Washington State Pharmacy and Therapeutics Committee/
Drug Utilization Review Board
Meeting Transcription
Wednesday, February 15, 2023

Leta Evaskus: All right. Alex, you can kick us off.

Alex Park: Thank you, Leta. Well, good morning, everybody. Welcome. It's 9:01 A.M. It's Wednesday the 15th, and it's the P&T Committee and DUR Board. My name is Alex Park. I am your Committee Chair, and I would like to go ahead and call the meeting to order and convene our business for the day. First order of business is to do roll call and ensure that we have all our attendees. When I call your name, could you please let us know that you are here by saying "here" or "present." And we also have three new members today. So when I call your name, in addition to announcing your presence, please feel free, we invite you to give a short introduction of yourself. So starting with the P&T Committee Members. Laura Beste.

Laura Beste: Present.

Alex Park: Thank you. Virginia Buccola.

Virginia Buccola: Here. Good morning.

Alex Park: Good morning. Kavita Chawla, I believe, is not able to attend today. Michael Corsilles.

Michael Corsilles: Here.

Alex Park: Jon MacKay.

Jon MacKay: Here.

Alex Park: Dimitry Davydow. Dr. Davydow, we welcome you to the Committee.

Dimitry Davydow: Thank you. Present. Dr. Dimitry Davydow. I am a psychiatrist and Chief Medical Officer for Comprehensive Life Resources, Community Mental Health Center Agency in Pierce County, Washington.

Alex Park: Great to have you. Thank you. And, Kevin Flynn, we welcome you to the Committee.

Kevin Flynn: Here. My name is Kevin Flynn. I am the Director of Pharmacy Purchasing for the University of Washington Medical System.

Alex Park: Welcome. And Christy, is it Weiland or Weiland?

Christy Weiland: That's correct. It's Weiland. Yeah. Present. Good morning. My name is Christy Weiland. I work with MultiCare. I am the Faculty Pharmacist at East Pierce Family Medicine Residency.

Alex Park: Wonderful. Thank you for joining us. Moving on to the Healthcare Authority Members. Laura Crocker.

Laura Crocker: Present.

Alex Park: Good morning. Luke Dearden.

Luke Dearden: Here.

Alex Park: Leta Evaskus.

Leta Evaskus: Here.

Alex Park: Amy Irwin. Is Amy Irwin with us?

Donna Sullivan: No. She's not joining us today. Sorry. I was on mute.

Alex Park: Okay. Thanks, Donna. Ryan Pistoresi.

Donna Sullivan: I don't think Ryan is here either.

Alex Park: Okay. Liz Punsalan.

Liz Punsalan: Here.

Alex Park: Donna Sullivan. I think they heard your name.

Donna Sullivan: Yep. I'm here.

Alex Park: I heard your voice. Marissa Tabile.

Marissa Tabile: Good morning. I'm here.

Alex Park: Good morning. Ryan Taketomo.

Ryan Taketomo: Good morning. I'm here.

Alex Park: Thank you. And Joey Zarate.

Joey Zarate: Good morning.

Alex Park: Good morning. From Labor & Industries, Jaymie Mai.

Jaymie Mai: Here.

Alex Park: Good morning. From the DERP Group, Sara Kennedy.

Leta Evaskus: She might be joining a little bit later since her presentation starts later.

Alex Park: That's right. The DERP part procedure piece a little bit later. Okay. The indefatigable, Umang Patel, from Magellan.

Umang Patel: Present.

Alex Park: Good morning. And we have our MCO Managed Care Representatives. I'll read off the names of the folks who might be with us here. Greg Simas from Molina Healthcare, Heidi Goodrich from Molina Healthcare, Petra Eichelsdoerfer from United, Omar Daoud from Community Health Plan of Washington, and Jeffrey Natividad from Community Health Plan of Washington. Leta, would you like to go over some meeting logistics?

Leta Evaskus: Yeah. Thanks, Alex. So for today, the Committee and Presenters can mute and unmute themselves. Please mute yourself when not speaking to limit background noise. Presenters, please share your webcams when presenting, and Committee, please share your webcams during discussions and motion considerations. For stakeholder participation, the Chair will read the list of stakeholder names who preregistered to speak first. Please raise your hand so we can find you and unmute you. After, the Chair will ask if there are any

other stakeholders. Use the raise hand function, and we will call on you and unmute you. Each stakeholder will have three minutes. You can also use the Q&A box, and we'll address your questions during the stakeholder time. We will be turning off the chat for stakeholders when the stakeholder testimony time is over so the Committee can make their motion uninterrupted. If we have a provider testify about their patients, they must disclose if they practice in Washington and if they accept Medicaid clients, and any examples if it's a Medicaid member. And lastly, the meeting is being recorded, so please state your name every time you speak. Back to you, Alex.

Alex Park: Thank you, Leta. I'll turn it over to you, Donna. I believe the next item is going over the P&T Committee process.

Leta Evaskus: And I am pulling up those slides.

Donna Sullivan: I was just asking you. So welcome, everyone. I am Donna Sullivan. I am the Chief Pharmacy Officer here at the Healthcare Authority. So I just wanted -- every February we usually go through the DUR Board process overview just as a reminder and a refresher course about the program. And if you have any questions, feel free to interrupt me and ask them during the presentation. So we can go to the next slide, Leta. So just some rules and responsibilities. I just introduced myself. We also have Ryan Pistoresi, who is the Assistant Chief Pharmacy Officer. He has joined us after Alex called roll call. Ryan manages our Public Employees and School Employees Pharmacy Policy Benefit Design Program along with Luke Dearden, who is also on the call. He oversees clinical policy development, and then he is our representative on the Drug Effectiveness Review Project Governance Board. So he attends all of the monthly meetings and represents Washington in any voting opportunities that the states have for doing research with DERP. Leta is our ArrayRX Operations Manager. She coordinates all of the P&T Committee Meetings, including the contracts with the Committee members and makes all the meeting logistics happen. She also manages the posted Washington Preferred Drug List that is online. She reviews that each quarter, and we update it each quarter. And then she oversees and manages the cost analysis process that the state goes through once the Committee has made their decisions. Next slide. Amy Irwin, who is not able to join us today, is our Medicaid Operations Manager. So she is in charge of our Medicaid fee-for-service Pharmacy Operations Program. We manage our fee-for-service program in-house, so, essentially, we run our own Pharmacy Benefit Management Company, if you will, in-house. She also oversees our Medicaid-managed care plans. So if

there are any concerns we have with the managed care plans, if you are having access issues with your patients or PDL questions about the managed care plans, those can go to Amy. And then she also assists with data submission for the cost analysis. Marissa Tabile is the Apple Health PDL DUR Manager. She is the one who makes the decisions on a weekly basis as new drugs come to market, and then she's also the one who will be going through the motions with you for the Apple Health PDL. We have Luke Dearden, who is a clinical pharmacist, who helps us with developing clinical policies. So on occasion you'll hear from Luke when he is presenting the policy that he's working on. Ryan Taketomo, also a clinical pharmacist, again, assists with clinical policies and also helps us determine which drugs get carved out of the managed care plan every six months when we update the managed care contract. We have Joey Zarate, who is the PDL Coordinator. So he is helping. He compiles the list of new drugs to market each week, as well, and then sends those off to Marissa for a clinical decision on those. He also works to configure our Point of Sales system when we're making changes to the PDL or when we have to add new drugs as they come to the market to make sure that they are covered correctly. Next slide. Jaymie Mai, who is the Pharmacy Director for Labor and Industries. We have Doug Tuman, who is the backup to Jaymie for the Prescription Drug Program. And then Christy Pham, who is also a pharmacist representing the Labor and Industries program and is responsible for the PDL changes. So just some background on the program itself. In 2003, the legislature created the Washington Prescription Drug Program. It directed us to create an evidence-based program, which is why we have contracted with DERP. The program itself was a coordinated effort between the two state agencies, but Healthcare Authority has its public employees' programs. So the Uniform Medical Plan and Medicaid participating in the WPDP, and then Labor & Industries Workers' Compensation Program also participates in the Prescription Drug Program. So our Preferred Drug List for Washington is a subset of each program's overall formulary or Preferred Drug List. It's only about 35 classes. And the goal was when it was originated is to develop a statewide evidence-based Preferred Drug List to control costs. And we'll go into a little bit more about that, how it's evolved over time later. Next slide. So there are several components. The Pharmacy and Therapeutics Committee, the Washington Preferred Drug List. There is an Endorsing Practitioner Therapeutic Interchange Program. That's a mouthful. We'll go into that later. ArrayRX, which is formerly the Northwest Prescription Drug Consortium, and then the Apple Health Pharmacy Policy Unit, and the Apple Health PDL. So our Committee is made up of 10 members. We have our membership based on

the federal Medicaid requirements for our DUR Board. The Committee is comprised of four physicians, four pharmacists, a physician assistant, and one advanced registered nurse practitioner. We meet by statute or by WAC. We meet at least quarterly, but we typically schedule six meetings a year, each of them being the even months. It's the 3rd Wednesday of every even month, with this one being the first one for this year. And then we review drugs for inclusion on the Washington PDL. And that's the P&T Committee portion. So there is a distinction between the P&T Committee and the DUR Board. And I believe there are slides on that later, so I'll get into that. But it's a very unique distinction between the Washington PDL and the Apple Health PDL. So, next slide. So the roles and responsibilities. We have a Chair and Vice Chair that are selected by members, and it's a two-year term. So the Chair is the Executive Officer of the Committee. They supervise and control the business of the Committee and preside over the meetings. The Vice Chair will perform all duties of the Chair if the Chair is absent. Committee members are required to fill out an annual conflict of interest form. We will provide you prior to each meeting reports from -- and I apologize. It's garbage day, and the garbage man just showed up here, if you can hear background noise -- review reports prepared by the Drug Effectiveness Review Project that compare evidence of drug safety and efficacy and use in special populations. So the DERP program will compile all of the literature from a certain time period, and they evaluate, grade the evidence, and compile that into a report, which we will get into more detail later. The Committee, after reviewing the reports, you'll determine if drugs are safe and efficacious or if they are able to be interchanged. For example, I am just going to use an old example like proton pump inhibitors are pretty much the same. It doesn't really matter which proton pump inhibitor you try, so they can be interchanged. So if the doctor wrote for Prilosec, and the preferred was Prevacid, it could be interchanged on the PDL. So the next slide, please. So really, the P&T Committee for the Washington PDL is considering the quality of evidence that is available at the time of review. So the quality of evidence is provided in the DERP report. And we're really asking you to only consider information that is included in the DERP report because that's been graded and evaluated. So any information coming from outside of the DERP report, you can consider as whether or not we should update the report, but it shouldn't be used in decision-making for the purposes of the Washington PDL, and that's because it hasn't been evaluated and graded for risk of bias whether it's low, high, or medium quality of evidence. We want you to evaluate the efficacy and safety from the provider and patient perspectives from your experience with your practices, produce explicit recommendations based on

the review. So typically, we'll recommend that they are safer and efficacious. Occasionally, if there is one that might be more effective or one that might be less safe within a particular class, the Committee is able to make a specific recommendation for that particular drug. But, in general, the Committee is making recommendations about the overall drug class and its relative safety and efficacy and interchangeability within that drug class. We ask that you evaluate the drugs in a manner free of bias. Again, emphasizing that the best evidence is in the DERP Report. We review direct evidence that addresses health outcomes rather than intermediate outcomes. And we're really looking at a clinically meaningful benefit rather than just a measure, such as the ability to lower LDL cholesterol versus reducing adverse cardiac outcomes. And then, again, consider harms and benefits of the drugs that are reviewed. So the (DERP) Drug Effectiveness Review Project is a collaborative of 13 states, and specifically Medicaid programs or public pharmacy programs. Again, they have produced these evidence-based reports, and the states that are currently participating are listed on this slide. States do come and go at times. We were up to 16 states at one point in time. But we do have a pretty set core of states that have been within the Drug Effectiveness Review Project since the beginning. Oregon, Idaho, and Washington are really the key states in this particular project or program, but we welcome all states to join. Next slide. So we asked the Drug Effectiveness Review Project to make several types of reports. As we identify a new drug class to review, we'll have a new class report or a new class review. But we know that evidence changes over time, so we have to have a process to update the existing class reviews. And we will do those in what we call surveillance reports. So the DERP Project Team will look at all of the new evidence that is published. They will look at evidence that might be on the FDA website or the clinicalstudies.gov website, or they will request information from manufacturers, and they will put that into a surveillance report. Their surveillance report doesn't really go into grading evidence as much as it tells us what kind of new evidence that is out there that could be considered, and then we determine from the DERP Governance Board, all those 13 states, if we are going to actually do a new drug update, or a report update for that particular class. So that's what we call an update to an existing class review. We can also do what we call a single drug addendum. So let's say a new drug comes out in a class that's been reviewed, but we're not going to do an entire class update. We can do a review on that particular drug and include it so that it can get included into the existing drug class. And so effectively, what that does is it updates the class review to allow inclusion in the PDF. And I'll get more into that later on what that means. And then we have Topic Briefs,

which are when we're trying to determine if we want to do a full review of a drug. The Drug Effectiveness Review Project will dabble in the evidence to produce to the states to determine if it's worth spending our research dollars in the project to do a review on that particular drug. And I've already gone through the surveillance reports. One difference between the surveillance reports and the other types of reports is that this is your opportunity to determine. Is the evidence that was summarized in the surveillance report, do you feel it's important enough where we need to do a full class review, or are you comfortable with saying that their surveillance report is adequate and that we don't need to incorporate that additional information into the report prior to you making a decision or recommendation on this particular drug class? So it's slightly different. You'll have two motions when we have surveillance reports. One is to accept it as a as an acceptable adequate update and then second would be the motion on the particular drug class itself. So the next slide, Leta. So our Committee process, the Committee makes recommendations based on evidence. And then we do a cost analysis. So we have contracted with Moda Health through ArrayRX to do a cost analysis once you make a recommendation. For example, going back to proton pump inhibitors, if you were to say they are all equally safe and efficacious, and they are interchangeable, we will compile all of the data from the Uniform Medical Plan and our workers' compensation program and determine which drug is the least costly to the state and make a preferred selection on that. And we have the actuary that has actually doing that analysis for us, and then we review it. So the workgroup then reviews that cost analysis, and we make recommendations to our Agency directors on what the preferred product should be in that particular drug class. So let's say we're going to recommend omeprazole because it's a generic, and it's the least costly for the two [indistinct] programs that are participating. The Agency directors approve the PDL selections, and then Leta will send out a notice of the PDL, updates to our stakeholders. And then each Agency before we send out that information, we will select a date for the implementation of any changes that that need to be made, and then we'll implement those changes to the PDL. So I am going to pause if there are no questions. Okay. So the Washington Preferred Drug List, we began or recreated it in January of 2004. It was the list of drugs selected by the agencies at the time to be used as the basis for their prescription drugs, trying to get that evidence-based prescription drug program established as a cost savings measure, and it has changed over time. And I keep using proton pump inhibitors. Back in 2004, it was the newer beta blockers, the statins, proton pump inhibitors, the COX-2 inhibitors. All of those drugs, believe it or not, were our budget breakers. And so those were

the original basis of the PDL. It has morphed over time as we have hepatitis C drugs that have come out that are newer. MS drugs, rheumatoid arthritis, all kinds of additional drug classes have been added. We have about 30 drug classes on the PDL. And then, also, the Washington PDL is impacted by the Endorsing Practitioner Therapeutic Interchange Program. Next slide, Leta. And I have said that a few times now. I am going to call it TIP going forward. So what the program is we have established this Evidence-Based Preferred Drug List. And the statute that established the P&T Committee and the Preferred Drug List also had a tool approved to allow providers to prescribe a non-preferred drug when the prescriber felt that the non-preferred drug was the best drug for the client or the patient without having to go through any type of prior authorization process specific to it just being a non-preferred drug. So it's called the Endorsing Practitioner Therapeutic Interchange Program or TIP for short. And providers in Washington are able to go to our website and sign up as an endorsing provider. And so we call those endorsing providers. We anticipate that they have reviewed our Preferred Drug List. They agree with our PDL selections, and by signing up, they have agreed to allow a pharmacist to make the therapeutic interchange of a preferred drug for any non-preferred drug unless otherwise directed, meaning they have signed the prescription as Dispense as Written. And so this means the law actually allows pharmacists to make this interchange without having to call the endorsing practitioner and getting a new prescription. The pharmacist is then just obligated to notify the prescriber of what was actually dispensed. And this, again, was trying to make it easier for reducing administrative burden from pharmacies from having to call and get a new prescription every time a non-preferred drug was prescribed and also to reduce administrative burden on providers. There was a clinical reason why the non-preferred drug was required, and they don't have to go through that process to get a request to get a non-preferred drug. So the pharmacist will automatically interchange the preferred drug for any non-preferred drug. And how that happens is the claim will be rejected, and the pharmacy will be given a message that says which drug to interchange for that particular non-preferred drug that was prescribed. And then they will make that interchange. There are some exceptions to the interchange in our statute. And that is whether it's a refill for an antipsychotic medication, an antidepressant, antiepileptic drugs, chemotherapy, antiretrovirals, or immunosuppressive drugs or treatment for hepatitis C. And it's actually specific to the peginterferon therapies for Hepatitis C is what is in the statute. It's a lot of words, so we didn't put that on the slide. The endorsing practitioner can indicate Dispense as Written on a prescription for any non-

preferred drug. And in these situations, the claim will be allowed to process through, and it won't reject like I had mentioned before. And we have about 7200 endorsing practitioners. A lot of people ask, well, what percentage of our provider network is endorsing practitioners? And we're unable to really estimate that because there are so many endorsing practitioners that might have left the state, or are no longer practicing here, or they could be retired. So we don't really know what percent of all licensed practitioners in Washington does the 7200 represent. So next slide, Leta. So status of drugs on the PDL. So if it's preferred, it means that that therapeutic interchange doesn't apply. So they might require prior authorization for clinical reasons, even if they are preferred, but it won't be stopped for therapeutic interchange purposes. So if they are non-preferred, they are subject to TIP. And we have some other exceptions. The Committee can determine whether or not they are interchangeable, so they are not automatically interchangeable, unless the Committee determines that it's clinically appropriate and safe to interchange these drugs without a provider prescribing a new prescription. So they are included in therapeutic interchange when the drug is in a new class review, or an update to an existing class review, or a single drug addendum. So our program, if we have a drug class, and I am going to say like proton pump inhibitors, and we have reviewed the proton pump inhibitors, and let's say now Nexium just came to market and it was not included in that original review. Nexium then is not eligible to be a preferred drug on the PDL. It's not nonpreferred either. So we don't do therapeutic interchange on Nexium. And each Agency will treat that drug as they as what meets your business needs. So it won't be included on the PDL or in the TIP program until we do a new class review and incorporate evidence for using Nexium data in our review. Or if we do a single-drug addendum on Nexium, then that evaluates its evidence, and it can be added to the drug class. So that is kind of that stipulation on when a drug is or is not eligible to be on the Preferred Drug List. Also, it is not subject to TIP if it's a continuation fill for one of the types of drugs listed below if the Committee determines therapeutic interchange isn't allowed. So there might be certain drugs where you feel they shouldn't be interchanged without intervention from the prescribing provider. And then it's also allowed when the endorsing practitioner has assigned Dispense as Written, assuming that the Committee has agreed that therapeutic interchange is appropriate. So, signing the prescription Dispense as Written does not necessarily apply where a non-preferred drug or therapeutic interchange has not been approved. Next slide. So, status on the drugs on the PDL, it's in a PDL class but not included in the DERP report. So, going back to my example, let's say

Nexium has just come to market. We have already reviewed proton pump inhibitors. Nexium would be covered according to program benefit design. Therapeutic interchange doesn't apply, and DAW does not apply. Drug classes not on the PDL, so if it's not one of those 30-some-odd drug classes that we review with the Drug Effectiveness Review Project, all of those other drug classes are covered according to the program benefit design. For Uniform Medical Plan, we use Moda Health's formulary to kind of wrap around our Washington PDL. Next slide. We also have a process to archive drug classes. So for example, the proton pump inhibitors, I believe are either archived or will be archived. Where it's a class that has gone almost completely generic. There is not a lot of new evidence that is being published. Then the Agency might recommend that we archive the class. The Drug Effectiveness Review Project is no longer updating those reports, and so there's really a little reason to consider making changes to that class because it's a pretty solid class, and the evidence is, I am going to say, stable. So we'll bring that recommendation to the Committee. You will review a final surveillance report of the drug class, vote on whether it's appropriate to archive the class, determine if therapeutic interchange and DAW rule should continue without further clinical review, and then direct agencies to change the preferred status or allow agencies to change preferred status based on cost when appropriate without having to come back to the Committee for a review. So if something were to change. Let's say we archive a class, and there are a few brands in that class, they become generic, we might then non-prefer those brands and prefer their generics instead. The archived classes will remain on the PDL, and then the Committee or the program can reactivate an archived class if we determine that significant changes are made to the evidence base for the class, or if there are significant changes in indications for any of the drugs within that class. Okay. So that was really a summary of the Washington PDL and the PDL process. Now, we are going to change our focus and focus on the Drug Utilization Review Board. So we will formally adjourn the P&T Committee. The P&T Committee only reviews the Washington PDL Program, and the P&T Committee makes recommendations that impact the state public employees, school employees, workers' compensation, and our Medicaid program. On the other hand, the Drug Utilization Review Board is specific to the Medicaid program only. So although it's the same group and body of people, we will adjourn the P&T Committee and reconvene as the drug DUR Board, and then the decisions and recommendations you make only impact the Apple Health PDL and Pharmacy Program. So the DUR Board is required by federal law. It is in Section 1927 of the Social Security Act. It's an extension of the P&T

