Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board
Meeting Transcription
April 19, 2023

Alex Park: Okay. Good morning, everybody. It's Alex Park here, Chair of the P&T Committee. Happy Wednesday, April 19th. I'd like to go ahead and convene our business for today. Today we'll be performing our duties as the DUR Board. If all of the P&T Committee Members could turn their cameras on and show their bright faces, I'm going to go ahead and read off the names of the participating attendees. Please say here or present when I call your name. We also do have one new P&T Committee Member joining us this morning, Peter Barkett. So we invite you to not only list that you are present but provide a short introduction for yourself on behalf of the Committee. And so starting with the Committee members, is Laura Beste with us?

Laura Beste: Here.

Alex Park: Thank you, Lauren. Dimitry Davydow. Is Dimitry with us? Might still be trying to sign on. Virginia Buccola.

Virginia Buccola: Good morning. Here.

Alex Park: Hi Ginni. Kavita Chawla is absent today. Michael Corsilles.

Michael Corsilles: Here.

Alex Park: Good morning, Michael. Kevin Flynn.

Kevin Flynn: Present.

Alex Park: Good morning, Kevin. Jon MacKay.

Jon MacKay: Good morning. Here.

Alex Park: Good morning, Jon. Christy Weiland.

Christy Weiland: Here.

Alex Park: Good morning, Christy. And Peter Barkett.

Leta Evaskus: I don't see Peter on yet.

Alex Park: Okay. We can come back. Let's see. Leta, do we have a quorum with the members that we listed?

Leta Evaskus: Yes, we do.

Alex Park: Okay. I'll circle back in case Dimitry and Peter sign on. Moving on to the Health Care Authority Members, Laura Crocker.

Laura Crocker: Present.

Alex Park: Good morning. Luke Dearden.

Leta Evaskus: Not here.

Alex Park: Maybe no Luke this morning. Leta Evaskus.

Leta Evaskus: Here.

Alex Park: Good morning. Amy Irwin. I heard a rustling.

Leta Evaskus: No, she's not here.

Alex Park: Okay. Ryan Pistoresi.

Ryan Pistoresi: Hi. Good morning.

Alex Park: Morning, Ryan. Liz Punsalan might not be with us. Donna Sullivan.

Leta Evaskus: She's not going to be here today.

Alex Park: Okay. Marissa Tabile. Morning, Marissa. Ryan Taketomo.

Ryan Taketomo: Good morning. I'm here.

Alex Park: Good morning. Joey Zarate.

Leta Evaskus: He's not here today.

Alex Park: Okay. And moving on to our L&I Members, Jaymie Mai.

Leta Evaskus: L&I actually isn't going to be here since we're not doing P&T topics.

Alex Park: Oh. Because we're just DUR, okay. Right. And then moving on to the Magellan folks, Umang Patel.

Umang Patel: Present.

Alex Park: Okay. And we often have our (MCO) managed care organization representatives. I'm going to read off these names for the good of the order. Greg Simas from Molina Healthcare, Heidi Goodrich from Molina Healthcare, Petra Eichelsdoerfer from UnitedHealthcare, Omar Daoud from Community Health Plan of Washington, and Geoffrey Natividad from Community Health Plan of Washington. I'll circle back to P&T Committee Members. Have Dimitry or Peter joined us?

Dimitry Davydow: I'm here. Dimitry Davydow.

Alex Park: Good morning, Dimitry.

Dimitry Davydow: Good morning.

Alex Park: And Peter Barkett.

Leta Evaskus: Oh, I see him logging in now.

Alex Park: Okay. Good morning, Peter Barkett. I think you're one of our new P&T Committee Members. And if you're able to come on video and unmute yourself, we'd love for you to list whether you're present or not and provide a short introduction of yourself.

Peter Barkett: Hi, thanks. Glad to be here. Yep. My name is Peter Barkett. I'm an internal medicine doctor by training. I have a practice in Silverdale, Washington.

Alex Park: Welcome to the Committee.

Peter Barkett: Thank you.

Alex Park: Okay. And now Leta is going to go over some meeting logistics for us.

Leta Evaskus: Thanks, Alex. Hi, I'm Leta Evaskus. The Committee and the presenters can mute and unmute yourselves. Please mute yourself when you're not speaking to limit the background noise. Presenters, please share your webcam when you're presenting, and the Committee, please share your webcams when you're deliberating for a motion or having discussions. For the stakeholder participation, the Chair of the Committee will first read the list of stakeholder names who pre-registered, and we will unmute you. You'll have three minutes. After, the Chair will ask if anyone else wants to speak. Just raise your hand in Zoom, and we'll unmute you. You'll have three minutes. You can also use the Q&A box, and we'll address your questions during the stakeholder time. And if you did not fill out a stakeholder conflict of interest form, we're going to post some questions on the screen about conflict of interest, so if you could please answer those first. And your three minutes will begin after you introduce yourself. And lastly, the meeting is being recorded, so please state your name every time you speak. All right. And back to you Alex.

Alex Park: Thank you, Leta. Just a point of clarification, for the stakeholders who have filled out the COI form in advance, do we need to announce those for the good of the order? Or is it okay to move on? [Cross-talk] --

Leta Evaskus: Yeah, if people can still state what organization you represent or if you're a patient or a physician and then if you're here today with any organization if you can state just that much with your name.

Alex Park: Okay, great. Okay. Well, let's move on to our business for today as the DUR Board, and I'll look to Umang Patel from Magellan if you're ready to go to talk to us about Asthma and COPD Agents.

Leta Evaskus: Umang lost audio, but he's back. Right?

Umang Patel: Sorry. Yeah, I just lost the audio, but I think I caught the tail end. I think I'm up, so I apologize, and we'll get started. For just a refresher for the Committee members and for our new Committee members. How I usually present the significant clinical information is if there are classes with significant clinical information in the last 12 to 13-ish months, and we define significant as in guideline updates, new indications, new drugs, new

formulation, things like that. I will provide some background, any relevant guidelines in the last year, and then we'll get right into the drug-specific details. If there is no significant clinical update in the last year or so, then we do not go into the background or anything at all, for that matter. So, Leta or Marissa, I may ask to go to Slide 3. And so going right to the COPD Agents. And, again, a refresher for the Committee members, Magellan Health and Apple Health PDL don't always have the same name for these classes. And so what we try to do is the top COPD agents is how it is found in Magellan Health Market Basket and programming. The names listed right below it are what they are listed in Apple Health PDL. So we have Asthma, COPD Agents: Anticholinergics, PDE4 inhibitors, long-acting muscarinic agents, and beta agonist combinations, and long-acting muscarinic agents, as well. I'm going to pause right there because for this class, there is no significant clinical update. And so I apologize if this was said when I lost connectivity, but Leta or Marissa, will I just continue to do the whole COPD and then the motions after that? Or should I pause right here?

Marissa Tabile: This is Marissa. Yeah, Umang. All of your Asthma and COPD, so getting into Immunomodulators, Asthma as Magellan calls it, let's go straight into that. Then we're going to do one motion for all of the Asthma and COPD Agents together.

Umang Patel: Okay. Okay. And then is it okay to continue with the Glucocorticoids as well? Or will that be paused [cross-talk] -- ?

Marissa Tabile: No. Once you get to the end of your Immunomodulators and the Monoclonal Antibodies, we'll do the motion after that.

Umang Patel: That sounds great. Okay. All righty. So moving right along. So the next slide we have here is Immunomodulators, Asthma, so Monoclonal Antibodies. A little bit of background right here. So the prevalence of asthma in the United States continues to rise. More than 25 million Americans have asthma, and over 4 million of these are children. The National Asthma Education and Prevention Program has defined asthma as a chronic inflammatory disorder of the airways in which many cells and cellular elements play a role. In susceptible individuals, inflammation may cause recurrent episodes of wheezing, breathlessness, chest tightness, and coughing. These episodes are usually associated with airflow obstruction that is often reversible, either spontaneously or with treatment, and the inflammation also causes an increase in bronchial hyper-responsiveness to a variety of stimuli. Studies

have demonstrated the efficacy of inhaled corticosteroids in improving lung function, reducing symptoms, reducing frequency and severity of exacerbations, and improving the quality of life of patients with asthma. The 2007 National Heart, Lung and Blood Institute states that inhaled glucocorticoids are currently the most effective anti-inflammatory medication for the treatment of persistent asthma. And the 2019 GINA full report advises that all patients with asthma should receive ICS containing control or treatment to reduce risk of serious exacerbation and to control symptoms. On the next slide here, going into the GINA Guidelines. So the global initiative for asthma did update their guidelines. This slide and the next slide are the same thing in two different methods. Here, I'm going to just verbally outline the main updates. On the next slide, they did create a decision pathway that is exactly what I said. And so I won't go over it again, but I do have that visual table for any of our Committee members who wish to see it. So the guidelines offer control-based management plan to adjust treatment and a continuous cycle of assessment, treatment and review of the patient's response as it relates to symptom control, future risk of exacerbation, and side effects. Equally important in the process is identifying the patient's own goals regarding their asthma management to ensure improved outcomes. In patients whose asthma is not adequately controlled on the preferred controller despite good adherence and correct technique, a step up in treatment may be added until control is achieved. This can be a short-term sustained step up in therapy. If control is maintained for at least three months on the current regimen, treatment can be stepped down to the lowest step and dosage that maintains control. Patients should be started on treatment based on symptoms, with infrequent symptoms beginning at Step 1 and patients with the most frequent, severe, or debilitating symptoms beginning of Step 4. Notably, reliever therapy can be considered for symptom management prior to exercise if needed, and the guidelines described two treatment tracks, Track 1 and Track 2. In Track 1, the reliever is an as-needed low-dose ICS-formoterol combination. In Track 2, the reliever is an as-needed SABA, which is an alternative approach when Track 1 is not an option or is not preferred for patient-specific reasons. We go to the next slide here. I bolded what I just stated in terms of updates. So in Track 1, you can see at Step 2, the as-needed low-dose ICS/formoterol was added. And then in Track 2, the reliever, as-needed SABA, which is the alternative approach when Track 1 was not an option is added here. Otherwise, everything else was pretty much the same. Moving onward. In terms of Guidelines, the CHEST Guidelines in 2020 created a report on the management of chronic cough due to asthma and non-asthmatic eosinophilic bronchitis inpatient in adults and

adolescents addresses the role of ICS in these patients. For patients with chronic cough due to asthma as a unique system (cough variant asthma), they recommend ICS as a first-line treatment. If this is inadequate, the dose may be increased. Treatment can be switched to a leukotriene inhibitor, or an ICS/LABA can be considered. ICS are also recommended first-line for chronic cough due to NAEP. Although they are not FDA-approved for this use. In terms of the National Asthma Education and Prevention Program in 2020, they did recommend a similar classification of asthma severity and control to guide in the initiation adjustment of therapy. Asthma severity and control are defined in terms of two domains, impairment and risk. The distinction between these domains emphasizes the need to consider separately asthma's effects on quality of life and functional capacity on an ongoing basis along with risks for adverse events, such as exacerbations and progressive loss of pulmonary function. The group recommends a step-wise approach to asthma management, which is detailed in the table below. And in addition, all asthma patients should have SABA inhaler for use on an as-needed basis. As-needed ICs with formoterol is recommended instead for patients 5 to 11 years of age at Step 3 and 4, but a SABA is recommended as an alternative. And for combinations of an ICS and LABA for patients 5 years of age or older, the group states the single inhaler is preferable, and the table referenced can be found in the Appendix. So moving onward to drug-specific updates. So first, we have Dupixent here. In October 2021, FDA expanded the indication of add-on maintenance treatment with moderate-to-severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma to patients six years of age or older. Previously, this was patients 12 years of age or older, so they just expanded the indication age. I should pause there again for the Committee members who are new. For the drug-specific updates, what I try to do is bold the significant updates. As you can see, Dupixent and other drugs will have a lot of information. I try to bold what is the update from last year, in this case, the expanded indication. The dosage, as you can imagine since Dupixent has so many different indications, it is stratified by indication, age, and weight. And for that I refer you to the TCR as the package insert. And the updated availability 200 mg/1.14 mL solution in a single-dose pre-filled pen. Going onward to the next slide, we have Tezspire. In February 2023, FDA-approved a single-use 210 mg/1.91 mL autoinjector for self or caregiver administration. Again, no changes to Precautions, Dosage. And I mentioned, just a new formulation availability for patients. Go to the next slide. I'll pause right here for the Committee.

Alex Park: Thank you, Umang. Marissa, are we going to do a drug list review for the Committee before attending to the motion?

Marissa Tabile: Hi. This is Marissa. Yes. I shouldn't be displaying the Excel spreadsheet. Let me know if you cannot see that [cross-talk] --

Alex Park: That's coming through for me, yes.

Marissa Tabile: Okay, perfect. So I'm actually just going to filter this. So it's a little bit easier on the eyes when we scroll. So my name is Marissa. For the new DUR Board Members who have not met yet, I am the Apple Health Preferred Drug List Manager. So I'm really in charge of our Preferred Drug List for Apple Health, which you see partly displayed here. It's a very large Preferred Drug List, over 400 drug classes that we have. But at these meetings we are only reviewing a snippet of really what our Preferred Drug List is, and we try to spread it out amongst all of these DUR Board Meetings. So at this meeting, specifically, we're really only going over maybe about 20, give or take, 20 to 30 drug classes today. So I will be presenting also the Apple Health Preferred Drug List and the statuses as well as doing a clinical presentation later on. So for this particular section, I'll just be going through the Preferred Drug List and letting you know what the statuses are and answer any questions you might have about our Preferred Drug List. So I'm just going to go in order that I see it on the screen. For our first class, we have the Asthma and COPD Agents : Anticholinergics. And as you can see, we have pretty much all of the products preferred in this drug class. So that is Atrovent, Combivent, generic cromolyn, and ipratropium bromide. Moving on to our inhaled corticosteroid combinations. Our preferred products in this class are Advair Diskus, Advair HFA, generic budesonide/formoterol, which is the Dulera generic, and we have brand, as well. And then we also have the generic Advair, which is the fluticasone/salmeterol generic preferred as well in that class. Moving on to our inhaled corticosteroids. These are just the single-ingredient inhaled corticosteroid inhalers. For this class we have generic budesonide, brand name Flovent both the Diskus and the HFA formulations as well as Pulmicort Flexhaler. Going into the long-acting muscarinic, long-acting beta agonist combination inhalers, we have Anoro Ellipta preferred as well as Stiolto Respimat. And then going into long-acting muscarinic agents, our preferred product in this class is the Spiriva Handihaler. Going to our Monoclonal Antibodies, our preferred products in this class are Cinqair, Fasenra, Fasenra Pen, and Xolair. And then moving into our Phosphodiesterase 4 Inhibitors,

we have Daliresp and Roflumilast preferred. And I can take any questions from the Board.

Alex Park: Let's see. Any questions Committee or Board, I should say, for Marissa? Okay, thank you, Marissa. And thank you, Umang, and your presentation on GINA reminded me that they help put on that World Asthma Day, which is coming up in May. I can't remember what day it is, but it's coming up and pretty timely considering that's the time when most people's asthma flares up due to spring allergies. Let's see. Leta, I think we have at least two stakeholders. So if the Committee has no questions for Umang or Marissa, we'll move on to the stakeholders. I'll just pause a minute to see if the Board has any questions. Okay. So, I'd like to recognize first Christine Dube. Apologize if I said your name wrong. Please correct us if that happens -- with AstraZeneca. You'll have three minutes to share your materials with the Board. And before you begin before your time starts, if you could introduce yourself with your name, who you're speaking on behalf of, whether it's a company or an organization, or if you're a physician or provider or a patient. And Leta has provided a write out of the questions that we'd love for you to answer. And some of these I recognize are duplicative of the COI form, but thanks for participating with our process in the meeting. So Christine from AstraZeneca. Are you with us?

Leta Evaskus: This is Leta. I don't see Christine on the attendee list here. So Christine, if you're on, if you can raise your hand so I can find you. Okay.

Christine Dube: Unmute. Hello. Can you hear me now?

Leta Evaskus: Yeah. Is this Christine?

Christine Dube: Yes. I had my camera on. I'm not sure why it's not showing because I don't see any option on the screen to show my camera. Although it is turned on. I apologize for that. Is that all right?

Leta Evaskus: Yeah. That's fine. I'm sorry, I don't know if we can -- I'll see if I can allow attendees to share. But go ahead and get started.

Christine Dube: Okay. Thanks, everybody. So good morning. My name is Chris Dube. And I am a pharmacist and Clinical Account Manager with Medical Affairs for AstraZeneca. I want to thank you for the opportunity to present recently updated information on Fasenra (benralizumab) injection for subcutaneous

use. As a reminder, Fasenra is indicated for add-on maintenance therapy of patients with severe asthma aged 12 or older with an eosinophilic phenotype. Recommended dose of Fasenra is 30 mg once every four weeks for the first three doses and then 30 mg every eight weeks thereafter by subcutaneous injection upper arm, thigh, or abdomen. I'd like to remind the Committee that Fasenra offers every eight weeks maintenance dosing with at-home and in-office administration options via PFS or autoinjector. Please refer to the Fasenra prescribing information for complete product Information, Warnings, and Precautions particularly. Today, I'd like to share the results of two new real-world observational retrospective cohort studies of patients with asthma taking benralizumab called ZEPHYR 1 and ZEPHYR 2, which further support the value of considering maintaining Fasenra as preferred on the Preferred Drug List. In the primary data set for ZEPHYR 1, the study was looking at benralizumab to identify its impact on exacerbations. The study utilized data from a large medical and pharmacy claims database between November 2016 and 2019, and the results showed a significant reduction in the annual [audio cuts out] exacerbation rate from 3.25 in the pre-index period to 1.47 in the post-index period, representing a 55% statistically significant reduction. Additionally, 41% of patients in that primary cohort were exacerbation free. In a subgroup analysis of ZEPHYR 1 looking at Medicaid versus non-Medicaid patients, the Medicaid patients experienced patients experiences statistically significant 49% reduction in the rate of asthma exacerbations and a 35% reduction in the proportion of OCS dependent Medicaid patients in the post-index period versus the pre-index period. Medicaid patients also had higher statistically significant exacerbation rates in both pre- and post- periods, really underlining the unmet need in that population. For switch cohorts in those who switched from omalizumab to benralizumab, the annual exacerbation rate increased from 1.71 the pre-index period is 0.79, which represents a 54% reduction [indistinct] 000.05. And for those who switched from mepolizumab, the annual exacerbation rate decreased from 1.56 in the pre-index to 1.02. Again, a reduction of 34% at this time and with a [indistinct] 0.05. Additionally, in switch of cohort of the primary [indistinct], those patients changed from omalizumab to benralizumab. In the post-index period, 61% were exacerbation free, and of those patients changed from mepolizumab, 61% were exacerbation free. Of note the exact reasons for a transition from one to another agent cannot be ascertained from that database. And in separate, too, across all levels of baseline EOS lab measurements, the observational results showed significant reductions in annual exacerbation rate per person per year and oral corticosteroid use. This result was also seen with those who

switched from either omalizumab or mepolizumab. Based on the results from these observational studies, AstraZeneca respectfully requests that Fasenra remain preferred on the Preferred Drug List for the Washington State Medicaid Program. Thank you for your time. I will take any questions at this time.

