

Ginni Buccola: I'm sorry to interrupt. We're at three minutes so I'll just invite you to close.

Devin Wakefield: Okay. Thank you so much and let me just close out by saying that patients work hard enough for their own care and we should not be putting more obstacles in between patients and their medication. Thank you so much, everyone.

Ginni Buccola: Thank you very much, Devin, for your testimony. Committee members, do you have any questions for Devin? Okay, thanks again. We're going to move next to Siri Vaeth with Cystic Fibrosis Research. Siri, can you hear us?

Siri Vaeth: I can hear you. Can you hear me?

Ginni Buccola: Yes, just go ahead and introduce yourself and your affiliation and then you'll have three minutes to present.

Siri Vaeth: Good morning. I'm Siri Vaeth and I'm the executive director of Cystic Fibrosis Research Incorporated. So I will launch in. In addition to being the executive director of CFRI's cystic fibrosis research, I am the mother of a young adult living with cystic fibrosis. And on behalf of CFRI and the hundreds of Washington residents impacted by CF that we serve, I want to express our sincere hope that patients with CF whose mutations make them eligible for CFTR modulators and specifically Trikafta will have access to this transformative therapy. CFRI is one of the largest and oldest CF organizations in the country. We're proud to support CF researchers at the University of Washington and to provide our services to those residents of Washington impacted by CF. Our board of directors and staff include renowned CF clinicians and researchers and those living with CF. We know this disease intimately and its devastating impact. I know it personally. We're also intimately aware of the unprecedented positive impact that CFTR modulators and specifically Trikafta have had on the lives of many with this debilitating disease. Those children who have access to modulators at a young age will have a chance to live a much fuller life. And while quality of life and life expectancy have improved for many, CF still remains a fatal disease. Those who were recently born and have access to the new therapies have better odds, but half the individuals who died from CF related complications last year were under 30 years old. And as you just heard from Devin Wakefield, those who battle CF face hours of daily respiratory therapy, countless pills, and often multiple injections, IVs and hospitalizations. And those hospitalizations are painful, isolating, yes, very expensive, and incredibly frightening, especially now. For those with advanced lung disease, the fear of a catastrophic hemoptysis or pneumothorax is ever present. And a double lung transplant does extend life possibly but it is not a cure and it's fraught with its own tremendous risks. The importance of Trikafta enhancing lung function and physical health is especially critical in light of the Covid-19 pandemic. CFTR modulators, in particular, Trikafta have given many individuals with CF hope they'll have a better quality of life. Many on Trikafta have improved lung function, decreased dependence on insulin, fewer exacerbations and reduced hospital stays and of course these positive physical impacts translate to improve mental health. On behalf of CFRI and the

Washington residents living with CF we serve, I thank you in advance for following FDA approved labeling criteria when determining your authorization steps. We hope that Trikafta will be included on the preferred drug list. We hope you'll not adopt policies that interfere with the doctor/patient relationship and create burdensome reauthorization steps that tax our already overloaded physicians and medical teams. We do worry this could lead to lapses in adherence by patients which could have catastrophic and far more expensive implications. So again, thank you so much for facilitating access to this desperately needed therapy. And thank you for including the patient voice into your discussions.

Ginni Buccola: Thank you, Siri. Committee, do you have any questions for Siri Vaeth? Okay. Alright, let's go ahead and go back to the motion for the cystic fibrosis agents.

Leah Marcotte: This is Leah Marcotte. I move that all products in the respiratory agents: cystic fibrosis agents drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. products from this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Jordan Storhaug: This is Jordan Storhaug. I second.

Ginni Buccola: This is Ginni Buccola. All those in favor please say aye.

All: Aye.

Ginni Buccola: Any opposed? And the motion carries. Thanks, committee. So, now, we will go back to Umang for anticoagulants and thrombin inhibitors.

Umang Patel: Okay, alright. So the next class here we have will be the anticoagulants. This is specific for the HCA subclass Factor Xa and thrombin inhibitors. To give a little bit of background, in terms of VTE or venous thromboembolism, it manifests as a DVT or pulmonary embolism, and then a major consequence of various surgical

procedures and medical condition. It occurs when a thrombus of cellular material binds together with fibrin strands forms in the deep venous portion of the extremities, most commonly the legs. The exact number of patients impacted by DVT and PE is unknown but it is estimated that these conditions affect that between 300 and 600,000 Americans every year. If it's left untreated, approximately 30% of patients who develop PE will die within the first few hours of the event. Generally the risk of VTE increases with the number of risk factors present, such as major trauma and age, and due to the risk of morbidity and fatal PE associated with DVT prophylaxis has become the standard of care for patients at high risk for thrombosis. Now CAD or coronary artery disease and PAD, peripheral artery disease has approximately 14 million Americans for CAD and 8.5 million over the age of 40 have PAD. Prevention and treatment of atherosclerosis focuses on modifiable risk factors. Therapy includes lifestyle changes and medical treatment of hypertension, hyperlipidemia and diabetes, antiplatelet medication such as aspirin, clopidogrel, prasugrel, ticagrelor, or vorapaxar are indicated for the reduction of thrombotic CV events in patients with established CAD or PAD. On the next slide here to pivot over to aphid, atrial fibrillation is a common arrhythmia ranging in prevalence in two percent in patients under 65 years of age to nine percent for those 65 or older. The prevalence is higher in men than women and increases with age. More than a third of patients with A Fib are 80 years of age or older. Patients can have reduction in cardiac output resulting in cooling of the blood, atrial thrombus formation, and potential systemic embolization. Ischemic stroke is the most frequent clinical manifestation of A Fib associated embolization and A Fib increases the risk of stroke five-fold. In patients with A Fib, ACP recommends measuring thromboembolism risk using the CHADS 2 VASc score, which considers risk factors such as gender, age, history of stroke, transit ischemia attack, thromboembolism, as well as a history of CHF, hypertension, diabetes, or vascular disease, defined as prior Mis, PAD, or aortic plaque. And this score ranges from zero to nine, where the higher numbers indicate higher risk. On the next slide here, we do have some guideline updates. According to the AHA and ACC last year in 2020, they published guidelines on the diagnosis of treatment of hypertrophic cardiomyopathy. Notable pharmacological recommendations include the following: for symptomatic patients with left ventricular outflow tract obstruction, non-vasodilating beta blockers are recommended but alternatives for select patients can

include verapamil, diltiazem disopyramide. For non-obstructive hypertrophic cardiomyopathy with preserved left ventricular ejection fraction, beta blockers Verapamil or diltiazem are recommended and consideration of anticoagulants as the default treatment option for patients who also have A Fib independent of the CHAD2VASc score. And additional guidance on the use of antiarrhythmic therapy and heart failure agents was included in this update as well. Since we're focusing on that coagulants I didn't want to go into the weeds on that. And secondly, the ACC, the American College of Cardiology last year published an expert consensus decision pathway on managing bleeding episodes in patients taking oral anticoagulants. It updates part of the 2017 guidelines and it provides guidance on temporary or permanent interruption of therapy, general approaches to bleeding management, decision support for treatment with reversal agents, and indications and timing for reinstituting anticoag treatment. It does not recommend routine administration of platelets for patients on antiplatelet agents for major bleeding and they do not recommend routine oral anticoagulant reversal for non-major bleeding. But clinicians may interrupt therapy until the patient is clinically stable and hemostasis is achieved. The next and final slide for the updated information on anticoagulants. One, there is a discontinuation for Bevyxxa. By May 2020, the FDA reported Portola Pharmaceuticals will be discontinuing the Bevyxxa capsules in the strength of 40 milligrams and 80 milligrams. And there is a new generic that came out last year in January 2024, Apixaban. And this was the generic of Eliquis from Mylan and Micro Labs. Any questions?

Ginni Buccola: Thanks, Umang. If there are no questions, we have one stakeholder, Piao Ching with Pfizer.

Piao Ching: Good morning. My name is Piao Ching. I'm a pharmacist with our Pfizer medical affairs team. I'm here to provide medical information about a Apixaban or Eliquis in support of Pfizer's request to [indistinct] Apixaban on formulary. As detailed in the prescribing information, Apixaban is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation, prophylaxis, and treatment of deep vein thrombosis and pulmonary embolism. There is a box warning for premature discontinuation of any oral anticoagulant, which increases the risk of thrombotic events and spinal or epidural hematoma. The most common and most

serious adverse reactions reported with Apixaban were related to bleeding. The Apixaban for reduction in stroke and other [indistinct] embolic events study was the clinical trial that garnered the FDA [indistinct] approval. Apixaban was found to be superior in reducing stroke and systemic embolism and had fewer major bleeds than warfarin. It is the only direct oral anticoagulant in this space that has shown superiority. The other agents have shown non inferiority to warfarin. Apixaban has demonstrated continued efficacy and safety in other retrospective analysis. In closing, I urge you to maintain Apixaban on formulary given its consistency in efficacy and safety reward data. Thank you for your attention and I'll be happy to respond to any questions you may have.

Ginni Buccola: Thank you, Piao. Are there any questions from the committee? Okay, then we will go ahead and go to the motion on anticoagulants.

Catherine Brown: This is Catherine Brown. I move that all products listed in the anticoagulants: Factor Xa and thrombin inhibitors oral drug class are considered safe and efficacious for the medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Nancy Lee: This is Nancy. I second that motion.

Ginni Buccola: This is Ginni. All those in favor please say aye.

All: Aye.

Ginni Buccola: Any opposed? And the motion carries. And we will move on to antidiabetics. Back to you, Umang.