Committee advising on additional utilization controls for drugs within the Apple Health Preferred Drug List. So for example, the P&T Committee really is making recommendations on preferred and non-preferred status for drugs on the Washington PDL. The P&T Committee doesn't review like our prior authorization policies for Uniform Medical Plan or Labor and Industries. Whereas, the Drug Utilization Review Board, we are bringing to you our prior authorization policies for the Apple Health Program to review those policies and make changes to them as you see fit. You recommend DUR programs or interventions also based on data provided by staff, review and approve any Drug Utilization Review program proposed by Apple Health that we might recommend, offer guidance and modifications, and then engage in provider education activities when appropriate. So in the past, the Committee has written and drafted letters to providers about opioid prescribing and other initiatives that we were managing back probably about 10 years ago. So, next slide. So the Apple Health, PDL was implemented January 2018. It was a budget proviso that directed the Healthcare Authority to create a single Preferred Drug List that all of the Apple Health managed care and fee-for-service program needed to comply with. So we started implementing in January of 2018, and it took us several years to get a comprehensive list created. And I believe that was in April of 2020 that we completed the implementation. And then the Healthcare Authority, we contract with Magellan. And so through the Optimal PDL Solution, which is a supplemental rebate pool administered by Magellan, and that is where we obtain our supplemental rebates. And that's why Umang is here. So Umang will provide clinical therapeutic class reviews on the drug classes on Apple Health PDL in addition to what we hear from the Drug Effectiveness Review Project. So, next slide. And I already said that. So like I said, Magellan reviews each drug class. They are reviewing the published peer reviewed clinical trials. They are looking at data regarding efficacy and safety that Umang usually goes over the side effects and indications for each of the drugs. And then he'll present that information to the Board, and then the Board will make a similar motion as you do with the therapy with the Washington PDL, recommending if drugs are safe and efficacious and make recommendations on interchangeability and whether or not they should be allowed to have a continuation of therapy. So, an example would be those drug classes with the TIP Program. There are certain other drug classes where we might not want to change a person's medication once they are stable on it if a change to the preferred status is made for that particular drug. So next slide. So, Magellan does a financial analysis of drug classes twice per year. They update their rebate contracts with manufacturers on a biannual cycle. So half the drug

classes are re-contracted for a July 1st rebate start date, and the other are contracted for a January 1st start date. So they will take our data and perform a cost analysis based on the supplemental and federal rebates that we are eligible for, and then the state will consider the DUR Board recommendation, the P&T Committee recommendation, if there is one for that class, and then we'll look at that financial analysis and determine which drugs will be preferred on the Apple Health PDL. Next slide. And I think this is the last slide or second to last slide. We have lots of acronyms. I try to do my best of not speaking in acronyms, but I do fall back into old habits. But this will always be in part of the information that you get each meeting so that you have it to rely on if you are hearing an acronym and don't understand what it means. And feel free to always interrupt us.

Leta Evaskus: This is Leta. Donna just froze for me.

Alex Park: For me as well, Leta.

Leta Evaskus: Oh, okay.

Donna Sullivan: Can you hear me? [cross-talk] --

Leta Evaskus: I was like, is that my computer?

Donna Sullivan: I just got a [cross-talk] --

Alex Park: We can hear you now. [cross-talk] --

Donna Sullivan: I just got a message that says my internet is not stable, so I am going to stop my video, and hopefully that will keep my sound going.

Leta Evaskus: All right. Thank you.

Donna Sullivan: Are there any questions? I'll hand it back to you, Alex.

Alex Park: Thank you, Donna. A great summary. Always nice to have that reminder at the beginning of each year. Any questions for Donna on our process? I just had one question, Donna, which was I think the DERP terminology changed a little bit. They used to have the literature scans. And is that what the surveillance report is now?

Donna Sullivan: Yes. We used to have a scan -- we call them scans -- but now it is a surveillance report.

Alex Park: Okay.

Donna Sullivan: And the quality of that surveillance report is, I think they are better quality reports. It gives a little bit more information about the data or the evidence in the study rather than the scans. We are just more counting how many studies were out there rather than summarizing their randomized controlled trials. They are a meta-analysis or whatnot. So I do believe that these surveillance reports are an improvement upon those scans.

Alex Park: I agree. And then the Committee will -- it's not the next topic, but it's the topic after next when we review the CGRP report, So that, I think, they called it a systematic review in the new terminology. Does that kind of replace all the new class reviews or update to existing class reviews, some of the older terminology that was present?

Donna Sullivan: I believe so. Ryan, do you know if this is a new updated report or if it's a surveillance report for the CGRPs?

Ryan Pistoresi: I believe this is the updated report. I can double-check and actually see the file that we're going to be presenting, but I thought this was going to be the updated one.

Leta Evaskus: This is Leta. It is a full report.

Donna Sullivan: Okay, so yes, Alex. That is an updated report.

Alex Park: Great. So there's a new drug on that list. So that could be eligible for inclusion on the PDL when the Committee reviews that then.

Donna Sullivan: As long as there was evidence evaluated in the report, yes. Sometimes the Drug Effectiveness Review Project might include a drug that is still in the pipeline because there is evidence available on it. And then if they are able to do that, we can incorporate that into our program because it has been reviewed once it hits the market. But sometimes the drug is included in the class, but there is actually no study that met their inclusion criteria for inclusion in the report. And if that is the case, then that drug is not

considered eligible to be preferred because there was no evidence for it that was reviewed.

Alex Park: Got it. That makes sense. And when the Committee is deciding therapeutic interchange, it's only within that class. Correct? There might be other drugs in other classes that might serve the same indication, but the Committee, as I understand it, is only [cross-talk] --

Donna Sullivan: Correct.

Alex Park: Yeah, yeah.

Donna Sullivan: Correct. And that is one of the reasons why we break out some of the drugs as granular as we do. So insulin, for example, we have them broken out by long-acting, short-acting, immediate-acting and ultra-short, whatever because we don't want there to be an interchange between a long-acting and a short-acting. Right? We want a long-acting for long-acting that are interchangeable, and so that's why they are broken out. But yes, it's within that class. The P&T Committee does not make decisions of should this be first-line therapy versus second-line therapy as a drug class. So an example when the angiotensin receptor blockers came out, our Committee wanted them to be second-line to ACE inhibitors. Well, if they are going to be on the PDL, they are there on the PDL. We have preferred products therapeutic interchange applies. In order to get them to be step therapy for ACE inhibitors, we would have had to not have those drugs on the PDL at all, and then the program can implement whatever clinical edits that they wanted to.

Alex Park: Thank you. That's an important point. I think it actually might apply to our CGRP motion that's coming up. So we'll keep that answer of yours in mind. It's 9:46, so we should be moving on to the next topic. But before we close this, are there any other questions from the Committee? Great. Thank you, Donna. And I think you are up again, Donna. Sorry to keep you on the boil here, but to talk about the archiving and removing of the classes.

Donna Sullivan: Sure. So we have had drugs that are archived on the PDF for quite some time, and it's a lot of work to go through and review some of those classes every quarter. The NSAIDs have hundreds if not thousands of NDCs that we have to go through and potentially consider when we're reviewing that. So we have 16 drug classes and subclasses on the PDL that have been archived for five to eight years with no updates on the market. There have been no surveillance

reports on them. And the Drug Effectiveness Review Project is not going to review these classes. The governing Board has voted that we're not going to spend our research dollars on updating classes that are all generic or no longer really have fiscal impact on the state. We are going to let the states use their own P&T Committees or use their own resources to manage those particular drug classes. So many of these classes are no longer prescription. They have gone over the counter. So an example would be the antihistamines, proton pump inhibitors, as I have mentioned, the H2RAs, or they have all gone generic. And so the Uniform Medical Plan no longer covers OTC medications. It is now considered a benefit exclusion, so that's another reason why we might archive a class. And then oral contraceptives, actually, I think all contraceptives are now required to be covered as preventive by federal law. So that might be another reason to archive a class if that there is either a state law or a federal law that mandates coverage for a particular drug or drug class. Next slide. So we have a process. Again, we have identified those that the DERP program will not review. HCA will recommend that they be archived. The Committee will review a final report and vote on whether to archive or not, including the TIP and DAW impacts, and then allowing us to make changes. The new thing about archived drugs is that the class will remain on the PDL for at least two years as archived. And then, again, the Committee or the program this, the agencies can reactivate a class if significant changes are made. Or if there is another drug class that comes out that may or may not interact with that. So I'm going to say an example would be like the PCSK-9 inhibitors. When they came to market, I believe we were going to archive the statin class, but we chose not to because they both treated cholesterol, and we wanted to still have preferred options for the statins on the Washington PDL. That might change in the future. So what's the next slide, Leta? So now the change that we are recommending making is that if we have archived a drug class and it's been archived for two years, there hasn't been any significant changes to the class, and we don't anticipate there to be significant changes, we are going to recommend eliminating the drug class from the PDL altogether. So that means it will no longer be published online as part of the PDL. And so for those classes, we are no longer required to follow the motion that was recommended when it was archived and that the programs will manage those drug classes separately on their own formularies or Preferred Drug Lists. And then Luke did a lot of work reviewing all of these archived drug classes, and we have come up with this list of classes to eliminate. As you can see, some of them had been archived since 2015, so eight years or close to eight years. And so we are going to be eliminating these drug classes from the PDL effective -- I don't

know if we have created an effective date yet. But that's our intention, it is to remove these from the PDL. And is there another slide? And then we would like to archive, and I think we have these maybe on the Agenda for later this afternoon or later this morning, the antiemetics, the hep C peginterferons, and the statin class. And we just want, I guess, just a head nod. I'm not sure if we need a motion, but maybe we will just for procedural stake to say that the Committee agrees to eliminate or archive the classes that are listed on Slide 5, and that will move to archive. Leta, I'm not sure if the second motion, do we have those reviews to review before the Committee makes a decision?

Leta Evaskus: We do not have that for today, but we would do that in the future to archive the class.

Donna Sullivan: Okay, okay. I don't think we need the second motion, then. I think just the first one to eliminate the drugs listed on Slide 5 from the PDL. If we could just get a motion and a vote from the Committee on that. And then the Committee will make the decision on archiving those other three drug classes when we bring them for final review.

Alex Park: Thank you, Donna. Well, we'll give a moment to the Committee. And maybe, Leta, would you mind showing Slide 5 again so that the Committee could peruse that drug class list? Again, we would be voting on a motion that we agree or not to go ahead and eliminate these as per the protocol that Donna had run through. The only question I had was in the Alzheimer's drug class. We do have those new aducanumab and lecanemab drugs that are coming out, which kind of throws a wrench into that class. Are those being looked at in a different designation as a class or --?

Donna Sullivan: I believe so. They are not included in this particular class. This is the [indistinct] the older medications, the oral ones that were on the market. They have all been generic. If the Drug Effectiveness Review Project chooses to review the newer classes, then they would be in a different class.

Alex Park: Okay. Any other questions from the Committee? We'll give everybody another moment to look at this list here. Okay, hearing none. It is a class of older drugs. Just looking at the top ACE inhibitors and [cross-talk] --

Laura Beste: This is Laura Beste. I am concerned about the whole Alzheimer's drugs thing, too. That doesn't need to be spelled out more clearly. This is fine as is just for this.

Donna Sullivan: So this is Donna. So I'm sorry, Laura. Can you maybe explain your concern a little bit more? I am not quite sure I am following you.

Laura Beste: Along with Alex, I just thought that Alzheimer's drugs was rather broad, so I just wanted to make sure for clarity reasons it doesn't need to be spelled out as far as like actual classes of Alzheimer's drugs. Or could that be included? This is fine as is. It doesn't really matter because you are just stating it's archived, and it's known which ones are being archived.

Ryan Pistoresi: Yeah. So this is Ryan. This was an old report from some of the older drugs that treated Alzheimer's. As you can see, it hasn't really been updated in seven years. And I know that there are going to be some newer therapies being studied for Alzheimer's, so this wouldn't include some of these newer treatments that are for the Alzheimer's disease. This is just saying for the drugs that were identified in the older DERP reports in the early part of the 2010s. These drugs are going to be considered archived because they are all generic now, and there really hasn't been any new evidence or new drugs within these older classes.

Laura Beste: Okay, as of 2016. Okay, got it.

Ryan Pistoresi: [Cross-talk] And it states that [cross-talk] go ahead [cross-talk] --

Donna Sullivan: [Cross-talk] Yeah, and I believe the title of the report is "Alzheimer's Drugs." And so I believe the class is named after the report title.

Laura Beste: Okay, thank you.

Ryan Pistoresi: So Donna, just to make sure that Laura's concerns are adequately addressed, the Alzheimer's drugs, I think when that other report came out, it must have just been the cholinesterase agents in the Memantine. That's probably all it was. Is that right?

Donna Sullivan: Yeah, exactly. The other drugs weren't on the market. So the other drugs actually came to market after this class was archived to begin with. So they were never included in that class.

Ryan Pistoresi: So is it the case that we have to keep the title of the report as it was presented to the Committee at that time?

Donna Sullivan: We could put in parentheses -- I don't know if any of them were injectable. I am trying to -- I was going to say they are all oral, but then they had patches. So I am not really sure. We could, Ryan and Luke, come up with the mechanism of action of those drugs so we can say they are in the cholinesterase drugs or whatever, more their therapeutic drug class name as opposed to just Alzheimer's in general.

Ryan Pistoresi: Yeah. I am on the DERP Clearinghouse website. So the last time that it was updated in a full report was 2006. So this is pretty dated in terms of the drugs that are in this Alzheimer's drugs class that we have on the PDL. So yeah. I think what we can do is just add in a little bit more information. We have done that for some of the other drug classes like the asthma and COPD drugs. And we can work together with DERP and with Leta to make sure that that update reflects exactly what we have in this class. Okay. Thank you.

Alex Park: Thank you. [Cross-talk] --

Donna Sullivan: [Cross-talk] And just a reminder, you can always -- this is Donna. Sorry, Alex. You can always bring a class back. So if we have determined that if we are going to review the new Alzheimer's medications, the infused and injectable ones, if we think that it's relevant to bring back these older products, then we could. But I don't think that there will be any comparable evidence between the newer products and the older products as far as a head-to-head trial on efficacy of the newer ones over the older ones.

Alex Park: Yeah, I agree. I was just going to suggest this process. I mean, you guys can take the lead how you like, but you could also just put the date that the report was last done. That would sort of timestamp what drugs were available in that era.

Donna Sullivan: And Leta, do you want to put 2006? Yeah.

Dimitry Davydow: This is Dimitry. I just think it's just kind of striking. All the other reports are specific or titled by mechanism as opposed to a specific condition or disease. And also from a clinical standpoint, cholinesterase inhibitors, memantine, are frequently prescribed more broadly for not just Alzheimer's dementia but other dementias, as well. So for consistency's sake, it seems like it would make more sense to go with the others.

Ryan Pistoresi: This is Ryan, and that's a great observation. So a lot of the ways that these older reports were done were how they were scoped. And, as I mentioned, this last report was from 2006, and so I think at the time the way that the states were looking at this was just specific to that, whereas, because of the level of evidence between the ACE inhibitors and the calcium channel blockers and the beta blockers. They had to separate them out so that way they could do a focused study on just the comparative effectiveness between the different ACE inhibitors that were on the market in the early 2000s versus the calcium channel blockers, which, as you know, are going to be slightly different in how they are prescribed and how they treat. So I think that it's just a relic of how these reports were named and presented for states.

Dimitry Davydow: Yeah. It's just a sign of how old that report is and how time has moved on.

Donna Sullivan: And I just want to reiterate removing them from the PDL does not mean they are no longer covered and that there is no longer access. It just means that this Committee is not going to be reviewing them. It will be turned over -- for Uniform Medical Plan, they will just revert to the Moda Health PDL, and they will follow their P&T Committee processes.

Alex Park: Okay, Committee. Leta, if you could return to the -- yes. So I will entertain a motion from the Committee to look at the top line. And if you were to make the motion, go ahead and please state it, and Leta will record your name, and then we'll look for a second, and then we'll vote.

Laura Beste: This is Laura Beste. I motion that the P&T Committee agrees to eliminate the drug classes listed on Slide 5 from the Washington PDL.

Virginia Buccola: This [Cross-talk].

Dimitry Davydow: This is Dimitry Davydow, and I second the motion.
It

Alex Park: Thank you. I saw you there, Ginni, too. So we'll consider it a dual second. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? Okay, the motion passes. Thank you, Committee, and a great discussion. Okay. We have a big topic ahead of us

next, the systematic review on the CGRPs. I believe the systematic review -- this is like the most deluxe that we'll get from DERP. It's a very thorough report, and so we look forward to that. And we'll hand it over to Sara Kennedy.

Leta Evaskus: And Sara, sorry. This is taking just a minute because I needed to save the last one.

Sara Kennedy: Sure. Take your time. Hello, everyone.

Alex Park: Morning, Sara.

Leta Evaskus: All right. All ready.

Sara Kennedy: All right. Well, I am Sara Kennedy, and this is the deluxe presentation on the Calcitonin Gene-Related Peptide Inhibitors for Migraine Prevention and Treatment and for Cluster Headache Prevention. Next slide, please. So this slide shows the overview of today's presentation. I will briefly go over background, then the PICOS, key questions, and methods, and then we'll spend most of the time on Findings and Conclusions and then conclude the discussion. Next slide, please. So this slide shows background on migraine headache. The International Classification of Headache Disorders defines the diagnostic criteria of migraines as attack with headaches that lasts 4 to 72 hours with specific characteristics, such as if they are unilateral, have a pulsating quality, or are aggravated by activity. Migraine can occur with or without aura symptoms, and these are sensory disturbances like light flashes, blind spots, and tingling, or with other symptoms such as nausea, vomiting, and sensitivity to light. Chronic migraine is defined as 15 or more headaches per month for at least three months. An episodic migraine is diagnosed for fewer than 15 headaches per month. Migraine headaches are more common among women than men. And available migraine preventive treatments include antidepressants, anticonvulsants, beta blockers, botulinum toxin, and available acute treatments include triptans, ergot drugs, nonsteroidal anti-inflammatories, and anti-nausea drugs. And calcitonin gene-related peptide (CGRP) is a neuropeptide that plays a role in the vasodilation of cerebral and Dural blood vessels and thus is involved in the pathophysiology of migraines. So unlike other available preventive medications, CGRP inhibitors were developed specifically for migraine prevention. Next slide, please. So cluster headaches typically present as multiple headaches occurring within a period of days, weeks, or months, and this time is referred to as a cluster period.