Alex Park: Thank you very much, Christine. Any questions from the Board for Christine from AstraZeneca? Okay. I'm hearing none. Thank you very much. We'll move on to Judy Calloway from GSK. And I believe you are speaking on two different classes. So Leta has budgeted five minutes for you. If you could introduce yourself, and who you're speaking on behalf of for the record, and your five minutes will begin.

Judy Calloway: Thank you. Can you hear me?

Alex Park: Yes.

Judy Calloway: Great. My name is Judy Calloway, and I'm a Medical Account Lead and Pharmacist in our Medical Affairs Team at GSK. So thank you for giving me the opportunity to talk with you today. I'm here to provide clinical updates on Trelegy Ellipta and Nucala. And I'm also requesting your consideration of a formulary change from non-preferred to preferred status for both of these medications. As a reminder, Trelegy Ellipta is the only once-daily single inhaled triple-therapy that's indicated for the treatment of COPD or asthma. It's a combination of an ICS, a LAMA, and a LABA. Please refer to the package insert for Full Prescribing Information. Your current PDL requires asthma patients to fail two PDL preferred agents prior to stepping up to Trelegy. This practice is not consistent with the Washington community standards considering the majority of commercial plans and Medicare and, as you just mentioned in guidelines, GINA guidelines respectively allow and recommend triple therapy when an asthma patient is uncontrolled on one dual-controller and needs additional therapy. Please consider removing this Step edit, or at a minimum change the Step edit and allow Trelegy to be used after a patient fails on one preferred dual controller. In terms of new data, GSK has published retrospective cohort studies in COPD and asthma, showing that patient adherence and persistence of triple therapy were statistically improved in patients using one inhaler given once daily versus patients using multiple inhalers, which are often commonly given twice daily in different devices and is cumbersome for patients. Adherence in the COPD study increased by over two times. So please consider making Trelegy available,

which is the only single inhaled triple therapy available once a day for COPD and asthma. I'll move on to Nucala. Nucala (mepolizumab) is a targeted treatment that is indicated for [indistinct] use in eosinophilic disorders, severe eosinophilic asthma, chronic rhinosinusitis, nasal polyps, eosinophilic granulomatosis with polyangiitis, and hypereosinophilic syndrome. Nucala is given subcutaneously every four weeks and is added as maintenance treatment to other therapies that alone do not adequately manage these diseases. And it's available in at-home administration and in-office. Nucala is the only IL-5 treatment for eosinophilic debilitating disorders. Please update your PA as there are currently only two indications listed for Nucala. And since this was last done, ATS and chronic rhinosinusitis with nasal polyps has been added, so please [indistinct]. Also Nucala is the only medication approved for the rare diseases of EGPA and HES. Nucala has a longstanding history of safety and improved patient outcomes in clinical trials and real-world studies for severe eosinophilic asthma, which is the largest population served by Nucala. And as mentioned here by your group, asthma is very prevalent in adults and in pediatrics. Patients that have severe eosinophilic asthma experience high rates of exacerbations, hospitalizations, and ER visits. Randomized controlled trials and open-label studies for Nucala have shown consistent durable reductions in exacerbations and a reduction in oral corticosteroids. And recent prospectively designed real-world evidence studies showed that Nucala reduced exacerbations by 71% after 12 months and 74% after 24 months. Also of importance to the Medicaid community is to be reminded that Nucala is the only IL-5 so you have Fasenra and Cinqair, which are considered IL-5. Nucala is the only IL-5 with a pediatric indication down to age five. Thank you so much for updating your PA criteria with the new indications I mentioned. And for your consideration to place Nucala on a preferred status for patients, especially for those who don't have other medications available, such as EGPA, HES, and pediatrics. Thank you so much.,

Alex Park: Thank you, Judy. DUR Board, any questions for Judy from GSK? Peter Barkett.

Peter Barkett: Hi, Judy. Thanks for sharing. A couple of quick questions. First, you had mentioned the adherence study for patients on triple therapy Trelegy vs. dual inhalers to achieve triple therapy. And I was just wondering if I can get the reference for that. And then, second, you had mentioned other payers in the market paying for Trelegy as a preferred agent. Are you able to specify which payers have Trelegy as a preferred agent?

Judy Calloway: Yes. It's my understanding and -- again, I live in Minnesota, and I am subbing for my colleague [indistinct] was going to be sharing another product that it is all the payers in your commercial area, except for one. So that's why I stated the majority of commercial plans allow Trelegy, especially in asthma because it's the only triple therapy available with an indication for asthma. So it's my understanding that's all except for one. And my colleague, Craig Sexton, who's our Account Manager is also attending this meeting. I don't know if you can unmute him at this time. But I will send you the reference on the adherence trials. Thank you.

Ryan Pistoresi: Hi. This is Ryan Pistoresi. Could you please make sure that if you're sending materials that you send it to HCA so that way we can disseminate it to Board members?

Judy Calloway: Okay. So send it to HCA [indistinct]?

Ryan Pistoresi: Yeah. You will need to send it to HCA. Correct.

Judy Calloway: Okay. Thank you.

Alex Park: Just directly to HCA, please, Judy. Not to any Board members.

Judy Calloway: Okay. Thank you for that information.

Alex Park: Thank you.

Leta Evaskus: Yeah. This is Leta Evaskus. So, Judy, if you're not on our stakeholder list, then please sign up for it. I send out Gov Delivery messages that tell how to sign up to speak as well as if you have written testimony. It's also on our webpage on the P&T Meeting and materials webpage on how to submit.

Judy Calloway: Thank you.

Alex Park: Okay, Leta. Sorry, Dr. Barkett, do you [cross-talk] other questions?

Leta Evaskus: Yeah.

Alex Park: I see your hand is still raised.

Peter Barkett: No. Sorry. I'll take it down.

Alex Park: Okay. Great.

Leta Evaskus: Okay. And I see that Craig Sexton wanted to speak, so I'm going to unmute him.

Alex Park: Craig, if you could introduce yourself and who you're speaking on behalf of, and Leta will start your three minutes.

Craig Sexton: I don't need three minutes. This is Craig Sexton. I'm the Payer Account Director for Washington, and I was just going to answer the question about commercial coverage, if that's still a request. It's preferred on every commercial payer in Washington with the exception of Kaiser, with no restrictions.

Alex Park: Thank you for that clarification. Marissa, can I ask? I was looking at the Excel sheet that you were putting up earlier. I can't figure out where some of these drugs fit. But I think you mentioned that not all drugs are shown here.

Marissa Tabile: Yeah. This is Marissa. Let me actually switch over to the publication. It should share in a minute, hopefully. Let me see. Okay. Is it not? I apologize. Okay. Is the publication showing now Alex?

Alex Park: Yes.

Marissa Tabile: Okay. Was there a particular product of interest that you were looking for?

Alex Park: Well, oh, there is Trelegy. I don't know why I couldn't see it.

Marissa Tabile: Yeah. I mean, the list is pretty extensive, so it's easy to get [audio cuts out] in it, but it is in our Inhaled Corticosteroid Combinations drug class.

Alex Park: Okay. And then Umang earlier presented on some FDA indication updates on Dupixent.

Marissa Tabile: Yes.

Alex Park: Is that under Monoclonal Antibodies?

Marissa Tabile: So actually because of the way that Dupixent first came out to the market and was approved by the FDA, I believe the first indication that came out for that product was atopic dermatitis. So that product, even though Dupixent has an array of indications that it serves now, it falls under our I think it's Atopic Dermatitis Monoclonal Antibodies drug class. And the naming I might have a little bit skewed, but it falls under that just because of the nature of how it was FDA-approved initially. We are looking at ways as to how we may want to reclassify that particular product because it falls in so many different disease state areas now. So unfortunately, it's not on this list. It's not being displayed here, and it's not up for review today, just because we like to lump it with the other atopic dermatitis products. So that's why you don't see Dupixent here.

Alex Park: Okay.

Marissa Tabile: But if anyone was curious, I believe as of April 1, 2023, I believe that product should be preferred on our PDL.

Alex Park: Okay. That's important to know. Thank you. Okay. Any other stakeholders, Leta, besides the ones that were on the list?

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

Alex Park: Hearing none. Okay. Well, DUR Board, let's turn our attention to the motion, then.

Leta Evaskus: I see Laura Beste has her hand raised.

Alex Park: Oh, I'm sorry. I didn't see that. Laura.

Laura Beste: That's okay. So I just wanted to confirm. And I know we've reviewed this before. If it's a nonpreferred agent, so if the patient needed Nucala or an agent that is not preferred, they just have to get prior authorization and they can still obtain the medication?

Marissa Tabile: This is Marissa. So it really depends. Sometimes if it's nonpreferred, sometimes it'll just be a trial of either one or two [audio cuts out]. Our typical blanket step-throughs are two preferred products in order to get it. Sometimes we have classes with one. In this case, it looks like Nucala does not have -- it doesn't look like there is any PA on it that I can see. But I might

have to double check. So I think this would just require a step through of two preferred products in order to get Nucala.

Laura Beste: Okay. Thank you.

Alex Park: Thank you. I'm not sure why, Leta, but my view on Zoom it's kind of hard for me to see the whole list. Is there anybody else who has a hand up or any other Committee Board member that would like to ask a question?

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

Alex Park: Okay. Let's turn our attention to the motion. We'll give the Board a moment to digest that, and we'll entertain a motion.

Virginia Buccola: This is Ginni Buccola, and I moved 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 nonpreferred products require a trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Jon MacKay: This is Jon MacKay. I second.

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

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

Alex Park: Any opposed or abstentions? And the motion carries. Thank you, Board, and thank you stakeholders, and thank you, Leta. Okay. Umang. Let's move on to Corticosteroids if you're ready.

Umang Patel: Yep. Perfect. Thank you. So the next class we'll have is Inhaled Glucocorticoids on the Apple Health PDL that's listed as Asthma and COPD Agents : Inhaled Corticosteroid Combos and Inhaled Corticosteroids. As you can imagine, this all kind of falls under the scope of Asthma/COPD background that we just reviewed a little bit, so I won't be going into the background of it yet. We'll go right into the drug-specific update. On the next slide here. [cross-talk]

Marissa Tabile: Umang [cross-talk] this is Marissa. I apologize. Actually, Umang, in your presentation, you should have actually gone through this particular section because this is still Asthma and COPD. I got it confused because we're actually reviewing glucocorticosteroids in the next section. So DUR Board, you did just make a motion on this particular drug class, but if we want to go back to it, if you feel comfortable, we can go back and do the motion again. But Umang did not go through this one yet at the beginning, and I apologize for the mix up.

Alex Park: Thanks for clarifying, Marissa. It's a big class of drugs. So how would it be if we had Umang finish off with glucocorticoids under the Asthma COPD heading, and then we can stop and ask the Board if they have any questions or concerns about the motion that was carried. And, if not, we could move on. How would that be?

Marissa Tabile: This is Marissa. That works for me. I apologize.

Alex Park: No, thank --

Marissa Tabile: Who would have thought that corticosteroids and glucocorticosteroids are right next to each other. I apologize.

Alex Park: Yeah. And that's okay. It's a complicated jumble of classes. Okay. Back to you, Umang.

Umang Patel: Okay. So going right into the drug-specific updates. There are only two here. So first one being Armonair Digihaler. So in April of last year, the FDA-approved this medication for the maintenance treatment of asthma as prophylactic therapy in adults and pediatric patients four years of age and older. Previously, it was just for [audio cuts out] pediatric patients 12 years of age or older. So it expanded the indication age. And no changes to Precautions, Dosage or Availability. And then on the next slide here, we have Airsupra. In January of this year, the FDA-approved this new combination of albuterol, a beta2-adrenergic agonist, and budesonide for as-needed treatment or prevention of bronchoconstriction, and to reduce the risk of exacerbation and patients with asthma 18 years of age or older. Since this is a new drug here, some Precautions here are hepatic impairment. Budesonide systemic exposure may increase in patients with severe hepatic impairment, and it's recommended to monitor those to have hepatic disease. If

paradoxical bronchospasm occurs discontinuing treatment immediately and institute alternative therapy and see the effects that may occur. In terms of Dosage, the recommended dosage is 180 mcg and 160 mcg combo by oral inhalation as needed for asthma symptoms. Do not take more than six doses in a 24-hour period. And as you can imagine, the availability is a pressurized metered-dose inhaler that delivers the albuterol/budesonide combination here. So I'll go ahead and pause there for the Committee.

Alex Park: Thank you, Umang. And I don't think there were any stakeholders relative to that piece under Asthma and COPD. Is that right, Leta? I'm hearing none. Laura [cross-talk] --

Leta Evaskus: I'm sorry. My mute didn't come off. I was talking. Yeah, I don't see any hands raised. Thank you.

Alex Park: Okay. Laura, I saw you come on camera. Do you have a question?

Laura Beste: I did have one question. So about Trelegy being a third-line agent choice, I guess, because they have to fail two preferred combination products. Is there any way to change that so that they will only have to fill one product? Or is that something that Board could recommend? Just having worked in the respiratory rehab field previously, I know there are a lot of patients that really struggle with compliance, and Trelegy is a big help for that.

Marissa Tabile: This is Marissa. We can take that back to take it into consideration for a future drug class review. If the Board all agrees that you might want to change the motion, we can put that recommendation in there. But I'll leave that up to you, Alex, if that's something the Board agrees to.

Ryan Pistoresi: Hi. This is Ryan Pistoresi from HCA. You know, one of the reasons that we typically have two preferred products in these is that, just as you said, some patients may have compliance, but we try to direct them to some of the other preferred before they may go to the nonpreferred drugs. So I think the way that we've always approached this and other drug classes is if the first one doesn't work, that the next one that they try is also one of the preferred drugs that does work is safe and efficacious and has a lower cost to the program before we open it up and look at some of the more other drugs.

Alex Park: So just to level set for the Board here, our charge when we make these motions is that Magellan presents the class review or updates, and then the

Board is looking at, are all the drugs basically equal in terms of safety and efficacy within their FDA-approved indications and equally eligible for preferred status? And so that's our duty. And then HCA ultimately thinks about that recommendation, and then they have additional analysis that's presented to them outside of our Board through Magellan. That would be financial and utilization data, etc. And then the HCA ultimately will make the determination on the final selection of preferred drugs for the PDL. So, if Laura or other Members of the Committee were to feel that Trelegy has a distinct superiority that needs to stand out, and that's something that this Board wants to call out and a recommendation for HCA, we can make an amendment to the motion that was done earlier. Dr. Barkett?

Peter Barkett: Yeah. I would just say that I think that this issue is analogous to smart therapy in a sense in terms of jumping to a more expensive agent to achieve higher adherence rates. Although -- and this is the reason I asked for the reference on the adherence data -- I don't think that the quality of the evidence on adherence for Trelegy compared to the SMART trials is at the same level. So I would be totally comfortable keeping Trelegy where it is at as nonpreferred but making a recommendation or a consideration to HCA to consider shortening the number of preferred agents. But I don't feel strongly about that, and I'm totally comfortable keeping it at a nonpreferred status.

Alex Park: Thank you for that comment. Marissa, do you know what the cadence of policy review is on that drug? I wonder if that would help the Board if we knew that was coming up again at some point.

Marissa Tabile: So this is Marissa. So for that particular product, I don't believe -- I believe right now on our PDL it really is just a step through, so there are not really any [indistinct] restrictions or clinical criteria that I think you're alluding to that [audio cuts out] we would have for that. So there would be no, I guess, real policy that we would present to the DUR Board. In this case, it would be maybe considering shortening the try and fail I think would be maybe our best one. But if this is something that the Board also maybe feels strongly that we might need a clinical policy created for, we could take that into consideration, too. So yeah. Unfortunately, Alex, off the top of my head, I don't believe we would -- we don't have Trelegy specifically up for any kind of clinical criteria review for this year.

Alex Park: Okay. Thank you. I mean, I know there are so many drugs and classes that you need to work on, and certain things have policies and certain things have

step-throughs. So it sounds like we have a step-through process, and it sounds like clinical efficacy and safety is observed in that for patients as to whether they fail those drugs and move on. We have had the comments from Dr. Barkett, and we've had the comments from Laura. I'll pause a minute here for the Board to think about this -- if you'd like to make an amendment to the motion or if we are satisfied with how it stands with regard to that class.

Laura Beste: I'm fine with that. I haven't looked at that study either. So I can't really speak to if there is any increased efficacy. Otherwise, I was just thinking along the lines of compliance, why they would have to fail two preferred agents first, so, but I'm fine with that decision.

Alex Park: Okay. Thank you, Committee. A really thoughtful discussion here. Okay. So the motion will stand. And I think we've done the Asthma/COPD side of the glucocorticoids. So, Umang, if you're ready, could we move on to the corticosteroid general class of glucocorticoids?

Umang Patel: Yes, absolutely. And this is going to be quick on, Dr. Park, so don't go anywhere. No significant clinical updates for this class. I'll go ahead and give it to you.

Alex Park: Okay. And I think Marissa is here with our preferred list review.

Marissa Tabile: This is Marissa. Apologies that took so long. I had to filter through. So this is our Corticosteroids : Glucocorticosteroids drug class. And just to note, this is specifically just the oral and the injectable formulations of corticosteroids. So we have a plethora of preferred products that we have in this class. I'll try to just note the preferred products right now. So we have budesonide. It looks like there are some tablets and ER formulation. We have some generic cortisone acetate preferred, dexamethasone of several different formulations, so elixir solutions and tablets. We also have a dexamethasone suspension, which I think might be oral. Sometimes it's hard to tell based off of the formulation if it's injectable or oral. We have dexamethasone sodium phosphate, which I believe is injectable. We also have dexamethasone, sodium phosphate, sodium chloride, Dexonto 0.4%. That's a brand name that is preferred. Doubledex kit, preferred. Hydrocortisone tablets. Kenalog-10 suspension, preferred. Kenalog-80, preferred. We also have Mas Care-Pak, which is a kit preferred. We have several different methylprednisolone. So we have tablet suspensions, tablet packs, and solutions. We have P-Care K0, P-Care K80, which I am going to assume as a Kenalog type of kit. We have

several prednisolone formulations preferred. So we have solutions and tablets. Several different prednisone formulations preferred, so tablets, suspensions, and solutions. We have some of these proceed or five kits. These are clearly brand name, which I believe are probably injectable kits. We have Readysharp dexamethasone, Solu-Cortef, and we have different other corticosteroids here, Tarpeyo, Topidex, triamcinolone suspension, and Uceris tablet preferred. So lots of different corticosteroid options are preferred on our Preferred Drug List. And I can take any questions from the Board.

Alex Park: Questions for Marissa? Anybody on the Board? Okay. Hearing none. Thank you, Marissa. Leta, there are no pre-assigned stakeholders. Do we have any hands raised for this class?

Leta Evaskus: Alex, I do not see any hands raised.

Alex Park: Okay. Well then, Committee, let's turn our attention to the motion. And we'll entertain a motion.