Umang Patel: Perfect, thank you. So similar to cystic fibrosis clinically, these next few subtopics and I assume separate motions are bundled together for clinical relevance. So I will present antidiabetics as a whole. And this includes the Amylin Analogs SGLT2 inhibitors, DPP4, and DPP4

SGLT2 inhibitor combos, DPP four and TZD combos, GLP1 and GLP1 insulin combos as well. Please note, not all of these sub classes have updates. But since it is as a whole, I'm just going to go through all antidiabetic agents that had clinical updates or relevancy in the last year. Alrighty, so on the next slide here, to take a step back into the disease state, for diabetes mellitus, it's estimated that over 34 million Americans have diabetes, of which 90 to 95% have type two and it's responsible for increased morbidity and mortality. Adequate glycemic control is crucial to minimize chronic microvascular and macrovascular complications. Microvascular is defined as blindness, renal dysfunction and macro is things such as CVD. Exogenous insulin supplements deficient levels of endogenous insulin and temporarily restores the body's ability to properly utilize carbs, fats, and proteins. Multiple insulin products are available and are used as replacement therapy and the management of both type one and type two diabetes when glycemic goals are not met with oral antidiabetic agents. In addition to exogamous insulin, there are several pathways by which blood glucose may be regulated. The SGLT2 inhibitors for the first subclass here reduce renal glucose reabsorption in the proximal convoluted tubule, leading to increased urinary glucose excretion. On the next slide here, we do have the Endocrine Society 2019. They released essentially recommendations for diabetes in patients 65 years of age or older. They recommend simplified outpatient medication regimens and glycemic targets tailored to improve compliance and prevent complications such as hypoglycemia and falls, particularly in patients with cognitive impairment. First line very similar to the other guidelines you'll see is lifestyle modification. When pharmacological therapy is indicated, metformin and additional lifestyle management is recommended. If the glycemic targets, again, are not attained after that, then oral and injectable therapies with low risk of hypoglycemia are suggested. The guidelines recommend management of common comorbidities in the patient including things like hypertension, hyperlipidemia, CHF, retinopathy, neuropathy, and CKD. And additionally, a SGLT2 inhibitors have been shown to reduce major adverse cardiovascular events, heart failure, and progression of CKD. Consequently, they should be prescribed early in the treatment and due to adverse effects related to volume depletion with canagliflozin, doses should be limited to 100 milligrams per day in the susceptible patients defined as the elderly. On the next slide, two new guideline updates from last year. The ACC published an expert

consensus decision pathway for CV risk reduction in patients with type two diabetes. They identify opportunities to initiate an SGLT2 inhibitor or a GLP1 agonist with demonstrated CV or renal benefits in patients with type two. A medication from either class may be initiated in any patient and ASCVD at the time of diagnosis of type two or ASCVD of any time after diagnosis, including at hospital discharge. An agent from either class can also be started in patients with type two diabetes without established ASCVD risk score but are at high risk for said ASCVD. In addition, initiation of an SGLT2 inhibitor with demonstrated CV or renal benefit is recommended in patients with heart failure and/or diabetic kidney disease and a GLP1 agonist is an alternative in patients with a GFR of less than 30 mils per minute. The KDIGO last year published its first guidelines on managing diabetes in patients with CKD. Key recommendations included patients with diabetes, hypertension, and albuminuria should be started with an ACE inhibitor or an ARB and monitor glycemic control using an A1C in patients with diabetes and CKD. The target A1C should be less than 6.5% to less than 8% in those not on dialysis, depending on their risk for hypoglycemia. Metformin and SGLT2 inhibitors are recommended in patients with a GFR greater than or equal to 30. And if glycemic targets are not met then of GLP1 agonist is recommended. On the next slide, ADA also updated last year in 2020. They updated select sections of their living standards of medical care and diabetes. For diabetes technology and automated insulin delivery systems should be considered in adults with type one who have the skills to use the device in order to improve the time and range and reduce A1C and hypoglycemia. These systems may also be useful to help improve glycemia in children. Regarding obesity management, ADA states that lorcaserin should no longer be used as the FDA requested its market withdrawal. For pharmacological type two diabetes therapy, the guidelines advice to interrupt a SLT2 inhibitor therapy before scheduled surgery to avoid ketoacidosis, and this aligns with label revisions as well in said PIs. And lastly, for management of CVD in patients with type two, the guidelines recommend to consider an SGLT2 inhibitor in patients with heart failure with reduced ejection fraction to reduce the risk of worsening heart failure and CV death. Okay, on the next slide, we have our first medication update. So for Invokamet and Invokamet XR, in January 2020, the FDA approved a new indication to reduce the risk of end stage kidney disease, doubling of serum creatinine, cardiovascular death, and

hospitalization for heart failure in adults with type two diabetes and diabetic neuropathy with albuminuria of greater than 300 mgs per day. Previously, this was only approved to reduce the risk of MACE and as an adjunct to diet and exercise to improve glycemic control in type two diabetes. In August 2020, the FDA issued a drug safety communication to update an earlier communication regarding the risk of leg and foot amputations with canagliflozin containing medications. The update states that based on review of data from three new clinical trials, they have removed the box warning language from PIs of canagliflozin containing medications and the risk of amputation remains a warning in the label. I know there's a lot on this slide. As I mentioned earlier to the committee, I've only tried to bold the updated information for this medication. And just an FYI, in case anyone's wondering why August 2020 is in a different font, that is a hyperlink. So if anyone wanted to see the FDA drug safety communication, you can just click on the hyperlink in the text and it'll take you there. On the next slide here we have for Farxiga. In May 2020, FDA approved a new indication to reduce the risk of CV death and hospitalization for heart failure in adults with heart failure with a reduced ejection fraction defined as an NYHA class two through four. As you can see, it already had other indications for type two diabetes but since this kind of bundles together, I felt it prudent to present it here. Everything else has remained the same, dosing, precautions, formulations as well. Excuse me, dosing, there's a heart failure dosing of 10 mgs per day. Otherwise everything else remains the same. On the next slide, here, we have Trijardy XR. This is a triple combination as you can see. In January 2020, FDA approved this medication. It's a combination of an SGLT2 inhibitor empagliflozin, a DPP4 inhibitor, linagliptin, and metformin, which is a biguanide as an adjunct to diet and exercise to improve glycemic control in adults with type two diabetes. The limitation here is it is not recommended for patients with type one or for the treatment of diabetic ketoacidosis and it has not been studied in patients with a history of pancreatitis. There are black box warnings, as you can tell, since Metformin is one of the triple combos in there. There's post-marketing cases of lactic acidosis with Metformin. So clinicians do need to keep an eye on that along with lactic acidosis. Again, Metformin. The dosing is individualized based on the patient's current regimen. And as you can see, there are various tablet formations in differing strengths here. Okay, on the next slide, here we have Ozempic semaglutide. So in December 2019, FDA

approved a new formulation of a new pen injector that incorporates a three millimeter cartridge and is designed to deliver four doses of one milligram of Ozempic. And in January 2020, FDA approved a new indication to reduce the risk of major adverse CV events or MACE defined as CV death, non-fatal MI, or non-fatal stroke in adults with diabetes and established CV disease. As you can see, it already had a second indication. Otherwise, the dosing and black box warnings remain the same for this GLP1 specific black box warning and the formulation that was updated now to have it be a single use pen that delivers a one milligram dose per injection as well. On the next slide here for Trulicity, in February 2020, FDA approved the new indication for the reduction in MACE as well, in adults who have type two diabetes with established CV disease or multiple CV risk factors. It already has, as you can see, an indication for type two diabetes and similar limitations of use, we saw earlier, have not been studied in patients with history of pancreatitis, not for treatment of type one diabetes or diabetic ketoacidosis, and it is not for patients with preexisting severe GI disease. Dosing precautions, black box warnings, and formulations all remained the same, just that added indication there. Okay, on the next slide here we have Saxenda and this is an expansion. So in December 2020, the FDA approved this medication for pediatric patients 12 years of age or older or 60 kilograms or greater, and have an initial BMI corresponding to 30 kilograms per meter square for adults which is classified as obese according to the BMI calculation by international cutoff. Previously, this medication was only in adults. And so essentially this is indicated as an adjunct to reduced calorie diet and increased physical activity for chronic weight management here. The dosing as you can see, is an injection and it is .6 mgs per day for one week in weekly intervals. There are similar black box warnings just like all other GLP1 agonists. And then the formulation is an injection. Now in terms of renal and hepatic impairment for this for special populations, there is limited experience in patients with mild, moderate, or severe renal and hepatic impairment. On the next and final slide for this diabetic medication treatment class, there was an FDA communication. Again, the hyperlink is in the text. The FDA issued a communication stating that Januvia, Janumet, and Janumet XR are not proven to improve glycemic control and patients 10 to 17 years of age with type two diabetes. And this was based on results of three clinical trials that did not demonstrate an improvement in A1C and labeling was updated

accordingly. That is all I have for that class. I can pause there. The next subclass is insulin and so I can take any questions from the committee and Leta, I can pause here as the committee was going to vote on this class.

Ginni Buccola: This is Ginni, Umang. I wonder, we have stakeholders for this class, but we don't for the next class. My indication would be to go ahead and have you review the anti-diabetic insulin slides and then to do the two motions back to back.

Leta Evaskus: This is Leta. I'm fine with that if that's how you want to do it.

Ginni Buccola: Since you paused, are there any questions from the committee from Umang about the content that he just reviewed? Okay. Alright, Umang, I'll turn it back.

Umang Patel: Perfect, thank you. Okay, so next we'll pivot a little bit over to insulin. Again, I'm not going to go over background or anything like that since it all encompasses under here. There were some FDA announcements that I did want to bring to the committee's attention. So again, hyperlinks are in the text if anyone in the committee wants to have direct access. But in December 2019, the FDA published a statement regarding the pathway for approval of chemically synthesized polypeptides. In March 2020, the majority of the protein products will have the potential for biosimilar and interchangeable products to increase competition through FDA approval under abbreviated pathways. However, products that are deemed "chemically synthesize polypeptides" are not eligible for abbreviated approval pathways utilized for biosimilar or interchangeable products. And the statement addresses how removal of this exclusion would allow for chemically synthesized follow-on insulins and other products to become approved through this abbreviated pathway. In March 2020, as part of the biosimilars action plan, FDA announced that insulin and certain other biologic products have transitioned to a different regulatory pathway as of March 23, 2020. And in October 2020, FDA issued a communication to clarify the intent of the November 2019 revisions to labeling for insulin pens, which state that healthcare practitioners should dispense the pens to a single patient in the original sealed carton. Insulin pens are not labeled for dispensing as individual units because sealed cartons of insulin pens are intended to be dispensed to