Cluster headaches are characterized by severe unilateral pain, often located around the eye and associated with tearing, runny nose and sweating. Cluster headaches are also characterized as either episodic or chronic, with episodic being characterized by at least two cluster periods separated by a pain-free remission of three months or longer, whereas chronic is characterized by a lack of a sustained remission between clusters. Cluster headache is less common than other primary headache syndromes, and it affects more men than women. Acute treatments include supplemental oxygen, triptans, lidocaine, ergots, and preventive treatments include Verapamil, steroids, ergots, topiramate, lithium, and nerve blocks. And unlike preventive treatments for migraine, which is taken regularly, preventive treatment for cluster headache is started at the beginning of a cluster period to reduce the severity and frequency of the headaches during that time. The path of physiology of cluster headaches is complex, but CGRP is thought to play a role. Next slide, please. So this figure shows the CGRP inhibitors by their mechanism, and this includes agents that are monoclonal antibodies targeting CGRP receptors, specifically erenumab. And then monoclonal antibodies targeting the CGRP ligand, eptinezumab, fremanezumab, and galcanezumab, and these are all used for migraine preventive therapy. And then galcanezumab also has an indication for cluster headache prevention. And since the last DERP report, the FDA has also approved one new oral small-molecule inhibitor, atogepant, for acute migraine prevention. And then rimegepant is now approved for both migraine prevention and acute migraine treatment. Ubrogepant is approved for acute migraine treatment only. And then zavegepant, which was new to the scope of this report, is not yet approved by the FDA, but approval is anticipated soon, sometime in the first quarter of 2023. Next slide, please. So this was a previous report that was completed in October of 2018 that assessed for drugs eptinezumab, erenumab, fremanezumab, and galcanezumab for the prevention of chronic and episodic migraine. And then we completed an update report and 2020 that expanded the scope to include two additional drugs, rimegepant and ubrogepant, and two additional indications of acute treatment of migraine headache and prevention of cluster headache. And the current DERP report was again expanded to include two additional drugs, atogepant and zavegepant. Thank you. So this slide summarizes the PICOS for the current report. Populations included adults with episodic or chronic migraine, chronic cluster headache, or adults with acute migraine headache. And we included studies assessing CGRP inhibitors as described a couple slides down. And the acceptable comparators were placebos, other CGRP inhibitors, or other standard-of-care treatment. Next slide. Outcomes of interest

included migraine events, pain relief, quality of life, functional or disability outcomes, use of rescue therapies in the studies of preventive treatments, healthcare utilization outcomes, and harms including adverse events, serious adverse events, and discontinuations due to adverse events. And then we included randomized control trials. Next slide. So this slide summarizes the key questions. And the first key question is about the effectiveness and harms of treatments to prevent migraine headache and cluster headache. And the second key question is about the effectiveness and harms of CGRP inhibitors for the acute treatment of migraine and cluster headache. And then the third key question is about ongoing studies of CGRP inhibitors. Next slide. So we'll move into the methods. Next slide, please. So this just gives a quick overview of the methods that are used for this report. Our search was through August 18th on Medline via PubMed and through October 27th in the Cochrane Library with active surveillance through November 8, 2022. And we searched those databases back to inception for the drugs that were new to the scope of the report. We conducted individual study risk of bias assessment and calculated risk ratios and confidence intervals where possible. We applied great methodology to rate the overall certainty of the evidence and, lastly, searched clinicaltrials.gov to identify the ongoing studies. Next slide. So just as a reminder, this is the DERP approach to risk of bias, and these are the risk of bias categories. Next slide. And here is a quick overview of the grade certainty of evidence. We graded efficacy outcomes, quality of life, serious adverse events, and discontinuations due to adverse events for this review. And as a reminder RCTs start at a high certainty and can then be downgraded for problems of consistency, precision, risk of bias, or reporting biases. Next slide. So now we'll move into the findings. So here it is our steady flow diagram. We screened 419 new titles and abstracts from the update search and two additional references that we identified through hand search. We assessed 56 articles to identify 30 new articles, and we carried forward 32 articles from a prior report for a total of 62 articles reporting on 42 RCTs. So the bottom row shows the study breakdown by condition. We identified seven RCTs of chronic migraine prevention, 18 of episodic migraine prevention, 6 that were conducted in mixed populations with chronic or episodic migraine, 9 of acute migraine treatment, and two of cluster headache prevention, and then we did not identify any studies of acute cluster headache treatment. Next slide. Here is an overview of some of the characteristics of those 42 included RCTs. So 15 were new to the update, and 27 were included in the previous report. We rated 41 of the 42 as moderate risk of bias, primarily because of industry sponsorship and the risk of bias from extensive manufacturer involvement in study design, conduct

analysis, and preparation of manuscripts. The single study that was rated as high risk of bias was rated as high because the relevant study groups were not blinded, and also because there was a high potential for selection bias due to an extension trial design with recruitment restricted to participants who had completed some previous trials. And this also shows the breakdown by condition that we detailed on the previous slide. And then, finally, you'll see that nearly all were placebo-controlled trials. One trial included both a placebo arm and a sumatriptan arm, and then one trial used topiramate as the comparator. Next slide. So let me just quickly outline how we structured the results. So this structure covers everything that was in the key questions, but we reordered it slightly to be consistent with the structure of the report and to put it in an order that I think is a little bit more digestible. So I will start out by describing the efficacy outcomes like migraine or headache events and functioning and quality of life outcomes by condition as listed here and then by drug within each of these categories. Then I'll describe the harms-related outcomes, specifically serious adverse events and discontinuations due to adverse events for each condition. And finally, I'll summarize the ongoing studies. And then just to give you a preview of what you'll see when we move into the detailed findings, the bottom line conclusions did not change much since the 2020 version of this report. We found several new studies, but they did not, for the most part, impact certainty of evidence grades. And we generally found moderate certainty of evidence favoring the CGRP inhibitors for clinical improvement and functioning outcomes. And we generally found very low certainty of evidence for harms outcomes, mostly because the events were just too rare for a relationship to be determined. All right, next slide. So briefly, here are some acronyms are associated with the most common outcomes using the study in the box at the top. And I just want to give you some context for what is clinically meaningful for these scales. So on the HIT-6, a 1.5 point between group difference is generally considered clinically meaningful. 4.5 points on the MIDAS is generally considered meaningful. And for the MSQL, it ranges from 5 to 10.6 points depending on the domains that were used. And then the clinically meaningful difference for the PGI-C and PGI-S varies depending on the Likert scale that was used and the condition being assessed. And at the bottom are other common abbreviations that are used throughout the presentation. Next slide. All right. So we'll move into the findings. First, we'll cover the clinical improvement and functioning outcomes for chronic migraine prevention. And I'll just start here by orienting you to where the information is on these slides. So the second row of the title shows the comparison, eptinezumab versus placebo. The first green box is clinical

improvement outcomes, which we graded as moderate certainty of evidence. And the bullets in the white box describe the number of trials, the sample size, the specific outcomes that we graded, and the results for each outcome. So in this instance, there were two RCTs with a total sample size of 1393 participants. One of the two studies was new to the current report. Both trials found significant reductions in migraine headache days per month compared with placebo, ranging from 2 to 2.7 days at 12 weeks. And both studies also found that participants in both eptinezumab dosage groups were significantly more likely to have a 50% or greater reduction in migraine days per month. The second green box is for functioning outcomes. We graded this as moderate certainty of evidence. Again, this outcome included both of the two trials comparing eptinezumab with placebo. Both trials use the HIT-6 and found statistically significant improvements in both 300 mg dosage groups. One trial found a significant improvement in the 100 mg dosage group, but the other trial did not. Next slide. So, we identified one study that compared a erenumab with placebo. It evaluated both 70 mg and 140 mg dosages over 12 weeks. And this was included in the previous report, so I won't go into detail on these findings. But we graded all of the outcomes as moderate certainty, and they all favored erenumab. Next slide. We identified three RCTs comparing fremanezumab with placebo, and one of these three was new to the current report. We graded the evidence related to clinical improvement as moderate certainty. All three studies found statistically significant improvements in migraine headache days per month, with reductions ranging from 1.3 to 2.1 days. Two of the three studies found a significantly larger percentage of participants in the fremanezumab group and had a reduction of 50% or more in migraine headache days per month compared with placebo. We graded the evidence related to functioning as moderate certainty. Two of the three trials reported significantly larger improvements on the HIT-6 favoring fremanezumab, and the third trial did not report any functioning or quality of life outcomes. Next slide. We identified one trial that compared galcanezumab with placebo. There were two publications reporting new data related to healthcare utilization outcomes since the previous report. As in the previous report, we graded the evidence related to clinical improvement as moderate. This study reported significantly larger reductions in migraine days per month compared to placebo, ranging from 1.9 days in the 240 mg group to 2.1 days in the 120 mg group. And this study also reported significantly larger improvements in other efficacy outcomes, including a 50% reduction in the number of migraine days per month for both doses. And we rated the evidence related to functioning as moderate quality. There were statistically significant

improvements for both doses compared to placebo across all three domains on the MSQL. I think we are at galcanezumab, Slide 22. Are you able to [cross-talk] --

Leta Evaskus: Yeah, hey [cross-talk]. Sorry about that.

Sara Kennedy: No, that's okay. On more forward. Should be 22 galcanezumab versus placebo.

Leta Evaskus: This one is 22.

Sara Kennedy: [Cross-talk] Oh, looks like 23.

Leta Evaskus: [Cross-talk] Oh, here it is, 23.

Sara Kennedy: Sorry. Okay, so I think we covered the functioning outcomes. And then I should note really briefly, the data from the two new published studies, we didn't grade it, but they found no significant difference between groups and emergency room visits, hospital admissions, or healthcare professional visits. And we didn't include it on this slide because it wasn't graded. All right, next slide. Okay. So now we're going to move into the Clinical Improvement and Functioning Outcomes for Episodic Migraine Prevention. So we identified two new studies of atogepant to prevent episodic migraine. And as a reminder, atogepant was approved since the previous report so isn't new to the current report. We graded the evidence related to clinical improvement as moderate to low. Specifically, we graded the evidence for reduction in migraine headache days per month as moderate certainty. Both studies found a statistically significant reduction in mean change in migraine headache days ranging from 0.7 days to 1.7 days at 12 weeks. We graded the evidence as low certainty for percentage with a 50% reduction in migraine days per month. There were improvements favoring atogepant in all dosage groups, but the difference with placebo was only statistically significant one of the two trials. And then we graded the evidence related to functioning as low certainty. Only one of the two trials reported functioning outcomes, and that trial found statistically significant improvements, but the competence intervals were quite wide. The next slide. We identified two trials comparing eptinezumab to placebo, and there was one publication new to the current report reporting longer-term outcomes on one of those trials. We graded the evidence related to clinical improvement as moderate. There was a significantly larger change in monthly migraine days for both doses

compared with placebo and significantly more participants achieved a 50% reduction in monthly migraine days compared with placebo in the larger of the two trials. And we graded the evidence related to functioning as low. There were improvements in all dosage groups, but they were only statistically significant in the larger of the two trials. Next slide. All right. We identified a total of six RCTs that compared erenumab to placebo for episodic migraine. One of these RCTs was new to the current report. There were also two new publications reporting additional data related to three RCTs that were included in the previous report. We graded the evidence related to clinical improvement as moderate. All six studies reported statistically significant reductions in migraine days per month compared to placebo. And the range was 1 to 2.3 days for the 70 mg dose group and 1.6 to 1.9 days for the 140 mg group. These studies also reported larger improvements for active doses compared to placebo on secondary efficacy outcomes, specifically those with a 50% reduction or more in the number of migraine days per month. We graded the evidence related to functioning as moderate. All six studies reported significantly larger improvements in all dosage groups compared with placebo on the HIT-6. Next slide. So we identified three RCTs comparing fremanezumab with placebo for episodic migraine prevention. One of these RCTs was new to the current report, and we graded the evidence related to clinical improvement as moderate. All three studies found statistically significant improvement in migraine days per month ranging from a reduction of 1.3 to 3 days. The studies also reported significant improvements in the proportion with a 50% reduction in monthly migraine days. We graded the evidence related to functioning as moderate certainty. All three studies reported statistically significant improvements in MIDAS scores and active dosage groups compared with placebo. Next slide. So we identified five RCTs that compared galcanezumab with placebo, and one of these RCTs was new to the current report. We graded the evidence related to clinical improvement as moderate certainty. There were significantly larger reductions in migraine days per month across dosages and studies ranging from 0.9 to 3 days. All of the studies also reported significant improvements in [audio cuts out] the 50% reduction in monthly migraine days. And then we graded the evidence related to functioning as moderate. Five of the six studies reported statistically significant improvements on the MIDAS or MSQL favoring galcanezumab. Next slide. So this section reports the results of trials that were enrolled participants with chronic or episodic migraine. In the 2020 report, all but one study enrolled participants that were distinctly characterized as having either episodic or chronic migraine. And so we note an increase in more recent studies

enrolling mixed populations that include both types of participants within the same study. So for this update, we are reporting the results separately. Next slide. So we identified one new study that compared eptinezumab with placebo to prevent migraine in participants with chronic or episodic migraine. We graded the evidence related to clinical improvement as moderate certainty of evidence, and there were statistically significant reductions in migraine headache days per month of 2.7 days in the 100 mg dosage group and 3.2 days in the 300 mg group over 12 weeks. This study also reported a significantly larger proportion reporting at least a 50% reduction in the number of migraine days per month in both the 100 mg and 300 mg groups compared with placebo. And we graded the evidence related to functioning outcomes as moderate certainty. There were statistically significant improvements in both the 100 mg and 300 mg groups compared with placebo. Next slide. We identified one new study comparing a erenumab with placebo to prevent chronic or episodic migraine, and we graded the evidence related to clinical improvement as moderate certainty. There was a statistically significant reduction in migraine headache days per month of 1.6 days at weeks 12 to 24, and the percentage of patients supporting at least a 50% reduction in the number of migraine days per month also favored erenumab. And this study did not report any functioning or quality of life outcomes. Next slide. We identified one new study comparing eptinezumab to topiramate. So this is one of those two studies in the current report that included an active comparator. We graded the evidence relating to clinical improvement as moderate certainty of evidence. There was a statistically significant reduction in migraine headache days per month of 1.8 days in the 70 mg group and 140 mg group. The percentage of patients reporting at least a 50% reduction in the number of migraine days per month also favored eptinezumab in both groups, and we graded the evidence related to functioning as moderate certainty. There were statistically significant improvements in both the 70 mg and 140 mg groups compared with topiramate on the HIT-6. Next slide. So we identified one study comparing fremanezumab with placebo. And this study was included in the previous report in the chronic migraine prevention section, and it was the only study at that time that recruited a mixed population, and they had 61% of participants with chronic migraine. We graded the evidence related to clinical improvement as moderate certainty of evidence. There was a statistically significant reduction in migraine headache days per month of 3.1 days in the 225 mg group and 3.5 days in the 675 mg group. This study also reported a significantly larger proportion of participants reporting at least a 50% reduction in migraine days per month in both dosage groups compared

with placebo. We graded the evidence related to functioning outcomes as moderate certainty. There were statistically significant improvements in both the 225 mg and 675 mg dosage groups on the HIT-6. Next slide. So we identified one new study comparing galcanezumab with placebo, and we graded the evidence related to clinical improvement as moderate-to-low certainty. Specifically, we graded reduction in migraine headache days per month as moderate. This study observed a significantly larger reduction of 3.1 days at 15 weeks compared to placebo. This study also reported a significantly larger proportion of participants in the galcanezumab group reporting at least a 50% reduction in number of migraine days per month, but the confidence intervals were wide. We graded the evidence related to functioning outcomes as low certainty. There was a statistically significant improvement as measured by the MIDAS but, again, the confidence intervals were wide. Next slide. We identified one new study comparing rimegepant with placebo, and we graded the evidence related to clinical improvement as moderate-to-low certainty. We graded reduction in migraine headache days per month as moderate certainty. This study observed a significantly larger reduction of 0.8 days at 12 weeks compared to placebo. This study also reported a significantly larger proportion of participants in the rimegepant group achieving at least a 50% reduction in the number of migraine days per month, but the confidence intervals were wide. And we graded the evidence related to functioning outcomes as a very low certainty. There was no significant difference between groups as measured by the MIDAS at 12 weeks. Next slide. All right. So now we'll move into the harms of their migraine prevention drugs. Next slide. For harms, I am going to summarize the findings for each indication on one slide. So this slide is for chronic migraine prevention. There were seven RCTs reporting on just over 5000 participants. Serious adverse events and discontinuations due to adverse events were rare and, therefore, we were unable to determine a relationship for this outcome, which we graded as very low. And to give you a sense of what I mean by rare, these were generally serious adverse events or discontinuations due to adverse events in less than 1% or 2% of participants in each group. Next slide. This slide is for episodic migraine prevention. There were 18 RCTs reporting on 2673 participants. We graded the evidence for serious adverse events and discontinuation due to adverse events as very low certainty. There were rare events and again, a relationship cannot be determined. Next slide. END PART 1 This slide is for the mixed chronic and episodic migraine prevention studies comparing the CGRP inhibitor to placebo, and there were six RCTs reporting on 3200 participants. And again, we graded the evidence for serious adverse events and discontinuations due

to adverse events as very low certainty. Because these events were rare, a relationship could not be determined. Next slide. This slide is also for mixed chronic and episodic migraine prevention studies comparing a CGRP inhibitor, but instead of placebo, to topiramate. So there was one RCT with 777 participants. And again, we graded the evidence for harms as very low certainty. There were rare events, and a relationship could not be determined. And we graded the evidence for discontinuation without adverse events as moderate. There were fewer discontinuations in the erenumab group compared to the topiramate group. Next slide. So this slide summarizes the grade and certainty of evidence ratings and the direction of effect for each condition, comparison, and outcome. And just to briefly orient you to the table, the rows are stratified by condition, so chronic migraine, episodic migraine, and then chronic or episodic migraine. And the columns align with the outcomes that were covered on the previous slides. And the color coding indicates the relationship. So green indicates the CGRP inhibitor was favored, yellow means there was no significant difference, and gray means that a relationship could not be determined. The circles in each cell correspond to the certainty of evidence grade. So as you can see, most of the clinical efficacy and quality of life outcomes were rated as moderate certainty of evidence, and with one exception that favored the CGRP inhibitor. And then for harms outcomes, serious adverse events, and discontinuations due to adverse events were also nearly always rated as very low certainty of evidence since we could not determine a relationship. All right, we'll move into the next section. So this is a section on Acute Migraine Treatment. Next slide, please. So we identified one new RCT comparing 100 mg of eptinezumab with placebo for acute migraine treatment. We graded the evidence related to clinical improvement as low certainty. The study found statistically significantly larger improvements in freedom from pain at two hours post-dose and freedom from most bothersome symptoms at two hours post-dose. But the sample size was less than 500 participants, and confidence intervals were wide. We graded the evidence related to functioning as low certainty. There were statistically significant improvements favoring eptinezumab but, again, the sample size was small, and the confidence intervals for wide. Next slide please. We identified three RCTs of rimegepant compared with placebo for acute treatment. All three of these trials were included in the previous report, and they all administered a 75 mg dose. So I won't go into these findings in detail, but we graded the certainty of evidence as moderate for all outcomes, and they all favored rimegepant. Next slide. So one study compared rimegepant versus sumatriptan, and we graded the evidence related to clinical improvement as a very low certainty. There was

no significant difference in freedom from pain at two hours post-dose or sustained pain freedom at 48 hours post-dose between rimegepant and sumatriptan. And this study did not report any functioning or quality of life outcomes. Next slide. We identified three RCTs comparing ubrogepant to placebo for acute migraine treatment. And we identified one new publication reporting data from two previously included trials, and new data included additional functioning and quality of life outcomes. We agreed to the evidence related to clinical improvement as moderate certainty. All three studies found statistically significant larger improvements in freedom from pain at two hours post-dose. The absolute risk difference ranged from 7.4 to 16.6 percentage points higher for active treatment compared to placebo. And two of the studies also reported statistically significant larger improvements in freedom from most bothersome symptoms at two hours post-dose for active treatment compared to placebo, and we rated the evidence related to functioning as moderate. Two studies reported significant improvements in ability to function normally within two hours post-dose in the active treatment group. And the odds ratio was 1.7 for the 50 mg dose and 1.9 for the 100 mg dose compared to placebo. Next slide. So we identified one new RCT comparing zavegepant with placebo, and zavegepant was new to the scope for this update and has not yet been approved by the FDA. We graded the evidence related to clinical improvement as low certainty. There was a statistically significant larger improvement in freedom from pain at two hours post-dose and in freedom from most bothersome symptoms at two hours post-dose in the 10 mg and 20 mg groups but not in the 5 mg group. Next slide. So now we'll move into the Harms for the Acute Migraine Treatment Studies. Next slide. So this slide summarizes the harms findings for all the studies of acute migraine treatment. There were nine RCTs reporting on 7670 participants. Serious adverse events were rare and, therefore, we were unable to determine a relationship for this outcome, which we rated as very low certainty. None of these trials reported discontinuations due to adverse events. Next slide. There was one RCT comparing rimegepant with sumatriptan in 885 participants. Again, we graded the evidence related to harms as very low. Serious adverse events and discontinuations due to adverse events were rare and, therefore, we were unable to determine the relationship. Next slide. This slide summarizes the grade ratings and direction of effect for outcomes in the acute migraine treatment section. We have low-to-moderate certainty of evidence favoring eptinezumab, rimegepant, ubrogepant, and zavegepant compared to placebo for freedom from pain at two hours post-dose and freedom from most bothersome symptoms at two hours post-dose We had low-to-moderate