Dimitry Davydow: This is Dimitry Davydow. I will go ahead and move forward with a motion. I move that all products in the Corticosteroids : Glucocorticoids class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Michael Corsilles: [Cross-talk] This is Michael Corsilles.

Laura Beste: [Cross-talk] This is Laura Beste. Go ahead.

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

Alex Park: Michael and Laura are big fans of steroids. Okay, all those in favor, please say Aye.

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And the motion carries. Thank you, Committee. Okay. Let's see. Umang, if you're ready, we can move on to Hematopoietic Agents.

Umang Patel: Perfect. Next one will be Erythropoiesis Stimulating Proteins. In the Apple Health PDL, it's listed under Hematopoietic Agents : ESA. Moving right along, a little bit of background here. So anemia, there are two main things I want to review. Next slide, please. For anemia, it is a frequent complication affecting over 3 million Americans. It's associated with a number of serious diseases such as CKD, diabetes, heart disease, cancer, as well as chronic inflammatory conditions like rheumatoid arthritis or inflammatory bowel disease. The conditions can cause anemia by interfering with the production of oxygen carrying the red blood cells. Sometimes as in the case of cancer chemotherapy, anemia can be caused by the treatment itself. To go down in a little bit more of a micro level, erythropoietin is a glycoprotein produced by the kidneys that stimulates red blood cell production from bone marrow. It acts on the erythroid progenitor cells in the bone marrow to cause late differentiation and maturity of the red blood cells. Endogenous production of erythropoietin via the kidney is normally regulated by the level of tissue oxygenation. Hypoxia and anemia generally increase the production of erythropoietin, which in turn stimulates erythropoiesis. In normal subjects, plasma erythropoietin levels range from 0.01 to 0.03 units/mL and may increase 100 to 1000 fold during hypoxia anemia. In contrast, patients with CKD have impaired production of erythropoietin, which is the primary cause of their anemia. Anemia in cancer patients may be related to the disease itself or the effect of the concomitantly administered chemotherapy agents. On the next slide here, beta thalassemia is a rare inherited blood disorder marked by the reduction of functional hemoglobin levels, has an incidence of approximately 1:100,000 individuals in the general population. There are three subtypes of beta thalassemia minor, intermediate, and major. The individuals with major require regular blood transfusion as often as once every two to four weeks and are dependent on medical care for survival. Intermediate beta thalassemia is highly dependent on type of thalassemia, progression, severity, and the presence or absence of certain symptoms. Treatment options may include regular blood cell transfusions, chelation therapy, folic acid treatment, removal of spleen and/or gallbladder, and bone marrow transplantation. Reblozyl is the first FDA-approved erythroid maturation agent, which reduces patient transfusion burden by regulating late-stage RBC maturation. It is approved for the treatment of anemia in adult patients with beta thalassemia, who require regular red blood cell

transfusions. On the next slide here, we have guidelines. So according to the NCCN in 2020 -- I know there is a lot of information here. I'll try to kind of focus on what I've highlighted. They state that ESAs that are associated with an increased risk of thrombosis, decreased survival, and shortened time to tumor. Physicians are advised to use the lowest ESA dose possible to maintain hemoglobin level sufficient to avoid blood transfusions. They should be discontinued once the course of chemo has been completed and anemia resolves. And there is not enough evidence to support the use of the ESAs for the treatment of anemia related to myelosuppressive chemotherapy with curative intent, patients receiving non-myelosuppressive therapy or patients with cancer not receiving therapy. According to the ASCO and the ASH Guidelines, they updated their 2010 recommendations for the use of erythropoiesis stimulating agents in patients with cancer. They emphasize the intent of treatment be considered when weighing the benefits and risks of these agents, such as thromboembolism. ESAs may be offered to patients with chemotherapy-associated anemia whose cancer treatment is not curative in intent or whose hemoglobin level is less than 10 g/dL. They can also [audio cuts out] be used for low-risk myelodysplastic syndrome. And lastly, the hemoglobin goal should be the lowest value that prevents need for transfusion. And they should be discontinued if there is a lack of increase by 1 to 2 g/dL by six to eight weeks. Going into the drug-specific updates. And I apologize for my pronunciation. In February 2023, the FDA-approved Jesduvroq, a hypoxia-inducible factor prolyl hydroxylase inhibitor as the first oral treatment for anemia due to CKD in adults who have been receiving dialysis for four or more months. Limitation of use here has not shown improved quality of life, fatigue, or patient well-being not indicated for use as a substitute for transfusion in patients requiring immediate correction of anemia or in patients not on dialysis. As you can imagine, there are multiple Blackbox Warnings for this medication. The increased risk of thrombotic vascular events such as major adverse cardiovascular events. Additionally, targeting a hemoglobin level greater than 11 g/dL is expected to further increase the risk of death in arterial venous thrombotic events as it occurs with ESA. It is recommended not to use in patients who are pregnant as it may cause fetal harm. For those who have hepatic impairment, it's recommended to reduce the starting dose in patients with moderate hepatic impairment classified as Child-Pugh Class B, as in beta, not recommended in severe hepatic impairment as Child-Pugh Class C, as in Charlie. And lastly, patients who have malignancy may have unfavorable effects on cancer growth and is not recommended if actively malignant. The Dosage is based on hemoglobin level, [audio cuts out] liver function, and concomitant

medication. And for Dose Titration and monitoring recommendations, I refer you to the PI or TCR. And the Formulation for this our oral tablets in various doses of 1 mg, 2 mg, 4 mg, 6 mg, and 8 mg.

Marissa Tabile: Umang, this is Marissa. So we're actually going to do one motion for all of the Hematopoietic Agents. So if you can just -- well, I'll just have you go through all of those classes, and then at the end we'll do the stakeholder PDL review and [indistinct] motion. So you can just go straight into [cross-talk] --

Umang Patel: Sounds great.

Marissa Tabile: -- the presentation.

Umang Patel: Absolutely. All right. So the next one we have -- so we'll go through all the Hematopoietic Agents, as Marissa stated. So next, we have Gaucher's disease. There is no clinical update regarding this specific disease, this niche disease. So we'll continue onward to Hematopoietic Agents : Granulocyte Colony Stimulating Factors (G-CSF). So, as you can imagine, there is a little bit of overlap in disease state and guidelines, but there are still significant differences where I will review it specifically for this class. While the suppressive chemotherapy can induce neutropenia, which is defined as less than 500 neutrophils per microliter or less than 1000 neutrophils per microliter and a predicted decline in febrile neutropenia, which is a dose-limiting toxicity of chemotherapy. Febrile neutropenia can cause increased diagnostic and treatment costs, prolonged hospitalization, and broad-spectrum antibiotic use, which may necessitate chemotherapy dose reduction, treatment delays, and may ultimately compromise treatment outcomes. The risk of febrile neutropenia is dependent on treatment and dose intensity, which is often underreported. Colony stimulating factors are the hematopoietic growth factors that have been shown to decrease the likelihood of neutropenia complications resulting from chemotherapy and to improve relative chemotherapy dose intensity. Colony stimulating factors act on hematopoietic cells and stimulate proliferation, differentiation commitment, and some end-cell functional activation. Prophylactic CSF can reduce the severity, risk, and duration of febrile neutropenia and decrease rates of infection and hospitalization. Drugs such as Rolvedon, Neupogen, Nivestym, Releuko, Zarzio, Neulasta, Nyvepria, Udenyca, Fulphila, Ziextenzo, Stimufend, Fylnetra, Granix, are G-DSF. Medications, such as Leukine, are granulocyte-macrophage colony stimulating factors (GM-CSF). Moving to the next slide here, we have guidelines from the NCCN practice guidelines for

hematopoietic growth factors in patients with solid tumors and lymphoid blood cancers. Due to recent approval, Nyvepria and Releuko are not currently addressed by NCCN. Safety data appears similar between Neupogen and Neulasta and their biosimilars, and the cutaneous route is preferred for all agents. To date, there are insufficient head-to-head comparative studies on the clinical benefits of G-CSF and GM-CSF Subcutaneous filgrastim, tbo-filgrastim, and pegfilgrastim have a category ! recommendation stating there is high-level evidence from randomized controlled clinical trials, and there is uniform NCCN consensus that they prophylactically reduce the risk of febrile neutropenia. However, the guidelines advise caution should be used as a prophylactic use of the G-CSF administered with chemo and radiation concurrently. Next, we have drug-specific updates. So here we have Stimufend. In September of last year FDA-approved this medication, which is a biosimilar to Neulasta indicated to decrease the incidence of infection as manifested by febrile neutropenia in patients with non-myeloid malignancies receiving myelosuppressive anticancer drugs associated with a clinical significant incidence of febrile neutropenia. It carries a limitation of use that it is not indicated of the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. In terms of precautions, there is fatal sickle cell crisis. Discontinue if sickle cell crisis occurs. And glomerular nephritis, where the healthcare practitioner should evaluate and consider dose reduction or interruption of treatment if causality is likely. For Dosage, patients with cancer receiving myelosuppressive chemotherapy, it is 6 mg subcutaneously once per chemo cycle, and it is recommended to not administer between 14 days before and 24 hours after administration of cytotoxic chemo, and the availability is 6 mg/0.6 mL injection solution in a single-dose prefilled syringe. On the next slide here we have Rolvedon. In September of last year FDA-approved this, a leucocyte growth factor indicated to decrease the incidence of infection as manifested by febrile neutropenia in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with clinically significant incidence of febrile neutropenia not indicated for the mobilization of peripheral progenitor cells for hematopoietic stem cell transplantation. Very similar Precautions as the previous slide. In terms of Dosage, the recommended dose is 13.2 mg administered subcutaneous once per chemo cycle. It is recommended to administer approximately 24 hours after cytotoxic chemotherapy. Do not administer within the time period within the period of 14 days or before 24 hours after administration of cytotoxic chemotherapy. And the Availability is a 13.2 mg/0.6 mL solution in a single-dose prefilled syringe. And lastly, we

have Udenyca. In December of last year FDA-approved an expanded indication to increase survival in patients who are acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome). Please note that it does have an additional Indication, as you can see here. No changes to the Precautions or Availability. In terms of Dosage for this new indication, it is recommended a two-dose, 6 mg each administered subcutaneously one week apart. Administer the first dose as soon as possible after suspected or confirmed exposure to myelosuppressive doses of radiation and a second dose one week after. It is recommended to use a weight based dosing for pediatric patients weighing less than 45 kg, which I refer to the PI. We'll go ahead to our next slide. Our next topic we have here are Sickle Cell agents. Again, no clinical updates for this class. I will pause right here because the next slide we will go into Oncology. So we'll pause here for the Committee.

Alex Park: Thank you Umang. When you say Oncology, is that the Immune Modulator thalidomide class? I just want to make sure we're not missing a class like we did on the last series.

Marissa Tabile: This is Marissa. So Alex, yeah. We bunched the immune modulators with the oncology agents due to the kind of nature of what those thalidomide analogs treat, so we lump those together just for reference for the next section after the break. The immune modulators will be a separate motion [audio cuts out] but we'll just go through all the oncology go through that whole section at once and then do the motions at the very end for that, but it will be included in that.

Alex Park: Okay, so we've completed our presentation on Hematopoietic Agents. Right?

Marissa Tabile: Yes, that's correct.

Alex Park: All right, Marissa. Over to you for the drug list review.

Marissa Tabile: All right. This is Marissa. Let me just go ahead and filter through our Hematopoietic Agents. Okay. So these are our hematopoietic agents and our subclasses as well, so I'll go through it in the order that I see it. So we have our Erythropoiesis Stimulating Agents, and our preferred products in this class are Aranesp, and looks like Retacrit. Moving on to our Gaucher disease drug class, we do have Miglustat, which is generic preferred, and Zavesca preferred in that drug class. Moving on to our G-CSF drug class, we have

Granix and Neupogen preferred in that drug class. Moving to our sickle cell anemia drug class, we do have Droxia as preferred and this tpo-stimulating agent that was added by mistake, so we're not reviewing that drug class today. So it would just be these four drug classes. And I can take any questions from the Board.

Alex Park: Thank you, Marissa. Questions from anybody on the Board for Marissa.

Kevin Flynn: This is Kevin Flynn. Just as a question in general. So the long-acting colony stimulating factors don't really apply here because we're only focusing on outpatient, and those would only be given in the [indistinct] the clinic setting? That's why there is none on the preferred list?

Marissa Tabile: This is Marissa. So Kevin, which colony stimulating factors were you thinking of? Are they not included here?

Kevin Flynn: Well, you have no pegfilgrastim or anything that's long-acting. You only have the short-acting ones which would require daily administration.

Marissa Tabile: Um, I believe we do. I can't tell the generics, but from what I can remember, I believe we do have some pegfilgrastim products included in this class. For these products, specifically, even though they are administered -- some of them are in the medical, you probably only see them like through a medical benefit. We do include them still on our PDL, so I believe they should be included in this drug class. I can't tell the generic names [laugh] based off of the brand, but I do know that we do include some type of filgrastim in here, as well.

Kevin Flynn: Yeah because just looking at the lists. Unfortunately, my current other civilian side at my other job I have spent a lot of time looking at this class, and none of these are pegfilgrastim. Pegfilgrastim will be like Fulphila, Neulasta, Neulasta-Onpro.

Marissa Tabile: I think Neulasta is there. Yeah. So we have Fulphila, and we have Neulasta right here, as well. They are just nonpreferred, if that was what you were asking If that's a question that you were wondering.

Kevin Flynn: Yeah. So we require a patient to fail to short-acting ones before they could get long-acting? I believe we have a policy for this specifically. So I believe that try and fail does not apply because we list it specifically in a policy that we

have online. So from what I can off the top of my head, I don't believe we require any [audio cuts out] for these particular agents. It would just go through a PA. And then based off of clinical review, if the clinical reviewer does deem that they would need a pegfilgrastim product over filgrastim product, then they would be eligible to be approved for that product.

Kevin Flynn: Got it. Thank you.

Alex Park: Thanks for the question, Kevin, and Marissa for pointing out the policy piece. Any other thoughts or questions from the Board before we move on to stakeholders? Okay. We have four listed stakeholders, so richness of supporting documentation in this class from industry. I'd like to recognize Bethany Boyd first from Pfizer. And I believe, Bethany, you'll be speaking to us about two classes. So Leta has allowed five minutes. Again, if you could introduce yourself and who you're speaking on behalf of, and your time will start.

Bethany Boyd: Thank you. My name is Bethany Boyd. I'm a pharmacist, and I'm with Pfizer Oncology Medical Affairs. So Pfizer is the key company that I'm representing. First, I'm going to talk about Retacrit (epoetin alfa-epbx) biosimilar to Epogen. And the indications for Retacrit. It is an erythropoiesis stimulating agent, and it's used for the treatment of anemia due to chronic kidney disease in patient on dialysis and not on dialysis [indistinct] in patient with that overheating and patients with HIV infection, the effects of contaminant myelosuppressive chemotherapy when there is a minimum of two additional months planned of chemotherapy, and the reduction of allogenic red blood cell transfusions in patients undergoing elective noncardiac or nonvascular surgery. It's important that providers elevate the iron status before enduring treatment and maintain iron repletion during treatment and correct or exclude other causes of anemia before initiating treatment. Dosage and Administration info can be found in the Full Prescribing Information. The most common adverse reactions are hypertension, arthralgia, muscle spasms, pyrexia, dizziness, medical device malfunction, vascular occlusion, upper respiratory tract infections, injection site irritations, injection site pain, nausea, vomiting, myalgia, leukopenia, bone pain, thrombosis, headache, deep vein thrombosis, and cough. Retacrit also as a boxed warning for increased mortality, myocardial infarction, stroke, thromboembolism, thrombosis and vascular access, and increased mortality and/or increased risk of tumor progression or recurrence in patients with cancer. I would encourage you to look at the Full Prescribing Information for the complete

boxed warning. Retacrit is an FDA-approved biosimilar to Epogen, and it offers an additional treatment option for patients requiring treatment with ESA agents in Washington Medicaid population. So based on the efficacy and safety of Retacrit, I respectfully request that the Committee continue the availability of Retacrit to this population. Next is Nivestym, and that's filgrastim-aafi the short-acting agent that was discussed earlier. And I'll also address Nyvepria, which is pegfilgrastim-apgf, which is the biosimilar to Neulasta, the long-acting agent. Nivestym, the short-acting agent, filgrastim, is a leukocyte growth factor increase indicated to decrease the incidence of infections manifested by febrile neutropenia, and in patients with non-myeloid malignancies receiving myelosuppressive anticancer drugs to reduce the time to neutrophil recovery and duration of fever in patients with acute myeloid leukemia, to reduce the duration of neutropenia and neutropenia-related clinical sequelae in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation, to mobilize autologous hematopoietic progenitor cells in the peripheral blood of collection for leukapheresis and reduce the incidence and duration of sequelae of severe neutropenia in patients with symptomatic congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. As far as the most common adverse reactions for those patients taking Nivestym are pyrexia, pain, rash, epistaxis, bone pain, anemia, diarrhea, hypoesthesia, alopecia, headache, cough, and dyspnea. Regarding the long-acting pegfilgrastim, its indication is as a leukocyte growth factor that's indicated to decrease the incidence of infection as manifested by febrile neutropenia in patients with non-myeloid malignancies receiving myelosuppressive anticancer drugs associated with a clinically significant incidence of febrile neutropenia. It's not indicated for the mobilization of peripheral blood progenitor cells for hemopoietic stem cell transplantation. The Warnings and Precautions include fatal splenic rupture, acute respiratory distress syndrome, serious allergic reactions, including anaphylaxis, fatal sickle cell crisis, glomerulonephritis, leukocytosis, capillary leak syndrome, the potential for tumor growth stimulatory effects on malignant cells, and aortitis. So my request is hearing the information about Nivestym, the filgrastim product, and Nyvepria, the pegfilgrastim product, which both offer additional treatment for patients requiring treatment for leukocyte growth factors. Please continue with those availabilities to your Medicaid patients.

Alex Park: Thank you very much, Bethany. Any questions DUR Board for Bethany from Pfizer? Okay. Hearing none, we'll move on to next on the list, which is

Amanda. If you're with us, Amanda, if you could introduce yourself and who you represent, and Leta will start your three minutes.