a single patient. Each carton contains a single copy of the drug's PI and instructions for use. FDA strongly encouraged insulin pen manufacturers to consider developing smaller carton sizes to better accommodate variable insulin doses. And the FDA suggests organizations facing challenges with multiple pen cartons contact the manufacturer to express the need for smaller and single pen carton sizes. In April 2020, Lilly announced the launch of a new authorized generic for Humalog, Junior KwikPen. which is insulin lispro injection, 100 units per ml. Okay, on the next slide here, first medication we'll pivot over to is Fiasp insulin aspart injection. So in January 2020, the FDA expanded the approval for improving glycemic control in patients with diabetes to include pediatric patients, including for the use as continuous subcutaneous insulin infusion, previously only approved in adults. Everything else remains the same. As you can imagine, with insulin dosing is very individualized. Precautions and contraindications for all the classes of insulin will be similar, hypokalemia, never to share prefilled pens, and contraindications with episodes of hypoglycemia, as one can imagine. On the next slide here, we have a new medication, Lyumjev. I apologize if I pronounced that incorrectly. In June 2020, FDA approved this rapid acting human insulin analogue indicated to improve glycemic control in adults with diabetes. Dosing, again, very individualized. For subcutaneous injection, it is recommended to administer at the start of the meal or within 20 minutes after in adipose tissue. And for IV, it can only be administered under medical attention, supervision as one can imagine. Identical precautions and contraindications and as you can see for the formulations, they are multi dose vials and KwikPens as well. On the next slide here, in April 2020, Lilly announced the launch of a new authorized generic for the Humalog Mix 7525 combo KwikPen as well. Next slide here we'll go to Basaglar. And so in December 2019, FDA approved the expanded formulation of the addition of a modified prefilled insulin pen that can be used with connected devices, mobile applications, or other technology. And this will be a three milliliter single patient use Basaglar Tempo Pen. And essentially, it's able to be connected to high tech at this point. Nothing else has really changed. Everything else in the PI remains the same. Next slide here we have Toujeo, Solostar, and Max Solostar. In December 2019, the FDA expanded indication include pediatric age six to 17 years of age with diabetes mellitus. Previously it was just adults. But again, nothing else was changed here. On the next and final

slide, we have Semglee. So in June 2020, FDA approved Semglee under the 505b2 NDA pathway and is now deemed a biologic. And it is a long acting human insulin analogue indicated to improve glycemic control in adult and pediatric patients with type one diabetes and adults with type two diabetes. So, again, limitations for insulins for this specific one, it is not recommended for treating diabetic ketoacidosis. The dosing is very individualized. Precautions contraindications are identical and the formulation is available with a 10 milliliter multi dose vial or a three mil single patient use prefilled pen. That is all I have for the insulins. Any questions I can take from the committee?

Ginni Buccola: This is Ginni. Thanks again, Umang. Committee members, questions? Okay, so we're moving back to our prior category of antidiabetics to hear from our stakeholders. I have two listed and then I have seen a message from Shawna Purcell asking to be a third stakeholder. So Shawna, just so you know that I see your name there. But we will be hearing from Anthony Wheeler with Eli Lily, Mark Maneval from Boehringer Ingelheim Pharmaceutical, and then Shawna Purcell. So we can start by going to Anthony. Anthony, can you hear me? Are you unmuted?

Anthony Wheeler: Yes, I can. How's my microphone?

Ginni Buccola: It's good. So if you can just let us know your name, your affiliation, and then you'll have three minutes to speak. Thanks.

Anthony Wheeler: Okay. Thank you. I'm Anthony Wheeler and I'm an employee of Eli Lily and Company, which manufactures Trulicity. This is also known as dulaglutide and it's part of the GLP1 receptor agonist class of drugs. This was originally approved about six years ago as an adjunct to diet and exercise to improve glycemic control in adults with type two diabetes. There's a new indication that was received last year which Umang mentioned. This is to reduce cardiovascular events in adults with type two diabetes who have established cardiovascular disease or multiple cardiovascular risk factors. And the one other update I wanted to provide to you that is new since your last review of Trulicity is the approval of two new doses. This drug has originally been available as a 0.75 or 1.5 milligram dose once per week. And Trulicity is now also available as a three milligram or a 4.5 milligram dose, again, once per week. And it's for additional glycemic control.

These doses were studied in a trial called [indistinct] 11 where the 4.5 milligram dose demonstrated superiority to the 1.5 milligram dose in terms of A1C change and weight change from baseline. And the new doses are still delivered using the same single dose pen device which has a hidden, pre-attached needle inside and there's no mixing or reconstitution necessary to use it. So thanks for letting me come provide these updates. And I'm happy to try to answer any questions if you have them.

Ginni Buccola: Thank you very much, Anthony. Any questions committee members? Okay, we'll move next to Mark Maneval. Are you there?

Mark Maneval: Hi, good morning. Can you hear me?

Ginni Buccola: I can hear you. Yeah. Just introduce yourself and your affiliation and you'll have three minutes to share with us. Thanks.

Mark Maneval: Great. Thank you. My name is Mark Mandeville. I'm a pharmacist and health economics and outcomes research liaison for Behringer Ingelheim. I'm sharing information with you today related to our SGLT2 two inhibitor Jardiance. Jardiance is currently indicated to reduce the risk of cardiovascular death in adults with type two diabetes and established cardiovascular disease, and as an adjunct to diet and exercise to improve glycemic control in adults with type two diabetes. In placebo controlled randomized clinical trials and in non-inferiority trials in adult patients with type two diabetes, treatment with Jardiance reduced A1c compared with placebo, with the lower A1C observed across subgroups, including in the presence of mild to moderate renal impairment. Jardiance has demonstrated statistically significant reductions in A1C as both mono therapy and as add on therapy. In our [indistinct] outcome trial, a randomized, double blind parallel group study comparing the risk of experiencing a major adverse cardiovascular event between Jardiance and placebo when these were added to standard of care for adults with type two diabetes and established cardiovascular disease, Jardiance significantly reduced the risk of a major adverse cardiac event. The treatment effect was driven by a significant 38% reduction in the risk of cardiovascular death in subjects randomized to the 10 milligram and 25 milligram doses of Jardiance. Peer reviewed manuscripts have been published recently showing the effects of Jardiance on risk of

hospitalization for heart failure, worsening heart failure, and mortality among patients with and without type two diabetes. Regarding safety in clinical trials, genital mycotic infections and increased urination were seeing more frequently in Jardiance versus placebo. SGLT 2 inhibitors can cause intravascular volume contraction, renal impairment, and symptomatic hypotension. However, in clinical trials of Jardiance versus placebo, volume depletion occurred with the same frequency in the two groups. Jardiance is not recommended during pregnancy or while breastfeeding. We have a robust clinical trial pipeline investigating Jardiance in other disease states and we continue to gather real world evidence to quantify the clinical and economic outcomes associated with Jardiance across those disease states. Thank you for your time and I and my team are here to answer any questions you may have.

Ginni Buccola: Thank you, Mark. Committee members, do you have any questions? Okay, we'll go next to Shawna Purcell. Shauna, are you unmuted?

Shawna Purcell: Hi, good morning. Thank you so much for having me. I'm Dr. Shawna Purcell and I have been treating type two diabetes exclusively for over a decade. And so I really wanted to bring to everybody's attention and add on to what Anthony had to say in regards to --

Ginni Buccola: Dr. Purcell? I'm sorry. Could you just share your affiliation? And then I'll start your time. I'm sorry, I didn't get that in before you started talking.

Shawna Purcell: Oh, yes, I'm a private physician in the community. And so I have a diabetes type one and type two clinic. And that's basically my affiliation. So I really wanted to just bring forth more information regarding specifically Trulicity as the GLP1 receptor agonist and then the impact that I've seen over now six years using this medication. So I appreciate Anthony's comments. Thank you. I wanted to just really bring out the two higher doses, as Anthony was saying, of Trulicity, 3.0 milligrams once a week and 4.5. That has added to the arsenal of the original .75 and 1.5 that we had for about five and a half years. Also in the GLP1 receptor agonist class, Trulicity is really coming far ahead of, for example, liraglutide and Ozempic. The recent rewind Trulicity primary prevention cardiovascular outcomes trial is important to look at. It literally reduces cardiovascular risk in primary

prevention population. So these are patients with diabetes and did not have known cardiovascular disease by 12% risk reduction, which brings it further along than the other GLP1 receptor agonists because it's the only one that has primary prevention as well as secondary prevention. So if we looked at the other cardiovascular outcomes trials, for example, with [indistinct] and Victoza and Ozempic and sustain, those to only have secondary prevention. And I really just want to make it clear that the ADA also suggests that after diet and exercise with A1C and a cardiovascular indication, GLP1 receptor agonists are the next line. And Trulicity with its now four doses is going to be a great add on for all of our Medicaid and Medicare patients to get better efficacy for A1C reduction. And also, we were seeing some weight changes as well. The presentation showed a lot of SGLT2, which is excellent. And all of the data that was just presented is great as far as cardiovascular and heart failure. And so those two classes really need to be emphasized. But I believe that emphasizing specific drugs such as Trulicity for the cardiovascular outcomes, trials that we have, primary prevention and secondary prevention, as well as four doses. The two higher doses, that three and 4.5 milligrams once a week is really making a huge impact on our type two diabetics in changing their lives, also decreasing their A1C and their further complications, which in the long run is going to help all of our type two diabetics. So I really want to just make sure that the information is updated. And I have a ton of experience with this. I also speak for Trulicity as well. And I would be happy to share all of my clinical data that I have at a personal level with my clinic and my patient experience. It's been wonderful. So thank you for having me. I really appreciate being a part of this wonderful conversation.

Ginni Buccola: Thank you. Committee members, any questions for Dr. Purcell? Okay, so we will then go to our two motions, the first are the antidiabetics, the amylin analogs, et cetera. And then the second motion will be insulin.

Constance Huynh: This is Constance Huynh. I move that all products listed in the drug classes on slide nine are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of two preferred products with

the same indication before a non-preferred drug will be authorized unless contraindicated or not clinically appropriate.

Leah Marcotte: This is Leah Marcotte. I second that motion.

Ginni Buccola: This is Ginni Buccola. All those in favor please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. We'll move to the next motion.

Nancy Lee: This is Nancy. I move that all products listed in the drug classes on slide 12 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require trial of two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated or not clinically appropriate.

Alex Park: This is Alex Park. I second that motion.

Ginni Buccola: This is Ginni Buccola. All those in favor please say aye.

All: Aye.

Ginni Buccola: Any opposed? The motion carries. And we will go back to Umang for endocrine and metabolic agents.