certainty of evidence favoring eptinezumab, rimegepant, and ubrogepant for ability to function normally within two hours post-dose. There was no significant difference between rimegepant and sumatriptan on efficacy outcomes. And for trials that reported serious adverse events or discontinuations due to adverse events, we graded the evidence as very low as we were unable to determine a relationship because the events were so rare. Next slide. So moving into our last section, Clinical Improvement and Functioning Outcomes for Cluster Headache Prevention. Next slide. So we identified two RCTs comparing galcanezumab with placebo. One of the two trials was new to the current review, and we graded the evidence related to clinical improvement as low certainty. There was a significantly larger improvement in the number of cluster headache attacks per week at weeks one to three in the galcanezumab groups compared to placebo, but there was no difference by weeks 8 to 12. There was no significant difference for the percentage of participants who had at least a 50% reduction in the number of cluster headache attacks per week between groups. And we graded the evidence related to functioning as very low. One of the two studies reported the Patient Global Impression of Improvement scale (PGII), and the authors observed no difference between the galcanezumab group and the placebo group. Next slide. So now we'll cover the Harms for Cluster Headache Prevention. Next slide. So both RCTs that compared galcanezumab with placebo reported serious adverse events and discontinuation due to adverse events, and we graded the evidence related to harms as very low. Again, the events were rare, and we could not determine a relationship. Next slide. And this slide summarizes the findings for cluster headache. We graded the evidence as low certainty for both of the efficacy outcomes and very low for all other outcomes. And there were no studies of acute cluster headache treatment. And I will note there are no CGRPs with FDA approval for acute cluster headache treatment. Next slide. So we'll just briefly go over what we found as far as the ongoing studies go. Next slide, we identified a total of 17 ongoing studies. One is an open-label RCT comparing erenumab with oral preventive medication, and all of the others are placebo-controlled. And all 17 have a primary efficacy endpoint. Next slide. We did not identify any ongoing studies of atogepant. We found four RCTs of eptinezumab. There was one trial each being conducted in participants with chronic migraine, episodic migraine, chronic or episodic migraine, and cluster headache. And there were three RCTs of erenumab, one for chronic migraine prevention and two for episodic migraine prevention. Next slide. We identified one RCT on fremanezumab for chronic or episodic migraine, two RCTs of galcanezumab, one for cluster headache prevention and one for vestibular migraine

prevention. There were five RCTs of rimegepant, two of acute migraine treatment, two of chronic or episodic migraine prevention, and one of episodic migraine prevention. And finally, we identified two RCTs of zavegepant for acute migraine treatment. Next slide. Now for the discussion. I will summarize the key findings and then the limitations both of the evidence and of the reports. Next slide. Thank you. In summary, there were no head-to-head studies of CGRP inhibitors. There was one study comparing rimegepant to sumatriptan for acute migraine treatment and one study comparing erenumab to topiramate for migraine prevention in a population with episodic or chronic migraine. All of the other studies were placebo-controlled. We identified studies of two agents that were new to the scope of the review. Specifically, there were two studies of atogepant for episodic migraine prevention and one study of zavegepant for acute migraine treatment. And there were no studies of CGRP inhibitors for acute cluster headache treatment. Next slide. So this slide summarizes the findings for migraine prevention. We found that eptinezumab, erenumab, fremanezumab, and galcanezumab were more effective than placebo for chronic and episodic migraine prevention. And we graded this evidence as moderate certainty. Atogepant was more effective than placebo for episodic migraine. And we graded that evidence as moderate to low certainty. Serious adverse events and discontinuations due to adverse events were rare in both active drug and placebo group, so a relationship could not be determined. And we graded that evidence as very low certainty. In head-to-head comparisons erenumab was more effective than topiramate. We graded this evidence as moderate certainty. And there were similar serious adverse events in both groups but fewer discontinuations due to adverse events in the erenumab group compared to topiramate. Next slide. So to put these findings into a greater context, the magnitude of the treatment effect of CGRP inhibitors for migraine prevention was modest, ranging from a reduction of 0.4 days to 3.7 days. And this is similar to other available preventive treatments. The clinical significance of this reduction may vary based on the severity of an individual's headache condition and their ability to tolerate other medications. And I want to note that on the HIT-6 a between-group difference of 1.5 points is considered clinically significant, and 15 of the 17 studies that reported this measure observed a difference of 1.9 points or greater. So this does suggest that most of the studies found a clinically important improvement on this measure. Next slide. And this slide summarizes the findings for acute migraine treatment. We found evidence that rimegepant, ubrogepant, and zavegepant were all more effective than placebo for acute migraine treatment. And we graded the certainty of this

evidence as moderate to low. The proportion of participants who achieved freedom from pain at two hours post-dose range from 4.2 to 16.6 percentage points higher across studies with active treatment compared to placebo. Again, serious adverse events were rare, so a relationship could not be determined. And we graded this evidence as very low certainty. In one head-to-head comparison, there was no difference in efficacy between rimegepant and sumatriptan. We graded this as very low certainty, and discontinuation due to adverse events for rare for both so also graded as very low certainty. Next slide. For cluster headache prevention, the findings were mixed based on time point. Galcanezumab led to significantly fewer cluster attacks at weeks 1 to 3, but there was no significant difference by weeks 8 to 12. And we graded this as low certainty. It is unclear if this reflects a lack of efficacy or if this could be due to the natural course of cluster headaches, which is characterized by spontaneous remission of attacks. And we did not identify any RCTs for acute cluster headache treatment. Next slide please. Thank you. I'll just briefly touch on a few limitations of the evidence and then of the report. So the evidence is limited by the fact that all of the studies were industry-funded, and some included authors who were employees of the manufacturer. Many of the trials only had follow-up through 12 weeks, and nearly all required participants to complete an electronic diary in the run-in phase, and most excluded pregnant people and participants with any clinically meaningful psychiatric or medical condition. Next slide. So this slide summarizes the limitations of this review. As previously mentioned, we observed changes in the ways studies enroll participants with chronic or episodic migraine since we completed the previous version of this report in 2020. Early studies enrolled participants who are distinctly characterized as having either episodic or chronic migraine, and studies published more recently often included mixed populations with either episodic or chronic migraine. And some studies noted that they did this to make recruitment more feasible or to make study populations reflective of the patients who would be seen in headache clinics, and it may also be because there seems to be no meaningful difference in treatment effectiveness between the two groups. And as a result of this shift, it may be appropriate for future synthesis to combine these populations. And finally, we only included studies published in English, and we did not include data from press releases, conference abstracts, or trial registries. Next slide. Are there any questions?

Alex Park: Thank you, Sara. That was remarkably comprehensive. Certainly met the criteria of the highest level of the DERP reports that are available to us. Questions from the Committee at this time?

Dimitry Davydow: Dimitry Davydow, here. Sara, that's a wonderful report. I had a question about the trials that were included that you reviewed. And I may have missed this in the presentation, so I apologize for that. But in those trials, were there allowances for rescue treatments? Specifically for the acute migraine treatment, did they allow for rescue treatments with things like triptans and things like that, or not?

Sara Kennedy: They did. And it's detailed in the evidence tables in the full report. It was an item that we did capture for each of those studies if they were allowed. And some of them reported as an outcome in the amount of use of rescue therapies. I don't have exactly what they found at my fingertips, but it is in the full report.

Alex Park: Anybody else from the Committee? Any questions? We do have three stakeholders that we should hear from, as well. Okay. Thank you. I just had one question, Sara. In terms of migraine prevention, was there anything you found between the subcutaneous IV and the P.O. options that suggested, you know --

Sara Kennedy: Yeah. We didn't look at it by mode of administration.

Alex Park: No. And people don't like to do head-to-head trials is generally what we find out. Yeah. Okay.

Sara Kennedy: Its a massive gap in this literature for sure.

Alex Park: Yeah. Trying to make the best of what's available, and there is a lot that you put together there. Well, let's move on and hear from Leta. I have three stakeholders on my sheet. Did we get any more signed up in the interim?

Leta Evaskus: No, we didn't. But after these three stakeholders speak, we can see if anybody else wants to raise their hand.

Alex Park: Okay, thank you. Well, just to remind the stakeholders, we allow three minutes for you to represent your thoughts. And the clock will start once you go through some of the questions that we ask you to bring to the Committee so that we know your context. So we would like for you to introduce yourself and who you represent, whether it's a company or an organization. If you are a clinician, where do you practice? And do you see Medicaid patients in the

State of Washington? If you are a patient or if you are representing a patient, please let us know if you are a state resident. And then, of course, please disclose any conflicts of interest. That's a lot to get through and remember, so Leta has the reminder sheet on the screen there. We would like to hear from Erin Nowak from AbbVie. And I believe, Ms. Nowak, you are representing two products for which the Agenda has allotted you five minutes. Leta, we could change the clock to five minutes or reset it when it gets to zero, I guess. Erin, are you with us?

Erin Nowak: I am. Can you hear me?

Alex Park: Yes. Please go ahead.

Erin Nowak: Great. Thank you. Hello. I am Erin Nowak, PharmD with Medical Affairs at AbbVie. And thank you for allowing me the opportunity to speak today. There are two products in this category I will be highlighting, Qulipta and Ubrelvy. First, I'll touch on atogepant with the trade name Qulipta. Atogepant is a calcitonin gene-related peptide or CGRP receptor antagonist, and it is indicated for the preventive treatment of episodic migraine in adults. The recommended dose is 10 mg, 30 mg, or 60 mg once daily, with dose modifications for drug interactions in special populations as listed in the prescribing information, which can be found at rxabbvie.com. Following oral administration, atogepant has peak plasma concentration at approximately one to two hours and a half-life of approximately 11 hours, affording this suitability for daily preventive dosing as well as less clarity of the drug in approximately three days if needed. Atogepant was evaluated in a 12-week Phase 3, multicenter, randomized, double-blind, placebo-controlled, parallel-group study, and the primary endpoint of change from baseline in mean monthly migraine days across 12 weeks compared to placebo was met with all three doses. Additionally, 55% to 60% of patients experienced at least a 50% reduction in migraine days across the 12-week treatment period, and the benefits of atogepant were evident as early as the first full day after administration. All six key secondary endpoints were met set for the 30 mg and 60 mg doses, including three patient-reported outcomes compared to placebo. These doses significantly improved function as it relates to social and work-related activities. Atogepant 30 mg and 60 mg significantly improved the AIM-D domain scores, which evaluates difficulty with performance of daily activities and physical impairment due to migraine. The most frequent adverse events reported in the Phase 3 trial were constipation, nausea, and upper respiratory tract infections. None of these adverse events

were considered serious. All reported cases of nausea and most cases of constipation were mild or moderate in severity. And discontinuation rates due to adverse events for nausea, constipation, and fatigue were at 0.5%, and no [indistinct] cases were identified. Also, there are no contraindications, warnings, or precautions for atogepant in prescribing information. And next, I will discuss ubrogepant with the trade name Ubrelvy, a CGRP receptor antagonist indicated for the acute treatment of migraine with or without aura in adults. A migraine is a complex chronic disease with patients exhibiting intra- and inter-variability, therefore, having multiple dosing options is important for the individualization of migraine treatment. Poor acute treatment management increases the chance that migraine disease may progress to chronic migraine. Therefore, it's important to treat patients with a migraine-specific product such as ubrogepant, which is not associated with medication overuse headache. The recommended dose is 50 mg or 100 mg, with dose modifications depending on drug interactions and special populations as listed in the prescribing information, which can be found at rxabbvie.com. Migraine patients who have had nonresponding or recurrent migraine headache can take a second dose two hours post initial dose. Following oral administration, ubrogepant has a peak plasma concentration at approximately 1.5 hours and a half-life of approximately 5 to 7 hours. Ubrogepant was evaluated in two 12-week, Phase 3, multicenter, randomized, double-blind, placebo-controlled, parallel-group studies, and the co-primary efficacy endpoints of pain freedom at two hours post-dose and freedom from most bothersome symptoms at two hours post-dose, compared to placebo were matched for both the 50 mg and 100 mg doses. The most frequent adverse events reported in the Phase 3 trials were nausea, somnolence, and dry mouth, none of which were considered serious. In a long-term study, 2.5% of patients were withdrawn from the ubrogepant because of an adverse reaction, the most common being nausea. And no cases of [indistinct] were identified. Ubrogepant has one contraindication related to concomitant use with strong CYP3A4 inhibitors. And ubrogepant has no warnings or precautions in the prescribing information. And I would like to thank you for allowing me to speak today, and I would be happy to answer any questions that you may have.

Alex Park: Thank you, Erin. Any questions from the Committee for Erin Nowak from AbbVie? Okay, hearing none. Thank you for your comments, Erin. We'll move on to Rochelle Yang with Teva. And please introduce yourself and disclose the items that Leta has on the sheet displayed, and then we'll start your three minutes. Thank you. Is Rochelle Yang with us? Rochelle, I think I -- yeah.

Rochelle Yang: [Loud beeping] Can you hear me? Oh.

Leta Evaskus: Rochelle, we got some feedback from you.

Alex Park: Rochelle, if it's okay with you, it sounds like you are trying to work that audio situation. so we'll move on to Carrie Johnson, and we'll make sure to come back. So, next we have Carrie Johnson from Amgen.

Carrie Johnson: Oh, can you hear me okay?

Alex Park: We can.

Carrie Johnson: Hello?

Alex Park: Yes, I can hear you great.

Carrie Johnson: Oh, okay. Thank you so much. Sorry. Yeah. I am Carrie Johnson. I am a pharmacist with Amgen Medical Affairs. Thank you for the opportunity to testify in support of Aimovig or erenumab. Aimovig is the first and only CGRP monoclonal antibody that targets the CGRP receptor, and the only self-administered monoclonal antibody that comes in two dosing options, which allows for customized treatment for patients with episodic or chronic migraine. Aimovig has an established safety and tolerability profile. The most common adverse reactions and clinical studies were injection site reactions and constipation. Please see the full prescribing information at amgen.com for complete product information. I would like to provide three reminders about Aimovig. 1.) Aimovig has a unique mechanism of action as the only CGRP monoclonal antibody that targets a receptor. 2.) As noted in the review, Aimovig has published data comparing it to topiramate in the first randomized, double-blind, head-to-head study that compares an antibody targeting the CGRP pathway to an oral prophylactic migraine treatment, topiramate. In this trial, Aimovig demonstrated superior tolerability and efficacy against topiramate with 55.4% of patients in the Aimovig group achieving a reduction in monthly migraine days of at least 50% from baseline compared with 31.2% in the topiramate group. Discontinuation was 10.6% with Aimovig versus 38.9% with topiramate. Safety findings in this study were consistent with those seen in previous Aimovig clinical trials. Thirdly, for episodic migraine, Aimovig is the only CGRP therapy with five-year clinical trial, open-label extension data. Results from this study showed no

new safety signals or increased incidents of adverse events or serious adverse events over five years of exposure compared to the pooled double-blind treatment group data. In addition, 71% of the 214 trial participants that completed the study had a 50% or more reduction in their baseline mean monthly migraine days. The mean reduction in monthly migraine days was 5.3 days in a population that averaged 8.7 migraine days per month at baseline. Clinically relevant improvements in patient-reported outcomes were sustained throughout the trial, as well. In conclusion, migraine pathophysiology is multifactorial, complex, and heterogeneous. No two patients' migraine experiences response to treatment is the same. Aimovig has a unique mechanism of action, published head-to-head data, and five-year long-term data. Thank you for your time, and I am happy to address any questions.

Alex Park: Thank you, Carrie. Any questions, Committee, for Carrie Johnson from Amgen? Okay. Hearing none. Thank you, Carrie. And Rochelle. we'd love to circle back to you. Rochelle Yang from Teva.

Rochelle Yang: Hi. Can you hear me this time?

Alex Park: Yes. We can hear you just great.

Rochelle Yang: Perfect. Sorry about that. My name is Rochelle Yang, and I am a pharmacist with Medical Affairs at Teva. So I wanted to thank you for the great comprehensive DERP review, so I'll try to keep this brief. But just as a quick reminder, Ajovy (fremanezumab) is a monoclonal antibody which binds to the CGRP ligand and blocks its binding to the receptor. Ajovy is a self-administered subcutaneous CGRP inhibitor and the only one of which that's approved for both monthly and quarterly dosing for the prevention of migraine. In addition to the Phase 3 randomized-controlled trials, HALO and FOCUS trials, there have been several different real-world evidence studies that have been published where Ajovy has been associated with sustained reduction in monthly migraine days by an average of nine days from a baseline of 12.7 days at the 6-month mark post therapy initiation. Also seeing high adherence and persistence with one study showing three-quarters of patients in a claims review study were adherent to therapy based on the PDC of 80% or more. And it's also been associated with decreased claims for acute migraine medications such as opioids and triptans, and it has been found to be effective in migraine prevention for both patients also with comorbid depression and anxiety, which are common comorbidities associated with

migraine. So I'll note that there are important limitations with these retrospective observational studies, including the inability to prove causality. However, the real-world evidence to date is consistent with what was seen in the Phase 3 randomized-controlled trials and provides an important addition to the large body of evidence supporting Ajovy for migraine prevention. And we asked the Committee to consider adding Ajovy to the Apple Health PDL at your next decision time point. Thank you so much.

Alex Park: Thank you, Rochelle. Any questions, Committee, for Rochelle Yang from Teva? Dimitry, I see you are coming on video. Does that mean you have a question? Okay. Thank you. Leta, are there any other stakeholders?

Leta Evaskus: I don't see any other hands raised.

Alex Park: Great. Okay, Committee, let's turn our attention to the motion, if you are able to pull that up, Leta. So, question for you, Leta and Donna. Just a point of order. Previously, we had accepted the literature scan -- sorry, I keep using the old DERP term -- the surveillance review or report as adequate. Does the Committee also need to accept the systematic review as adequate?

Leta Evaskus: This is Leta. No, you do not.

Alex Park: Okay. So we know about that. Leta, would you mind just copying and pasting the below piece from October 19 up to the top just to give the Committee a place to start? And then I think we'll probably want to finesse the wording here based on the report that we have heard today. Another question I had for you, Donna, was -- and this pertains to the overview process that you provided for us earlier this morning. The previous motion had said that the Committee wanted the CGRP inhibitor class to be second-line on the PDL. But just to clarify, when we are voting on this motion, it's just within the class. Right? Or do we have the ability to talk about where the CGRP inhibitors go relative to other classes?

Donna Sullivan: No. This is Donna. I apologize. I probably missed that last year when we were reviewing this. We would not have you make any determinations of whether they are second or first line.

Alex Park: Okay. Leta is right in step with you, so she is taking those lines out. Let's see. And we didn't have that for the other class. Okay. Good. Okay, Committee -- well, let's see. I know I just had one other thought. I felt that based on the

systematic review that we heard that atogepant was reasonable to include in the migraine prophylaxis category. We didn't list it previously because it had not been reviewed in the literature scan or the systematic review that had been presented. But since that has been, and the level of evidence seems equally limited but equal, nonetheless, as to all the other drugs, I would propose that that be added so that we have a total of one, two, three, four, five, six drugs on that motion. So, one, two, three, four, five. Let's see, where is one missing? I am just thinking, Leta, of all the drugs that are listed for migraine prophylaxis. So we have erenumab, eptinezumab, fremanezumab, galcanezumab, atogepant, which we heard in the review are equally safe and efficacious. But, Committee members, feel free to jump in if you disagree. And then I think there was one other drug, rimegepant, was also listed under migraine prevention in the review. Any thoughts about that, Committee, in terms of adding those drugs based on the systematic review that we heard today and the evidence on safety and efficaciousness?

Laura Beste: This is Laura Beste. I agree with that. I've done some research on my own too. And based on what the presentation was, I think that having those oral agents added is a good option for patients.

Alex Park: Thanks, Laura. Let's see. So then we'll turn our attention to the last sentence. So the Committee had previously said that the four drugs that we knew about that had been presented to date could be subject to therapeutic interchange within this class. Does someone want to take a stab at reframing that sentence? I'm thinking we need to incorporate some of the newer drugs. So we had erenumab, eptinezumab, fremanezumab, and galcanezumab. Donna and Leta, could we simply say, "all the listed drugs in the motion for migraine prophylaxis are subject to therapeutic interchange," rather than listing them all out?

Leta Evaskus: Yes, yes. That's what we do for other motions.

Alex Park: Perfect.

Kevin Flynn: This is Kevin Flynn, just as a point of order information for eptinezumab since it's IV only. Is it really interchangeable if your provider is writing a prescription that would be given differently? Right?

Alex Park: Great question, Kevin. We look at it as a class, but let's turn this over to Donna. Does the Committee, Donna, need to move into the level of breaking these down in terms of modality?

Donna Sullivan: That's up to you if you feel like you could interchange an oral for an injectable, then you could. Or you could say that they are not interchangeable for that reason. And usually it would be by indication also. So oftentimes, if some are indicated for prophylaxis and some are indicated for treatment, but not all are indicated for both, you may not want to interchange because the pharmacist may not know what it's being used for when they are filling the prescription. So that is something to consider too with interchangeabilities. Do they all have the same indication?

Kevin Flynn: I was just thinking from a logistical standpoint. Like the IV drug would never be written as a prescription. You would be sending them to like an infusion center.

Donna Sullivan: Yeah. Okay.

Kevin Flynn: For practicality, I mean, you never really interchange it. Right?

Donna Sullivan; So thanks, Kevin. This is Donna again. Yeah. In that, we typically don't apply the PDL to medically physician-administered drugs. On very rare occasions have we done that in the past. So thank you for reminding me about that. So that wouldn't be an issue because you are not seeing it at the point of sale. A pharmacy is not dispensing it at the point of sale unless it was a specialty pharmacy dispensing it kind of like a brown bag or white bagging. That would be the only situation where it could happen that I think we could consider that, make that -- I am not sure what I am trying to say here.