Amanda Haikalis: Hello, everyone. Thank you for this opportunity. My name is Amanda Haikalis. I'm a pharmacist by training and a medical advisor at Medunik USA. So today I'll be presenting Siklos as a treatment option for sickle cell disease patients. Sickle cell is the first and only FDA-approved hydroxyurea indicated for patients two years of age and older with sickle cell disease. The use of Siklos has been proven to reduce the frequency of painful crises, blood transfusions, and hospitalizations in these patients. Sickle cell disease is the most common serious genetic disease in childhood. It occurs more in African Americans and Hispanic Americans, and there are almost 2000 births with the disease reported each year nationwide; 45% of patients may experience neurological complications from sickle cell disease, such as strokes and brain hemorrhage. Only 35% of sickle cell patients will have a normal neurological development. Because of these complications, the rest of the patients should live with different degrees of disabilities. In addition, the most common cause of hospitalization for children with sickle cell disease and the root cause of more than 25% of their premature deaths is acute chest syndrome, which can result in lung injury, breathing difficulty, low oxygen to the rest of the body, and possible death. Hydroxyurea remains the gold standard disease-modifying treatment for sickle cell disease because of its safety and efficacy shown in several clinical trials. However, during these clinical trials, the dose was always precisely adjusted to the patient's body weight, which is not the case in real clinical practice. With the current formulations, a prescriber must either use higher dosing or lower dosing of capsules. Otherwise, they dose for every other day. This is not an optimal treatment, especially for a child with rapidly-changing weight, nor will it achieve the most effective result within a narrow therapeutic window for effectiveness. Siklos should be taken once daily with a glass of water. For patients who are not able to swallow tablets, these tablets can be dissolved in a small quantity of water on a teaspoon. The film-coated tablets are available as 100 mg scored tablet or 1000 mg triple-scored tablet, which offer a variety of strengths ranging from 50 mg to 1000 mg to help the physician titrate correctly and precisely each patient based on their weight. In a prospective and observational clinical study in almost 2000 pediatric and adult sickle cell disease patients treated with Siklos for one year, there was a highly significant decrease in painful crises, in acute chest syndrome, in hospitalizations, and in blood transfusions. For important safety information on Siklos, I will refer you to the Siklos prescribing information. Thank you for your time. And I

respectfully request that Siklos be added to the Preferred Drug List. And I'm happy to answer any questions that you may have.

Alex Park: Thank you, Amanda. Questions from anybody on the DUR Board for Amanda? Okay. Hearing none. Thank you. We'll move on to Charles Stark.

Leta Evaskus: This is Leta. Charles, I do not see your name on the attendee list. So if you could raise your hand. Okay. I don't see Charles. So let's move on to Foxy Davidson. And if Charles comes on, if you could please raise your hand.

Alex Park: Thanks, Leta. Okay. The Board will recognize Foxy Davison of the Sickle ell Task Force.

Foxy Davison: Hello, can you hear me? Yes. All right. Thank you for letting me come. My name is Foxy Davison representing the Sickle Cell Taskforce here in Washington State. I am here and probably will be here as many times as I can. I'm just continuing to remember to promote access to quality patients. As you probably know from last year coming here, we don't get a lot of medications in this space. I'm a mama of two kids who have sickle cell. Actually, both are home today not feeling well. And it is so important that we have access [audio cuts out] to all the medications that we possibly can to really help our children as well as our community. Hydroxyurea has been a part of the story for a very long time, but we are finally seeing new treatments. And so you will see me every time just trying to promote and ask you to remember those with sickle cell have been waiting for many, many years for new treatments to come. And so as they're coming on, we just want to make sure there are no barriers to access to this care. We are seeing that continuously, insurance companies not really being able -- for example, within Endari -- just not being able to get this medication that we have been waiting for. And so every time I'm just going to be here asking you all to please pass these treatments. You have a group of people who have been waiting and excited to be able to use these treatments. I'm not going to take all the time that I have because I don't need to. Thank you for your time.

Alex Park: Thank you so much, Foxy, for that statement. And any questions, DUR Board? Okay. Oh, Dr. Barkett.

Peter Barkett: Thank you, Foxy, for sharing and coming today. And I wonder if there are particular drugs. You mentioned Endari that you'd like to see better access

to, but are there any others? We just heard about Siklos. I'm curious which medications here you would most like to see better access to?

Foxy Davison: Um, yes. Siklos. Thank you. Absolutely. I think Endari right now is still such a hard medication to get and some of the insurances are not covering and people are paying out of pocket. I've just got a [indistinct], this is -- so y'all have to forgive me because I come to these, but I also don't know how much I can say in regards to what medications. But it was that folic acid and vitamin D these very simple things were a part and people could get them, and now all of a sudden we're getting more cases where we're being asked as the foundation to help support families who are not being able to get those basic supplements that were always a part of the plan. And so I'm not sure if there is something that you can do about that. But Endari, in regards to actual medications, has been the hardest one for us to access. But you hear me say I am here to honestly if you're looking at that chart, sickle cell continuously doesn't have a lot of drugs in that in that space. And so for us right now, we're just asking to make sure that any of these get passed through. Is that helpful?

Peter Barkett: Yes. Thank you.

Foxy Davison: Yeah, no problem.

Alex Park: Thank you. And Committee, I believe Leta had also forwarded a letter from a stakeholder Emma Andleson, who is Senior Program Manager of the Sickle Cell nonprofit for your reference. Let's see here. Did Charles Stark end up joining us?

Leta Evaskus: I do not see his hand raised. I see two phone numbers. I'm just going to allow to talk to see if that is Charles Stark or not because I don't think you can raise your hand from the phone. Okay. First caller with area code 503, If you can unmute yourself. Let me know if you're Charles Stark. Okay. Moving on to area code 715. If you can unmute yourself and let me know if you're Charles star. Okay. Well, I'm going to go with he is not here.

Alex Park: Okay. If there are no other stakeholders, we can turn our attention to the motion. All right. Looks like there is no one else. So Leta, could we -- there we are. Just need to advance probably one or two slides. Okay, DUR Board, if we could all get our cameras on and come online and study this motion, and we'll entertain a motion.

Kevin Flynn: This is Kevin Flynn. I move that all products in the drug classes listed on Slide 5 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 nonpreferred 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.

Alex Park: Any opposed or abstentions? Okay. And the motion carries. We are about 12 minutes behind schedule, Leta, but I do think we probably want to take a quick break here.

Leta Evaskus: Yeah. Let's take a 10-minute break and come back at 10:42.

Alex Park: All right.

Leta Evaskus: Thanks.

Alex Park: See everybody back at 10:42.

[break]

Alex Park: Okay, DUR Board, it's 10:42. Hopefully everybody enjoyed a nice break. And Umang, if you're back, we are ready to proceed with Immune Modulators. And I think you're doing this -- you're tag teaming with Marissa on this one.

Marissa Tabile: Hi, this is Marissa. Yes, Alex. So we're doing things a little bit differently for this meeting. I don't think we've ever done it before. So me and Umang will be kind of splitting up our presentations. And the reason for that is because the classes that I will be reviewing at this meeting are not really managed by Magellan, so they don't really fall within a basket or a category on their end. So I try my best to do a clinical review, and the classes that I'll be presenting

on my behalf, at least, have never been reviewed by the DUR Board, so I'll get into a little bit later. But some of that information presented there, you'll see might be a little bit outdated, but it's just to be comprehensive for this section. And for this section specifically, it's pretty hefty. I will say that's a lot of oncology classes and products. So we're just going to go through all of it at once including the Immune Modulators : Thalidomides. And then at the very end, we'll do one big motion for the Oncology Agents, and then the Immune Modulators will have their own motion at the end, which will do for that. So just wanted to give everyone a reference point for that. And Umang, whenever you're ready, just let me know.

Umang Patel: Sounds great. All righty. And, Marissa, please if I'm jumping into your section, please let me know, but we'll go right along. First will be Hematologic : Oncology Agents. Next slide. And as Marissa alluded to, our classes and subclasses don't always line up one-to-one. Magellan stratifies when it comes to the Oncology classes. Magellan usually stratifies it by cancer type. For example, hematologic. And the Apple Health PDL does break these down by mechanism of action. So here, for Hematologic, we have an overview of all the subclasses by Apple Health Organization. These consists of alkylating agents, anti-neoplastic, Bcl-2 inhibitors, deacetylase inhibitors, IDH-1 and IDH-2 inhibitors, JAK inhibitors, proteasome inhibitors, XPO1 inhibitors, and anti-metabolites, as well. The ones I have bolded here are the ones that have respective clinical updates. We have lenalidomide here, Rezlidhia, Tibsovo, Copiktra, and Ninlaro. So on the next slide, just a little bit of background. Actually, before I go into this -- as the Committee can imagine, there are a lot of cancer types that fall under hematologic cancers. I'm only reviewing the ones that are relevant to the updated clinical information that I will be presenting. So please note that there are many other disease states that could be under this cancer class, but we won't be going over them. So the first, graft versus host disease. This is an immune-mediated disease that can result following hematopoietic stem cell transplant when the transplanted cells graft recognize the recipients body as foreign. Organ systems most commonly impacted by acute graft versus host disease include the skin, GI tract, and liver. Chronic graft versus host disease is generally an extension of acute that often develops more than 100 days after transplant, but it can also occur in those without acute graft versus host disease. Symptoms include ocular manifestation, oral or GI manifestations, respiratory manifestations, and neuromuscular manifestations. In terms of treatment, the American Society for Bone and Marrow Transplantation renamed the American Society for Transplantation and Cellular Therapy in 2019, published a clinical

practice guideline in 2012 around the first- and second-line treatments. These guidelines state that corticosteroids and standard of care for the initial treatment of acute graft versus host disease and note that the literature does not support the choice of any specific [audio cuts out] agent centered therapy. These guidelines were published prior to May 2019. FDA approval of Jakafi for the treatment of corticosteroid refractory acute graft versus host disease in adult and pediatric patients 12 years of age or older. In 2019, the NCCN Guidelines published their first set of clinical practice guidelines around hematopoietic stem cell transplantation. This version of the guidelines recommend ruxolitinib as a category 1 option for patients with steroid refractory acute graft versus host disease. The National Institute of Health recommended the corticosteroids are most commonly the initial systemic therapy for most patients with moderate-to-severe chronic graft versus host disease. Adjunct supportive care may also be used such as artificial tears or artificial saliva. Ibrutinib was the first drug approved for chronic graft versus host disease in patients who have failed one or more systemic therapy. So many of the therapies have been used off label and for primary or secondary therapy. And the NCCN Guidelines listed ibrutinib as a category 2A recommendation for steroid refractory chronic graft versus host disease along with multiple other agents also listed as category 2A recommendations here. Moving to the next slide here we have Waldenström's macroglobulinemia. And this is a B-cell disorder presenting as bone marrow infiltration and lymphoplasmacytic cells that are CD19+, CD20+, and CD22+. The 2022 NCCN Guidelines recommend treating only those patients who are symptomatic, and these symptoms may include hyperviscosity, neuropathy, symptomatic adenopathy or organomegaly, amyloidosis, cryoglobulinemia, and cytopenia. Both zanubrutinib and ibrutinib with or without rituximab are listed as options for primary treatment, while ixazomib combined with rituximab and dexamethasone is a category 2A, other recommended regimen for primary therapy. For patients who have received previous therapies for Waldenström's macroglobulinemia, zanubrutinib and ibrutinib with or without rituximab are category 1, preferred regimens. Acalabrutinib is a category 2A, other recommended treatment option. Up to 40% of Waldenström's macroglobulinemia patients may have recurrent mutations in the CXCR4 gene and certain CXCR4 mutations may confer resistance to ibrutinib. Therefore, NCCN Guidelines recommend consideration of CXCR4 gene mutation testing for patients before being initiated on ibrutinib therapy, as category 2A, useful in certain circumstances recommendation. No current US guidelines exist for the treatment of erythema nodosum leprosum,

hypereosinophilic syndrome, or chronic eosinophilic leukemia here. On the next slide, we have Philadelphia chromosome positive (Ph+) ALL. This is rare in pediatric cases of ALL, occurring in approximately 2% of cases. In contrast, approximately 25% of adult cases of ALL are Philadelphia chromosome positive. In terms of guidelines, the NCCN recommends incorporation of a TKI in the frontline regimen for Philadelphia chromosome positive ALL as an established standard of care for adolescents and young adults and young and adult patients. The TKI may be combined with either chemotherapy or corticosteroids depending on the patient's age and comorbidities. TKI options for induction therapy for Philadelphia chromosome positive ALL in adolescents, young adults, and adult patients include imatinib, dasatinib, nilotinib, bosutinib, and ponatinib. The guidelines state that dasatinib and imatinib are the preferred TKIs for induction therapy while ponatinib is preferred as part of the hyper-CVAD chemotherapy regimen. In addition, the NCCN ALL guidelines also not that bosutinib is an option but state there is limited data for that particular TKI. Mutation testing for the ABLE gene should be considered as this mutation can confer greater resistance or susceptibility to a particular TKI. And the choice of a specific TKI should also be based on disease-related features. Pediatric patients with Philadelphia chromosome positive ALL are also candidates for TKI therapy. The NCNN Guidelines for pediatric, specifically lists combined treatment regimens continuing imatinib or dasatinib. A study by the Children's Oncology Group utilizing imatinib for children with Philadelphia chromosome positive ALL demonstrated a five-year event-free survival of 70%, which is superior to historical controls prior to the introduction of imatinib. Next with have follicular lymphoma. It is the most common subtype of indolent NHL. Indolent lymphomas make up about 40% of all NHL, and with follicular lymphoma being the most common indolent NHL here. Due to the indolent nature of follicular lymphoma, the median survival is approximately 10 years. The NCCN Guidelines list lenalidomide plus rituximab as a category 2A, preferred regimen in both the first-line setting and second-line therapy. Leukeran with or without rituximab is listed as a first- or second-line therapy option for the elderly for infirm patients with follicular lymphoma. Moving onward to the drug-specific update. First, we have Tibsovo. Last year, the FDA-approved new indication for use in combination with azacitidine for newly diagnosed AML with a susceptible IDH1 mutation as detected by an FDA-approved test in adults 75 years of age or older, who have comorbidities that preclude the use of intensive induction chemotherapy. It was already approved for the treatment of relapsed or refractory AML and locally advanced or metastatic cholangiocarcinoma. No changes to any of the

Warnings here, Precautions, Dosage, or Availability. Next, we have some FDA communications here. First, we'll look at Copiktra. In February 2022, REMS modified to remove the follicular lymphoma indication from the Healthcare Provider REMS letter, Professional Society REMS letter, Fact sheet, and the Copiktra REMS Program website. Later in July of 2022, the FDA had issued a safety communication regarding the increased risk of death with Copiktra demonstrated in a clinical trial comparing the drug to ofatumumab. The trial also found that Copiktra was associated with a higher risk of serious side effects, and the FDA plans to hold a public meeting to discuss the findings and whether Copiktra should continue to be prescribed for patients with chronic lymphocytic leukemia or small lymphocytic lymphoma. Next, we have Zydelig. A few updates here. February of last year, Gilad announced the voluntary withdrawal of indications for the treatment of relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, which were approved under an accelerated approval based on objective response rates of 54% and 58%, respectively. The decision to withdrew these indications is based on an ongoing challenge of enrolling patients in the confirmatory trial. Zydelig's indication for relapsed chronic lymphocytic leukemia will remain. In April of this year, REMS modification to update the materials to align with the follicular lymphoma and SLL indications and associated proposed modifications to the approved Zydelig REMS. In July, the REMS Program has been removed because a communication plan is no longer necessary to ensure the benefits of the drug outweighing the risks. Continuing on with FDA Communications. Next, we have Ninlaro. In May of last year, indication was revised with limitation of use stating it is not recommended in the maintenance setting or in newly diagnosed multiple myeloma in combination with lenalidomide and dexamethasone outside of controlled clinical trials. Warnings and Adverse Drug Reaction section revised throughout with updated trial data, and addition of Stevens-Johnson syndrome, a subsection for increased mortality in the maintenance setting, new clinical studies for increased mortality in the maintenance setting, and a subsection for lack of efficacy in patients with newly diagnosed multiple myeloma. Lastly, in September of last year, there was a new generic lenalidomide. The FDA-approved its first generic for Revlimid 2.5 mg and 20 mg capsules from Dr. Reddy. Next, we have a drug update here, Rezlidhia. FDA-approved this medication, which is an IDH1 inhibitor for the treatment of adult patients with relapsed or refractory AML with susceptible IDH1 mutations as detected by an FDA-approved test. In terms of Warnings and Precautions, first, there is hepatotoxicity. It is recommended to monitor liver function tests during treatment. If hepatotoxicity occurs, interrupt and

reduce or discontinue the treatment. There are also a Blackbox Warning. Patients treated with Rezlidhia have experienced symptoms of differentiation syndrome, which can be fatal. If differentiation syndrome is suspected, initiate corticosteroid therapy and hemodynamic monitoring until symptom resolution. And just in case there are any of the Committee members who we're [audio cuts out] it's just like differentiation syndrome -- I looked into it -- is a group of severe reactions to the drugs used to treat acute myeloid leukemia and acute promyelocytic leukemia, both of which are types of leukemia or blood cancer treatment can sometimes involve the use of steroids with upfront leukemia treatment to prevent or reduce the risk of said differentiation syndrome. Lastly, it is recommended to advise patients who are nursing to avoid breastfeeding. In terms of Dosage, recommended dosage is 150 mg orally twice daily until disease progression or unacceptable toxicity. And in terms of availability, it is found in 150 mg capsules. Go ahead and pause right there.

Marissa Tabile: This is Marissa. Umang, you can just go straight into the rest of your section since we're doing the motion at the very, very end.

Umang Patel: Perfect. Thanks, Marissa. We'll pivot right over to Oncology : Breast Cancer. Going to the next slide here. So as you can see, there are three subclasses by Apple Health Organization. These consists of Antiestrogens - Oral Antimetabolites - Oral, and PI3K inhibitors. Specifically, we'll be looking at Orserdu and Xeloda here. Next slide we'll look take a step back for breast cancer. It is the most common site of cancer for women in the United States, accounting for 30% of all cancer diagnoses. And it is second only to lung cancer as the cause of cancer death in American women. It is estimated that there will be roughly 287,000 new cases of breast cancer diagnosed in the US. In 2022, there will be an estimated 43,000 deaths. The incidence of breast cancer in US women continues to increase by about half a percent per year. Known risk factors that may be contributing to this increased risk of breast cancer include a decline in fertility rates, and an increase in body weight. Despite the increasing incidents, death rates from breast cancer have declined by 42% since 1989, largely due to improvements in both early detection and treatment. The overall five-year survival for women diagnosed with breast cancer is 90%. Patients who present with a localized disease have a 99% five-year survival rate. However, prognosis for patients presenting with distant metastatic disease is much poorer with a five-year survival rate of about 29%. Breast cancer is most frequently diagnosed in women between the ages of 55 to 74, with the median age of about 63 years.