Umang Patel: Alrighty. So the next topic, we have our growth hormone releasing hormones for endocrine and metabolic agents. Here we see growth hormone and sensitivity or insulin like growth factor one, IGF-1 deficiency refers to a variety of disorders characterized by the resistance of growth hormone. It can be defined by deficiency in the production of growth hormone or the peripheral action of the IGF-1 on linear growth. Severe deficiency is due to mutation of the growth hormone receptor or post growth hormone receptor signaling. It is also characterized by the development of growth hormone in activating antibodies in pediatric patients with growth hormone gene

deletion. Patients are considered to have severe primary IGF-1 deficiency when the following criteria are met: height standard deviation score less than or equal to negative three, basal IGF-1 standard deviation score less than or equal to negative three and normal or elevated growth hormone. Now with HIV lipodystrophy, soon after combination antiretroviral therapies was found effective in treating HIV infected patients. Adverse side effects from the medications were reported including metabolic changes, morphological abnormalities, and lipodystrophy. It is found in patients on highly active antiretroviral therapy. Patients with HIV lipodystrophy were described as having loss of subcutaneous fat and limb space and buttocks and an accumulation of fat in other areas of the body including the abdominal viscera. In patients who have increased abdominal viscera and waist circumference are at an increased risk for metabolic syndrome, CV disease, or atherosclerosis in diabetes. On the next slide here, continuing on, kind of pivoting to guidelines, for severe IGF-1 deficiency growth hormone gene deletion, Increlex is the only available product approved for the indication of long term treatment of growth failure in pediatric patients with severe primary IGF-1 deficiency or with growth hormone gene deletion with development of neutralizing antibodies to growth hormone. Patients with a diagnosis that are not growth hormone deficient and will not respond well to exogenous growth hormone. And likewise, Increlex should not be used as a substitute for patients who require growth hormone therapy. It should not be used in patients with secondary forms of IGF-1 deficiency and all thyroid and nutritional issues should be corrected prior to initiating therapy and it should not be used for weight loss management. Now pivoting to HIV lipodystrophy, recombinant human growth hormone has been used with success in patients with AIDS related wasting syndrome since it has been shown to improve muscle mass. However, studies have shown that recombinant human growth hormone causes a reduction in visceral adiposity but super physiological levels of IGF-1 and symptoms of excessive growth hormone occurred causing treatment cessation. Egrifta offers a specific treatment option for the reduction of excessive abdominal fat in HIV patients with lipodystrophy as it appears to target the visceral fat compartments with little effect on subcutaneous fat or fat in the limb. The final slide here in this class, in terms of updates, there is a discontinuation. So for Egrifta in May 2020, brand name product Egrifta is being discontinued by the

manufacturer, which is Theratechnologies, and it's being replaced with a new smaller volume formulation Egrifta SV, which became available in December 2019 and can be stored at room temperature. And Egrifta was not available as of June 15, 2020. Go ahead and pause there for the committee.

Leta Evaskus: This is Leta Evaskus. I see that there is only one motion for both of these growth hormone categories. So we can stop for committee questions, but then I'll have Umang go through the next presentation before we do our stakeholders.

Ginni Buccola: Okay, thanks, Leta.

Umang Patel: Okay, if there's no questions, I'll march onward. And then Magellan has these classes separated and that's kind of why I've broken these out. So in the next slide for human growth hormone for somatropin, it is a 191 amino acid polypeptide hormone secreted by the anterior pituitary gland. It has important metabolic effects including stimulation of protein synthesis and cellular uptake of amino acids. Short stature and growth deceleration are common pediatric concerns and exogenous growth hormone is used to treat a variety of disorders in which endogenous growth hormone isn't sufficient to meet the needs of the patient. Growth hormone deficiency results from inadequate production of growth hormone and can produce various medical conditions depending on age. It can be congenital or acquired in childhood or adult life in addition to being partial or complete. Infancy and childhood growth failure may be the major effect. Adults with growth hormone deficiency may have diminished lean body mass, poor bone density, and a number of physical and psychological manifestations. It is usually permanent and maybe an isolated deficiency or it could occur in association with deficiencies of other pituitary hormones. And between 40 and 50% of childhood cancer survivors develop an endocrine disorder during their lifetime, with some developing decades following cancer treatment. According to the AACE Growth Hormone Taskforce in 2019, they do not advocate use of one product over another but they do recommend using individualized dose adjustments to improve effectiveness and minimize side effects. In terms of updates, there's a discontinuation for Humatrope. In July 2020, on the next slide, Eli Lilly reported to the FDA plan to discontinue one presentation of Humatrope. And that's

the five mg kit. There are specific NDC numbers here for the committee members' reference. And distribution will continue until the end of December 2020. Other Humatrope presentations will continue to be available. On the next and final slide here for growth hormones, in August 2020, FDA approved Sogroya, a human growth hormone analog indicator for the replacement of endogenous growth hormone in adults with growth hormone deficiency. In terms of precautions and indications, there is an increased risk of neoplasms. There are risks of malignancy progression in patients with active malignancy and of malignant changes of preexisting conditions. Monitor patients with preexisting tumors for progression or recurrence. In terms of glucose intolerance and diabetes, they may decrease insulin sensitivity, particularly at higher doses. And as we just pivoted from the diabetes section that can lead to diabetes. And it is contraindicated in patients with acute critical illness and/or patients with active malignancy. As you can see there dosing instructions here and the formulations are in injection form in a single patient use of prefilled syringe. In terms of special populations, there is no available data for pregnancy. And there is hepatic and renal impairment dose adjustment for moderate hepatic impairment. And it is not recommended in severe hepatic impairment. So that is all I have for this subsection of growth hormones. Again, I'll pause here for the PNT committee members.

Ginni Buccola: Thanks, Umang. Just a point of clarification, this is most probably for Leta, Leta, did you want us to go all the way through GI agents before we do all the motions? or shall we go back to stakeholder?

Leta Evaskus: No. that will be a separate motion.

Ginni Buccola: Okay. Alright. So we'll go then to our stakeholder PR Piao Ching with Pfizer. Piao, are you unmuted?

Piao Ching: Yes, Ginni. Thank you again for this opportunity. My name is Piao Ching. I'm a pharmacist with Pfizer medical affairs team. I'm here to provide medical information about Genotropin in support of Pfizer request to retain Genotropin on formulary. As mentioned earlier, Genotropin is a recombinant human growth hormone indicator for treatment of children with growth failure due to growth hormone deficiency. It is also indicated for [indistinct] syndrome, small for

gestational age, Turner Syndrome, idiopathic short stature, and treatment of adults with adult onset or child onset growth hormone deficiency. Genotropin is contraindicated in patients with acute critical units, children with [indistinct] syndrome, who are severely obese, or have severe respiratory impairment, active malignancy and hypersensitivity to somatropin. Pfizer international growth database and Pfizer international metabolic database are the largest patient databases available for patients with growth hormone disorder. Pfizer international growth database has collected data on 83,000 children and Pfizer international metabolic database has data on 16,000 adults. Data in with patients from 30 to 50 countries and has generated over 100 publications. Longitudinal analysis of Pfizer international growth database found increases in the proportion of patients in a normal weight range after growth hormone treatment. Genotropin also offers patient support with the Pfizer Bridge Program. The program provides comprehensive personalized patient support, including benefit verification, device training, and telephone support 24/7. In closing, Genotropin offers a wide range of indications and the Patient Support Program for Pfizer Bridge. With over 20 years of experience with Genotropin, we are committed to growth hormone rare diseases and urge you to retain Genotropin on formulary. I'll be happy to respond to any questions you may have. Thank you.

Ginni Buccola: Thank you. Any questions from the committee? Okay, so we'll take a look at those two motions.

Leta Evaskus: And this is Leta. It's actually one motion.

Ginni Buccola: One motion. Thanks, Leta.

Susan Flatebo: This is Susan Flatebo. I move that all products in the drug classes on slide 15 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. Non-preferred products require a trial of two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Constance Huynh: This is Constance Huynh. I second.

Ginni Buccola: This is Ginni Buccola. All those in favor please say aye.

All: Aye.

Ginni Buccola: Any opposed? The motion carries. Thanks committee. We'll go back to Umang for GI agents, Inflammatory Bowel agents.

Umang Patel: Perfect. For the next and final class here we have Inflammatory Bowel agents. A little bit of background, ulcerative colitis is a chronic inflammatory disease, primarily affecting the colon and rectum. It affects approximately a million people in the United States and the incidence continues to increase worldwide. The CDC estimates the current prevalence is at 238 per 100,000 adults. It may present at any age, but onset typically peaks between 15 and 30 years of age, and the disease is characterized by superficial infiltrates of the bowel wall by inflammatory white cells resulting in multiple mucosal alterations and crypt abscesses. The predominant symptoms is diarrhea, which is usually associated with blood in the stool. Additional symptoms may include pain in the lower quadrant of the rectum along with systemic features including fever, malaise, and weight loss, which are more common if a greater portion of the colon is affected. The initial attack may be fulminant with bloody diarrhea but the disease more commonly begins indolently and non-bloody diarrhea progressing to bloody diarrhea. It can present initially with any extent of anatomic involvement ranging from disease confined to the rectum, to the entire large intestine, and that's called pancolitis. And most commonly, ulcerative colitis follows a chronic intermittent course with long periods of quiescence interspersed with acute attacks lasting weeks to months. However, a significant percentage of patients suffer a chronic continuous course. On the next slide here we have an update to guidelines, first being by the AGA, the American Gastroenterology Association last year. I tried breaking it down so for moderate to severe ulcerative colitis, they consider patients with moderate to severe to be those who are dependent on or refractory to corticosteroids, exhibit ulcers upon endoscopic assessment, or are at high risk for colectomy. Long term management can include medications of the following classes: TNF alpha antagonists, immunomodulators. If the agents selected for inducing remission is