Alex Park: I think I am following you Donna to address Kevin's concern. What if we were to add a statement or just tag on a phrase to the last sentence of that upper motion. These drugs can be subject to therapeutic interchange in the Washington Preferred Drug List, within respective modes of delivery and approved indications. I mean, that might get us into, you are only going to be able to move a subcutaneous to a subcutaneous or a P.O. to a P.O. And again, within each approved indication as you were indicating, Donna, because there are multiple indications with these drugs.

Donna Sullivan: Right.

Alex Park: How do you feel? What do you think, Kevin? I think you brought up a point there.

Kevin Flynn: Yeah. I don't really see a concern with doing between the subcutaneous and the P.O. necessarily. I guess we can declare them equal but, in practicality, you are never really going to interchange between a P.O. drug that is given at the pharmacy counter versus one that is given at a physician office.

Laura Beste: This is Laura Beste. I've got a little bit of concerns about the subcutaneous to the P.O. because I think the data supporting the injectable medications was a lot better than the oral medications. So the oral medications have low-to-moderate efficacy compared to it was pretty solid moderate on all of the injectable medications, so I would be a little bit uncomfortable substituting an oral medication for one of the subcutaneous injectable products. But I don't know that I would qualify them as being equally efficacious.

Alex Park: Yes, Laura, I'm with you. And what I am thinking what we're trying to do [cross-talk] --

Laura Beste: So I like that last statement you added there.

Alex Park: Okay, yeah. You get what we're saying.

Laura Beste: I'm just supporting that statement. I agree 100% with your last line there.

Alex Park: Okay. So I think that top piece, let's leave that for a moment and turn our attention to the bottom piece. This is a little bit less complicated because there just were less drugs in the acute treatment bucket. I think it was just rimegepant and ubrogepant. Let's see. Leta, I think we do need to remove the second-line agent piece to match the top. And they are both orals. For the sake of the procedure here, the Committee does need to make a statement about therapeutic interchange. And so that is there. Okay. Zavegepant is, from what I heard from you, Sara, too new, and we just don't have the body of evidence in the review to do anything about that. And so by not indicating it in the motion, otherwise, that drug is not being folded in. And correct me if I am wrong, Donna, that drug cannot be eligible for preferred based on how it was presented in the review, or does the Committee need to specifically call that out in the motion?

Donna Sullivan: So I am sorry. Which drug again?

Alex Park: Zavegepant, that was the new one that had very limited evidence.

Donna Sullivan: Right. So if there was evidence, was it included in any of the trials that were reviewed? I apologize. I must have missed that.

Alex Park: Sara, would you like to jump in really quick? Because you did a great job summarizing the limitations on that drug.

Leta Evaskus: I think Sara may have left.

Alex Park: Oh.

Donna Sullivan: Okay. Ryan, is this one considered included when you were looking at the report? Was there any evidence? Like you need placebo-controlled trials with it?

Ryan Pistoresi: Yeah. I was going to be pulling up the report.

Donna Sullivan: Okay.

Ryan Pistoresi: So I might just take a sec. I am on the DERP website right now.

Alex Park: Actually, I don't even know if it's approved yet, guys. Is it [cross-talk] --

Laura Beste: I don't think so.

Donna Sullivan: Oh. If it's not on the market, then it's not included, then we would not include it in the class.

Ryan Pistoresi: Yeah. I think it's [cross-talk] -- yeah. It's not approved as of today either.

Alex Park: Okay. And the Committee does not need to call that out in the [cross-talk] --

Donna Sullivan: No. No, you do not.

Alex Park: Okay, Committee. So we have the cleaned-up motion. We have worked through this. Any other comments or questions or alterations that are recommended? And if not, we'll go ahead and entertain a motion in a second.

While the Committee is reviewing it one more time, Leta, could we change. It's a little column where it says reiteration. We're not quite reiterating the prior motion, but it does apply to the October 19 row.

Leta Evaskus: In October, you did reiterate the motion. For today, I put "not applicable."

Alex Park: Okay. Perfect. Perfect. Thank you.

Ryan Pistoresi: And this is Ryan. Yeah. So back then because it was a surveillance document, you can't add new drugs, and the level of evidence doesn't really go into the detail of the safety and efficacy. So that's usually why we have the reiteration for prior motion for surveillance reviews but not for updated reports or new reports.

Alex Park: Okay, thank you. So this is a new decision Committee, and I'll give you all another minute to review some of the changes we made and thinking about the body of evidence that Sara presented, and we'll entertain a motion.

Ryan Pistoresi: And this is Ryan. Just an update. So there was only one RCT for the unapproved medication, and there are two ongoing studies. So in the future, we may be re-reviewing this class and including a fuller body of evidence for it.

Alex Park: Thanks, Ryan.

Jon MacKay: This is Jon MacKay. I move that after considering the evidence of safety and efficacy for the treatment of migraine prophylaxis, I move that atogepant, eptinezumab, erenumab, fremanezumab, galcanezumab, and rimegepant are safe and efficacious for the treatment of their approved indications. These drugs can be subject to therapeutic interchange in the Washington Preferred Drug List with their respected modes of delivery and approved indications. After considering the evidence of safety and efficacy for the treatment of acute migraine, I move that rimegepant and ubrogepant are safe and efficacious for the treatment of their approved indications. Rimegepant and ubrogepant can be subject to therapeutic interchange with each other in the Washington Preferred Drug List.

Alex Park: Thank you, Jon.

Michael Corsilles: This is Michael Corsilles [cross-talk] --

Alex Park: Michael Corsilles seconds. Yes. And I was just congratulating Jon on getting through those names. How do these drug companies come up with these names? Okay. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? Okay, the motion passes. Thank you, Committee. We are a little bit over time, and I think that just speaks to the complexity of that particular class and the due diligence that the Committee has put in. Leta, what would you like to do with our next steps on the Agenda here?

Leta Evaskus: Let's take a 10-minute break. So we'll just round it to 11:30, come back and start with the DUR.

Alex Park: Sounds great. See everybody at 11:30.

[break]

Leta Evaskus: I apologize. I know, see I had the wrong time on my break sign. We're resuming at 11:30, not 10:30. Alex, are you back?

Alex Park: Okay, Committee, it's 11:30, and hopefully everybody is back from a well-deserved break. And I think with the CGR report work that we did, that concluded the business of the P&T Committee. So we'll go ahead and convene the DUR Board. And we have quite a number of topics to go over today. So, Umang, I am going to ask you to say only every other word of what you plan. No, I'm kidding. But let's get started, Umang, and I'll hand it over to you. We'll start with Antibiotics.

Umang Patel: Perfect. And while Marissa is pulling up the slides, I just want to remind the Committee for the members who've been here before and for the new members, just a little bit of a summary on how I present. Usually, as Donna mentioned, at the very beginning of this meeting, I tend to provide a high-level overview of significant clinical updates within the last 12 to 13ish months. If there is a class that did not have any significant clinical updates, I hand it right back to Dr. Park. Significant clinical update can be new drugs, expanded formulations, indications, guideline updates, safety, FDA communications, etc. So go ahead, moving right to Slide 3. We have two

topics here. We have Antibiotics and Respiratory Agents. These are kind of lumped together because, as you can imagine, they go hand-in-hand clinically. The first in the Antibiotics, we have Aminoglycosides and Monobactams - Inhaled. And we also have the Respiratory Agents for Cystic Fibrosis. So moving right along a little bit of background [cross-talk] --

Marissa Tabile: I'm sorry, Umang. This is Marissa. Sorry to interrupt you. I just wanted to let the DUR Board note that the way that Magellan has it, like Umang said, they lump these products together in their market basket, but the way that we have them on our PDL, we do split them up. So at the very end for the motions, you guys will be doing two different motions. The one for the Antibiotics, and then the Inhaled classes, and then the Cystic Fibrosis Agents. So just wanted to give that disclaimer. And I will move your next slide, Umang.

Umang Patel: Thanks, Marissa. Yeah. So these will be lumped together because they kind of fall into one clinical category here. There is a clinical update for the cystic fibrosis subsection, not any for the inhaled antibiotics. So moving right along to a little bit of background. So cystic fibrosis is a serious autosomal recessive multiorgan disorder. It affects about 31,000 children and adults in the US, and it is the most common fatal genetic disease in Caucasian. The median survival in patients is 50 years, with 80% of patients reaching adulthood. Children are anticipated to live to approximately 40 years of age with current treatments. And in 2020, adults comprised approximately 57% of the cystic fibrosis population, while in 1990 they comprised about 32%. Mutations lead to the disease of the exocrine gland function, resulting in the formation of a thick mucus that builds up in the lungs, digestive tract, and other parts of the body. The CFTR or the Cystic Fibrosis Transmembrane Conductance Regulator functions as a chloride channel. Mutations in this result in abnormalities of chloride transport across the epithelial cells in the mucosal surfaces. And the goal for cystic fibrosis in terms of treatment are threefold. First, to maintain lung function by controlling infection and clearing mucus; second, to maintain appropriate growth by providing nutritional support; and third, managing disease complications. On the next slide here, in terms of guidelines, the goals of cystic fibrosis, as I mentioned, include maintaining lung function, appropriate growth, and managing disease complications. CFTR modulators, which are also called potentiators or correctors, are the newest class of medications available for the disease and improve chloride ion transport abnormalities. Now, just a reminder for the Committee, if the guidelines are roughly a year old or older, I tend to not review them or put

them in the Appendix, or they can be found in the TCR for the Committee. I kept the cystic fibrosis here because they are very summarized, although they are almost roughly 10 years old. I won't be going over them, but they are just here for your reference. And moving on to the next slide, we have an updated information for a medication. Again, bolding. Sometimes there is a lot of information for drug-specific topics. I try to bold the relevant updates. So if you see bolded, that is regarding the recent update. So for Orkambi, in September of last year, the FDA approved an expanded indication for the treatment of cystic fibrosis in patients one year of age or older for homozygous for the F508del mutation in the CFTR gene, and previously indicated for patients two years of age or older, so an expanded indication here. And with an expanded indication, you do get possibly dosing depending on it. Orkambi is a combination of lumacaftor and ivacaftor. So for pediatric patients one to two years of age, patients 7 kg to less than 9 kg is one packet of the 75 mg/94 mg granules. Patients 9 kg to less than 14 kg is one packet of the 100 mg/125 mg granules. And if they are over 14 kg, it is one packet of the 150 mg/188 mg granules here. If you want to go to the next slide, I will pause here as that is the end of the cystic fibrosis subsection. And I will hand it off to Dr. Park.

Alex Park: Thank you, Umang. Any questions for Umang from the Committee? Okay. I believe we have one stakeholder relative to the cystic fibrosis section. Before that, I see that Marissa has pulled up something for us to look at on the screen.

Marissa Tabile: Yeah, this is Marissa. So for the newer DUR Board Members, this is a snapshot of the drugs that you are going to be making motions on today. So this is a snapshot of our AHPDL. It is over, I think, 400 classes. But as you can see, you are not reviewing all 400 today, so will just be going over the relevant ones today. So to start with our Antibiotics : Aminoglycosides - Inhaled, you can see that our preferred products in this class are Bethkis and Kitabis. And in our Monobactams - Inhaled Antibiotics class, we have Cayston, and that's the only product in that class, and that is preferred. And then I apologize for the scrolling, moving down to our Respiratory Agents : Cystic Fibrosis Agents, the products that we have preferred in that class are Bronchitol and Pulmozyme. And then moving on to our cystic fibrosis CFTR Potentiators class, we do have Kalydeco, Orkambi, Symdeko, and Trikafta as preferred in that class. So I can take any questions the DUR Board might have about the PDL. But if not, Alex, you can go ahead and move on to any stakeholders.

Alex Park: Thank you, Marissa. That's really helpful. Okay, I have one stakeholder on my sheet Carla Boolean-Larson. And Leta will pull up the ask on your introduction. And if you can state your name and who you represent, and then we will hear your comments.

Carla Boulianne-Larsen: Good morning. My name is Carla Boulianne-Larsen, and I am with Medical Affairs at Vertex Pharmaceuticals. Thank you for this opportunity to provide public testimony on behalf of Vertex Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) modulators. CFTR modulators are the only cystic fibrosis or CF medicines that work by targeting the underlying cause of CF, which is a defect in the CFTR protein. There are currently four CFTR modulators approved for the treatment of CF based on age and genotype. Trikafta, which is elexacaftor/tezacaftor/ivacaftor/ivacaftor. Symdeko, which is tezacaftor/ivacaftor/ivacaftor. Orkambi, which is lumacaftor/ivacaftor. And Kalydeco, which is ivacaftor. Of important consideration for the Committee is that in September of 2022, the FDA approved expanded use of Orkambi to include children with CF ages 12 to less than 24 months, who are homozygous for the F508del CFTR mutation. Orkambi was previously approved by the FDA for use in people with CF ages two years and older with two copies of the F508del mutation. Orkambi is the only FDA-approved CFTR modulator indicated for patients with CF age one year and older who are homozygous for the F508del CFTR mutation. This recent label expansion is supported by the results from a Phase 3, two-part, open-label trial of Orkambi that enrolled children ages one to less than two years at screening, who are homozygous for the F508del mutation. This is referred to as Trial 7 in the USPI. The full results from this study were published by Rayment et al in the American Journal of Respiratory and Critical Care Medicine, and demonstrate the safety, tolerability, and pharmacodynamics of Orkambi in this young patient population. Please refer to the full prescribing information for complete lists of Warnings and Precautions associated with each modulator as well as additional safety data. We appreciate your continued support in covering CFTR modulators to label. Thank you for your time, and I am happy to answer any questions you may have.

Alex Park: Thank you, Carla. Committee, any questions for Carla from Vertex Pharmaceuticals? Okay. Thank you. Anyone else we should be hearing from, Leta, before we move to the motions.

Leta Evaskus: I do not see any other hands raised.

Alex Park: Okay, Committee. So we are going to backtrack just a little bit. Umang presented several different sections here, but we have one motion for the aminoglycosides and monobactams, and we have one motion for the cystic fibrosis agents. So this will be the motion for the aminoglycosides and the monobactams. So if the Committee could turn on your cameras and join us, and look over the motion here, remembering that we are making a recommendation as a DUR Board as to whether all the agents are equally eligible to be considered for being preferred by the HCA based on what Umang has updated us on. Who will entertain a motion?

Virginia Buccola: This is Virginia Buccola, and I move that all products in the drug classes listed on Slide 2 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 at least 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.

Laura Beste: This is Laura Beste. I second the motion.

Alex Park: Thank you, Laura and Ginni. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Any opposed or abstentions? And the motion passes. Thank you. Okay, Leta, let's turn our attention to the CF Agents motion. From there we have a Committee. We will entertain a motion on this class, as well.

Dimitry Davydow: This is Dimitry Davydow. I move that all products in the drug classes listed on Slide 4 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 at least two preferred products with the same indication before a non-preferred product will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Kevin Flynn: This is Kevin Flynn. I second that motion.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you, Committee.

Marissa Tabile: Sorry, Alex. I've missed who seconded the motion.

Alex Park: Oh, it was Kevin Flynn.

Marissa Tabile: Okay. How do you spell your last name? I'm sorry.

Kevin Flynn: It's okay. F-L-Y-N-N.

Marissa Tabile: Okay. Thank you.

Alex Park: Thanks, Marissa. Okay, Umang, back to you for anticoagulants.

Umang Patel: Perfect. This one is a quick one. So, again, for the Committee, if there are classes that didn't have significant clinical updates, we still address them, but I will pause there because I will be giving right back to Dr. Park since this class did not have any in the last year.

Alex Park: Thank you, Umang. And Leta, I think no stakeholders on this class, and Marissa is going to show us the Apple Health PDL.

Marissa Tabile: This is Marissa. I apologize for the scrolling today. So we are going through the Anticoagulants : Factor Xa and Thrombin Inhibitors. So you can see in this drug class we have generic dabigatran, brand name Eliquis, brand name Pradaxa. And then we do have Xarelto tablets and the starter pack as our preferred products in this class. Nonpreferred products are Savaysa and then Xarelto suspension. And I welcome any questions.

Alex Park: Any questions for Marissa, Committee? All right. Thank you, Marissa. Okay. Let's turn our attention to the motion here. So Umang has said that there are no updates on this from the last time that the Committee approved this class as it stands. I will entertain a motion.

Laura Beste: This is Laura Beste. I move that all products in the Anticoagulants Factor Xa and Thrombin Inhibitors oral drug class are considered safe and efficacious for their medically acceptable 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 at least 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.

Michael Corsilles: This is Michael Corsilles. I second that motion.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you, Committee. Back to you, Umang, for Antidiabetics.

Umang Patel: All righty. Perfect. So this next class we have Antidiabetics here. This will encompass all the medications that you can probably think of. Amylin Analogs, SGLT2 Inhibitors, DPP4 Inhibitors and combinations, GLP-1 Agonists, and combinations, as well. And just to give a little bit of background here. With diabetes [cross-talk] --

Marissa Tabile: [Cross-talk] Oh, sorry, Umang. It's Marissa. Sorry to interrupt you.

Umang Patel: Yeah.

Marissa Tabile: I just wanted to let the DUR Board know, Magellan, this is another example of the splitting of the classes is a little bit different. So as the DUR Board, you guys will be making one motion for pretty much all of the antidiabetic products, including the insulins. Umang will be doing a separate presentation with these products and then also insulin. So after this particular presentation, Umang, if you want to just jump next to the insulin, and then at the end we will do the motion and the stakeholders for all-encompassing antidiabetic products.

Umang Patel: Yep. Sounds great. Yeah, I'll go ahead and do that. Perfect. So moving right into a little bit of background. So it is estimated that over 34 million Americans have diabetes, of which about 90% to 95% have Type 2 diabetes.

It is responsible for increased morbidity and mortality. Adequate glycemic control is crucial to minimize chronic microvascular and macrovascular complications. Exogenous insulin supplements, deficient levels of endogenous insulin and temporarily restores the ability of the body to properly utilize carbs, fats, and proteins. Multiple insulin products are available and are used as replacement therapy in the management of both Type 1 and Type 2 diabetes when glycemic goals are not met with oral antidiabetic agents. In addition to exogenous insulin, there are several pathways by which blood glucose may be regulated in diabetic patients. The SGLT2 inhibitor reduces the renal glucose reabsorption in the proximal convoluted tubules, leading to increased urinary glucose excretion as well, and we'll be going over that subclass. Moving right along. Again, I have the guidelines that are roughly about oneish year old. Anything older than that can be found in the Appendix or the TCRs. According to the American Gastroenterological Association, they estimate up to 70% of individuals with Type 2 diabetes have non-alcoholic fatty liver disease. They inform that GLP-1 agonists, SGLT2 inhibitors, and pioglitazone can improve the cardiometabolic profile and reverse steatosis in patients with diabetes and in non-alcoholic fatty liver disease. They recommend GLP-1 or pioglitazone in patients with indeterminant or high-risk clinically significant liver fibrosis. SGLT2 inhibitors appear to provide benefit in patients with non-alcoholic steatohepatitis and associated comorbidities. And they also advise to prescribe GLP-1 agonist and SGLT2 inhibitors according to the ADA Guidelines. Next, we have the ADA 2021 guidelines. As you can imagine, there are a lot of updates. I bolded the more significant ones here. In patients using ambulatory glucose profiles, glucose management indicators to assess glycemia, a parallel goal is a time and range of greater than 70% with a time below range of less than 4% for A1C readings. During pregnancy, the ADA recommends a target A1C of 6% to 6.5% being reasonable but can be adjusted based on hypoglycemia risk. More frequently, such as monthly A1C monitoring may be required. In regarding diabetes technology, an automated insulin delivery system should be considered in adults with Type 1, who have skills to use the device in order to improve time and range and reduce Agency and hypoglycemia. These systems may also be useful to improve glycemia in children. Regarding obesity management, they state that lorcaserin should no longer be used, as the FDA requested its market withdrawal. For pharmacologic Type 2 therapy, ADA advises to interrupt SGLT2 Inhibitor therapy before scheduled surgery to avoid diabetic ketoacidosis. And this aligns with label revisions for SGLT2 inhibitors and for management of COVID in patients with Type 2. They advise to consider an