Rarely breast cancer may be diagnosed in men. Other risk factors include various endocrine, genetic, environmental, and lifestyle factors. Some of these risk factors are modifiable, some are not, and the impact of these factors are variable. There are guidelines, but there are no recent guidelines. So those that are over a year can be found in the appendix or the TCR. Moving right into the drug-specific updates. Here we have Xeloda. December of last year, FDA-approved indications to include treatment of adults with unresectable or metastatic gastric, esophageal or gastroesophageal junction cancer as part of combination chemotherapy regimen. Treatment of adults with HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma who have not received prior treatment for metastatic disease as component of combination regimen, and adjuvant treatment of adults with pancreatic adenocarcinoma as part of a combination chemotherapy regimen. As you can see, it does have a list of other Indications: Breast cancer, colorectal, gastric, esophageal or gastroesophageal junction, along with pancreatic cancer. In terms of Warnings and Precautions, there is a Blackbox Warning here. Altered coagulation parameters and/or bleeding including death reported in patients taking Xeloda along with vitamin K antagonists. Based on findings from animal reproduction studies and its mechanism of action, Xeloda can cause fetal harm when administered to pregnant women. Dosage is stratified by indication and body surface area. And the availability here are 150 mg and 500 mg tablets. Next, we have Orserdu. In January of this year, FDA-approved this medication, which is an estrogen receptor antagonist for the treatment of postmenopausal women or adult men with ER+, HER2-, ESR1-mutated advanced or metastatic breast cancer with disease progression following one or more line of endocrine therapy. Warnings include embryo fetal toxicity. It can cause fetal harm, so be advised for patients who are of childbearing age or trying to get pregnant. In those who have hepatic impairment, avoid use in patients with severe hepatic impairment (Child-Pugh C), and reduce the dosage for those with moderate hepatic impairment (Child-Pugh B), and dyslipidemia may cause hypercholesterolemia or hypertriglyceridemia. For Dosing, select patients for treatment based on the presence of ESR1 mutation. The recommended dosage is one 345 mg tablet daily with food. And that is its availability, as well, tablet forms of 345 mg and 86 mg. Moving right along to Injectable Oncology. Here we have four subclasses that make up this class. We have the Imidazotetrazine, Nitrogen Mustards, the Autologous Cellular Immunotherapy (CAR-T), and the Mitotic Inhibitors. And moving right along. Here we go to the next class. We have the specific medications that make up this injectable class. The main ones that we will be

focusing on here will be Breyanzi, Kymriah, and Yescarta, who are all under the CAR-T subclass. Really quickly just to give a little bit of background for those specific updates. First, we have diffuse large B-cell lymphoma, the most common types of lymphoma in adults and accounts for approximately 30% of all NHL. There are several subtypes of DLBCL including DLBCL arising from follicular lymphoma. Some patients with follicular lymphoma may undergo conversion of more aggressive lymphoma such as DLBCL, and this risk increases over time. Transformation of follicular lymphoma to this occurs in about 15% of patients at an annual of 2% to 3%. There is a treatment, lenalidomide plus Monjuvi is a category 2A preferred option while lenalidomide with or without rituximab and ibrutinib are both category 2A, useful in certain circumstance options for non-germinal center B-cell like DLBCL and selinexor is an option for DLBCL third-line as subsequent therapy, including DLBCL arising from follicular lymphoma after at least two prior systemic therapies, including patients with disease progression after transplant or chimeric antigen receptor T-cell therapy. Next, we have Yescarta. So in April of last year, FDA-approved a new indication for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy including diffuse large B-cell lymphoma, not otherwise specified primary mediastinal large B-cell lymphoma, high-grade B-cell lymphoma, and DLBCL arising from follicular lymphoma. For this indication, it carries a limitation of use stating it is not indicated for the treatment of patients with primary CNS lymphoma. In terms of Warnings and Precautions, Blackbox Warning for cytokine release syndrome, including fatal or life-threatening reactions. For Dosage, administer a lymphodepleting regimen or cyclophosphamide and fludarabine before infusion. Premedicate with Tylenol and an H1 antihistamine. Dosing is based on the number of chimeric antigen receptors. And the target is 2×10^6 CAR-positive viable T cells per kg body weight, with a maximum of 2×10^8 CAR-positive viable T cells. This can only be administered in a certified health care facility. In terms of availability, it's a cell suspension for infusion, and it comprises a suspension of 2×10^6 CAR-T cells per kg of body weight with a maximum of 2×10^8 viable options in a 68 mL solution. Next, we have Kymriah. In June of last year, FDA-approved a new indication for the treatment of adults with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy. No changes to Warnings. In terms of Dosage, the dosage for this new indication is to administer 0.6 to 6.0×10^8 CAR-T cells IV. And as you can imagine, it is available in a single-dose of 0.6 to 6.0×10^8 CAR-T cells suspended in one to three patient-specific infusion bags for IV infusion. And lastly, we have

Breyanzi. So in July of last year, FDA-approved an expansion to indications of large B-cell lymphoma including diffuse large B-cell lymphoma, Not Otherwise Specified, high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B to include second-line treatment of patients who have refractory disease to first-line chemotherapy or relapse within 12 months of first-line chemoimmunotherapy or refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation due to comorbidities or age. Previously, this was only approved in patients with relapse or refractory large B-cell lymphoma after two or more lines of systemic therapy. As you can imagine, the dosing is very stratified by indication. And so I would reference the TCR PI for specific dosing instructions. And no changes to Availability here. Next, we have Oncology, Prostate subclass, specifically the Estrogen-Antineoplastic. No clinical updates for -- I will let the Committee know the next few do not have clinical updates. So I apologize. I'm kind of just breezing right through them. On the next slide here we have Oncology, Oral - Other. Now this is comprised of Imidazotetrazines - Oral, and Nitrosoureas. And these are medications such as temozolomide or Gleostine, respectively. No significant clinical updates here. Next, we have Topical Antineoplastic Agents, specifically Selective Retinoid X Receptor Agonists. Meds in this class are bexarotene and Targretin. There was no significant clinical update. There is just one update here. There is a new generic bexarotene gel in May of last year. The FDA-approved the first generic by Amneal Generics for Targretin capsules are still available. So it wasn't too significant here. I did want to mention it to the Committee. And we will pause there while I catch some water.

Marissa Tabile: This is Marissa. Thanks, Umang. So, we will actually transition over to my presentation, which still continues in the Oncology agents drug class. So let me just get my presentation all teed up. And I think this gives Umang a great break. Those were pretty hefty sections. Okay. So like I stated before, this is really the first time that HCA has one reviewed these drug classes that I'm about to go through both right now and later on today. And also, like I mentioned, Magellan does not actively manage these products that fall within this drug class. So it leaves it with no -- the clinical review will be done by HCA specifically. So for my presentation, I tried to keep it pretty similar to what Umang is doing -- disease state overviews, any guidelines, and really some drug-specific information. Because these classes that I'm going to go through have never really been reviewed by the DUR Board. I figured it would be good just to include specific guidelines that may be within the last

five years or any guidelines that I could find. So moving forward after today's review, if there are any guidelines that have been updated or product updates to products within these classes, I will be noting them and presenting them. But if not, we might do similar to Umang and just say there are no updates. So moving forward, I'll be going through the Oncology Agents Antiadrenals - Oral class. Some disease state overview. I try to keep the disease state overview pretty relevant to the drugs that fall within that class, so making sure that I go through some of the particular indications that the drug class that the particular drug really treats. So for this particular drug class, it's really specific to adrenocortical carcinomas. They are a rare aggressive tumor that may be functional or nonfunctional. They form in the adrenal cortex. And the difference between the two functional or nonfunctional tumors is, for functional tumors there is virilization. They present as virilization or Cushing syndrome. And for nonfunctional tumors, they really present to patients as fever, weight loss, abdominal and back pain and abdominal fullness. There is an increasing number of adrenocortical carcinomas, and they're really identified in a lot of asymptomatic patients as incidental findings. So it could be that the doctor went in and did some type of scan, MRI, CT, and just happened to find that the patient had these carcinomas on the adrenal cortex. So management of this disease is through either complete surgical resection, which is really the only potential curative treatment for these patients. And patients who have potentially resectable Stage I to Stage III disease who are surgical candidates, surgical resection is really recommended as the first initial therapy for patients who do happen to go through surgical resection adjuvant therapy, so drug therapy is really based upon the risk of disease recurrence. So you want to take into consideration the tumor stage, the completeness of the resection and the proliferation rate of the actual cancer. So going into guidelines that I could find, these guidelines that you can see are from 2009, so they are relatively old [audio cuts out] just for completeness' sake. The American Association of Clinical Endocrinologists and American Association of Endocrine Surgeons came up with a management of adrenal incidentalomas. They do recommend that open adrenalectomy by an experienced surgeon is a procedure of choice. The patients if you were to do that should undergo an en bloc resection of the involved adrenal gland and surrounding tissues and lymphadenectomy may be required as well. They recommend that adjuvant mitotane treatment may be considered post-op, depending on what the outlook is looking for these patients. Moving on to some other guidelines, there is the National Cancer Institute. This is specific to pediatric patients. So for childhood adrenocortical carcinoma treatment, this was in 2020. They recommend for these particular

patients that an aggressive surgical approach towards the primary tumor and all metastatic sites is recommended. That is if that is feasible or not. There is little information about the use of mitotane in the pediatric patient population specifically. So it wasn't really a good recommendation that it shouldn't be used, but they didn't note that the response rates for these patients appear to be seen like those that are in the adult population. Radiation therapy in pediatric patients has not been thoroughly investigated. So adrenocortical tumors are generally considered to be radioresistant. Moving on, they did get a little bit specific as far as the staging for these patients. So there is Stage I and II. For those particular stages, they do recommend complete surgical removal as the treatment of choice and then adjuvant mitotane, depending on the patient. If a patient is in Stage III, they recommend surgical removal with or without regional lymph node dissection, radiation therapy, chemotherapy with mitotane. So you could possibly use mitotane, streptozotocin plus streptozotocin, etoposide, doxorubicin, or cisplatin. Getting into NCCN Guidelines, which were just updated in December of 2022, for resectable disease, they do recommend the open adrenalectomy versus suspected carcinoma. And depending on if it's unresectable or a suspected metastatic disease, if it's localized or local regional, there are two different pathways. So if it's localized NCCN recommends to resect the tumor and any adjacent lymph nodes. And if they have a high risk for recurrence to also consider after resection radiation therapy or adjuvant mitotane therapy. If the disease is local regional and it's unresectable or metastatic, they recommend, of course, observing with a chest CT, resection of the primary tumor, and local therapy of radiation, and then also systemic therapy as well. So getting into drug-specific NCCN Guidelines recommendations, the preferred regimen for this particular type of carcinoma is cisplatin plus etoposide with or without doxorubicin and mitotane. Or you could do carboplatin, etoposide with or without doxorubicin and mitotane. The other recommended regimens that are in the guidelines are pembrolizumab with or without mitotane or just mitotane monotherapy. And then therapy that might be useful in some circumstances are streptozotocin with or without mitotane. So getting into the drug-specifics of mitotane or Lysodren as the name. As far as I could find it was approved by the FDA in 1970's, so quite a while ago. It is an adrenal cytotoxic agent. It's indicated for the treatment of inoperable functional or nonfunctional adrenocortical carcinoma. The dosing for it is 2 g to 6 g by mouth every day in three or four divided doses. You can increase the dose incrementally to achieve a blood concentration of 14 mg to 40 mg/L or as the patient tolerates it. There is a Blackbox Warning for adrenal crisis fort his

medication. And the availability is a 500 mg tablet. So I think that is the end of our Oncology Agents review. Me and Umang can take any questions that the Board might have regarding the clinical information. And if we're ready, we can go into the Preferred Drug List with you.

Alex Park: Bravo, Umang and Marissa on that large class of unwieldy names and drugs and conditions. Well done. Questions from the DUR Board for our presenters? Okay. Hearing none. Marissa, I imagine it would be hard to go through the Excel sheet on this one. I'm not sure if that's something that we should or can do. It's a very [cross-talk] too much scrolling. [Cross-talk] but if there is anything you want to point out to the Board, feel free.

Marissa Tabile: Yeah. So I can actually -- these classes are pretty straightforward. So I'll just display it for completeness' sake. Generally, how we manage our Oncology Agents on our Apple Health PDL is pretty much everything is preferred. The only instance that something would be nonpreferred in an oncology class is if there is a brand with a generic readily available on the market. So as you can see, which I think like [indistinct] is largely generic, but the brand name would be [audio cuts out] nonpreferred. So just scrolling down -- and I apologize for any scrolling that might happen. A lot of these Oncology agents are just preferred in their drug class and they have PA. The only exception that I want to note is our CAR-T therapy. And that is really in its own class. It's the autologous cellular immunotherapy CAR-T drug class. These we include. It's similar to what happened at the last meeting, they are considered carve outs on our Apple Health PDL, but we do include them to align them for both our fee-for-service and our MCO Program. So the reasons and there are certain criteria that we decide whether or not a drug is going to be carved out. Usually, in most cases, it's a very rare disease, where the cost of the drug may be very expensive. And that can actually cause a disproportionate amount of patients within our MCOs that they're treating. So it does kind of affect the rate for the MCOs. So we just decided to carve those drugs out of MCO responsibility, but we do include them on our PDL to give guidance to them to let them know what drugs are carved in and carved out. So you'll see here, these CAR-T therapies are not subject to any preferred or nonpreferred statuses, but we do include them. And you would largely see these drugs really come through the medical benefit. So we would really only allow them through covered medical or -- we cover them only on the medical side, so you wouldn't see it really on a pharmacy point of sale retail type of dispensing. And that's really the only thing I think that sticks out unless any of the Board has any questions about the PDL?

Alex Park: Any questions for Marissa? Anyone on the Board? Okay. Thank you very much, Marissa. Great. Oh, Kevin, you're coming on video.

Kevin Flynn: Oh, no. I had no questions. I just thought we were about to [cross-talk] --

Alex Park: [Laugh] Thank you for moving us along there. And no, there are no listed stakeholders, Leta. Has anybody popped in who wishes to speak to this class?

Leta Evaskus: I don't see any hands raised. If anyone would like to speak, if you want to raise your hand now. I don't see any hands.

Alex Park: Okay. So let's move on. There will be two motions, I think, for this class.

Marissa Tabile: This is Marissa. Yes. That is correct, Alex. So first we will do the Immune Modulators : Thalidomide Analogues. And then after that, we'll do all of the Oncology Agents in one bulk motion.

Alex Park: Okay. Okay, Committee. So Leta has displayed the Immune Modulators Thalidomide Analogues class motion. And I'll give you a minute to study that. And we'll entertain a motion when ready.

Laura Beste: This is Laura Beste. I move that all products in the Immune Modulators : Thalidomide Analogues class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically approved, or only one product is preferred.

Michael Corsilles: [Cross-talk] This is Michael Corsilles. I second that motion.

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

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: And any opposed or abstentions? Hearing none. And the motion carries. Okay. And we'll turn our attention now to the second piece of this large class.

Oncology Agents. We needed three slides to list out all the subtypes. Here we are at the motion, which we will entertain when ready.

Dimitry Davydow: This is Dimitry Davydow. I move that all products in the drug classes listed on Slides 8, 9, and 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 nonpreferred products require a trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

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

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

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: And any opposed or abstentions? And hearing none, the motion carries. Thank you, Committee. Okay, Umang. Hopefully you've got your breath here, and if you're ready, we can move on to antihyperlipidemics.

Leta Evaskus: Umang, you're on mute.

Umang Patel: Yep! Double muted myself. I apologize. Okay. So next we have Lipotropics, Others, specifically the Adenosine Triphosphate-Citrate Lyase Inhibitors. The only medication in this subclass on the Apple Health PDL is Nexletol. And so there are no significant clinical updates here. So I'll pause here for the Committee.

Alex Park: Okay, Committee. I'm going to guess there are not many questions or any based on the fact that there are really no updates, but feel free to pop in and ask a question of Umang if you have any. Meanwhile, we'll let Marissa come and show us the Excel sheet.

Marissa Tabile: This is Marissa. So the AHPDL should be showing, and there is only one product in this class, which is Nexletol, and it looks like it is preferred in that drug class [indistinct].

Alex Park: It's in line with how we structure the motions when we say unless only one drug is referred in the class. Okay. Any stakeholders, Leta?

Leta Evaskus: I do not see any hands raised.

Alex Park: Okay, Committee. So if there are no other questions for Umang and Marissa, then let's turn our attention to the motion. And we'll entertain a motion when ready. This is Dimitry Davydow. I moved that all products in the Antihyperlipidemic Adenosine Triphosphate-Citrate Lyase 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. Nonpreferred products in this class may be considered medical ly necessary when the preferred agent is not indicated.

Jon MacKay: This is Jon MacKay. I second.

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

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? Hearing none, the motion passes. Okay. Let's move on, Umang, if you're ready to, Bone Density Regulators.

Umang Patel: Yes. The next few will be a little repetitive, and I apologize. These were kind of grouped together because a lot of these don't have significant clinical updates. Next class is the Bone Resorption and Suppression-Related Agents, specifically Selective Estrogen Receptor Modulator (SERM). Medications in this class on the Apple Health PDL encompass Osphena, Evista, and raloxifene hydrochloride. Again, no clinical updates here. So I'll pause there.

Alex Park: Thank you, Umang. Anything to point out on the PDL list, Marissa?

Marissa Tabile: This is Marissa. Sorry, that took me a little bit. So looking at our Apple Health PDL in the Selective Estrogen Receptor Modulators class. we do have the preferred product that is in this class as raloxifene, the generic. And then we do have Osphena and Evista, but those are nonpreferred. I can welcome any questions from the Board.

Alex Park: Not hearing any. So let's move on and see if we have any stakeholders for this class.

Leta Evaskus: There are no hands raised.

Alex Park: Okay. Then we'll turn our attention to the motion. You know, Marissa, I noticed that the language on the motion has shifted slightly compared to what we've had prior. When we talk about nonpreferred agents, the format has previously been all nonpreferred products require a trial of at least two with the same indication, etc. But now we're just saying nonpreferred products might be considered medically necessary when the preferred agent is not indicated. Does that have to do with the number of drugs in the class?

Marissa Tabile: This is Marissa, I believe Alex -- and I apologize -- I think that was an oversight. So I can actually update that language to be consistent with the previous motions. I think that's probably better, actually, so let me just copy over that language so it is consistent. And I can actually change it for the other -- the previous motion that we just did. I don't know, Board, if you want to go through this Antihyperlipidemics one again since I'm going to be updating it? If anybody is opposed to just updating the language, please let us know. Otherwise, I think we can update it and consider the motion amended. Okay. This is Marissa. I updated the language for both of those classes. And if there are any inconsistencies moving forward with those, I will make sure those get updated as well.

Alex Park: Great. Thank you. Okay, Committee, we'll entertain a motion when ready.

Michael Corsilles: This is Michael Corsilles. I would like to make a motion. I move that all products in the Bone Density Regulator Selective Estrogen Receptor Modulators drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

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

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

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Thank you. Any opposed or abstentions? And hearing none, the motion carries. Okay. Let's see here. Umang, I think we're at Cardiovascular Agents when you're ready.

Umang Patel: Sure. Next will be Cardiovascular Agents, specifically the Transthyretin Stabilizers. In the Apple Health PDL, this comprises of Vyndamax and Vyndaqel medications. No significant clinical updates here.

Alex Park: Thank you, Umang. Anything to point out on the Apple Health PDL, Marissa?

Marissa Tabile: I was on mute. I apologize. This is Marissa. So this is looking at the transthyretin stabilizers drug class on the PDL. And we have Vyndamax and Vyndaqel, and they are both preferred at this time. And I can take any questions from the Board.

Alex Park: Okay. Hearing none, and I think no stakeholders are on the list, Leta. I think.

Leta Evaskus: No, there is not. And there are no hands raised.

Alex Park: Okay. Let's turn our attention to the motion. And I see you updated the language there. Thank you, Marissa. Okay, Committee, when ready.

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

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

Umang Patel: Thank you. All those in favor, please say Aye.