effective, it is usually continued as maintenance therapy. The exception to this would be when corticosteroids or cyclosporin are used for induction of remission. The following agents are recommended over no treatment for adult patients with moderate to severe ulcerative colitis listed in order of FDA approval. And we have infliximab, adalimumab, golimumab, vedolizumab, tofacitinib, or ustekinumab. In patients who are biologic naive, infliximab, or vedolizumab are suggested rather than adalimumab for induction of remission. However, patients with less severe disease who value the convenience of self-administration over the relative efficacy of therapy may select adalimumab instead. For induction of remission, thiopurine monotherapy suggested against use. However, it is suggested over no treatment for maintaining remission. In methotrexate monotherapy is suggested against use for induction as well as maintenance of remission. The combination of TNF alpha antagonists is suggested with thiopurines or methotrexate over biologic monotherapy or thiopurine monotherapy. Early use of biologics with or without immunomodulator therapy is suggested rather than gradual step up to these agents following failure of 5-ASA. And additional recommendations for adult outpatients with moderate to severe ulcerative colitis are provided regarding the use of tofacitinib and management of non-responders to infliximab. For patients who achieve remission with biologic agents and/or immunomodulators or tofacitinib, it is suggested against continuing 5-ASA for induction and maintenance of remission. On the next slide here, the AGA 2019 guidelines, I essentially tried to highlight or underline the main points here. For mild to moderate ulcerative colitis the guidelines recommend starting standard dose of mesalamine for induction and maintenance. High dose oral mesalamine combined with rectal 5-ASA may be required for patients with sub optimal response to standard dose therapy or those with moderate or extensive disease. Oral prednisone or budesonide may be added in those refractory. Proctosigmoiditis or proctitis can be treated with topical mesalamine rather than 5-ASA. In patients with sub optimal response, or intolerance correct on the sounding rectal corticosteroids, such as an enema or foam may be used. Patients who do not respond adequately to therapies as outlined above may need to escalate to systemic corticosteroids, immunomodulators, or biologics. The guidelines make no recommendations regarding these probiotics, curcumin, and FMT. While they appear to be safe, their use could

delay initiation of proven efficacious treatments and potentially lead to worsening symptoms or complications. On the next slide here, I do have the final AAFP guidelines in 2013. Again, since this is about eight years old now, this is here just for the committee's reference for guidelines in this class. I will not go over these in detail. And that is it in terms of updates. I will pause here for any questions from the committee.

Ginni Buccola: Thanks, Umang. Committee members, any questions before we go to the motion? Okay, I guess we're ready to go take a look at that then Leta.

Diane Schwilke: This is Diane Schwilke. I move all products in gastrointestinal agents, inflammatory bowel agents drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of two preferred products at the same indication before nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Catherine Brown: Catherine Brown. I second.

Ginni Buccola: This is Ginni Buccola. All those in favor say aye.

All: Aye.

Ginni Buccola: Are there any opposed? Alright, the motion carries. It looks like we're scheduled for a break and it's 10:40. So would say, Leta, does it sound okay to be back at 10:50.

Leta Evaskus: Sounds great.

Ginni Buccola: Okay, thanks everybody.

[break]

[unrelated discussion]

Marissa Tabile: Okay, so the next part of the meeting will be going through the Apple Health PDL archived drug classes. So the last time we went through these archive drug classes was I think, in October of 2020. So it's been a couple of months since we've presented them. This is the first time that we will be presenting pretty much the majority of what we have left on the Apple Health PDL. So just to give some background, again, we do have the AH PDL fully implemented with over 430 something drug classes, which is a lot. So to help make the DUR board meetings more efficient, we have gone through the AH PDL and kind of went through and made decisions on which classes we would like to archive and which ones we would like for regular drug classes that we just did with Umang. Most if not all of the drug classes that we are presenting for archiving are pretty much composed largely of generic products. So there's not much change to them. So sometimes there'll be like one new product that's added to the class. But generally, these classes don't have very much change to them. So it's not like there's new products constantly being added to the class. So that's kind of one of the criteria that we use for archiving. We identified about roughly over 200 and I want to say maybe 80 or 90 drug classes, maybe give or takes that number that we are moving forward or presenting for archiving. So what the plan is, is for these archived drug classes that we will be presenting, we will just re-present them annually. And it won't really be an in depth review kind of what Umang does. It's going to be a really high level overview. And for the interest of time, we'll just kind of be going through any new products that might have come to the market that have been added to that class in the past two years. I do two years because we just fully implemented our AH PDL. Last year. So I'm trying to take into account the years of 2019 up until today. But moving forward, when I present the archived drug classes at future meetings, it'll just be classes or new products or changes that have occurred within the last year. So the process of how I figured out any updates to the classes or any updates to the product is I looked on the FDA drug safety communications. So checked the FDA website. I looked at manufacturer websites, any updates to their label, any press releases that manufacturers have released, and then also looked at drugs on the drugs at FDA website looked up. So I've done a search of new products seeing what has gone on with their application, how it got approved, why it got approved, and use that information to list them in updates for the archive drug classes. So feel free to stop me at any point if you have any questions. Like I said, this is going be a very

high level overview. It's not going to be in depth going into any guidelines. It's just any updates to the classes and new products that came out, any FDA warnings that I've seen, any expanded label indications to products that are already in the drug class. So I'll go ahead and get started. We have about, I think, 216 or 15 drug classes to go through. So just bear with me. Okay, so any drug classes that have had any updates I will be calling out specifically, but the ones that don't have any updates, you'll just see here listed on the slide. I'll have the drug class name listed and then no updates in red. So for the antibiotics, anti-infective agents, there's no updates. For the anti-depressant classes, we have the alpha two receptor antagonists, the MAOIs, the norepinephrine, dopamine reuptake inhibitors, the SSRIs, the SNRIs, serotonin modulators, and tricyclic agents all have no updates to them. I couldn't find any new products or any updates to the class in general. So I'll go ahead and leave that up there for just a couple of seconds for the committee to look over. Okay. And then moving on, so next we have the anti-diabetics. So the anti-diabetics, that alpha glucosidase inhibitors, there's no updates. But for the anti-diabetics biguanides, I thought this would just be worth mentioning, as far as there's been recalls of Metformin ER that have been released, recalls that the FDA has released due to NDMA impurities, and it varies from different manufacturers. So just wanted to put that on your radar if you're not already aware. But it's not really an update, just something I thought worth mentioning. For the anti-diabetics, diabetic other drug class, there were two new products that came to the market. So the first one is Baqsimi, which is a glucagon nasal powder. It was approved in July of 2019 and the formulation for that particular [indistinct] is a dry nasal spray and it's used for hypoglycemia. The next product is Gvoke, and that is a glucagon injection. And that came to the market or FDA approved September of 2019. And what makes this product different is that it's already a premix autoinjector and of course used for hypoglycemia. So those are two new products that came to the market in 2019 and they're both glucagon products. Next is the dopamine receptor agonist. There's no updates to that class. And for these drug classes here, we have the meglitinide analogues, sulfonylureas, thiazolidinediones, chelating agents, antifungals, injectable, oral, and vaginal. There's no updates to those classes as well. So I'll go ahead and pause for a couple of seconds. Okay, so moving on. Next we have the antihyperlipidemic and this is the miscellaneous class. So, in December of 2019, there was

a label expansion for Vascepa which is icosapent ethyl. And the label expansion was now for a new indication for use as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction stroke, coronary revascularization, and unstable angina requiring hospitalization in adults with elevated triglyceride levels 150 or higher. And patients must have established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease. So that has been added now to the Vascepa label for the indication. And other updates that we have in this class as well is there was a new product that came to the market in February of 2020. And that is called Nexlizet. I apologize if I'm pronouncing that incorrectly. But it is bempedoic acid and ezetimibe in a combination pill. So it combines an ACL inhibitor plus a cholesterol absorption inhibitor in one. And it is indicated as an adjunct to diet and maximally tolerated statin therapy for adults with heterozygous familial hypercholesterolemia or establish atherosclerotic cardiovascular disease, who require additional lowering of LDLs. So update to those two. So moving on, for the rest of these anti-hyperlipidemics and antihypertensives, there's really no updates to the bile acids sequestrants, fibric acid derivatives, HMG COA reductase inhibitors or the statins and their combination, ACE inhibitors, ARMS, ARBs, and antiadrenergic combinations. There's no updates that I could find for these classes. So I'll leave that up for a couple of seconds. Okay, so moving on, we have some more antihypertensives. So we have the antiadrenergic beta blocker combinations and beta blockers and the calcium channel combinations. There's no updates to those but there is one update to the calcium channel blockers class and these are just the single agent regimens in this class. There is a new calcium channel blocker that came out or was FDA approved December of 2019 and it is called Conjupri or levamlodipine maleate. It is indicated for the treatment of hypertension in adults and pediatric patients six years and older. So there's new calcium channel blocker that is FDA approved. Next, we have the antihypertensives other and the vasodilators. There's no updates to that class or those classes. For the anti-parasitic amebicides there's no updates that I could find. For the anti-parasitic anthelmintics, there is a new product that was FDA approved in February 2019 and it is called Egaten. I apologize if I pronounced that incorrectly. But the active ingredient name is triclabendazole. And this particular medication is indicated for the treatment of fascioliasis in patients six years of age and older.

And then in the anti-malarials drug class, there's no updates as well. So next, we have the anti-protozoal agents. And there was a new product that was FDA approved in August of 2020 and that is called Lampit or nifurtimox. It is indicated for pediatric patients, so from birth to less than 18 years old, so birth to 18 years old and weighing at least 2.5 kilograms. It is indicated for the treatment of Chagas disease caused by Trypanosoma cruzi. So that's the new product that has come to the market. For the scabicides and pediculides, there's no updates. And then moving on now to the antiparkinson agents, the anticholinergics, there's no updates that I could find for that class. So moving on to the COMT inhibitors. There was a new product that came to the market called Ongentys or opicapone and that was in April of 2020. And this particular medication is indicated as an adjunctive treatment to carbidopa/levodopa in patients with Parkinson's disease experiencing off episodes. Okay, so moving on. We have the anti-psychotics, antivirals, and some asthma and COPD agents that are listed here on this slide. As you can see, there's no updates to these classes. So the antimanic agents, first generation antipsychotics, CMV agents, hepatitis B agents, herpes agents, RSV agents, and then moving on to asthma and COPD. We have the long acting beta agonist and the oral beta agonist. There's no updates to these classes. So I'll pause for just a couple of seconds to let the committee review this slide. Okay, so moving on, for the short acting beta agonist, there's no updates to that class. There was an update, not necessarily to the class, but there was a box warning that the FDA released for leukotriene modifiers, specifically Montelukast and that was in March of 2020. So the FDA is now requiring box warnings to be added to prescribing information to describe seriously mental health side effects for Singular or Montelukast. So it's recommended now, they have a recommendation to be reserved to treat allergic rhinitis in patients who are not treated effectively or cannot tolerate other allergic medications. And for this particular FDA warning, it didn't look like it was applied to the class in general. So all leukotriene modifiers, so [indistinct] or xylitone. I couldn't find anything on the FDA website. So as of today, it looks like that warning is only applied to montelukast right now. And then for the xanthines for asthma and COPD agents, there's no updates. And then for these bone density regulators, the calcitonins and the parathyroid hormone derivatives, there's no updates to those classes as well. So moving on, for some of these cardiovascular agents and contraceptives, and the