SGLT2 inhibitor in patients with heart failure with reduced ejection fraction to reduce risk of worsening heart failure and CV death. Moving onward to the AHA. The American Heart Association last year published a scientific statement on comprehensive management of CV risk factors for adults with Type 2 diabetes. In terms of drug therapy, weight loss medications are discussed as adjunct to diet, physical activity, and behavioral therapy for patients with a BMI greater than 27. FDA-approved drugs for weight management with CV safety and A1C lowering. Our include Orlistat, lorcaserin, liraglutide, naltrexone/bupropion sustained-release combination, and phentermine/topiramate combination. Although long-term CV event reduction has not been evaluated, notable CV risk reduction has been demonstrated for liraglutide at lower doses in patients with ASCVD or high CV risk. Additionally, once-weekly semaglutide 2.5 mg has also shown weight loss and CV risk factor improvement. It is FDA approved for chronic weight management in adults with a BMI over 30 or BMI over 25 with comorbid conditions. The CV outcome trial data for newer antihyperglycemic agents is also reviewed, and a selection of diabetic agents should be individualized based on the patient's risk and preference. And blood pressure management lipid-lowering therapies and antithrombotic therapy were also addressed. Moving onward to the AHA in the ACC the American Heart Association and the American College of Cardiology last year along with the Heart Failure Society of America published guidelines for the management of heart failure that includes SGLT2 inhibitors as a new treatment strategy in heart failure. They recommend that SGLT2 inhibitors in patients with Type 2 diabetes and heart failure for hyperglycemia management. In addition to recommending patients with Type 2 diabetes and established CVD or at high CV risk to prevent heart failure hospitalization. While the mechanism is not clearly understood, the heart failure benefits SGLT2 inhibitors provide appear to be independent of glucose lowering. Notably, SGLT2 inhibitors are recommended to reduce hospitalization for heart failure and CV mortality in patients with symptomatic chronic heart failure regardless of the presence of Type 2 diabetes. All right. Moving right along to drug-specific updates. So first being Jardiance of last year February. The FDA expanded the indication to reduce the risk of CV death and hospitalization for heart failure in adults with heart failure. Previously, the indication was to reduce the risk of CV death plus hospitalization for heart failure in adults with heart failure and reduced ejection fraction. As you can see, it does have a list of other indications. No changes to anything regarding precautions, dosing, or formulation. And just to give a little bit of expanded dose adjustments in special populations, there is no dose adjustment recommended in patients

with hepatic impairment. And in terms of patients with renal impairment, higher incidences of adverse reactions were related to reduced renal function, as well. Next, we have Ozempic. April of last year, the package insert was updated to add a third maintenance dose of Ozempic 2 mg subcutaneously once weekly. Previously, the maximum recommended dosage was 1 mg once weekly. However, now, additional glycemic control is needed after a patient has been on it for four weeks or greater on the 1 mg dose. The dosage can be increased to 2 mg once weekly, and the updated maximum recommended dosage is 2 mg once weekly. Additionally, along with the new dosing recommend, the FDA approved a new strength, 8 mg per 3 mL in a new single patient-use pen that delivers 2 mg per injection. As you can see, no changes to indications or precautions, just the dosing. The maximum dosing as well and the new 8 mg formulation. Similarly to the previous slide, in terms of patients with special population, patients with hepatic impairment, there is no adjustment needed. And for patients with renal impairment, no dosage adjustment needed either. Next, we have Mounjaro. In May of last year, the FDA approved Mounjaro, which is a glucose-dependent insulinotropic polypeptide receptor and GLP-1 agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with Type 2 diabetes. And limitations of use include that it has not been studied in patients with a history of pancreatitis, and it is not indicated for use in patients with Type 1 diabetes. In terms of precautions, similar to a lot of other GLP-1s that you will see. Blackbox Warning for thyroid C-cell tumors and contraindicated in patients with personal or family history of multiple endocrine neoplasia. Additionally, it has an acute gallbladder disease warning, and if cholelithiasis or cholecystitis are suspected, gallbladder studies are indicated. For dosing, recommended dosing is 2.5 mg subcutaneously once weekly. And after four weeks, we increase to 5 mg once-weekly subcutaneous, and if additional glycemic control is needed, to increase the dosage to 2.5 mg increments after at least four weeks on the current dose for the max dose of 15 mg subcutaneous weekly. And as you can see, the formulations available are injections of 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg per 0.5 mL in a single-dose pen. Additionally, for specialized population, no dosage adjustment is needed for patients with hepatic impairment or renal impairment. Next, for this subclass, we have Trulicity. Two updates regarding Trulicity. November of last year, the FDA approved as an adjunct to diet and exercise to improve glycemic control in patients 10 years of age or older with Type 2 diabetes. Previously, this is only for adults. In December of last year, the FDA is recording potential intermittent periods of backorder for Trulicity due to increased demand for this drug. Delays in

full shipments may occur until early of January 2023. Pens are still available. And so I am sure, as you can see, the precautions are very similar to its subclass. The dosing. The pediatric dosage that is now recommended for this expanded indication is the starting dose of 0.75 mg subcutaneous once weekly, and no changes to formulations here. And similar to the other medications in this subclass, no dosage adjustment needed for patients with hepatic or renal impairment here. Okay. And now, as discussed with Marissa, we'll move right along through the insulins, since this will be one motion for the Committee. Here we will have, as you can see, the insulins in the Apple Health PDL are broken down by duration effects, so broken down to intermediate-, long-, premixed, rapid-, and short-acting insulins. And since the disease state was all covered, we'll go right into drug specific. First, we have Rezvoglar. In December 2021, the FDA approved the second biosimilar insulin product to Lantus. It's a long-acting human insulin indicated to improve glycemic control in adults and pediatric patients with Type 1 diabetes and adults with Type 2. Limitation of use is not recommended for treating diabetic ketoacidosis. As you can imagine, in regard to precautions just like you would imagine insulin, hyperglycemia or hypoglycemia can happen with changes in insulin regimen. Hypokalemia due to insulin mechanism of action, and fluid retention and heart failure with concomitant use of (TZD) thiazolidinediones. Dosing is individualized based on the patient, the blood glucose monitoring, glycemic control. And the formulation is 100 units/mL (U-100), available as a 3 mL single-patient-use prefilled pen. And then just some updates here to notify the Committee. First, Discontinuations. Insulin lispro (Humalog Mix 50/50) in July of last year, Eli Lilly decided to discontinue manufacturing Humalog 50/50 10 mL vials. They will be available until August of this year. And Humalog 50/50 will continue to be available in 3 mL prefilled pens, known as KwikPens. In terms of recalls for Semglee, there were a few last year. First, in January of last year, Mylan voluntary recalled one batch of its non-interchangeable Semglee packaged in a label carton of five pens due to potential for the label to be missing on some of the prefilled pens with the labeled carton for this batch. Next, in April, Mylan issued a voluntary recall due to the potential for the label to be missing some bio. And in July of last year, Mylan voluntarily recalled one batch of unbranded insulin due to the potential for the label to be missing sometimes, as well. This was a wholesaler, retailer, and consumer-level recall. No adverse events were reported. And lastly, for last here we have -- and I apologize for my pronunciation, Lyumjev. So in October of last year, FDA approved an expanded indication to improve glycemic control in diabetes, and it was expanded to include pediatric patients. This may be

administered subcutaneous, continuous subcutaneous, or an IV infusion. No changes to precautions. As you can imagine, dosing is very individualized, and no changes to formulations here, either, just now, it can be used in pediatric patients, as well. I will go ahead and pause there, and the hot potato back to Dr. Park.

Alex Park: Thank you, Umang. Marissa, do we have scrolling to watch?

Marissa Tabile: This is Marissa. Unfortunately, yes you do. [Laughter]. I going to go ahead and hop into that next if you all are ready.

Alex Park: Go for it.

Marissa Tabile: All righty. So I am just going to go in the order that they are listed here on our Apple PDL. So for our first class, we will go through the Amylin Analogues. As you can see, Symlinpen 120 and 60 are the only products in this class, and they are both preferred. For our DPP4 inhibitor/SGLT2 inhibitor combinations, we have no preferred products in this class because they are combinations. We usually try to steer them towards the individual ingredients, so that's why they are not preferred at this time. DPP4 inhibitor/TZD combinations. You can see we have alogliptin-pioglitazone or brand name Oseni. Same thing, as well, nonpreferred. And then I'm looking at our DPP4 inhibitors, just the single-ingredient products. We do have preferred in this class Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, Kombiglyze XR, Onglyza, and Tradjenta. Those are all preferred in that class. Moving on to our GLP-1 agonist insulin combinations. We have Soliqua and Xultophy. They are both nonpreferred and the only products in that class. And moving on to our GLP-1 agonist class, which is the single ingredients. Our preferred products in this class are Byetta and Victoza. And moving into our Insulin -- Intermediate-acting drug class, our preferred products in this class are Humulin-N and Humulin-N KwikPen. And then moving on to our long-acting insulins. This one's pretty big. We do have insulin glargine, which this one is a generic. We do have insulin glargine Solostar. We have Levemir. The Levemir FlexPen, Levemir FlexTouch preferred. And it looks like that is I sat this time. And then moving into our Insulin -- Premixed class, we have different formulations of Humalog. So we have the 50/50, both the pen and the vials, 75/25 vial and KwikPen, 70/30 vial and KwikPen. And then we have the generic versions of those, as well. And that looks like that's it preferred in that class. And Novolog mix 70/30 that is preferred as well. Moving on to rapid-acting insulins. In this class we

have Humalog. We do have the Junior KwikPen, and the KwikPen. And then we have some generic insulin, Lispro Junior KwikPen, KwikPen, and vials, and brand name Novolog. And it looks like those are the vials and some pens, as well. And then short-acting insulins in this class, we do have Humulin-R, different, I think formulation with different kinds of sizes. But overall, Humulin-R is our preferred product in that class. And then I think this is the last class of our antidiabetics, the SGLT2 inhibitors. We do have Farxiga, Invokamet, Invokana, Jardiance, Synjardy, Trijardy XR, and Xigduo XR as our preferred products. I went through a lot, so I'm happy to answer any questions from the Board.

Alex Park: Thank you, Marissa. Any questions from the DUR Board? Could you scroll up back to the GLP-1 part again? Okay, so Byetta and then liraglutide are preferred. Okay. And the "Y" on that Column F, does that mean -- let's see, what does that mean? Probably means PA.

Marissa Tabile: Sorry. I was trying to get off mute, Dr. Park. This is Marissa. Yes. That means that there is a PA. So for our GLP-1s, we actually do have a clinical policy that we use, and it's posted online. In that policy, off the top of my head, we do require step-throughs in order to get the once-weekly formulations. So I believe we require a trial of metformin, SGLT2s, and then one of the preferred GLP-1s in order for someone to get a once-weekly GLP-1 agonist.

Alex Park: And does that take into account patient comorbidities? And I'll give you an example. Like, for instance, if somebody had cardiovascular disease, would that order in the PA change?

Marissa Tabile: I believe -- this is Marissa -- we do separate it out by indication because some of the GLP-1s do have that cardiovascular indication, the step-throughs. I am pulling it up right now. The step-through for the cardiovascular indication is different. So it does look like for the cardiovascular indication, we would just require a step-through a preferred SGLT2 and then liraglutide because it does have that cardiovascular indication. So those would be the step-throughs for that indication. And then the ones I mentioned previously, are for Type 2 diabetes only.

Alex Park: And that would be the Metformin SGLT2 and then the GLP-1.

Marissa Tabile: That's correct.

Alex Park: Okay, thank you. If there are no other questions from Marissa at this time, I think we should hear from our stakeholder. And then the DUR Board can deliberate and entertain the motion. I have on my list, Nicole Ehrhardt, from the UW Diabetes Institute.

Nicole Ehrhardt: Hello. Good morning. Can you hear me? I guess now, afternoon. How are you today? I am Nicole Ehrhardt, one of the Adult Endocrinologists at the University of Washington, and I've been practicing clinically, only seeing diabetes in Washington state for almost three [audio cuts out] years now and have almost 15 years of experience as an endocrinologist. I see about 30% of my patients with Medicaid. And like I said, all I see is diabetes. I am also representing 15 other endocrinologists at the University of Washington and advanced practitioners who also share my feelings about the GLP-1 class. So we are going to be talking to you a little bit about the need to open up the formulary, hopefully, for weekly GLP-1s. And right now, as just was highlighted, you have to utilize either Byetta or liraglutide, and each of those are daily injections. First, what we'll highlight is Byetta. It has to be timed to meals, and 30 to 40 minutes before meals, and it's a twice a day dosing. It also does not have the cardiovascular indication as was also brought up. And so these daily GLP-1s are effective from a cardiovascular, and there are ongoing research looking at it from a renal perspective. But the weekly GLP-1s are not new, and the reason we prefer to use them is because of the increased efficacy and weight loss potential of them. And so, let's talk a little bit about that. So just as to use as a comparison, I am going to highlight semaglutide versus liraglutide. So the average A1C lowering in head-to-head studies -- and this is the 1 mg of semaglutide and 1.8 of liraglutide -- is 1.1 versus 1.6. And it's not head-to-head, but with our 2 mg dose of semaglutide, you can see over a 2% A1C lowering. So significant difference in efficacy. Similarly, with weight loss, you might see an average of five to six pounds with the liraglutide and 10 to 12 pounds with the 1 mg of semaglutide. And again, the weight loss potential with the 2 mg of semaglutide is even greater. When we're talking about the weekly dulaglutide, the efficacy at the higher doses at our 4 mg dose is equal to the weekly semaglutide, the weight loss potential is slightly less. And the ADA 2023 Standards of Care do actually sort of highlight that high-dose dulaglutide and semaglutide for A1C efficacy, and then a weekly semaglutide for the weight loss potential. The other thing I want to highlight are barriers to taking a weekly versus daily insulin. There have been real-world studies that have shown that you can see better outcomes with the daily injections. And then finally, because I am running out of time, I want to highlight clinical scenario. Right? In someone who is

already on a daily GLP-1 basal insulin and metformin, you don't want to utilize a sodium glucose cotransporter because you are creating more pill burden for them. And so we would like to remove that indication that you need to try and fail or be on maximum dose of sodium glucose cotransporters in addition before you can try the weekly GLP-1. I'm sorry, I can't tell I've run out of time. Should I stop now?

Marissa Tabile: This is Marissa. Yes, your time has come up.

Nicole Ehrhardt: Okay.

Marissa Tabile: Thank you.

Nicole Ehrhardt: No problem.

Alex Park: Thank you, Dr. Ehrhardt. And I'll just note for the Committee, I believe a letter was included as part of the packet as another stakeholder input that I think relates to some of Dr. Ehrhardt's. I think it's from your group, Dr. Ehrhardt. So just to confirm that the Committee has seen and received that additional letter. Questions for Dr. Ehrhardt from the Committee? Okay, thank you. And Dr. Ehrhardt, I am so sorry. We forgot to ask. Did you have any conflict of interest to report? Thank you. Yes. I do. I do serve on the Advisory Board for Novo Nordisk, and I do serve on Advisory Board for Dexcom. I also have received investigator-initiated grants from Dexcom and educational grants from Novo Nordisk and from Merck.

Alex Park: Thank you. Who was the first organization?

Nicole Ehrhardt: Novo Nordisk. [Cross-talk] I sit on the Advisory Council for them. Correct.

Alex Park: Thank you. Thank you, Dr. Ehrhardt. Okay, Committee, are there other stakeholders that have signed up, Leta?

Leta Evaskus: I don't see any. If anybody else would like to speak, if you could raise your hand. Okay. We do have Shawn Hansen.

Alex Park: Shawn, please introduce yourself, and let us know who you represent and if you [coughing] report and we'll start your three minutes. Shawn Hansen, are you with us?

Leta Evaskus: It doesn't look like Shawn is muted. Shawn, do you have yourself muted?

Alex Park: Leta, do we have to do one of those ask to unmute deals?

Leta Evaskus: It's not on there. It looks like he's unmuted. Shawn, if you want to put your comment in the Q&A if you are having audio issues. I don't know.

Alex Park: Leta, can we provide the call-in info to -- oh, I'm seeing somebody else. I saw Shawn [cross-talk] --

Leta Evaskus: I'm sorry. That was me. I tried to undo Shawn's, and he just moved on the list there. Okay. He's going to try to go on a different [cross-talk] --

Shawn Hansen: Okay. Can you hear me now?

Leta Evaskus: Yes. There you are.

Shawn Hansen: Oh, you can?

Leta Evaskus: Great.

Shawn Hansen: Third time's a charm. I clicked unmute three times.

Alex Park: [Cross-talk] Yes. Please introduce yourself, let us know where you are from, and we will hear your comments.

Shawn Hansen: All right. Good afternoon. My name is Shawn Hansen. I am a Pharmacist and a Medical Account Director with Novo Nordisk. I am here today to respectfully request that you consider adding Ozempic to the PDL as a preferred weekly option for patients with Type 2 diabetes at high risk of cardiovascular events. Ozempic contains semaglutide, an injectable once-weekly GLP-1 approved for glycemic control and cardiovascular risk reduction in patients with Type 2 diabetes. ASCVD is the leading cause of death in the US overall and especially in patients with Type 2 diabetes. According to the AHA, adults with Type 2 diabetes have a two to four-fold higher risk for cardiovascular morbidity and mortality than adults without diabetes. Accounting for the vast majority of disease burden, including approximately 50% of deaths and over 50% of the lifetime medical costs of diabetes complications. The FDA decision to approve Ozempic for cardiovascular protection in January of 2020 was based on the combined datasets from the SUSTAIN 6 and PIONEER

6 trials. SUSTAIN 6 demonstrated a 26% relative risk reduction in major adverse cardiac events with Ozempic, and PIONEER 6 demonstrated a 21% relative risk reduction in MACE events with Rybelsus, which is oral semaglutide. Patients in these trials were adults with Type 2 diabetes at high risk for ASCVD events. In this context, high risk was defined as established ASCVD or age greater than or equal to 60 and at least one additional CV risk factor. In the overall SUSTAIN clinical trial program, a number of comparative trials Ozempic 1 mg lowered mean A1C by up to 1.9%, with up to 80% of patients achieving an A1C target of less than 7 and a mean weight loss of up to 14 pounds. All of these findings achieved statistical superiority in head-to-head trials against Bydureon, Trulicity, Januvia, Lantus, and Invokana. In terms of adverse events with Ozempic, they were mainly GI in nature and typically resolved within the first couple months of therapy in most patients, consistent with the overall GLP-1 class. Please check the label for more detailed Safety Information. In conclusion, I again ask that you consider the addition of Ozempic to the PDL based on its weekly administration and potency in the relevant outcomes of glycemic control, weight loss, and cardiovascular protection in appropriate patients. Thank you.

Alex Park: Thank you, Shawn. Any questions for Shawn from the DUR Board? Okay. Has anyone else raised their hand to speak, Leta?

Leta Evaskus: I don't see any other hands raised.

Alex Park Okay. Let's turn our attention to the motion, Committee. I keep saying Committee. It's the DUR Board now. Donna, I wanted [cross-talk] no, go ahead, please.

Laura Beste: This is Laura Beste. So as the DUR Board, what is our authorization to make a recommendation to add a once-weekly agent?

Alex Park: I'll take a stab at that, Donna. But I would love for you to back me up here. So the DUR Board, Donna did a great job earlier this morning on the process overview. Our role is to review the therapeutic class review that Umang has presented. And he does include those expert consensus-based guideline reports, ADA, AGA, etc., for us to consider. And then from that, the Board is determining superiority, equivalency, efficacy, inferiority of the agents within the class. And we then make a recommendation as to whether all the agents in the class are safe and efficacious or whether we feel that certain agents are

not as safe or need to be highlighted as a potential for being placed on a higher rung based on higher efficacy in the data. And then that is encapsulated in the motion. And that then goes to HCA, which incorporates our recommendation along with the financial analysis that Magellan does and other data, and then the HCA has the final determination on what ends up on the PDL and in what format. Regarding a policy, I think Marissa presented the policy earlier. The policies do also come to this Committee, and we can make recommendations on that. Donna, comments?

Donna Sullivan: In the past you have -- I was going to say it was like the P&T Committee, which I don't think would be unreasonable for the DUR Board either, is recommended that we have different formulations on the PDL. So sometimes you've said we should have a pediatric -- make sure that we have a formulation that's indicated in pediatrics. Or we have a formulation for difficulty swallowing, or topical, injectable, oral. So like with the triptans, the Committee wanted us to have like one of each preferred. So I think it's well within your purview to make that recommendation.

Alex Park: Did that answer your question, Laura. Okay.

Laura Beste: Yes, it did.

Alex Park: I am thinking about your comment, Laura, and the data that Umang presented with the guidelines. And the ADA seems to be pretty clear on within the GLP class that certain drugs have benefit in the cardiovascular prevention world more than other drugs in that class. The three biggies being dulaglutide, liraglutide, and semaglutide. One of those, liraglutide, is currently preferred. I think Marissa showed us that. But as a Board, we do have an option to highlight certain drugs if we wish.

Laura Beste: So this is Laura Beste. So my concern with not having a once-weekly product would be what was brought up by some of the other speakers, was that for patient compliance, especially you improve patient outcomes if the patients are going to conform to compliance with the once-weekly formulation versus a daily injection of the medication. So long term, your efficacy is going to improve because they are complying with their therapy.

Alex Park: I think there is a way to incorporate that, Laura, if you are suggesting that we make an addendum or a modification to this motion as it stands. As Donna mentioned, we could make a recommendation to the HCA that certain

delivery modes should be included. Or we could make a recommendation that certain numbers of drugs or certain listed drugs that we list out should be considered more efficacious than others in the class, based on the data and the benefit that's presented in the literature.

Jon MacKay: This is Jon MacKay. I also like to mention that I have been wondering if Mounjaro represents a unique drug class, given its additional benefit, or if it should be lumped in with the traditional GLP-1s.

Alex Park: Marissa, Umang, I know that Magellan has a very specific way of categorizing drugs. Would you care to comment?