Multiple Speakers: Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And hearing none, the motion carries. And that takes us through where we were supposed to be before lunch. Let's have a [cross-talk] process check.

Leta Evaskus: Yeah. This is Leta. I think if we could do Endocrine and Metabolic Agents now before lunch, that would be great, if Umang and Marissa are okay with that.

Marissa Tabile: This is Marissa. That works for me all.

Alex Park: Is that okay with you, Umang?

Umang Patel: Yes. I'm sorry. I just -- I was nodding.

Leta Evaskus: Okay.

Alex Park: All right.

Leta Evaskus: All right. Thank you.

Alex Park: Okay. Well, when you guys are ready.

Umang Patel: Okay. So what I'll do is kind of go through similar to Oncology. We will go through all of the Endocrine and Metabolic Agents since there are subsections here. The first slide here we have Fabry's disease. The only medication on the Apple Health PDL under this subclass is Galafold, and there are no specific clinical updates for this subclass. On the next slide here, we have Homocystinuria Agents, medications in the Apple Health PDL that fall under this subclass are -- again apologize for my pronunciation -- betaine anhydrous, Cystadane, and Zertin. No clinical updates in this class. And then moving on to Urea Cycle Disorders. And so this is comprised of Hyperammonemia Agents, Oral and Urea Cycle Disorder Agents. And there are some updates here, and so we'll go to the next slide. A little bit of background, urea cycle disorder are inherited deficiencies of enzymes or transporters that function in the synthesis of urea from ammonia within the body. The urea cycle maintains low levels of ammonia that would otherwise accumulate in the blood due to protein breakdown. The purpose of urea cycle, which converts 2 moles of nitrogen [audio cuts out] one from aspartate to urea is to transform nitrogen into a water soluble form that may be excreted. Urea cycle disorders are most often related to the first four enzymes within the cycle. We have CPS, OTC, AS, and ASL. They may also

result from a deficiency in N-acetyl glutamate synthetase. The enzyme for the cofactor in N-acetyl glutamate production. Arginase deficiency also affects urea production as arginase is required in the last step of urea production. So in the United States, the combined incidence of multiple types of urea cycle disorders is estimated to be about 1 in 20,000 to 25,000 live births. However, some are estimated to be much more frequent, such as 1 in 8000 internationally. Most affect males and females equally. Cases may be inherited or acquired. Those presenting as newborns often develop symptoms within one to two days following birth. Presentation at birth or childhood is most common. However, urea cycle disorders may occur later in life. Diagnosis relies on recognition of elevated ammonia level further evaluation, amino acid and/or tissue enzyme analysis, and ultimately genetic testing. Testing for this is now included in many newborn screening programs. And the urea cycle disorder consortium consists of 14 sites in the US, Canada, and Europe, and populations data has been published as a result of research from these sites: Genetics of hyperammonemia. In terms of guidelines, the Trans-European Guidelines and 2019 suggest the diagnosis and management of urea cycle disorders address all products for acute hyperammonemia. IV sodium benzoate, sodium phenylacetate is indicated for any urea cycle disorder in this setting. Carglumic acid is recommended to treat acute hyperammonemia in patients with NAGS deficiency and in urea cycle disorder diagnosis in combination with other treatments. One stabilized, maintenance therapy with an agent within this class when appropriate may be initiated. The suggested guidelines recommend nitrogen scavengers at individualized doses to improve metabolic stability in the long term. Dividing the dose and administering with ample fluid limits, mucositis or gastritis associated with phenylbutyrate products. Carglumic acid is recommended first-line for the treatment of NAGS deficiency. In addition, protein restriction while maintaining an adequate supply and needed for growth is fundamental for treatment of these disorders. And select patients with urea cycle disorders are also candidates for liver transplant. Next, we'll go into drug-specific updates. July of last year FDA-approved a new formulation of sodium phenylbutyrate oral pellets as Pheburane, as adjunctive therapy to standard of care, which includes dietary management for the chronic management of adult and pediatric patients with urea cycle disorders involving deficiencies of CTS, OTC, and AS. A Limitation of Use here: It is not indicated for the treatment of acute hyperammonemia. In terms of Warnings and Precautions, neurotoxicity of phenylacetate may occur. It may be associated with neurotoxicity in patients with UCD. Consider reduction of dose if neurotoxicity symptoms are present. For Dosing, the

treatment must be done under the supervision of the healthcare provider who is experienced in the treatment of UCD. The recommended dosing measured as sodium phenylbutyrate is patients weighing less than 20 kg are recommended take 450-600 mg/kg/day of sodium phenylbutyrate. In patients weighing over 20 kg or more are 9.9-13 g/m^2 / day of sodium phenylbutyrate orally. It is recommended to monitor ammonia levels to determine the need for dosage adjustment. And for patients with hepatic impairment, it is recommended to start with a lower dose. And the Availability our 84 g of sodium phenylbutyrate oral pellets per bottle. Next, we have Olpruva. In December of last year, FDA-approved this oral suspension for use as adjunctive therapy to standard of care, which includes dietary management for chronic management of adult and pediatric patients weighing 20 kg or more with a body surface area of 1.2 m^2 or more with urea cycle disorders involving deficiencies of CPS, OTC, or AS. And very similar Limitations of Use and Warnings and Precautions, as dictated earlier. For dosage, again, needs to be done under the supervision of a healthcare practitioner that is experienced in the treatment of UCD. The Dosing is 9.9 - 13 g/m^2/day, recommended similarly to monitor plasma ammonia levels, and lower dose for patients with hepatic impairment. And in terms of Availability, it is an oral suspension that can be found in 2 g, 3 g, 4 g, 5 g, 6 g, and 6.67 g sodium phenylbutyrate as pellets in packets for reconstitution. On the next slide here, we have Vasopressin Receptor Antagonists. So this includes medications such as Jynarque, Samsca (tolvaptan) on the Apple Health PDL. There are no significant clinical updates here. And I will pause there for the Committee and/or Marissa.

Marissa Tabile: This is Marissa. Yep. So I can go ahead and take over for this part of the presentation, so let me just switch over. Okay. All righty. Let me go ahead and get my slides. Okay, perfect. So continuing on with our Endocrine and Metabolic Agents, I will specifically be going through the Hereditary Tyrosinemia Type 1 (HT-1) Agents, and these are all oral on the Apple Health PDL. So just to give some disease state overview, hereditary tyrosinemia Type 1 (HT-1) is how I will refer to it moving forward -- because it's a mouthful -- is a severe disorder of tyrosine metabolism. It occurs in about 1 in 12,000 to 1 in 100,000 individuals of Northern European descent. It is caused by a deficiency of -- and I apologize if I can't pronounce this -- fumarylacetoacetate hydrolase (FAH) is how I will refer to it going forward. So the clinical symptoms of this disease typically start before two years old in patients, and a lot of children who do present with this present before six months of age, and they usually present with evidence of acute liver failure

and renal dysfunction. It's characterized by severe progressive liver disease and renal tubular dysfunction. Typical management of this disease is usually with nitisinone and dietary restriction of protein. Getting into some of the guidelines. And specifically for these types of rare diseases, I was finding more so recommendations, not necessarily guidelines. So this is a recommendation from the American College of Medical Genetics and Genomic. For their diagnosis and treatment of each one, they recommend nitisinone and dietary therapy should be initiated as soon as possible following the diagnosis of HT-1 in patients. It should be initiated at 1 mg/kg/day. The real kind of dietary goal that you want for your patients is to restrict the phenylalanine and tyrosine, and you would need to restrict protein in order to cause those types of restrictions. So a lot of patients who have this HT-1 , typically you could find them using medical foods, which they have the amino acid mixtures that don't have phenylalanine or tyrosine inside of those types of mixtures. Getting into nitisinone drug-specifics. The brand names for those are Orfadin and Nityr, I think is how you pronounce them. It was approved by the FDA in 2002. The mechanism action or drug class for this as a 4-hydroxyphenylpyruvate dioxygenase inhibitor. It is indicated for the treatment of adult and pediatric patients with HT-1 in combination with the dietary restriction of tyrosine and phenylalanine. So you can see that the dietary restriction is really a key component in managing this disease state. The Dosing for both adult and pediatric patients is to first start at 0.5 mg/kg by mouth twice a day, then increasing that to 0.75 mg/kg twice a day, and then you pretty much titrate it up until you get to a max dose of 1 mg/kg twice a day. The Availability of this particular drug comes in several different formulations. It comes as an oral capsule, an oral tablet, and an oral suspension. And you can see that the strengths kind of vary. For the capsule, it is 2 mg, 5 mg [audio cuts out] and 10 mg of both generic and brand. The oral tablet is brand name only, Nityr, and that comes in 2 mg, 5 mg, and 10 mg strengths. And then the oral suspension is brand name only, which comes as 4 mg/1 mL. I'm not sure how big the total bottle is, but that is brand name Orfadin. And me and Umang can take any questions from the Board.

Alex Park: Questions anybody, DUR Board for Umang and Marissa? Okay. Marissa, do we have any things to point out on the PDL?

Marissa Tabile: This is Marissa. Let me actually pull it up here. I'm just trying to filter through. And let me see if there is anything of note and let me share. Okay, so I have all of our Endocrine and Metabolic Agents drug classes pulled up. So

the only thing -- I'll guess I'll go through it drug class by drug class. For the Fabry Disease Agents - Injectable, that doesn't have a particular status. I believe that is a carve out as well, similar to the CAR-T's that I discussed earlier. So it's not subject to any preferred or nonpreferred because it is a medical drug. We have the HT-1 Agents. The preferred products in this class are nitisinone and Nityr. And then we also have it looks like there might be a particular strength of Orfadin. In the Homocystinuria Agents, we have Betaine and Xuriden preferred. For Hyperammonemia Agents, we have carglumic acid preferred. For Urea Cycle Disorder Agents, we have the sodium phenylbutyrate. And then for the Vasopressin Receptor Antagonists, we have the Jynarque and -- okay, there is probably a particular strength of Samsca and tolvaptan preferred on our PDL. And I can take any questions about the PDL from the Board.

Alex Park: Great. Thanks for going through that, Marissa. Thanks for going through that. Marissa. Any questions from Marissa, Board? Okay. Hearing none. I believe we had at least two stakeholders on the list. So let's see, Amanda Haikalis. I believe we heard from you earlier today, and you might be wanting to speak on this class as well. Leta will prepare the timer here for us. Yep. There we go. So if you could introduce yourself again and who you represent, we'll start your three minutes.

Amanda Haikalis: Thank you. My name is Amanda Haikalis, and I'm a pharmacist by training and Medical Advisor at Medunik. I will be discussing Pheburane as a new treatment option for Urea Cycle Disorder. So you see these are inherited deficiencies and enzymes of the urea cycle, the process that clears the blood from toxic ammonia resulting from protein metabolism. Hyperammonemia, which has increased plasma levels of ammonia is the main life-threatening man infestation of the deficient urea cycle in all UCD patients who are not under metabolic control. Ammonia is toxic to neurons and other brain cells, and severe, prolonged, and/or repeated episodes of hyperammonemic coma can lead to brain damage, impairment of intellectual function, and ultimately death. Sodium phenylbutyrate is a nitrogen scavenger drug established decades ago as the gold standard adjunctive therapy to the standard of care, which includes dietary management, has changed their prognosis of this condition by saving patients lives and drastically improving their outcomes. The noncoated sodium phenylbutyrate has been used since 1987 under an investigational new drug and was approved for marketing as Buphenyl in the United States in 1996. However, bad taste or taste aversion are amongst the most frequent adverse events reported with noncoated formulations of

sodium phenylbutyrate, and this bitter taste can cause taste disturbance and vomiting at intake. The intolerable taste makes their chronic use very difficult, thus jeopardizing compliance, which can trigger serious and life-threatening hyperammonemia crisis, especially in children. Since commercial non-coated formulations of sodium phenylbutyrate have an offensive taste, an improved palatable, tasteless, pellet formulation of sodium phenylbutyrate (Pheburane) was developed to improve adherence in patient outcomes whereby coding of individual pellets results in a formulation which has no immediate taste meaning when swallowing the drug. The Pheburane dissolution in mouth allows for a lifetime of 10 seconds before a slow progressive release of 60% of the drug over 8 minutes, compared to the non-coated formulations of sodium phenylbutyrate, where the drug is completely released within less than 60 seconds. The Pheburane was approved for marketing in the EU in July 2013, and in Canada in January 2015, and several other countries. Data from a French compassionate program demonstrated that in comparison with the non-coated formulation used before entering the cohort, the Pheburane improved acceptability and ease of administration where patients swallowed it without any reconstitution, and it resulted in no vomiting in patients who had previously reported vomiting with the non-coated sodium phenylbutyrate. The Pheburane and also improved control of ammonia plasma levels with no hyperammonemia crisis for up to 30 months of treatment, even in patients who have previously experienced hyperammonemic episodes on the non-coated sodium phenylbutyrate formulations. Medunik is dedicated to improving the management of orphan diseases and offers Pheburane, the first palatable FDA-approved sodium phenylbutyrate for UCD patients in order to help them improve their compliance and thus their outcomes. Therefore, we respectfully request to include Pheburane as preferred in your products list agreement. Thank you once again for your time. And I'm available for any questions.

Alex Park: Thank you. Any questions for Amanda from the Board? Okay. We'll move on to Nicole Tran. If you could introduce yourself and who you represent, and Leta will start your time.

Nicole Tran: Yes. My name is Nicole Tran. Can you hear me okay?

Alex Park: Yes, we can.

Nicole Tran: Okay, perfect. Good afternoon. My name is Nicole, and I'm a pharmacist and a Senior Medical Liaison with Recordati Rare Diseases. I'm here to provide you

information on Carbaglu indicated for the acute and maintenance of N-acetyl glutamate synthase (NAGS) deficiency and acute hyperammonemia in PA and MMA in the class of urea cycle disorders and organic acidemia. NAGS stands for N-acetyl glutamate synthase and Umang Patel pointed out. PA stands for propionic acidemia, and MMA stands for methylmalonic acidemia. The incidence of NAGS deficiency is less than one per two million births, and for PA, it is one per 100,000 births, and MMA is one per 50,000 births. Acute hyperammonemia is a medical emergency as the previous person pointed out, and therapies are needed to be started as soon as possible to prevent decompensation and death; however, lab tests and newborn screening results may take several days to get back. So although most states have newborn screening for PA and MMA, it is not available for NAGS deficiency because very few labs can perform the test and, furthermore, do it accurately. According to babysfirsttest.org, Washington has newborn screening for PA; however, it does not have newborn screening for MMA. The guidelines for diagnosis and management of UCDs by Haberle in 2012 in the assessment by Magellan RX Management are correct in that Carbaglu is recommended for the first-line treatment of NAGS deficiency. Haberle also pointed out that there is potential toxicity of repeated boluses of sodium benzoate or phenylacetate. In our pivotal trial, Carbaglu [audio cuts out] control of metabolic parameters, preventive decompensation, and neurological consequences. Adverse events include GI disorders, infection, and nervous system symptoms. No serious safety issues were identified. Moving on to the guidelines for PA and MMA by Forney in 2021, it included carglumic acid for acute metabolic decompensation. In an NIH study by Dr. Mendel Tuchman, it showed that Carbaglu safely enhanced ammonia lowering along with the standard of care. The adverse events that occurred during the hyperammonemia episodes were either mild or moderate, and three deaths occurred and deemed unrelated to study treatment. [Indistinct] these were acute hyperammonemia reported incidents. Also mentioned in the Magellan report, once the patient is stabilized the maintenance therapy with an agent within this class may be initiated. I request the Committee to consider Carbaglu to not be interchangeable with the generic carglumic acid because of the differences in the indication. Generic carglumic acid does not have the indication for PA or MMA. Thank you, and I am available for questions.

Alex Park: Thank you very much, Nicole. Questions for Nicole from the Board? Okay. Hearing none. Thank you. Anybody not on the list who wishes to speak, Leta?

Leta Evaskus: Yes. We have Abigail Hatta.

Alex Park: Okay, Abigail. The Board recognizes you. If you would introduce yourself and tell us who you're speaking on behalf of. We'll start your time.

Abbi Hatta: Great. Thank you. Can you hear me? Yes. Perfect. So many. Again, my name is Abby Hatta. And I appreciate the opportunity to present and share some important information. Today, I am presenting on behalf of Horizon Therapeutics in support of Revicti, which is glycerol phenylbutyrate and is used to treat urea cycle disorders. I am first and foremost a genetic counselor by training and work clinically actually seen these patients in the metabolic clinic for more than a decade. So this subject is near and dear to my heart on the patient's behalf as well. So I know there has been a little bit of a review already, but I'm just going to highlight a few additional points. So as a review, when an individual consumes protein, it is metabolized to amino acids and subsequently ammonia. And, as we know, ammonia is a neurotoxin. So in healthy individuals ammonia is converted to urea via the urea cycle and subsequently excreted in the urine. These disorders are devastating inherited diseases related to the inability to convert ammonia to urea, and patients, therefore, required individualized treatment plans which include protein restriction and medication called nitrogen scavengers that help remove the ammonia. UCDs exhibit of broad spectrum of serious clinical manifestations ranging from impaired cognition to permanent brain damage and death. A single hyperammonemic crisis can cause death or result in brain damage. In addition, physical development may also be affected due to chronic protein restriction in these patients. So chronic compliance and adherence is a critical component of better UCD patient outcomes. The nitrogen scavenger sodium phenylbutyrate, as already mentioned, is associated with body odor, an obnoxious taste, high sodium content, and ingestion of as many as 40 large capsules per day that limits compliance and adherence. This is something that I experienced in my clinical care. This was something that patients just couldn't continue to take daily and, again, this is a lifelong treatment. It is currently unknown with the newer taste-masked versions of sodium phenylbutyrate whether they produce improved chronic compliance and adherence and as clinical manifestations of sodium phenylbutyrate, such as body odor, the abdominal pain, [audio cuts out] nausea, heartburn, and the headache are not necessarily addressed by taste masking. The robust clinical trial programs that led to the approval of Revicti in 2013 were designed to address this exact issue of compliance and adherence. Revicti is nearly odorless and nearly tasteless, with no time limitation placed on the ingestion of the medication, whereas the taste-

masked versions of sodium phenylbutyrate have a very limited timeframe by which the taste is actually masked. In addition, Revicti can be administered via G-tube while the taste-masked versions cannot. Chronic ammonia control is a primary goal of UCD management. Lower is always better. Revicti has demonstrated ammonia control over a chronic period of years in adults, pediatric patients, toddlers, infants, and newborns. When Revicti first became available, it was approved for patients two years of age and older, then the FDA approval was extended down to two months of age and older in 2018, Revicti was approved down to birth, so it can be used across the life spectrum of the patient. This approval was extended based on a robust clinical trial program that looked at usage of Revicti in the early newborn period and throughout the lifespan. This data does not exist for the taste-masked versions of phenylbutyrate. The ability to provide treatment across the lifespan regardless of age or weight is a significant advantage that Revicti offers to this patient population. In addition, Revicti has been approved for all subtypes of UCDS, except for NGAS while the taste-masked versions are only approved for three UCD subtypes. Most importantly, there exists a large amount of chronic management data for Revicti. This data demonstrates a significant reduction in hyperammonemic crises, significant decreases in clinical manifestations when compared to sodium phenylbutyrate, significantly improved brain executive function, and improved growth and development. [Cross-talk] Data continues [cross-talk] --

Alex Park: [Cross-talk] Thank you very much, Abigail. I think your time is up.