bisphosphonates, there's no updates there. So no updates to nitrates, the antianginal agents, other antiarrhythmics, cardio glycosides, peripheral vasodilators, oral phosphodiesterase inhibitors, and combination contraceptives, oral, there's no updates to those classes. So I'll take a couple of seconds to pause. Okay, moving on, there's some more contraceptives that we have for the AH PDL. So we have the biphasic oral, the continuous oral combination contraceptives, oral extended cycle, and oral triphasic combination contraceptives. There's no updates to any of those classes. Okay, so moving on, we do have an update in the combination contraceptives, transdermal. So there is a new product that was FDA approved in February of 2020 and that product is called Twirla. So that one is a levonorgestrel-ethinyl estradiol transdermal patch. And this actually was approved as a new dosage form. So there is levonorgestrel-ethinyl estradiol oral tablets that you can take but now there's a patch. Hence that's why this product is now FDA approved as of recently. For the combination contraceptives vaginal, the copper contraceptives, emergency contraceptives, non-pharmaceutical, progestin contraceptives implants, there's no updates to those classes. So moving on, we have a couple of updates to some of these classes here. So the progestin contraceptives injectable, there's no updates there. For the progestin contraceptives IUD, there was an expanded label indication for Liletta, which is Levonorgestrel. So in October 2019, the FDA approved a supplemental NDA to extend the use of Liletta for up to six years. I believe previously it was only three years. So now the use is extended for six years. And for the progestin contraceptives oral, there is a new product that came out in May of 2019 called Slynd or drospirenone. And this product is a little different than the other ones on the market in that it’s the only progestin pill with a 24 hour intake window and there's 24 active and four inactive pills in the pack. So typically with some of these progestin or many pills, you have to take it within a certain amount of time. But now the window for this particular medication is 24 hours that you can take it instead of the narrower window. And now this particular product has four inactive pills in the regimen compared to some of the other progestins which are just continuous throughout the whole pack. So that's a new contraceptive that has come out. So next we have some corticosteroids, cough and cold, and dermatologics. For the glucocorticosteroid combinations mineralocorticoids, there's no updates to those classes. No updates to the antitussive, expectorants, decongestants, and miscellaneous cough

and cold products. And for acne products, oral acne products, topical and agents for genital and perianal warts, there's no updates for any of those classes that I could find. Okay, so next, there was a new product that was approved in December of 2020 for the antineoplastic or premalignant lesion agents topical drug class and that new product is - I apologize if I pronounce this incorrectly - Klisyri or tirbanibulin. And this product is a microtubule inhibitor. And it is indicated for actinic keratosis on the face or scalp. So this was fairly recent, just in 2020, December. But for these other dermatologic drug classes, so for the antipruritics topical oral, anti-psoriatic, oral, topical, antiseborhheic products, and burn products, there's no updates to those drug classes. So next, the emollients and keratolytic agents, enzymes topical, immunomodulating agents, topical keratolytic anti-mitotic agents, there's no updates to those drug classes. There is a new product that came to market in the rosacea agents drug class, and this particular product is called Zilxi and it is a minocycline topical foam. It was approved in May of 2020. And it is a tetracycline topical foam. And it is indicated for the treatment of inflammatory lesions of rosacea in adults. And then moving on to the topical steroids, high potency, there's no updates to that drug glass. So moving on, we have the other topical steroids. So we have the low potency, medium potency, very high potency. No updates to those drug classes. Wound care products, growth factor agents, no updates. Pancreatic enzymes, I could not find any updates. And then for the diuretics, we have the carbonic anhydrase inhibitors, diuretic combinations, and loop diuretics. There's no updates to those classes as well. So I'll pause. So we have some more classes with no updates. So we have the potassium sparing diuretics, thiazides and thiazide-like diuretics. And then we move into the endocrine and metabolic agents drug classes. So for the adenosine deaminase SCID treatment agents, injectable, no updates, anabolic steroids, oral no updates, androgens, other anti-thyroid agents and calcimimetic agents, oral there's no updates to those classes as well. So I'll go ahead and pause. Okay. And then it's more endocrine and metabolic agents. So we have the carnitine replenisher agents oral, the corticotropin, estrogen, various estrogen and androgen, progestin, selective estrogen receptor modulator combinations. There's no updates to those classes as well. So not much going on with some of these archived classes. Next, we have some more endocrine and metabolic agents. We have various estrogen products. So we have injectable, oral, topical, and vaginal.

And then we have the growth hormone receptor antagonists. There's no updates to those products or those drug classes. Okay, moving on, some more endocrine and metabolic agents. So the hypophosphatasia agents, injectable oxytocin, PKU agents, both injectable and oral, and posterior pituitary hormones, both nasal and oral. There's no updates to those classes as well. I'll pause for a second. Okay and we have the progesterone receptor antagonist, progesterones vaginal, prolactin inhibitors, thyroid hormone oral, and tripeptidyl peptidase 1 deficiency agents. There's no updates to those classes. So next, we have the x-linked hypophosphatemia agents. There's no updates there. We do have a couple of updates in these gastrointestinal agents. So for the H-2 antagonists, the FDA requested withdrawal of all prescription and OTC ranitidine products from the market due to NDMA impurities. So I believe you can't even find any ranitidine products out on the market. And that was requested April of 2020. And so next is the proton pump inhibitors. There's no updates there. And for the antidiarrheal agents, there was just something I thought would be worth noting. For Imodium, specifically brand name, the FDA approved changes to packaging for the name brand Imodium or loperamide, which limits the carton to no more than 48 milligrams of loperamide and requires the tablets and capsules to be packaged individually to help address abuse and misuse of loperamide. And that was in September of 2019. I didn't see anything specifically on generics when I did look on the FDA website. They only really mentioned brand name Imodium. So I'm not quite sure if that applies to the generic OTC products that are out there. But at least for brand name Imodium, there is changes to the packaging it looks like. Next we have gastrointestinal agents and genital urinary agents. So we have gallstone solubilizing agents, laxatives, other, and antacids. There's no updates there. And then for these miscellaneous genital urinary agents, so the alkalinizers, urinary analgesics, urinary anti-infective, there's no updates. And then for the acidifiers there's no updates as well. I'll go ahead and pause. Okay, moving on, there is an update to Procysbi, which is in the cystinosis agents. And that's cysteamine bitartrate. And there was an update February of 2020. So now, there's a new delayed release oral granule formulation that comes in packets for adults and children. And they can use it in one year of age and older for Procysbi. So that's new as of recently, almost a year ago. We have no updates to the interstitial cystitis agents, urinary stone agents. But there is an update to the H pylori antibiotics.

So there was a new product that came out in November of 2019. called Talicia and it is omeprazole, amoxicillin, and rifabutin product all in one. So it's composed of a proton pump inhibitor, penicillin, antibacterial, and rifamycin antibacterial. And the name is kind of indicative of what it's used for. It's indicated for the treatment of H. Pylori infection in adults. So another option for H. Pylori treatment. And then for the GI ulcer agents, miscellaneous, there's no updates to that class that I could find. Okay, so moving on to the gout agents. There was an update to Uloric or febuxostat. And that was in February of 2019. So the FDA is now requiring a box warning to be added to Uloric products, so to the prescribing information for increased risk of death. So that's now included on the label. And further hematological agents other, there's no updates. There was quite a bit of updates to some products and new products that came to market for the antihemophilic products. So I'll go through those a little bit. So there is a new expanded label indication for this product, Xyntha. And I apologize if I pronounced that incorrectly. But it is an antihemophilic factor recombinant. So the label now includes the new indication of routine prophylaxis to reduce the frequency of bleeding episodes in children and adults with Hemophilia A. So that's new to that product as of August. And there was a new product that was FDA approved in February of 2019 called on Esperoct. And that is an antihemophilic factor recombinant as well. It is a coagulation factor eight concentrate and it has a various amount of indications. So it's indicated for use in adults and children with Hemophilia A for, and these are the various indications, so on-demand treatment and control of bleeding episodes, perioperative management of bleeding, routine prophylaxis to reduce the frequency of bleeding episodes. However, this particular product is not indicated for the treatment of von Willebrand disease. Just wanted to note that. We have a couple more updates to some of these antihemophilic products. So Wilate, which is an antihemophilic factor eight von Willebrand factor. On October 2019, there is now an expanded label indication to include routine prophylaxis to reduce the frequency of bleeding episodes and on demand treatment and control of bleeding episodes. So that's been added to that product. There is a new product that came to market April 2020 called Sevenfact and that is a coagulation factor seven A. It's a coagulation factor seven A concentrate and it is indicated for the treatment and control of bleeding episodes in adults and adolescents 12 years of age and older with Hemophilia A and B with inhibitors. A new product there. There

was an expanded label indication for Ixinity. I apologize if I pronounced that incorrectly. That is a coagulation factor nine recombinant. And as of September 2020, there is a new indication for routine prophylaxis to reduce the frequency of bleeding episodes in adults and adolescents 12 years of age and older with Hemophilia B. There are a couple of new expanded label indications and new products that have come to market. So next, I just wanted to make a note for Soliris. I believe what's published online is a little bit different. I did update this slide with the indications because I did find that there were numerous indications. So I listed them here in the update. So for the complement inhibitors for the hematologic agents, we have Soliris, eculizumab. And this was approved in June of 2019. It is a complement inhibitor. And what I've updated in this slide compared to what's posted online is the indications. So these are all the indications for this particular product. So neuromyelitis optica Spectrum Disorder who are anti-aquaporin, antibody positive, atypical hemolytic uremic syndrome to inhibit complement mediated thrombotic microangiopathy, and I apologize for the spelling there, paroxysmal nocturnal hemoglobinuria to reduce hemolysis and generalized myasthenia gravis in adult patients who are positive for anti-acetylcholine antibody. That was a mouthful. But these are the indications for that product or the various indications for that product. So moving on to some of these hematological and hematopoietic agents. So platelet aggregation inhibitors, there's no updates. Cobalamins, folic acid and iron combinations, and single agent products, there's no updates to those products. So moving on, we have hemostatics. So we have the systemic injectable and systemic oral. No updates to those products. There was a new product that came out last month in the cyclosporin analogues oral and I believe it's called Lupkynis. I apologize if I pronounced that incorrectly. But it is a voclosporin. This was just approved in January of 2021, so very recently. It is a calcineurin inhibitor immunosuppressant and it is indicated for treatment of adult patients with active lupus nephritis. So very, very new, within the last month. Then we have these immunosuppressive agents, inosine monophosphate dehydrogenase inhibitors, oral, and macrolide immunosuppressants. There's no updates to those classes. Next we have these immunosuppressive agents monoclonal antibodies. So Enspryng satralizumab is the name of that product. It was FDA approved in August of 2020. It is an interleukin, 6 IL-6, receptor antagonist and it is indicated for the