Marissa Tabile: Yes. This is Marissa. So when that drug came to market -- and I think it came in the market, I think Umang mentioned in May. We did take a look at. We didn't know the differences in the mechanism of action compared to GLP-1s. The reason why we did lump it in that particular class is because it is shared essentially at the time that it was approved the same indications as a traditional GLP-1. So we felt that it would be best to lump it in that class. But, of course, as more data comes out as the product changes the longer that it's on the market, we can definitely consider moving it to a different class, creating a class separate for it. But that's just kind of the rationale as to why it's lumped in there today.

Christy Weiland: This is Christy Weiland. I just want to re-emphasize Laura, to your point. I think the once-weekly injections I kind of get to see firsthand that adherence does improve for a lot of our patient population, and I think that would be a strong recommendation from us.

Alex Park: Would either of you like to take a stab at amending the motion to reflect your suggestions?

Michael Corsilles: This is Michael Corsilles. Before we add that, I agree with Christine and Laura, too. I think it's great to add that, but I think -- correct me if I am wrong -- is the biggest limiting factor is typically the cost. Is that right? Because the research shows that we have probably seen that it works great clinically preventing cardiovascular disease and diabetes as well as weight. But is that true that we can make our recommendation? And I agree. I think we should. But is the big limiting factor like the cost?

Marissa Tabile: [Cross-talk] This is Marissa.

Donna Sullivan: [Cross-talk] This is Donna. Marissa, I'll take this one. So in that regard, yes. We do look at cost as part of our selection process. So to give us the most flexibility, it would be best for the Board to direct us to pick a weekly injectable rather than naming one, and then we can go and look at the cost since we don't look at cost here. We can look to see if there is one that is less costly that still meets the criteria that we could make as preferred.

Laura Beste: So this is Laura Beste. So how do we include the wording on this? So do we include that the drug classes listed on seven and eight considered safe and efficacious for the medically preferred status, including one weekly -- does anyone have any suggestions on how to word that [cross-talk] --?

Donna Sullivan: I would add a sentence maybe after "eligible for preferred status and grandfathering at the discretion of HCA." I would insert a sentence that says one weekly injectable. And I don't think it's every class. I think this is encompassing multiple classes. So is there a particular drug class that has the weekly injectable that we're referring to?

Multiple Speakers: [Cross-talk] [indistinct].

Alex Park: [Cross-talk] one.

Donna Sullivan: Okay.

Marissa Tabile: [Cross-talk] agonist class so I can split that out and create a new motion for that class specifically.

Donna Sullivan: Or I think you could say and just add a sentence that says, one GLP agonist weekly injectable or something like that should be preferred.

Marissa Tabile: Okay. Just for everybody's reference, this is Marissa. At our last meeting for the anticonvulsants. We did include a sentence at the very, very end that said, "I recommend that an FDA-approved intranasal benzodiazepine product be preferred on the Apple Health PDL." So if that suffices, I can just copy that, change it to GLP-1 if that works.

Alex Park: Thank you, [cross-talk]. Yeah. Thank you, Marissa. Let's give that a go and see if the Board feels that it reflects what they would like to represent.

Marissa Tabile: This is Marissa. I have word-smithed it a little bit, so hopefully that fits the need. But I am open to any other suggestions. DUR Board, what do you think? Does that capture the intent?

Michael Corsilles: This is Michael Corsilles. I think it looks great.

Alex Park: Okay. Marissa, just pertaining to one of the other questions that had been brought up by the stakeholder regarding policy. They had asked about thinking about the algorithm with the SGLT2s. I think that's out of scope with this motion. But a question relating to that would be, what is the cadence for bringing that policy to the DUR Board?

Marissa Tabile: This is Marissa. Yeah, that's a great question, Dr. Park. So yeah, unfortunately, at this meeting, you wouldn't be making really any policy changes to that clinical criteria. It's been a while. I will admit that we have presented clinical policies to these meetings, but because that would be criteria change, we would probably bring it at another meeting. We are planning to bring back our clinical policies probably sometime in the summer, just because the process of that is pretty intricate as far as reviewing. So most likely, if we do bring anything back, you may see it sometime in the summertime is when we'll put that up for any review. I can't guarantee it, just kind of depending on the need for clinical policies, but that would probably be around a tentative timeline. Of course, any changes that we make to the PDL, if it happens anytime throughout the year, we do take our clinical policies into consideration. So any changes that need to be made, that will reflect changes to the PDL. We do take a look at our policies and see if we need to change anything there, as well.

Alex Park: Thank you. Okay, Committee, we have done some good work on this motion as it stands. Let's all review it together. And if there are any additional comments or concerns, please raise them. And if not, we'll go ahead and entertain a motion.

Michael Corsilles: This is Michael Corsilles. I want to make a motion. I move that all products in the drug classes listed on Slides 7 and 8 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 at least 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. I recommend that a once-weekly FDA-approved GLP-1 agonist product be preferred on the Apple Health PDL.

Dimitry Davydow: This is Dimitry Davydow. I second.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you. I believe that brings us to lunch.

Leta Evaskus: Yeah. This is Leta. Would it be okay to come back at 1:00? So that will give us 25 minutes. Just since we're a little bit behind. That's okay?

Alex Park: I'm not hearing anybody oppose, Leta. I think that works.

Leta Evaskus: Okay. Thank you so much. See you guys back at 1:00.

Alex Park: Thank you.

[lunch break]

Alex Park: Okay, Committee. I am sorry. I keep saying Committee. Okay, DUR Board. Hope everybody enjoyed a tasty lunch and replenish some blood sugar there. We have one, two, three, four, five, six topics ahead of us to review. And, Umang, if you are ready, I'll turn it over to you for Antiparkinson Agents. Actually, maybe we won't do that. I'll give it another minute for everybody to get back from lunch.

Umang Patel: Oh, I'm sorry. I'm here.

Alex Park: Oh, you are here. Okay. Go ahead and go [cross-talk] ready.

Umang Patel: Perfect. So for the next class, we have our Antiparkinson Agents, and this has three subclasses in here. As you can see, we have the Adenosine Receptor Antagonists, the Dopaminergics, and the MAOIs. And moving right into Antiparkinson's. So Parkinson's is a progressive, neurodegenerative disorder with cardinal motor features of tremor, bradykinesia, and rigidity. It affects

approximately 1% of individuals older than 60 years, and the incidence increases significantly with age. The term parkinsonism describes the motor syndrome of bradykinesia, rigidity, tremor, and balance and gait disturbances. Secondary parkinsonism, which has a different etiology and pathology than Parkinson's is the predominant clinical manifestation of a number of disorders including brain tumors near the basal ganglia, cerebral atherosclerosis, head trauma, and progressive supranuclear palsy. Secondary parkinsonism can also be caused by toxins and drugs, especially antipsychotic agents. Despite advances in treatments over the years, there is no cure for Parkinson's disease. Symptomatic therapy can provide benefit for quite some time, but the continued, however, slow progression of Parkinson's eventually results in significant disability. Patients may not require treatment in the early stages of Parkinson's if symptoms do not cause functional impairment. As the disease progresses, however, therapy becomes more complex, requiring dosage adjustments, incorporation of multiple medications, and the use of rescue treatments. On the next slide here, RLS. I need to pause there for a second. Magellan Health categorizes (RLS) Restless Leg Syndrome under Parkinson's agents because some of the Parkinson's medications provide indications for RLS. So RLS is a neurological sensory disorder in which patients experience irrepressible sensations in the legs or arms while sitting or lying still to cause them to move their arms or legs. Providers will need to rule out other movement disorders with similar symptoms to RLS such as Periodic Limb Movement Disorder, antipsychotic drug adverse effects, and dyskinesis to correctly diagnose and treat these symptoms. Studies do suggest that RLS is associated with the dopamine system and depletion of iron stores. Historically, it has been treated with opioids, benzodiazepines, anticonvulsants, iron replacement, and dopaminergic agents. Prior to 2000, levodopa was the dopaminergic agent most studied for RLS. Mirapex, Requip, Neupro are approved for an indication of RLS, and there has been increased focus on the use of dopamine agonists in the treatment of this disorder. Now Horizant is an FDA-approved medication for RLS. Next, you have guidelines. So AA and the American Academy of Neurology in 2021 updated the guidelines to state that treatment with levodopa provides superior benefit at reducing motor symptoms when compared to treatment with either dopamine agonists or MAOB inhibitors. While incidence is low. levodopa is more likely than other agents to cause dyskinesia in the first five years of therapy. Discontinue rates are lower with levodopa than dopamine agonists and MAOB inhibitors. Immediate-release levodopa is preferred over controlled-release levodopa or levodopa/carbidopa entacapone for early PD. And guidelines for the

treatment initiation for Parkinson's disease is under development. Lastly, here, we do have a new generic, apomorphine hydrochloride from February of last year. It is the first new generic drug cartridge only of MDD Pharma's Apokyn from Sage Chemical. The ANDA approval is for the drug cartridge only, and these are compatible with the Apokyn Pen brand name pen injector. I'll go ahead and pause there before passing it back to Dr. Park.

Alex Park: Thank you, Umang. Marissa, would you like to walk us through the PDL?

Marissa Tabile: This is Marissa. Yes. So I tried to scroll ahead of time. So getting into our Anti-Parkinson Agents on our AHPDL. The first class is our adenosine receptor antagonists. The only product in that class right now is Nourianz, and that is preferred. Moving on to our dopaminergic drug class, our preferred products in this class are generic amantadine. We have capsules and solution. I think this is the same, and this is probably a different maybe strength. We have carbidopa individually. We have carbidopa/levodopa, and we have the ER formulation as preferred, as well. And pramipexole is preferred. And we have generic ropinirole tablets preferred in that class. And then our last class is our MAOI class. And in this class our preferred products are the selegiline capsules and tablets. And I will welcome any questions from the Board.

Alex Park: Any questions for Marissa? Okay. Thank you, Marissa, for going over that. Leta, I don't believe we have any stakeholders for this one. Is that right?

Leta Evaskus: We do not have any registered. If anyone wants to speak, if you could raise your hand. I don't see any hands raised.

Alex Park: Okay. Let's turn our attention to the motion. Now would be the time to ask any questions or make any recommendations for amending this motion. Otherwise, we'll go ahead and entertain a motion as it stands.

Virginia Buccola: This is Virginia Buccola, and I am ready to make the motion unless I am cutting anybody off. I move that all products in the drug classes listed on Slide 10 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 at least 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.

Jon MacKay: This is Jon MacKay. I second.

Alex Park: Thank you. All those in favor, please say "Aye."

Laura Beste: Aye.

Kevin Flynn: Aye.

Virginia Buccola: Aye.

Jon MacKay: Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you. Umang, back to you for Sleep Disorder Agents.

Umang Patel: All righty. Next one we have is our Sleep Disorder Agents. I don't believe I have mentioned this to the newer Committee members, but if you see these in these title slides duplicate names, what this means is Magellan's Clinical Market Basket may be a little bit different than the Apple Health PDL. The top is Sedative Hypnotics, which is how Magellan categorizes it. The subsections here are how they can be found in the Apple Health PDL. So we have Sleep Disorder Agents for Selective Melatonin Receptor Agonist, Tricyclic Agents, and Non-Benzodiazepine. So moving right along, insomnia is a complex symptom that comprises difficulty falling asleep, staying asleep, or non-refreshing sleep in combination with daytime dysfunctions or distress. The symptom complex can be an independent disorder, primary insomnia, or the result of another condition, secondary insomnia. It is divided into three types based on duration. Transient, which lasts up to one week and is often referred to as adjustment sleep disorder because it is caused most often by an acute situational stress such as test or deadline. It is often recurrent with the same or similar stresses. The second is short-term insomnia by definition lasting one to six months and is usually associated with more persistent stressful situations, such as a death or illness or environmental such as noise. And finally, chronic insomnia lasting more than six months. With children, the incidence of insomnia ranges from 1% to 6%. In children with neurodevelopmental or psychiatric comorbidities, the incidents can be as high as 50% to 75%. And insomnia in children may result in irritability, restlessness, lack of concentration, suicide risk, and poor memory. On the next slide here, we have a drug-specific update for Quviviq. In January of last

year, the FDA-approved Quviviq, which is an orexin receptor antagonist, indicated for the treatment of adult patients with insomnia characterized by difficulties with sleep onset and/or sleep maintenance. In terms of limitations, there can be CNS depressant effects and daytime impairment, as you can imagine, to help one sleep. Sleep paralysis, hypnogogic hypnopompic hallucinations and cataplexy-like symptoms, complex sleep behaviors, and compromised respiratory function. In terms of dosage, the recommended dosage is 25 mg to 50 mg once per night, taken orally within 30 minutes before going to bed with at least seven hours remaining prior to planned awakening. And the availability is 25 mg to 50 mg tablets. Really quickly in terms of special populations, patients who have hepatic impairment, it is not recommended in patients with severe hepatic impairment, and there is a dose adjustment for moderate. For pregnancy, there is no available data for the effects of Quviviq on patients who are pregnant. And lastly, here we have discontinuations. In June of last year at Atyu BioPharma stated they will be discontinuing Zolpimist 5 mg oral spray is anticipated to be available until the end of last year, and there are no generics available. And I'll go ahead and pause there for the Committee.

Alex Park: Thank you, Umang. Any questions from the DUR Board for Umang? All right. Marissa, would you like to walk us through the preferred list?

Marissa Tabile: This is Marissa. Yeah. So I will go through our Sleep Disorder Agents. So going through first, we have our Non-benzodiazepine drug class. And our preferred product in this class is generic zolpidem. We have both the regular and the ER tablets preferred. Moving on to our Selective Melatonin Receptor Agonist drug class, our preferred product in this class is Ramelteon. And then moving to our tricyclic agents, we do not have any preferred products in this class. But it is comprised of Belsomra, Dayvigo, generic doxepin, Quviviq, the new product that Umang had mentioned, Silenor. And I can welcome any questions from the Board.

Alex Park: Any questions? Okay. Hearing none. Thank you, Marissa. Leta, has anyone raised their hand to speak on this one? No, I don't see any hands raised. All right, let's turn our attention to the motion then. All right, everyone, we'll go ahead and entertain a motion on this.

Virginia Buccola: Alex, this is Virginia. I think I do have a question. Maybe Marissa already said it. I am wondering, Marissa, can you go back to preferred agents? And was it

only zolpidem and zolpidem ER that are preferred? And there is no preferred selective melatonin receptor agonist? Is that correct?

Marissa Tabile: This is Marissa. So yeah. In the non-benzodiazepine, zolpidem is the only preferred product. And then in the selective melatonin receptor agonists, we only have ramelteon preferred. The only drug class that doesn't have a preferred product is the tricyclic agents.

Virginia Buccola: Okay. I am just thinking out loud here, and maybe other prescribers of selective melatonin receptor agonists or providers who might prefer to try to use those. But it seems to be that I have trouble getting even ramelteon approved. So that might be just situational. I am not quite sure. Anyway, I don't know if it would benefit us to -- can we put in language that at least one selective melatonin receptor agonist and one non-benzodiazepine need to be preferred? Or am I just stating what is already policy?

Alex Park: I think I see what you are asking Ginni [cross-talk]. So I think there is at least one of the nonbenzodiazepine and the selective melatonin receptor agonists class that [cross-talk] are preferred. But hearing the challenges you are facing I'm wondering if it's because they are on PA.

Virginia Buccola: That's what I am wondering, too. It feels like there is a piece that I am missing in my understanding in terms of my practice. My assumption had been that none of these were preferred, and that's why I usually try to prescribe or try to get ramelteon through but haven't had luck. Again, right, making big generalizations around what specific -- most of the people I care for are Medicare or Medicaid. What specific plan were they covered by? Right? I couldn't say. So I think I'll let it go. I think I had my question has been answered by my rambling and by your responses. Thank you.

Alex Park: Do you want Marissa to go through what the PA? No? Okay.

Virginia Buccola: I don't think so. I think I just needed to process that out loud. And I think Marissa answered my question. Just knowing that we have one of each that is preferred. I think I can let that go. Thank you.

Alex Park: Thank you for your question. Sleep is important.

Dimitry Davydow: This Dimitry Davydow. I have a different question, which as I was looking at this while we were talking about it kind of brought up. And I am just

wondering why the orexin receptor antagonists are in the same category with the tricyclic antidepressant? Because my kind of, I guess, in the [indistinct] a little bit of my sort of [indistinct], perhaps I have some lack of understanding mechanistically here. But it seems to me that they don't have the same mechanisms of action, and certainly don't necessarily all have the same side effect profile. And so I'm just kind of wondering why they are lumped in together like that.

Marissa Tabile: This is Marissa. If I am understanding, it's really the Quviviq and these products in the tricyclic is what you were wondering?

Dimitry Davydow: Well, right. So that doxepin isn't in the same category with the orexin receptor antagonists, but they are all considered to be tricyclic agents. But it is my understanding is that actually only doxepin is the tricyclic antidepressant. And they are different. Again, they have different side effect profiles, different mechanism. And so, it seems like that should be its own. And, frankly, as I am sure, certainly Virginia would concur and probably some others that we certainly clinically have seen other tricyclic antidepressants being prescribed low-dose for the same purpose, as well, that aren't reflected in this list. So I'm just wanting for just a point of clarity, I guess, in making sure that this is as clear as it should be.

Marissa Tabile: Yeah. This is Marissa. So just to get into how we also named some of our AHPDL drug classes, is we do have a drug reference. I don't think it's a table but a big drug reference resource that we use that automatically when it comes into our system, it kind of [audio cuts out] already assigns itself based off of a unique number to a drug, to drug classes, or kind of drug categories. So at the time that Quviviq came out, that drug was classified under the Sleep Disorders: Tricyclic Agents. So we felt that just to kind of reduce the amount of splitting out-of-classes, we put it in the same class as the other sleep disorder tricyclic agents, just based off of kind of numbering convention. And then also we do try to take a look at the mechanism of action. Sometimes, if the mechanism of action is really very truly different that is really obvious, we will split it out. But sometimes with a lot of these newer drug products that come out, the mechanism of action for some of these products is really unknown. So it's kind of a potpourri if you will sometimes of, where do you put this class? So we err more on the side of putting it in similar drug classes at the time that they come approved. But earlier, like I alluded to before, with more emerging data and more indications that maybe that drug might come

out with, we definitely do consider if it's better to split that drug out from that class later on as it goes over time. So hopefully, that's helpful.

Donna Sullivan: And Marissa, this is Donna. We could potentially consider changing the name of the class, as well, so that it doesn't miscategorize something as a tricyclic, or revisit the breakdown of these particular classes, I think.

Alex Park: It's an interesting point. I mean, we could actually take all of those and just dump them under non-benzodiazepines. But then they are -- most of those in that tricyclic class outside of doxepin and Silenor really do fall into a different specific mode of action as Dimitry was pointing out. So it sounds like, Marissa and Donna, you guys are saying that's something that can be looked at, and notes have been made, and that's [cross-talk] --

Marissa Tabile: This is Marissa. Yeah. I can take that back as a point. And then for AHPDL improvement, we can consider, like Donna said, renaming the class or splitting out products where appropriate if we need to. And of course, if we do split those drug products out or rename them, they may appear in future DUR Board Meetings as a different name. So just wanted to give that disclaimer in the future that may happen.

Alex Park: Thank you. Have we, as a Board, reviewed the class that Dimitry was referring to?

Marissa Tabile: This is Marissa. So it is up for review right now. It's in the Tricyclic Agents right now. Are you talking about the orexin drug class?

Alex Park: Yeah. Have we ever specifically reviewed orexin receptor antagonists?

Marissa Tabile: I don't think we actually have that drug class named. We don't have a drug class named that on our PDL. And off the top of my head, I don't know exactly where those drugs live. I am assuming they might live here in the Tricyclic, but I would have to take a look deeper just because I am not too familiar with them off the top of my head.

Alex Park: Yeah. Okay. Thank you.

Donna Sullivan: Just a question. This is Donna. A question might be to Umang. How does Magellan classify these drugs? And are they included in one of their market baskets if they are newer-to-market drugs?

Umang Patel: Hey, Donna. I'm looking that up right now --

Donna Sullivan: Okay.

Umang Patel -- as that question was being formulated.

Alex Park: Umang, when you talked about Quviviq, it came under -- let's see, what did you put it under?

Umang Patel: For us, it is under Sedative Hypnotics, as well.

Alex Park: Yeah.

Marissa Tabile: This is Marissa. Just to verify on the HCA side, it does look like, for the most part, with just a quick search, our Orexin Receptor Antagonist class is our Tricyclic Agents.

Alex Park: Okay.

Marissa Tabile: So that's where they live.

Alex Park: Okay. Umang, did you have another comment?

Umang Patel: No. I just wanted to confirm that we have it under Hypnotics, as well.

Alex Park: Okay. Well, thank you, Donna and Marissa, for taking Dimitry's comment down. And as that class evolves, it sounds like there are more and more orexin receptor antagonists coming out. That's something that can be looked at over time. Okay, if there's nothing else, then we'll turn our attention to the motion, which is on Slide 13.