Abigail Hatta: Yep. Thank you. I appreciate it.

Alex Park: Yes. We appreciate the richness of your comments and presentation. Any questions for Abigail from the Board? Okay. Thank you very much. Okay, Committee. And Leta, let's turn our attention to the motion. We'll entertain any last questions or comments, if you have any. Otherwise, we're ready for a motion if you are.

Dimitry Davydow: This is Dimitry Davydow. I move that all products in the drug classes listed on Slide 15 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status in 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 nonpreferred

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. Aye.

Alex Park: Any opposed or abstentions? And the motion passes. Okay. We are almost right on time, Leta. 12:00?

Leta Evaskus: Yes, thank you. Perfect. So let's come back at 12:35.

[break]

Alex Park: All right. See everybody after lunch.

Leta Evaskus: Hi, everyone. This is Leta Evaskus. As the Committee is back, if you could turn on your cameras to let us know that you're all here. Thank you.

Alex Park: Okay, Committee. Hope everybody enjoyed a nice lunch. Leta and Umang and Marissa are all ready to launch back in. I think we are on Neuromuscular Agents.

Umang Patel: Perfect. All righty. So the next class we have here will be Neuromuscular Agents, specifically for Muscular Dystrophy : Duchenne Muscular Dystrophy. The medications that are in this class, from the Apple Health PDL are Amondys 45, Exondys 51, Vyondys 53, and Viltepso. And there are no clinical updates for this specific drug class.

Marissa Tabile: This is Marissa. Umang, it looks like this is one kind of overall class that we will be tag teaming. So I think we're still going to do one motion for all of these, so if you want to just go straight through it, and then I'll go after you.

Umang Patel: Sounds great. Okay, so the next class we'll go into will be Systemic Lupus Erythematous Agents : Immunomodulators. Lupus medications in this class on the Apple Health PDL are Benlysta and Lupkynis. And so on the next slide here, just a little bit of background. So systemic lupus erythematous is an autoimmune disease that affects about 1.5 million Americans, 90% of whom

are women. It's more prevalent among women of color, and black patients with lupus are more likely to experience organ system involvement. The most common form of lupus is systemic lupus erythematous, which accounts for approximately 70% of all cases, and half of SLE cases, tissue or major organ, such as heart, lungs, kidneys, or brains will be impacted. The other three forms of lupus are cutaneous, drug-induced, or neonatal. One third of patients with lupus report having a comorbid autoimmune disorder. Genetics can play a role in the development of lupus; 20% of patients with lupus have a parent or sibling who has developed or will develop lupus, a chronic autoimmune disease of unknown cause that can affect virtually any organ of the body. Immunologic abnormalities, especially the production of a number of antinuclear antibodies are a prominent feature of the disease. Patients present with variable clinical features ranging from mild joint and skin involvement to life-threatening kidney, heme, or central nervous system involvement. The clinical heterogeneity of SLE and the lack of pathognomonic features or tests pose a diagnostic challenge for clinicians. And to complicate matters, patients may present with only a few clinical features of SLE, which can resemble other autoimmune, infectious, or hematologic diseases. The diagnosis is generally based on clinical lab findings after excluding alternative diagnoses. In the absence of SLE diagnostic criteria, SLE classification criteria are often used by a clinician as guidance to help identify some of the salient clinical features when making the diagnosis. Serologic findings are important in suggesting the possibility of SLE with some antibodies highly associated with this condition. On the next slide here, kidney involvement is clinically apparent in approximately 50% of SLE patients and is a significant cause of morbidity and mortality. Thus, periodic screening for the presence of lupus nephritis with urinalyses, quantitation of proteinuria, and estimation of the glomerular filtration rate is an important component of the ongoing management of SLE patients. Several forms of glomerulonephritis can occur, and kidney biopsy is useful to define the type and extent of kidney involvement. The clinical presentation of lupus nephritis is highly variable ranging from asymptomatic hematuria and/or proteinuria to nephrotic syndrome and rapidly progressive glomerulonephritis with loss of kidney function. The current treatment landscape for lupus nephritis, though lupus nephritis is a common progression of SLE, there is no treatment specifically indicated for it until late 2020. Providers would typically aim to reduce inflammation in the kidneys and decrease overall immune system activity. And the treatments used were not effective in preventing new flares or inducing remission here. So on the next slide here, July of last year, FDA-approved for IV administration in

patients 5 to 17 years of age with active lupus nephritis who are receiving standard therapy. Excuse me, they approved Benlysta. IV administration was previously approved for adults with active lupus nephritis and patients 5 years of age or older with active SLE. In terms of Limitations of Use, the efficacy has not been evaluated in patients with severe active CNS lupus. Use is not recommended in that situation. For Dosing, IV dosing for adult and pediatric patients with SLE or lupus nephritis: 10 mg/kg at 2-week intervals for the first three doses at four-week intervals thereafter. Recommended to reconstitute, dilute, and administer as an IV infusion over a period of one hour, and consider prophylactic premedication for infusion reactions and hypersensitivity reactions. In terms of the Availability, as you can see, it was already approved as a subcutaneous injection and is now available as an IV infusion in 120 mg or 400 mg lyophilized powder in a single-dose vial for reconstitution and dilution prior to IV infusion. I'll go ahead and pause here, as that will be the end of my presentation.

Marissa Tabile: This is Marissa. So I can go ahead and take it from here along let me go ahead and get my presentation teed up for the Board. He's me okay. Let me turn on my camera. Okay. So, going with the Neuromuscular Agents overall class that Umang helped present also some of the other subclasses. I will be going through the Antimyasthenic/Cholinergic Agents drug class, so the AHPDL. So getting into some of the disease state specifics or overview, Myasthenia Gravis (MG) is an autoimmune neuromuscular disorder that causes weakness in the muscles. This weakness can be due to antibody-mediated immunologic attack directed at the protein in the postsynaptic membrane of the neuromuscular junction. Myasthenia gravis is the most common disorder of neuromuscular transmission. It manifests itself from mild to severe with respiratory failure in others, so that could present itself in some patients. There are two clinical forms of myasthenia gravis. There is ocular and there is generalized. Ocular myasthenia gravis is really weakness but limited to the eyelids and extraocular muscles. So really you would see the effect mostly on the face. And then there is generalized myasthenia gravis, which is weakness involved that can be a combination of ocular, bulbar, limb, and respiratory muscles. So kind of all over the body for that one. The aim of symptomatic treatment for myasthenia gravis is to increase the acetylcholine available at the neuromuscular junction. There are chronic immunotherapies that are available, but those mostly just target the underlying immune dysregulation. So it looked like there were glucocorticoids and nonsteroidal immunosuppressives and immunomodulatory agents that would really fall under that immunotherapies type of drugs. There are rapid

immunomodulating treatments, and then there is also surgical treatment, which is the thymectomy. The goals of therapy, overall, for myasthenia gravis is to make patients minimally symptomatic or better by minimizing side effects from other medications. So it really presents itself due to the kind of side effects that other drugs tend to have. Getting into a more specific type that kind of falls within the myasthenia gravis family is Lambert Eaton myasthenic syndrome or LEMS. It's a rare autoimmune disorder of the neuromuscular junction and is caused by a miscommunication between the nerve cell and the muscles, which ultimately leads to weakness. There are two different classes of LEMS. There is the one associated with small-cell lung cancer, and then there are also LEMS without cancer. It's characterized by weakness and fatigue, similar to myasthenia gravis, especially of the muscles in the legs and the arms. It's very rare. There are approximately 400 known cases of LEMS in the United States, and LEMS is often misdiagnosed with myasthenia gravis. There are key differences, which I will note. So overall, myasthenia gravis is weakness of the muscles, but in LEMS, specifically, the eye muscle weakness is mild, and it's not the only symptom that presents. The severe respiratory muscle weakness is very rare in LEMS, and the autonomic symptoms that affect LEMS patients are not present in myasthenia gravis. So treatment depends on the presence of whether or not there is cancer or not for patients. So it's usually aimed at improving their quality of life and then also trying to do symptomatic treatment for these patients. Getting into some guidelines. So the American Academy of Neurology, this was an international consensus and guidance for the management of myasthenia gravis. So ophthalmoparesis or ptosis in ocular myasthenia gravis that does not respond to acetylcholine agents should be treated with immunosuppressive agents, and these are their recommendations. Corticosteroids should be used as the initial immunosuppressive agent and ocular myasthenia gravis. Steroid-sparing immunosuppressive agents may be needed when corticosteroids alone are ineffective. Rituximab should be considered as an early option for patients with muscle-specific kinase Ab+ myasthenia gravis, who have not had a good response to initial immunotherapy. So really, rituximab sounds like a second-line therapy. Eculizumab should be considered in treatment of severe refractory AChR+ generalized myasthenia gravis, and eculizumab should be considered after unsuccessful trials of immunotherapies. So getting into some of the drug-specifics and the drugs that are in this particular class. So first is pyridostigmine bromide. There are different types of brands. It looks like there is Mestinon and Regonol. It was first approved -- at least from what I could find -- by the FDA in 1955, which was brand name Mestinon. The

mechanism of action for this particular product is a cholinesterase inhibitor. It's indicated for the treatment of myasthenia gravis as well as the reversal of neuromuscular blockade. The Dosing specifically for myasthenia gravis of pyridostigmine is 600 mg by mouth every day, spaced evenly throughout the day. Severe cases of myasthenia gravis may require up to 1500 mg daily. If you are using the ER tablets of pyridostigmine, the dosing for that is 180 mg to 540 mg by mouth daily or twice daily. The availability of pyridostigmine bromide is a ray of formulations. So there is an oral solution, which is generic in brand, and it is 60 mg/5 mL. There is a tablet which comes in the 30 mg and 60 mg, and it's generic. There is an extended release tablet, which comes in both brand and generic, and that's 180 mg. And then there is an injection solution, which is really only Regonol, which is 5 mg/1 mL injection. Next is amifampridine (Firdapse). This was approved by the FDA in 2018. It is considered a potassium channel blocker. The indication for it is for the treatment of LEMS in adults and pediatric patients 6 years of age and older. The Dosing for it is 6 years or older. If you're less than 445 kg, the dosing for it is weight based. It is 5 mg to 15 mg per day by mouth in three or four divided doses with a maximum dose of 40 mg per day. If you weigh 45 kg or greater and are over 6 years of age and an adult 18 years and older, that dosage is 15 mg to 30 mg per day by mouth in three or four divided doses, with a maximum dose of 80 mg per day. The specific Precaution for this medication is it can cause seizures. So there is a Seizure Precaution. And the Availability for this product is I believe it's only brand name, and it only comes in a 10 mg tablet. So I can pause for the Committee for any questions, and we can get into the PDL if none.

Alex Park: Thank you, Marissa and Umang. Any questions for our presenters? Anybody on the Board? Okay. Let's turn our attention to that spreadsheet, Marissa.

Marissa Tabile: Okay. So I have here the Neuromuscular Agents pulled up on our AHPDL. So I'll go through it line by line. So in the Antimyasthenic/Cholinergic Agents drug class, we have a brand name Bloxiverz, Mestinon brand name, generic neostigmine, and pyridostigmine preferred as well as brand name Regonol. Getting into the muscular dystrophy agents. Like Umang mentioned, we have Amondys 45, Exondys 51, Viltepso, and Vyondys 53. Those products, at least these ones, the last three here, Exondys, Viltepso, and Vyondys are carved out, so they don't have any assigned preferred or nonpreferred status because they are medical benefit types of drugs. But we include it for our carveout reason purposes. And also getting into Systemic Lupus Erythematosus Agents: We have been Benlysta, which is preferred, and then

the Lupkynis is nonpreferred in that class. And I can take any questions from the Board.

Alex Park: Anybody with questions? Okay. Thank you, Marissa. I believe we have one stakeholder for this category. And if Armen Khachaturian is with us, we'd love for you to introduce yourself and tell us who you represent. And you'll have three minutes to present to the Committee.

Armen Khachaturian: Excellent. Can everyone hear me?

Alex Park: Yes, we can.

Armen Khachaturian: Fantastic. Thank you. All right. Good afternoon, everybody. My name is Armen Khachaturian. I'm a pharmacist by training. I'm with the Medical Affairs Team at Sarepta Therapeutics. I'm here today to address the Committee regarding eteplirsen, golodirsen, and casimersen, which are known commercially as Exondys 51, Vyondys 53, and Amondys 45, respectively. These are all indicated for the treatment of Duchenne muscular dystrophy and patients who have confirmed mutations of the dystrophin gene that are amenable to the respective exon skipping modalities. All three were approved by the FDA via the accelerated approval pathway based on demonstrated increases in district and production measured by Western Blot and approved without age or ambulatory restriction statuses. In addition to the data related to ongoing regulatory requirements, Sarepta does continue to undertake development of long term post hoc and real world outcomes data regarding our portfolio of agents, the breadth of which I can't fully covered in the time allotted today but would gladly provide a more in-depth presentation at a later time if the group is amenable. Given the time allowed, I would like to use it to give a high-level overview of some of the more key outcomes that have been gleaned thus far with respect to eteplirsen launch. Regarding ambulation, multiple studies have demonstrated a delay in time to loss of ambulation ranging from 2 to 2.7 years in additional ambulatory time compared to matched external controls. This has subsequently been further supported in additional real-world analyses of 82 eteplirsen treated patients demonstrating an average age of loss of ambulation of 15.3 years compared to 13 years and matched non-exon skipping cohorts. Regarding pulmonary function improvements, a post hoc multi-study analysis of eteplirsen use in ambulatory and non-ambulatory demonstrated that eteplirsen slowed the rate of decline of forced vital capacity percent predicted by 42% compared to matched controls, which equates to a 6-year delay in reaching the milestone

needed for continuous ventilation support for breathing. Lastly, regarding some mortality outcomes and indirect treatment comparison of 579 eteplirsen-treated patients matched against large-scale domestic and global DMD populations demonstrated a 5.4 to 8.6-year survival benefit in the treated populations or 66% to 75% mortality risk reduction with the greatest benefits being observed in younger patients and patients who have been treated for greater than four years. Overall, the safety profile of our exon skipping portfolio has been well established with adverse events associated with it typically are mild-to-moderate in severity, most commonly associated with upper respiratory adverse events. Again overall well-tolerated by and large. We do have also additional safety and tolerability data for patients treated as young as six months of age in our eteplirsen populations. I will refer the Committee to the individual package inserts for a complete overview of our safety information for these products, as there are some differences between them. And as I mentioned, there is a wealth of additional post hoc and real-world evidence data that continues to be generated regarding our exon skipping therapies. And to best serve our DMD patient populations and subsequent Washington Health Care Authority clients, I will be happy to go over these data in more depth and granularity in a separate meeting.

Alex Park: Thank you very much, Armen. Questions for Armen from anyone on the Board? Okay. Hearing none. Thank you. Leta, anybody who is not on the list who wishes to speak?

Leta Evaskus: Yeah. We have Long Wen.

Alex Park: Okay. Please introduce yourself and who you represent. And Leta will start your three minutes.

Long Wen: Good afternoon. My name is Long Wen, and I am a pharmacist with Glaxo-SmithKline Medical Affairs Team. [Cross-talk] --

Alex Park: [Cross-talk] Thank you.

Long Wen: Yes. Thank you for the opportunity. I am here to provide some comments on Benlysta. Since its approval in 2011, Benlysta is indicated for patients diagnosed with SLE with or without active lupus nephritis in both adults and pediatric patients 5 years of age and older. Over the 12-year span and across multiple randomized controlled trials such as the BLISS-52, the BLISS-76,

and the BLISS NE ASIA, which specifically evaluated efficacy of Benlysta in Asia female. The EMBRACE trial, which specifically evaluated Benlysta in African-American descent in the PLUTO study. The addition of Benlysta to the standard of therapy demonstrated clinically meaningful and statistically significant reductions in disease activity and a decreased risk of severe SLE flares. These effects from randomized controlled trials are also supported by real-world evidence studies demonstrating a statistically significant reduction in rate and risk of organ damage progressions compared to standard therapy alone. These reductions that were observed in regard to risk are aligned with the EULAR Treatment Guidelines recommending that Benlysta should be considered an add-on therapy in patients with non-renal SLE who have inadequate response to standard therapy defined as residual disease activity not allowing tapering of glucocorticosteroids need and/or frequent relapse. As Dr. Patel mentioned in his report earlier, Benlysta is available in both the IV infusion and subcutaneous formulations to be administered either at the physician's office or at home using a prefilled syringe or an autoinjector respectively. Again, based [audio cuts out] on the patient and their physician's preference. So I want to conclude that Benlysta is currently a preferred agent on the Apple Health PDL, and we ask the Committee to keep as preferred due its broad indications. It is the only agent that is indicated for adults in pediatrics age 5 to 17 years old, and its multiple dosage forms availability. So thank you very much for your time. And I will be happy to answer any questions the Committee may have.

Alex Park: Thank you very much for your presentation. Any questions from any Member of the Committee? Okay. Hearing none. Thank you. Well, let's go ahead and start to review the motion then for Neuromuscular Agents. Okay, Committee, when you're ready, we'll entertain a motion.

Michael Corsilles: This is Michael Corsilles. I move that all products in drug classes listed on Slide 17 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 nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Jon MacKay: This a Jon MacKay. 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 carries. Thank you very much. Okay. Where did my Agenda go? Here it is. All right. Well, this is just going to be I think it's all you now, Marissa, for Gastrointestinal Agents and onward.

Marissa Tabile: This is Marissa. Yes. That is correct.

Alex Park: Okay.

Marissa Tabile: Umang got a nice break. So now you got to hear me speak for this next half. So let me go ahead and tee up my presentation, and then we will get going.

Alex Park: Terrific. Thank you.