treatment of neuromyelitis optica spectrum disorder. Same thing as kind of the Soliris in adults who are anti-aquaporin 4 antibody positive. And then moving on to these immunosuppressive purine analogues. Migraine agents, ergot derivatives, and other, no updates to those classes. And then we have the mineral and electrolytes classes, so calcium and fluoride oral agents. No updates to those classes either. Next we have various other classes. So we have mineral and electrolytes, miscellaneous mouth, throat and dental agents and then moving on to musculoskeletal therapy agents. So for phosphate, oral potassium, chelating agents, oral artificial saliva, saliva stimulants, skeletal muscle relaxants. There's no updates to those classes. I'll pause for a second. Okay, so moving on. There is a new product that came to the market in the neurological agents other drug class. So we have Xywav, I believe it's pronounced, and what it is, is a calcium, magnesium, potassium, and sodium oxybate product. It was FDA approved in July of 2020. It is a central nervous system depressant. And it's indicated for cataplexy and excessive daytime sleepiness in patients seven years of age and older with narcolepsy. So fairly new product that just came out. And for these neurological agents, transthyretin amyloidosis agents, ALS agents, both benzothiazoles and miscellaneous agents, there's no updates. And then we move on to the oncology agents. So antineoplastic progestogens oral, there's no updates to those classes. So moving on, we have some more oncology agents and then we move into the ophthalmic agents. So the aromatase inhibitors oral, the autologous cellular immunotherapy, chemotherapy, rescue, antidote agents, so urinary tract protective agents oral, folic acid antagonists, rescue agents oral, the radiopharmaceuticals. There's no updates to those classes. And then for the ophthalmic agents, the anti-allergic products, there's no updates to that class. I'll pause for a second. Okay, so moving on, we have the ophthalmic agents, antibiotics, sulfonamides, antibiotic steroid combinations, antifungals, antivirals, artificial tears and lubricants, and the cycloplegic mydriatics. There's no updates to those classes as well. I'll pause for a second. So next we do have a new product that came out in August of 2022 to the Cystinosis agents, and that new product is Cystadrops or cysteamine. It got approval, like I said, in August of 2020. It is a cystine-depleting agent and it is indicated for the treatment of corneal cysteine crystal deposits in adults and children with Cystinosis. And what makes this product different, I believe the other product that's in this class is another

cysteamine product. It's not Cystadrops. I believe they have the same active ingredient but what's different with this product is it has a four times per day dosing, whereas the other product has dosing where you use it every waking hour. So instead of having to put drops in every hour, now the patient can do four times a day dosing for this Cystadrops product. And then for these decongestants, gene therapy, local anesthetics, [indistinct] atomic agents, there's no updates to those classes as well. Moving on, we have a couple more agents. We have otic agents, respiratory agents, and sleep disorder agents. Really no updates for any of these classes. So for the ophthalmic steroids, the otic analgesic combinations, otic anti-infectives, miscellaneous otic steroids, alpha-proteinase inhibitors, no updates to the barbiturate hypnotics and the benzodiazepine hypnotics. No updates there. And I apologize, I actually repeated benzodiazepine hypnotics on this slide and the other slides. And I apologize. I take it back. There is one update, which I mentioned last time when I presented the archived classes for the benzodiazepines. In September of 2020, the FDA is now requiring a box warning for all benzodiazepines. So the box warning is going to be updated to describe the risk of abuse, misuse, addiction, physical dependence, and withdrawal reactions with benzodiazepines. So then now we have the smoking deterrence, the nicotine replacement products, substance use disorder, alcohol deterrence, and then we have all these vitamin products. We have B complex multivitamins and the vitamins A, D, and C. No updates to those products. And it looks like this is the last slide, which I went through this a lot quicker than I thought. But we have the prenatal vitamins, vitamin B1 and vitamin B6 drug classes. There are no updates to these classes. So somehow, I was able to get through all 216 or 15 classes that we have left for archiving in 30 minutes. I'll go ahead and pause here if the committee has any questions.

Alex Park: Marissa, It's Alex Park. Can you just remind me again what happens once these classes are archived?

Marissa Tabile: Yeah, so Dr. Park, once we get the motion to archive these drug classes, so these classes will only be kind of re-presented every year or annually in a big lump, kind of how I did it in this presentation. So it's not going to be an in depth drug class review. That's what Umang does or what we did previously this morning. But they'll just be brought back every year. And then if there's any updates then I'll go

ahead and note them in the updates when I'm going through it. But that's essentially kind of what happens when you guys approve to archive these classes.

Alex Park: Got it. Thank you. And how do you guys decide which classes get eligible to full into this large archiving? Like the cystic fibrosis presentation, there wasn't much change there when we did have a presentation on that.

Marissa Tabile: Yeah. So the kind of criteria that we go through when we're deciding to archive them is we have to go through pretty much all -- what we did was we went through all 430-something drug classes individually and looked at all the products that are in the class. And if we saw that pretty much the whole class is largely generic, we decided that that's probably a good class to archive because there's no new products that have come out. It's been generic for how many years. And then also, if there's not really any movement that happens in the class as far as new products that have come to market. So maybe there might be like, one or two products or if it's kind of a class that's not -- I don't want to say a hot topic, but it's not very -- what's the word I'm looking for? It's not kind of a high priority class or doesn't really have, I would say, pretty expensive products that we would want to look at regularly. So that's kind of the criteria that we used when we were going through these archive classes.

Alex Park: Thank you. That makes sense.

Marissa Tabile: Any other questions that I might be able to answer? And I'm also open to any feedback that the committee might have as far as going through these archived classes again, ways that we can improve the presentation for you all. And also one thing is that for these archived classes, it's not classes that Magellan is actively managing. So when I say that the classes that we usually do a regular drug class review are involved or are part of our Topps agreement that we have with Magellan. So Magellan is actively managing those classes with rebates. So a lot of these archived drug classes as well don't have any available rebates with them. So that was also another criteria for archiving or presenting it for archiving.

Alex Park: Marissa, Alex Park. Just one more question. Do any of the classes you're proposing to archive have an active Apple Health policy discussion that's pending from a prior meeting? I'm just recalling some classes, the ALS drugs and others that are sort of hotter topics. I can't remember if those are part of this or not.

Marissa Tabile: So that's actually something that I'm actively working on right now and it's a pretty intensive process. So one of my plans is to go through all of the 430-something drug classes that we have on the AH PDL and figure out which classes don't have policies for them. But to go back to what you said, we do still create policies even for these archived classes. I haven't identified exactly which products will need policies yet. I'm actively doing that now. But we will be presenting them to the committee once I identify and figure out which ones we want to bring to the board in what timeframes to you guys. So to answer your question, we do create clinical policies for these archived drug classes. I just have not identified them yet, which I'm in the process of doing.

Alex Park: Thank you. That's reassuring to know. So in other words, if we were to archive these, there would still be some background work that you're doing to ensure that the drugs are being looked at thoughtfully, the pathway that patients and providers follow. So yeah, I appreciate that reassurance. Thank you.

Marissa Tabile: Yeah, definitely. We would still definitely want the committee to look at these policies. Even though they're archived, we would still want you guys to review them as we create them. So you can imagine with 430-something odd drug classes, there's probably a lot of outstanding products out there that don't have policies yet. So I'm working and trying my hardest to get those identified and hopefully we can get them made. It'll be a process that is going to be long, along with the drug classes that we do review. But yes, you can expect to see some coming your way. Any other additional questions or feedback from the DUR board for the archived drug classes? I went through them a lot quicker than I was anticipating.

Ginni Buccola: Marissa, this is Ginni. I just wanted to say thanks, I thought it was actually pretty efficient. And I appreciated the way that you were able to pull out the changes. So from my experience, it was helpful and didn't drag on too long.

Marissa Tabile: So if there's no additional feedback from the DUR board, I do have a motion for them. So I'll go ahead and put up the recommendation and the motion. So then, for the DLR board, you guys can look over it and decide if you want to make these eligible for archiving.

Ginni Buccola: Marissa, this is Ginni again. Just a point of clarification. Your 40 slides of archived drug classes, is that the bulk of our agenda for this morning or for the totality of the archived drug classes that we're supposed to review today?

Marissa Tabile: It was pretty much the totality of all of the archived drug classes.

Ginni Buccola: Okay. I see that there were two stakeholders scheduled.

Marissa Tabile: Oh, yeah. I'm sorry.

Ginni Buccola: That's okay. I didn't know if they were on. I'll just jump ahead unless Leta wants to pop in.

Leta Evaskus: This is Leta. Yeah, we have one stakeholder for the archived classes and then we have one for the policy. Dylan is on. I'm going to unmute Dylan. Now I see you're self-muted as well. Dylan Bassett from Pierre Fabre Pharmaceuticals, if you would still like to speak now. Okay, he must be doing something else. I'll send him a chat just to see if I can get his attention.

Alex Park: While we're waiting for the stakeholder, can I ask a question, Ginni and Marissa about this archiving process?

Marissa Tabile: Sure, Alex.

Ginni Buccola: I know I probably won't know the answer but I bet Marissa will.

Alex Park: Well, if the agenda says this is supposed to go through 2:10 pm this afternoon, did we finish all of the archiving just now that was supposed to go through 2:10?

Marissa Tabile: Hi, this is Marissa. Yeah, it looks like we actually went through all of them.

Alex Park: Okay. And did you get what you needed from us. I have a little anxiety that this much time was blocked and I just worry that we're missing something on this process. So just want to make sure that we're doing our due diligence on it.