Marissa Tabile: This is Marissa. So can you see my screen, Alex?

Alex Park: Yes, I can see it. It's up there [cross-talk] --

Marissa Tabile: Okay. I just wanted to make sure. Thank you for verifying.

Alex Park: [Cross-talk] Thank you. At least I can. If anybody else on the Committee or the Board is unable to, please let us know. But I am on Slide 13 with Sleep Disorder Agents is what I am seeing.

Michael Corsilles: I'll make the motion. It's Michael Corsilles. I move that all products in the drug classes listed 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 nonpreferred products require a trial of at least 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.

Laura Beste: This is Laura Beste. I'll second the motion.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you. Umang, turning it back to you for Neuromuscular Agents.

Leta Evaskus: Umang, we can't hear you.

Umang Patel: Yeah, I double-muted myself. I'm sorry about that. So next, we have Spinal Muscular Atrophy, as defined by Magellan for Apple Health PDL. We have it under Spinal Muscular Atrophy, both Gene Therapy Agents and Antisense Oligonucleotides. So going right into a little bit of background here. So spinal muscular atrophy is a rare debilitating neuromuscular disease characterized by motor neuron degeneration, muscle weakness, and atrophy. The disease mainly affects the motor neurons in the spinal cord. It is not believed to impact a person's capacity to think, learn, and build interpersonal relationships. It is the leading monogenic cause of infant mortality and is the second most common autosomal recessive inherited disorder, with an incidence ranging from 4 to 10 per 100,000 live births. It is more common in males than females, particularly with the early-onset forms. Patients experience motor function decline with disease progression and morbidity, and mortality rates are inversely correlated with age of onset. Mortality due to SMA is most commonly related to respiratory infections and complications. Genetic testing is used to establish diagnosis in patients with

suspected SMA based on symptoms and universal newborn screening for SMA as part of the federal-recommended Uniform Screening Panel. Clinical classification is typically based on an age of onset and maximum motor function achieved. As you can see here, the SMA type is broken down by type 0 through 4 and, as I mentioned, it's based on age of symptom onset and highest motor function achieved and, therefore, it is correlated with the perspective life expectancy here. Moving along here, just specific drug updates. Evrysdi in June of last year received an expanded indication from the FDA to include patients less than two months of age for the treatment of SMA. No changes to any of the Warnings/Precautions. In terms of dosage for patients less than two months of age, which now is part of the indication, the dosing is 0.15 mg/kg. No changes to the availability, which is an oral solution here. And that's it for this subclass. Pretty quick. Go ahead and pause there for the Committee.

Alex Park: Thank you, Umang. Any questions from the Board to Umang? Okay. I'm hearing none. I do believe we have one stakeholder on the list for this class, or this group of classes. Lynda Finch from Biogen. Oh, I am so sorry. I skipped Marissa. We're going to come back to you, Marissa.

Marissa Tabile: This is Marissa.

Alex Park: [Cross-talk] Let's go take a look.

Marissa Tabile: No, that's fine. Pretty quick. So I will go through our Spinal Muscular Atrophy drug classes. So the first one is our Gene Therapy Agents. The only product that's really in this class is Zolgensma. And as you will see in column E, it does have a designation of X, so it is neither preferred nor non-preferred on our Apple Health PDL. That's really because it is a carve-out medication, so carved out of our MCOs responsibility. But to align both the fee-for-service and MCO programs, we do include our carve-outs on our Apple Health PDL. So that's why you'll see that it is included. One thing to note about this particular product is that you probably wouldn't see it most likely come through a pharmacy point of sale claim. It comes through mostly as a medical claim, so that's why it's not subject to any preferred or non-preferred statuses on our PDL, just because the route of administration is mostly on a medical type of claim that you'll see. Next, we have the Antisense Oligonucleotides. I probably pronounced that incorrectly. The products that we have in this class are Evrysdi and Spinraza. Evrysdi is an oral product, so it does have preferred or non-preferred statuses. You will see that come

through most likely through pharmacy point of sale. And just in our experiences with Spinraza, we have seen claims for this particular product come through pharmacy claims, as well. So that's why it is subject to as preferred and non-preferred status on our PDL as well. Both SMA drug classes are carved out, like I mentioned, of MCO responsibilities, so we do just include them to align the first service and MCO. So I can welcome any questions you might have.

Jon MacKay: Marissa, this is Jon MacKay. I am just wondering when something is decided to be carved out, is it when it reaches a certain cost threshold? Or what's the determinant for that?

Marissa Tabile: This is Marissa. Yeah. So there are different criteria that we do use to determine whether or not a drug will be carved out. And Donna and Ryan, feel free to jump in if I am missing anything. But there is cost consideration. There are new drugs to market. There are other existing drugs that treat the same condition, then we'll typically carve out drugs that treat that share the same indication. If there is a disproportionate amount of patients amongst the MCOs that this would affect, then we would usually decide to carve it out. And I am sure I am probably missing something, but those are the main ones.

Donna Sullivan: Sure. So this is Donna. I can jump in there. So especially with the Zolgensma, Spinraza, and Evrysdi for this particular class, SMA is a rare disease, and these are extremely expensive drugs. And so we carve them out because the managed care rates. If one plan pays for one of these medications, then it would inflate their capitated rate that we pay them on a per member per month basis artificially. So we would be overpaying some plans that don't have any utilization for these expensive drugs and then potentially underpaying plans that have these patients in their enrollment. And that's one of the reasons with a rare disease that are high cost, we carve them out. Other instances where we want to carve out is like a new drug comes to market that's extremely expensive. This was true with the hepatitis C drugs and why they are carved out. It's that Sovaldi. When it came out, it was moderately expensive. Obviously, not as expensive as some of the newer drugs coming to market, but it had a large population that it impacted. And so because we set managed care rates on utilization from two years prior, there was no data to show what that financial impact might be. So if there is a moderately high-cost drug that comes to market, and there is a large population, we would consider carving it out. So one of those might be these new Alzheimer's drugs, where we have a large Medicare population that we

treat. And these newer drugs are moderately expensive. And if there is a lot of utilization, it might impact the rate. So that's kind of the rationale for when we carve in and carve out and why we carve in and carve out.

Alex Park: Very good. Thank you, Donna and Jon and Marissa for that discussion. And I remember our Committee looked at the Spinraza policy, I think, two years ago. We spent a good amount of time on that one. Okay, let's go ahead and hear from our stakeholder, Lynda Finch from Biogen. Leta will put up the introduction questions that we'd love for you to share with us about, and then the clock will start for your three minutes.

Lynda Finch: Thank you. Can you hear me?

Alex Park: Yeah.

Lynda Finch: Okay. My name is Lynda Finch. I am a Medical Account Director for Biogen. They are the manufacturer of (nusinersen) Spinraza. And I think that would be my conflict of interest to report. And just wanted to state upfront that Washington Medicaid does have an excellent policy for treating SMA. And it does reflect the severity as well as the complexity of treating this very devastating disease. What I want to talk about today is that there are still patients who could benefit from treatment that are being excluded by Washington's policy. And these are patients that are dependent on permanent ventilation assistance. So the current policy allows treatment for these patients if they are ambulatory or can independently operate their wheelchair. But there are patients who could benefit from treatment that may not meet these criteria. One example would be an infant that's not yet ambulatory or able to operate a wheelchair, or an adult who doesn't have the ability to operate a wheelchair but may be able to still feed themselves and operate a computer mouse. So in our pivotal study that was done on infantile-onset SMA, infants that required permanent ventilation were excluded because one of our primary endpoints was time to permanent ventilation. And we define that as tracheostomy or 16 or more hours of respiratory support for 21 or more days in the absence of an acute reversible event, such as a respiratory infection. We didn't exclude those patients because we thought they wouldn't benefit from treatment, just because they had already met that primary endpoint. Now, what happened is that during our trials, some patients did, unfortunately, become ventilator-dependent, but we kept them on treatment. So we now have sham-controlled clinical trial data on nusinersen treatment of ventilator-dependent patients. And

what we have seen is that these patients who required permanent ventilation still achieved motor milestones, meaning that they benefited from treatment. They achieved more motor milestones and exhibited higher motor function scores than those who are on sham treatment. And none of these patients declined on the Hammersmith Infant Neurological Exam as you would normally expect in a severe form of SMA, 61% of these patients actually improved, and this is despite needing assistance from permanent ventilation. We also saw that 78% of the treated patients improved on the CHOP-INTEND score, whereas 82% of the sham-treated patients worsened. And they also required less time on ventilation and had a reduction in their serious respiratory events during the study. And we now have long-term data over four years from our extension study that demonstrated that nusinersen-treated patients that needed permanent ventilation during the trial had clinically meaningful improvements in motor function over time despite needing permanent ventilator assistance. Real-world studies that have been published since the approval of nusinersen have reinforced that respiratory function can improve with nusinersen treatment, and some patients can significantly reduce their ventilation assistance need. So a study presented last year showed that 5 out of 11 study patients who had Type 1 SMA and were ventilator-dependent, children were able to wean off permanent ventilation after treatment with Spinraza. So even if a patient has significant weakness in their muscles that support respiration and require ventilation assistance, it's still worthwhile to provide treatment that support survival as well as other motor function, especially critical functions that allow them to maintain essential activities of daily living, such as the ability to communicate, eat, and drink. So please consider allowing all permanently-ventilated patients to receive the benefits of treatment with nusinersen. Thank you very much for your time and your careful consideration of this policy.

Alex Park: Thank you, Lynda. Questions for Lynda from the Committee? What was the name of the new trial you mentioned, Lynda? Because I had just mentioned that this Committee spent some time on that policy, and at that time, we were looking at trials that had excluded ventilator-dependent patients.

Lynda Finch: So can you still hear me? Our trial that excluded the ventilator-dependent patients was our ENDEAR trial. The new study that I just mentioned just came out of the University of Oklahoma, and it was a small series of case reports, essentially only 11 patients, so it wasn't a sham-controlled trial, really an observational trial.

Alex Park: I see. Thank you for answering that question. Any other stakeholders, Leta?

Leta Evaskus: I don't see any other hands raised.

Alex Park: Okay, Committee, let's turn our attention to the motion. Any questions or discussion about this class or the motion on Slide 15? Feel free to speak up if you have concerns that you would like to raise. Otherwise, we will entertain a motion.

Dimitry Davydow: This is Dimitry Davydow. I move that all products in the drug classes listed on Slide 14 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 at least 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.

Virginia Buccola: This is Virginia Buccola, and I second.

Alex Park: All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you. Umang, we'll turn it back to you for Bone Density Regulators.

Umang Patel: Perfect. This one, Dr. Park, don't go off camera yet. This one's a quick one. There are no significant clinical updates for this class, so I'll pause there and pass it right back to you.

Alex Park: Thank you, Umang. And here's Marissa.

Marissa Tabile: This is Marissa. So looking at our Bone Density Regulators, we have the Sclerostin Inhibitors. But the only product we have in this class right now is Evenity, and that is nonpreferred.

Alex Park: Okay. Questions for Marissa? All right. Let's turn our attention to the motion.

Leta Evaskus: Hi. We have one stakeholder.

Alex Park: Oh, yes. Apologies. We have Carrie Johnson from Amgen. Carrie, if you are with us, we welcome you to introduce yourself and share your comments.

Carrie Johnson: Okay. Can you hear me okay?

Alex Park: Yes, we can.

Carrie Johnson: Okay, great. Okay, so yeah, I am Carrie Johnson. I am a Pharmacist with Amgen Medical Affairs. Thank you for the opportunity to speak in support of Evenity (romosozumab). Evenity was approved in 2019 and is indicated for the treatment of osteoporosis in postmenopausal women at high risk for fracture. Please see the full prescribing information at amgen.com for further details. The patient at very high risk for fracture needs rapid fracture risk reduction in the near term. A 2018 publication from Osteoporosis International described that in patients who suffered a recent hip or spine fracture, the majority of all their future fractures will happen within the first one to two years after that initial fracture. This underscores the need for immediate and aggressive treatments for these very high-risk patients. Evenity is unique, as it is the only agent for the treatment of postmenopausal osteoporosis that has a dual mechanism of action. By inhibiting the activity of sclerostin, Evenity both increases bone formation and decreases bone resorption, resulting in rapid increases in trabecular and cortical bone mass and improvements in bone structure and strength. Using the anabolic agent, Evenity, both increasing bone formation and decreasing bone resorption first is optimal based on the pivotal registrational ARCH study and current guidelines. The 4000-patient, Phase 3, registrational, active-controlled fracture study in postmenopausal patients with osteoporosis at high risk for fracture demonstrated that those who received Evenity for 12 months prior to switching to alendronate, had significantly lower fracture rates than patients on alendronate throughout the study. Overall adverse events and serious adverse events were generally similar between treatment groups. In terms of published guidelines, the recently updated and published Endocrine Society Guidelines for the Pharmacologic Management of Osteoporosis in Postmenopausal Women consider Evenity as first-line therapy in patients with multiple vertebral fractures or hip fracture and BMD in the osteoporotic range. The recently published update to the American Association of Clinical Endocrinologists and American College of Endocrinology now includes Evenity and recommends its use for patients unable to use oral therapy as

initial therapy for patients at very high risk for fracture. Of note, in the Phase 3, randomized, open-label, international structure study, the study evaluated the effect of romosozumab compared with teriparatide in postmenopausal women with osteoporosis. Evenity demonstrated statistically significant increase in hip bone mineral density and strength compared with teriparatide in postmenopausal women with osteoporosis transitioning from bisphosphonate treatment. The patient at high risk for fracture needs rapid fracture risk reduction in the near term. Using the anabolic agent, Evenity, which both increases bone formation and decreases bone resorption first is optimal based on the results described from the arch pivotal study Evenity dual-mechanism of action and current recommendations by the Endocrine Society and the American Association of Clinical Endocrinologists and American College of Endocrinology. I respectfully request that the Committee consider including Evenity as an option for patients with postmenopausal osteoporosis at high risk for fracture. Thank you. And I'll take any questions.

Alex Park: Thank you, Carrie. Questions from the Board for Carrie? Okay. Hearing none. Thank you. Let's turn our attention to the motion if there are no other stakeholders, Leta.

Leta Evaskus: There are no other stakeholders.

Alex Park: Oh. Actually, you know, Marissa, I did have one question. Where do teriparatide and abaloparatide -- ? I mean, I think of this drug as basically an Anabolic Agent. Are those other two drugs in a different class?

Marissa Tabile: This is Marissa. Yes, they are in a different class. The name of the class escapes me. But yeah, they are in a different class.

Alex Park: Okay. This one s sort of a unicorn in that class for the moment in terms of mechanism of action. Okay. Let's entertain this motion, Committee. Any thoughts or questions? And if not, we'll entertain a motion.

Laura Beste: This is Laura Beste. So I just have a question. So it's not preferred, but since there's nothing else in the class, you don't have to fail any other therapy. Correct? Even though there's another anabolic product available, teriparatide?

Donna Sullivan: This is Donna. There might be a prior authorization where we require them to try and fail a drug in a different class.

Laura Beste: Okay.

Donna Sullivan: I don't know off the top of my head what our policy is on this particular one, but there's no tried and failed within the class [cross-talk], but it could require step therapy through something else first.

Laura Beste: Like the bisphosphonate or something prior to [cross-talk] --

Donna Sullivan: Right. Yeah.

Laura Beste: Thank you.

Alex Park: Great question.

Laura Beste: Okay. So this is Laura Beste. I move that all products in the Bone Density Regulators : Sclerostin Inhibitors 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. Non-preferred products in this class may be considered medically necessary when the preferred agent is not indicated.

Christy Weiland: This is Christy Weiland. I second the motion.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Thank you. Okay, Umang, we're going to talk about Antidepressants.

Umang Patel: Perfect. So next, we have Magellan classifies them Antidepressants : Other. And the Apple Health PDL encompasses the GABA Receptor Modulator, the Neuroactive Steroids. So if you look at that, there's specifically one medication that has that mechanism of action, and that is Zulresso. Going right to a little bit of background, prevalence of 12-month and lifetime MDD is approximately 21 million American adults or 8.4% of the US population. Women experience depression more often than men. In addition, the prevalence of depression in 2020 was estimated at about 4 million

adolescents. With appropriate treatment, 70% to 80% of patients experiencing MDD achieve response. However, as many as one half of all patients do not experience efficient symptom improvement with initial treatment. Among patients who remit, residual symptoms are common and associated with impaired psychosocial functioning and increased relapse rate. Until recently, known differences among antidepressant drugs were generally limited to safety and tolerability issues. However, over the past handful of years, a number of studies have emerged to evaluate possible differences among antidepressant classes and their ability to resolve specific symptoms of depression. Each of the groups of drugs in this class have a potential role in the treatment of MDD, primarily as a result of their heterogeneous spectrums of activity. As with many psychotropic drugs, patients failing to respond to one type of antidepressant may respond to a switch-to or augmentation with an antidepressant with another mechanism of action. So with Zulresso here in June of last year, the FDA approved an expanded indication for the treatment of postpartum depression to include patients 15 years of age or older. Sorry, Marissa. Next slide, please. As you can see, no changes in Warnings or Dosage or Availability here, just that expanded indication for postpartum. We'll go ahead and pause there. That is the end for that subsection, and I'll pass it back to Dr. Park.

Alex Park: Thank you, Umang. Let's see. We do have one stakeholder and then -- well, I'll stop there. Any questions for Umang? Okay. And we have one stakeholder for this topic, which is Lynda Finch from Biogen. I am sorry, Marissa. I skipped you again. It's probably not that much on the [cross-talk] --

Marissa Tabile: No, it's fine. No worries. It's pretty easy, so I'll go through this pretty quickly. So like Umang alluded to, Zulresso is the only product in that class. I believe this is a carve-out similar to how I think the estimate agents are. That's why you do not see a status here. It's X. So it is, I believe, an IV product. So we would not see this product through a pharmacy point of sale claim. And in our experience, we have not seen it, so we have not subjected it to any preferred or not preferred statuses at this time.

Alex Park: Questions for Marissa? Okay. All right. Now we'll turn to Lynda Finch from Biogen. Lynda, please go ahead and introduce yourself and who you represent, and we'll hear your stakeholder comments.

Lynda Finch: Are you able to hear me?

Alex Park: Yes, we can hear you.

Lynda Finch: Oh, okay. Sorry, I was apparently still muted. I am going to defer my comments, but I did want to add one more thing on the SMA category. I just wanted to make a clarification that Evrysdi is not an antisense oligonucleotide. So just was going to suggest renaming that category. If you want to rename it as [indistinct] modifier, or you can look into how that drug works, But it is not an antisense oligonucleotide. So just wanted to provide that correction. And I will defer my rest of my time to my testimony. Thank you.

Alex Park: Thank you for that comment. Okay, Committee, let's turn our attention to the motion. Now is the time to voice concerns or recommendations for modification of the motion. And if there are none, we'll entertain a motion to approve.

Virginia Buccola: This is Virginia Buccola, and I'll make the motion. I move that all products in the Antidepressants : GABA Receptor Modulator Neuroactive Steroid 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 non-preferred products require a trial of at least 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.

Dimitry Davydow: This is Dimitry Davydow. I second.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? Okay. The motion passes. Thank you. And this next is our last topic, Asthma and COPD Agents. Back to you, Umang.

Umang Patel: Wait right there, Dr. Park. There are no significant clinical updates for this class. So passing it right back.

Alex Park: All right. Any stakeholders that have cropped up, Leta?

Leta Evaskus: There are no stakeholders.

Alex Park: Okay. What do we have, Marissa?

Marissa Tabile: This is Marissa. So our last drug class is our [audio cuts out] Asthma and COPD Agents : Leukotriene Modifiers. And the preferred products in this class are different formulations of montelukast. So we have chewables. It looks like there are some packets, some tablets. And then zafirlukast is also preferred in this class. And everything else is non-preferred. And I can take any questions.

Alex Park: Any questions for Marissa? Okay. Hearing none. Let's turn our attention to the last motion of the day. Any concerns or questions about the motion? No? Okay. Then we'll entertain a motion to approve.

Kevin Flynn: This is Kevin Flynn. I move that all products in the Asthma and COPD Agents : Leukotriene Modifiers 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 non-preferred products require a trial of at least 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.

Laura Beste: This is Laura Beste. I second the motion.

Alex Park: Thank you. All those in favor, please say "Aye."

Multiple Speakers: Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Leta and Donna, is there any other business for the DUR Board before we adjourn?

Donna Sullivan: I do not think so. Leta, was there anything else on the Agenda?

Leta Evaskus: No, that is it. Thank you, guys, so much for your conversation. And for our next meeting, why don't we take a 10-minute break before the Executive Session just to give everyone a little time? But thank you, all. And that's it for today.

Donna Sullivan: Great. Thank you.

Alex Park: Thank you, everybody.

Donna Sullivan: Bye.

Leta Evaskus: Bye.

Alex Park: Take care.

[end of audio]