Marissa Tabile: Okay. So I will be presenting on the Gastrointestinal Agents : Short Bowel Syndrome drug class today. Okay. So just to go over some disease state overview. Short bowel syndrome, or SBS, is a malabsorptive condition often caused by massive resection of the small intestine. Usually the surgical resection is due to maybe some Crohn's disease, malignancy, trauma, radiation, or even vascular insufficiency, so a plethora of different reasons why. SBS is the most common cause of chronic intestinal failure. It affects about 3 out of 1 million people per year. And the main symptom of how it presents is mostly diarrhea. The other signs and symptoms are really gastrointestinal, as well, so you'll see some bloating, cramping, fatigue, foul-smelling stool, heartburn, vomiting, and some weakness as well. And the management of SBS happens in different phases and happens after the resection of the small intestine. So after the small intestine is removed, there is something called management of the acute phase, so this is immediately after the surgery or the resection. So it's characterized specifically in this space. There are lots of intestinal fluid losses and metabolic derangements. So it happens during the initial three to four weeks after the resection, and the management of this particular acute phase is to stabilize large fluid and electrolyte losses and to also maintain an acid base and fluid balance. So that's typically done by IV replacement, so that's with normal saline, potassium, and magnesium, some acid suppression, so that's using PPIs or H2RA antagonists, a lot of parenteral nutrition, and then also enteral feeding. So after the management of the acute phase, we get into what's called the

adaptation phase. And this is characterized by structural and functional changes to the small bowel and colon in order to increase the absorption and slow gastrointestinal transit. So the adaptation phase usually lasts about one to two years. And in this particular time period patients are transitioned from the parenteral feedings to oral feedings, and it's done in a stepwise approach over time. It can be weeks, and it could be months. The goal of this particular phase also is fluid management, and patients really strive to maintain a urine output of at least 1 liter per day of urine. There could be other types of pharmacological treatments that can be used, as well, so antibiotics for any small intestinal overgrowth or the use of octreotide. Then there is also a complication that happens with these resections, and that's called intestinal failure. And this can happen anywhere within the plethora of the different phases. So what defines intestinal failure is there is a reduction in GI function below the minimum necessary for absorption of macronutrients, water, and electrolytes. So it can be transient, or it can be permanent in patients. It really just depends. And short bowel syndrome associated failures reverse completely in about half of the adults within the first two years and the use of medications. So there are GLP-2 analogues -- which I'll get into in a little bit -- which are available for patients to use if they are unable to be weaned from parenteral nutrition. So according to the American Gastroenterological Association, the management of short bowel syndrome, this is really best practice advice and not necessarily a hard set guideline. But the initial comprehensive nutritional assessment should always be performed by a dietician that is experienced in SBS. So there should be monitoring, very long-term monitoring of electrolytes, fluid balance, any weight changes, some serum micronutrient levels and bone density. The dietary therapy should focus on maintaining compensatory hyperphagia. The parenteral nutrition should be initiated and then adjusted, like I said earlier, to meet the patient's nutritional and fluid goals. So monitoring your fluids electrolytes, energy, protein, and other micronutrient needs. Fluid should be given, like I mentioned earlier with the NS, to compensate for any losses that the patient is experiencing, specifically fluid losses, and to help them maintain that urine output of at least 1 liter per day. You can also use what is called a glucose electrolyte oral rehydration solution to help with any fluid losses, as well. Getting into some of these recommendations. They did recommend using antimotility and antisecretory agents. So you can also use PPIs and H2RAs to control any stool losses. Octreotide, like I mentioned earlier, Sandostatin [audio cuts out] that is generally reserved for patients who experience really large volume losses, where they're having a really hard time managing their fluid and electrolytes.

So like I mentioned earlier, octreotide can also be used for those patients and is recommended. Antidiarrheals also are recommended to help reduce intestinal motility, but they can also cause a slight reduction in intestinal secretion. So the ones of note in the recommendation were loperamide, diphenoxylate with atropine, codeine, and tincture of opium. They do recommend loperamide over the opioid drugs, as it is the least addictive out of all of the drugs listed. And sustained and delayed-release medications should be avoided in patients with short-bowel syndrome just because of the issues that they have with absorption. So a lot of oral medications are absorbed within the proximal jejunum and can be used in SBS patients. And as I mentioned, that is the more immediate release. Oral medications can be used, but just use some caution using those delayed-release or extended-release formulations of drugs. So they did mention also the glucagon-like peptide-2 in the recommendations. So the recommendation is that they should be employed only after optimizing diet and conventional treatments. So going through the traditional treatments, and if patients have tried that and have intestinal failure, and they're still experiencing that, then you can move on. It's recommended to possibly use a glucagon-like peptide-2, which I will get into on the next slide. So teduglutide or Gattex -- if I'm mispronouncing it. This was approved by the FDA in 2012. It is a GLP-2 or glucagon-like peptide-2 analog. It is only indicated for the treatment of adults and pediatric patients one year of age and older with short bowel syndrome who are dependent on parenteral support. The dosing for it is 0.05 mg/kg subcutaneous daily. And the way that it is available on the market right now is via a kit. And when I looked into the kit, it looked like there were some prefilled syringes with the diluent, the vials of Gattex itself, dosing syringes, and alcohol swabs as well. So everything is there for the patient. And I can take any questions regarding the clinical presentation for this particular class.

Alex Park: Thank you, Marissa. Any questions for Marissa from the Board? Okay. Anything you would like to point out on the PDL list, Marissa?

Marissa Tabile: Yes. Let me just pull that up. Apologies, a lot of scrolling here. It is in Gastrointestinal. Okay. So looking at our PDL, the only product that lives in this class is Gattex or teduglutide, and we do have that preferred on our PDL. And I can answer any questions for the Board.

Alex Park That makes it easy for sure. Any stakeholders? There is nothing on the Agenda, Leta. Anybody who has popped in to speak in this category?

Leta Evaskus: There are no hands raised.

Alex Park: Okay. Well, let's review the motion, if we can. We'll entertain a motion when you are ready, Committee.

Dimitry Davydow: This is Dimitry Davydow. I move that all products in the Gastrointestinal Agents : Short Bowel Syndrome drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

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

Alex Park: Thank you, Dimitry, and Kevin. Okay. All those in favor, please say Aye.

Multiple Speakers: Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? All right, and the motion passes. Thank you everybody. We'll move on to Hematological Agents : Miscellaneous. Marissa.

Marissa Tabile: Okay. This is Marissa. Let me go ahead and get that teed up. Okay. So I will be going through Hematological Agents : Miscellaneous, Aminolevulinate Synthase 1-Directed SiRNA drug class. So just to go over some disease state overview for this particular class. Acute hepatic porphyria, or AHP, is a family of rare genetic diseases characterized by potentially life [audio cuts out] threatening attacks with chronic manifestations that negatively impact quality of life and daily functioning. There are four types of acute hepatic porphyria that fall within this umbrella, and it's associated with distinct enzyme defects in the heme biosynthesis pathway in the liver. So there is acute intermittent porphyria, hereditary coproporphyria, variegate porphyria, and ALA dehydratase deficiency porphyria. They are all caused, like I said, by [audio cuts out] enzymes within the heme biosynthetic pathway, and they can cause neurovisceral manifestations. A lot of it is abdominal pain. There is motor and sensory peripheral neuropathy, neuropsychiatric, or even some cutaneous photosensitivity type of manifestation. So that can be chronic blistering or acute non-blistering. The

most common presenting symptom is neuropathic abdominal pain. The most common type of porphyria is acute intermittent porphyria, and it's the most common of porphyria. The management of these types of diseases in this umbrella of diseases is the to help with an acute attack and to help abate the attack as soon as possible, to provide symptomatic and supportive treatment until the attack subsides. Prevention of attacks is managed by trying to avoid the exacerbating factors. So some of them could be medications that you're taking, smoking and alcohol, diet, treatment, and prevention of recurring infections, or infections, attention to your iron stores, and suppression of menstrual cycle-related attacks. Because of the rarity of these types of diseases, there really wasn't any particular guideline but was about best practice advice that I could find on my end at least. So the American Gastroenterological Association does have a best practice. And they recommend that women ages 15 to 50 years old with unexplained recurrent severe abdominal pain without a clear ideology should be considered for screening for acute hepatic porphyria. It's not really well known, so maybe thinking about that. Management of acute attacks should include pain management, antiemetics, management of [audio cuts out] cyst retention, tachycardia, hyponatremia, and hypomagnesemia, if present, in addition to intravenous Hemin, and [indistinct] therapy or [indistinct] -- which I'll get into a little bit later -- should be considered in patients with recurrent attacks. Recurrent attacks is defined as four or more attacks per year. I did find something pretty interesting from the American Porphyria Foundation as far as some emergency room recommendations that they came up with. I couldn't find the year when they came up with these, but I thought it was just interesting to note. So they recommend if a patient presents to the emergency room with an attack, these are the management strategies for how to help them. So the most effective therapy for an acute attack is Hemin or Panhematin. The harmful drugs, whichever ones are causing it, or any type should be stopped immediately and avoided. They recommend IV glucose loading should only be used for mild attacks, and hyponatremia, hypomagnesemia, which I misspelled, and electrolyte imbalances should be corrected and monitored. So narcotic analgesics can be used for pain, and phenothiazines can be used to help with nausea, vomiting, or agitation, and the use of beta blockers to help control tachycardia and systemic arterial hypertension in patients without hypovolemia. And then they also recommend gabapentin, benzodiazepines, and vigabatrin are considered safe to help treat seizures. So these emergency recommendations are to help treat the symptoms of the attack in the moment, but it's really not anything to cure the underlying disease, specifically. So getting into drug-specific for Givosiran

or Givlaari. Approved by the FDA in 2019. It is an aminolevulinate synthase 1-directed small interfering RNA. It is used for the treatment of adults with acute hepatic porphyria. The Dosing for it is about 2.5 mg/kg subcutaneous once a month, and it is Available as a 189 mg/mL single dose vial. So as you can see, it is not really recommended in any of the guidelines. And the guidelines that I could find really weren't, I think, taking this into account when they were made, so not really recommended first-line it looks like. And I can take any questions from the Board.

Alex Park: Thank you, Marissa, for that thoughtful run-through. Kind of a challenging topic. Appreciate your efforts there. Questions for Marissa? Kevin, you're on video there. So you might have a question.

Kevin Flynn: Yes. Just because I believe this drug is like physician's office only. So again, would it going back to like all [audio cuts out] would it just -- it's kind of different. Right? It's carved out on the Medical benefit?

Marissa Tabile: This is Marissa. I believe it is in the carve out. Yeah. But we just include it for carve out purposes.

Kevin Flynn: Got it. Thank you for the clarification.

Alex Park: And we could look at the spreadsheet, Marissa, but I'm guessing this is the only line item in that class. [Cross-talk] there may not be that much [cross-talk] --

Marissa Tabile: [Cross-talk] I'm going to assume so. [cross-talk]

Alex Park: Yeah.

Marissa Tabile: Yeah. I'll pull it up just in case anyone is really interested in it. Yeah. And like I was assuming, it is. Yeah. There are no nonpreferred or preferred status but the only product in the class [cross-talk] --

Alex Park: Great call out Kevin. Okay. So I don't have any stakeholders on my list. Anybody that has popped in Leta?

Leta Evaskus: No hands are raised.

Alex Park: Okay. Motion when you're ready, Committee.

Kevin Flynn: [Cross-talk].

Virginia Buccola: [Cross-talk].

Kevin Flynn: Go for it.

Virginia Buccola: Okay, thanks. This is Virginia. I move that all products in the Hematologic Agents : Miscellaneous Aminolevulinate Synthase-1 Directed siRNA drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of at least two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Peter Barkett: This is Peter Barkett. I'll second.

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

Multiple Speakers: Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? Great. The motion passes. Okay, Marissa. We're ready for Ophthalmic Agents when you are.

Marissa Tabile: This is Marissa. All right. Let me go ahead and get this ready. All right. So the next drug class we'll be reviewing is the Ophthalmic Agents Nerve Growth Factors drug class. And just to get into some disease state specifics. So Neurotrophic Keratitis (NK) is a corneal degenerative disease, which is characterized by a reduction or absence of corneal sensitivity, so it really affects the eye. Corneal innervation by the trigeminal nerve is [indistinct] usually impairs particular disease state, and the prevalence of this disease is less than 50 out of 100,000 people. The management for this particular disease state is the goal is to promote corneal healing and to help avoid complications. Treatment of it and management really depends on the stage of the disease. So to break it down a little bit more. Stage I is defined as improving the quality or at least the management goal is to improve the quality and transparency of epithelium and to avoid epithelial breakdown. In Stage II, the management goal is to promote persistent epithelial defect

healing and prevent development of a corneal ulcer. And then Stage III is to help with ulcer healing and prevention of a corneal perforation. So getting into some of the guidelines. This one is a little outdated. It's from March 2014, so not within the last five years, but they did have a diagnosis and management of neurotrophic keratitis. So like I said before it should be treated based on this the staging and the disease severity, they recommend using preservative-free artificial tears, which can help improve the corneal surface in all stages of disease severity. The use of steroids may increase the risk of corneal melting and perforation by inhibiting stromal healing, and they should be used with caution. Topical NSAIDS, so steroid eyedrops should be avoided as well. And if a patient happens to have stromal melting, topical collagen ACE inhibitors, which really is N-acetylcysteine and systemic tetracycline, or medroxyprogesterone may be considered. The use of a topical antibiotic eyedrop can be used to help prevent infection, especially in Stages II and III and is highly recommended for patients. So getting into some of the drug-specific details, I think, the only drug that is in this class is cenegermin-bkbj or Oxervate. It was approved by the FDA in 2018, and the drug classification is a recombinant human nerve growth factor, and it's indicated for the treatment of neurotrophic keratitis. So the Dosing for this particular drug is an eyedrop. So it's one drop in the affected eye or esyes six times a day at 2-hour intervals for eight weeks. So quite a bit of eyedrops that someone has to instill in their eye every day. And the availability of this drug is via a multiple-dose vial, which is 0.002% or 20 mcg/mL. And I can take any questions from the Board.

Alex Park: Thanks, Marissa. I'm cringing at the thought of stromal melting.

Marissa Tabile: Yeah.

Alex Park: Those are not good words to put together. Any questions from the Board? Okay. And stakeholders for us, Leta?

Leta Evaskus: There are no hands raised.

Alex Park: Okay. And was there anything you wanted to point out to the Board, Marissa, on the PDL list?

Marissa Tabile: This is Marissa. Like I said -- luckily I was right. This is the only product in this class, the Oxervate, and it is preferred on the PDL.

Alex Park: Okay. That's great to know. Okay. Let's review the motion. then. And we'll entertain a motion when you're ready. This is Laura Beste. I move that all products in the Ophthalmic Agents : Nerve Growth Factors drug class are considered [audio cuts out] 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 at least two preferred products with the same indication for a nonpreferred 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, Laura, and Dimitry. All those in favor, please say Aye.

Multiple Speakers: Aye. Aye. Aye. Aye.

Alex Park: Any opposed or abstentions? And hearing none, the motion passes. And Marissa, I think you're up for our last topic of the day, Vasopressors.

Marissa Tabile: This is Marissa. Yes, we are. So let me go ahead and get that slide ready. Okay. The last class for our drug review for today is Vasopressors : Miscellaneous - Oral. And just to give some disease state overview again, orthostatic hypotension or OH is a reduction in systolic blood pressure of at least 20 mmHg or a reduction in diastolic blood pressure of at least 10 mmHg. Orthostatic hypotension usually occurs within the first three minutes of standing up or head up tilt on a tilt table. So we might have all experienced it, you get up a little too quickly, feel a little bit dizzy. That is one of the telltale signs of orthostatic hypotension. It occurs when the baroreflex is impaired, and it's called neurogenic orthostatic hypotension. The management of this particular type of hypotension is to attenuate symptom burden and the risk of falls and also to reduce target organ damage and mortality. There are non-pharmacologic measures [audio cuts out] symptoms were mild. Patients that experienced mild disease, but there is also medication that patients can use who don't respond asymptomatic patients that experience mild disease. But there is also medication that patients can use who don't respond to the non-pharmacological measures. So getting into a little bit of the non-pharmacological measures because they are pretty important. The first one is to remove any if all offending medications. You want to try to increase salt and water intake and then also lifestyle modification. So rising slowly from

supine to seated to standing, so not giving up too quickly when you are sitting down or laying down. You want to try to limit walking in very hot or humid weather to avoid overheating. Luckily, right now, we're not really dealing with any heating or hot weather in April, but in the summertime, definitely be careful. And you also want to try to raise your head of the bed at least 30 to 45 degrees. There are also dietary interventions, and then the use of compression stockings and abdominal binders to help with orthostatic hypotension. Getting into some of the guidelines, the American Academy of Neurology, there is a Management of Orthostatic Hypotension, which they made in 2020. There are two strategies that they recommend, or they want to try to get to, which is to expand the intravascular volume and increase the peripheral vascular resistance with other medications. So, in particular, in patients who have persistent hypotensive symptoms, where the nonpharmacological measures don't work, they recommend a regimen that starts with fludrocortisone to help augment volume and provide symptom relief. For those patients with symptoms and nonresponsive to nonpharmacological measures and [audio cuts out], they recommend the use of short-acting midodrine or droxidopa and also atomoxetine, which I found very interesting. Getting into the drug specifics. The first one I'm going to go through is droxidopa or Northera. When I found it online on the FDA website, it was approved by the FDA in 2014. It might be a little bit sooner. It seems a little old. The drug classification is it really is just called a sympathomimetic. There wasn't really any clear type of, I think, mechanism of action. The indication for droxidopa is for the treatment of orthostatic dizziness, lightheadedness, or the feeling that you are about to black out, in adult patients with symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure. And, yes, I did pull this straight from the package insert of Northera when I found it. The dosing for this particular product is 100 mg by mouth three times a day. It's recommended to titrate it by 100 mg three times a day with a maximum dose of 600 mg three times a day. The Precautions for this, the Blackbox Warning is supine hypertension. And the Availability of droxidopa is very largely generic. It comes in oral capsules in 100 mg, 200 mg, and 300 mg strengths. The next drug I'll be going through in the last slide is midodrine. I really couldn't find a brand name for this product, but it was approved way back in the day. It looks like it was approved in 1996. It is a sympathomimetic, just like droxidopa. It is indicated for symptomatic orthostatic hypotension. The Dosing for this is 10 mg by mouth three times a day. There are Precautions with this, so monitoring for bradyarrhythmia. It also shares a Blackbox Warning of supine hypertension. And the Availability of this drug is only generic. You won't find any brand

name on the market. So the Dosing, the tablets that are available are 2.55 mg and 10 mg strengths. And I'll be happy to take any questions from the Board.

Alex Park: Any questions for Marissa? Okay, Marissa, we could look at the spreadsheet then.

Marissa Tabile: This is Marissa. So I have the drug class pulled up. It's pretty simple, just like the other one. So right now we have just midodrine preferred on the PDL and droxidopa as nonpreferred.

Alex Park: Questions about anything there, Committee? Okay. And any stakeholders that have dropped in, Leta?

Leta Evaskus: There are no hands raised.

Alex Park: Okay. Well, let's turn our attention to the final motion of the day.

Jon MacKay: This is Jon MacKay. I move that all products in the Vasopressor : Miscellaneous - Oral drug class are considered safe and efficacious for their medically accepted indications, are eligible for preferred status and grandfathering at the discretion of the 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 for the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Peter Barkett: This is Peter Barkett. I'll second that motion.

Alex Park: Thank you, John, and Peter. All those in favor, please say Aye.

Multiple Speakers: Aye. Aye. [audio cuts out]

Alex Park: And any opposed or abstentions? And the motion carries. Leta, is there any other business that we need to attend to?

Leta Evaskus: No. That is it. We are done early. Thank you very much. Great job, Alex, and great job, Marissa for presenting, and Umang. Thank you very much.

Alex Park: Thanks, everybody, for your work today. We'll catch you next time.

Laura Beste: Thank you.

Alex Park: Take care.

Marissa Tabile: Thank you so much.

Jon MacKay: Thank you.

Michael Corsilles: Thank you.

Peter Barkett: Bye-bye.

Laura Beste: Bye-bye.

[end of audio]