Donna Sullivan: Hi, Chris, this is Donna. This is the first time we've done this and it was 100 and some classes and we just overestimated how long it was going to take. So I don't think that we really missed anything. Once we get through the motion and the recommendation or the recommendation and the motion, then we'll have what we need for this particular topic. And we'll know to better estimate time the next time we bring these back for you to review.

Marissa Tabile: This is Marissa. I apologize. I definitely overestimated how long it would take to go through these archived classes. So that was a fault on my part. I apologize.

Alex Park: Not a bad thing to be ahead of schedule. We'll take that.

Donna Sullivan: I was wondering, do we have Dylan yet, Leta?

Leta Evaskus: He has not replied.

Donna Sullivan: Okay, can we maybe just move forward with the recommendation and motion? And then what I would suggest is can we review the policy before lunch and just quit early?

Ginni Buccola: This is Ginni. I'm all for that. Yeah.

Marissa Tabile: This is Marissa. Okay. So we're just going to go ahead and proceed with the motion?

Ginni Buccola: Yeah. Go ahead and move to the motion and take a look at that. And then we'll look at that last policy and that motion before lunch.

Marissa Tabile: Sounds good.

Susan Flatebo: This is Susan Flatebo. I move that all drug classes listed on slides two through 40 are eligible for archiving at the discretion of HCA. Products

in these drug classes may require prior authorization to determine medical necessity. All non-preferred products require a trial of two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Alex Park: This is Alex Park. I second that motion.

Ginni Buccola: This is Ginni Buccola. All those in favor, please say aye.

All: Aye.

Ginni Buccola: Any opposed? And the motion carries. And that will take us back to Marissa to review the policy on pulmonary hypertension agents.

Leta Evaskus: This is Leta Evaskus. I am contacting the stakeholder for pulmonary hypertension agents to see if she can log in early.

Marissa Tabile: Okay, so I will be going through the pulmonary hypertension agents policy. We did present this policy or I presented this policy in December. But there was some feedback from the committee to update the policies. So it was not approved. So I'm re-presenting it again today. So just to kind of give you some background, again, on this policy, it is an annual update of -- I'm sorry, let me present my screen or show my camera. There we go. Sorry about that. So this is an annual update of the current policy, which we implemented in August of 2018. And the updates that were made to this policy was to kind of make the criteria a little bit more specific. So right now, the current criteria that we have online or that we have implemented from August to 2018 is a little broad. So we've incorporated some more classification, we've included the World Health Organization classifications and we've separated the chronic thromboembolic pulmonary hypertension. So now it's combined into this criteria, just for some background, because it was presented in December. So just to go through the criteria. I did rearrange the criteria a little bit compared to what you saw in December. So for criteria one, now we have it where the patient must have either A or B, so one of the following. So I just kind of reordered this criteria here. So now the WHO groups three or four is listed in A, but I didn't change any of the criteria so it's still the same in which general treatment measures

have failed and pulmonary hypertension is thought to be unrelated to underlying lung disease, or now we have for B, the pulmonary arterial hypertension diagnosis WHO group one is now for 1B. And then the criteria one, documentation of PAH WHO functional class two, three, or four has not changed. I did reframe criteria 2 to put a little bit more emphasis on that the patient has tried or failed a calcium channel blocker. So previously, it was that the acute vasoreactivity testing was where number two would be. But now I think rearranging it where B2 is that we require a history, a trial and failure of a CCB. Unless of course, it's contraindicated or there's intolerance for the patient. So more emphasis on trying and failing a calcium channel blocker rather than the purpose of the acute vasoreactivity testing because the acute vasoreactivity testing is more so giving us an indication on who can use a CCB compared to who can't. So that's just been rearranged to make it a little bit more clearer. But the criteria for the AVT or what I've listed, I haven't changed any of that. I didn't update that. For number 2, this has stayed the same as well from what you've previously seen. So the requested therapy is now for any of the following. So a combination of a phosphodiesterase inhibitor and soluble guanylate cyclase stimulator or a combination of selexipag and proteinoid, that's still the same. I think what really varies now with what you saw in December compared to today was we did have in these criteria one through five, there was for non-preferred agents, it was that they had to try a preferred agent that was listed in the criteria. And I think that's what was causing a lot of the confusion because the feedback that we got from the committee was to create a pathway for how a patient could get a preferred agent. So I actually removed that nonpreferred criteria that was listed here. And I think that alleviates the confusion that it might have caused. So now it's just if they are currently established under requested therapy or if they're requesting for Selexipag specifically. These are still the same but just going to go through it. For [indistinct] or Selexipag, there's history of failure, contraindication, or intolerance to an endothelin receptor antagonists. It's prescribed by or in consultation with a specialist in cardiology or pulmonology. So essentially, as long as a patient meets all the criteria that's listed here in one through five, if it's applicable to them, then they are eligible to get the preferred agent for this particular policy. I didn't change anything as far as the approval so it's still for 12 months for the initial approval. And then we have this updated statement that I believe was still there even in December for

if all criteria are not met that there are documented medically necessary circumstances based on the professional judgment of the clinical reviewer. Requests may be approved on a case by case basis up to the initial authorization duration. That is still there. I didn't change any of the reauthorization criteria, so that is still the same. So medication used for the treatment of pulmonary hypertension, may be reauthorized when documentation of response. So an example is disease stability or mild progression indicated by a slowing of decline using the WHO functional class scale is provided. So if all of the above criteria are met, the request will be approved for another 12 months. And then we have that blanket statement here for the reauthorization duration as well, where it's reviewed on a case by case basis if it's clinically necessary by the reviewer. And I didn't change any of this criteria here below for the coating or the dosage and quantity limits. So that's pretty much the same. And these are just the appendices here with the different clinical classifications and then the functional classifications of pulmonary hypertension. So I'll go ahead and move over to the form. So this is the updated form that would go with the pulmonary hypertension policy. So here, this will just help guide the providers. And hopefully this makes a little bit more sense now we have updated it. So the first question it's asking, is this for a continuation of therapy? Yes or no? And then this right here, if yes, is there documentation supporting disease stability? Yes or No? That's pretty much for the [indistinct] criteria. And then for two, three, and four, I don't believe anything has changed for these. I think we just removed I think the nonpreferred criteria that we had previously. So now it's just asking for the diagnosis. Has the patient tried a calcium channel blocker? Yes or no? If not, was it due to one of the following? And then the provider would check off why they could not use one or what happened once they tried one. And then will the requested therapy be used in combination with any of the following, which was listed in the criteria. And then for [indistinct] we do have the history of failure, contraindication, or intolerance to the ERA. And then of course, asking for specialty. But of course, with these requests, we would require chart notes. So we will want to take a look at those if we get this in as a request. So I'll go ahead and pause here for any questions from the committee, whether that be the policy [indistinct].

Ginni Buccola: Thanks, Marissa. I want to make space for any questions and also wonder if Leta has been able to get in touch with Stephanie Yamamoto.

Leta Evaskus: Yes. This is Leta. She has logged in. Hey, Stephanie, are you able to unmute yourself?

Stephanie Yamamoto: Hi there. Are you able to hear me?

Ginni Buccola: Yes, Stephanie. Can you just give us your name and your affiliation and you'll have three minutes to share.

Stephanie Yamamoto: Thank you so much for your flexibility as well. And thanks for the heads up, Leta. My name is Stephanie Yamamoto. I am a pharmacist with Janssen Scientific Affairs and I'm speaking on behalf of Opsumit or macitentan. Opsumit is an endothelin receptor antagonist or an ERA indicated for the treatment of pulmonary arterial hypertension, PAH WHO group one to reduce the risks of disease progression and hospitalization for PAH. Effectiveness was established in a long term study called Serafin and pH patients with predominantly WHO functional class two and three symptoms treated for an average of two years. Patients had idiopathic inheritable PAH caused by connective tissue disorders as well as PAH caused by congenital heart disease with repaired shunts. And the primary endpoint was time to the first occurrence of death or a significant morbidity event. And a statistically significant risk reduction was seen for Opsumit 10 milligrams versus placebo. A key secondary endpoint in Serafin was death due to PAH or PAH related hospitalization. And there was a 50% risk reduction for Opsumit versus placebo. PAH is a severe, complex, and often deadly disease and the clinical and economic burden of PAH goes beyond pharmacy costs. Treatment strategy of all the appropriate diagnosis, initial risk assessment, as well as specialized clinical expertise, and access to as many options for individualized patient care is needed. The European Society of Cardiology and European Respiratory Society or the ESC guidelines list macitentan added to sildenafil as a class 1B recommendation for sequential combination therapy for WHO functional class two and three patients. And we respectfully ask the committee to add Opsumit to the preferred drug list for Washingtonians. Thank you so much.

Ginni Buccola: Thank you, Stephanie. Are there any questions from the committee? Okay, then, Marissa, can you take us to the motion?

Alex Park: Alex Park here. Can I ask something about number three on the policy?

Marissa Tabile: Hi, Dr. Park. Sorry, I was on mute. Yeah, go ahead.

Alex Park: So we are saying that the patient needs to be already established on the therapy that they're requesting. Is that right?

Marissa Tabile: No. So for number three, that's addressing the issue of if a patient is already established on pulmonary hypertension aging because I know that there can be consequences if they abruptly stop or switch. So that's just addressing if they are already on it then they wouldn't meet that criteria. So it would be or. So as long as they're not requesting for this or if they're already established on it then that would be grounds for criteria for them to be approved for it. Does that make sense?

Alex Park: Okay, okay. I didn't read it that way but it makes sense the way you explain it. Okay.

Leah Marcotte: This is Leah Marcotte. I move that the Apple Health Medicaid program implement the clinical criteria listed on policy 40.12.00-2 as recommended.

Diane Schwilke: This is Diane Schwilke. I second.

Ginni Buccola: This is Ginni Buccola. All those in favor, please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? Motion carries. And that takes us to the end of today's agenda. Leta, is there anything else that we need to take care of while we're together as a committee?

Leta Evaskus: Hi, this is Leta. No, that is everything that was scheduled today. So I really appreciate all your time.

Ginni Buccola: Well, wishing Connie good luck and farewell.

Constance Huynh: Thank you so much. Thank you for everything. It’s been a pleasure.

Ginni Buccola: Yeah, stay in touch Connie. Alright, so I officially then adjourn the DUR review board and we'll see you all in April.