Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board
Meeting Transcription
August 18, 2021

Ginni Buccola: Good morning. I'm Virginia Buccola. I'm the chair of the DUR board and P&T committee and we're going to convene the DUR board for today, August 18. We're using Teams and I know I'm not fluent in Teams so thanks for everybody's patience with button pressing and things like that. I'm going to read off the names of the participating attendees. And if you could, please unmute at say here when I call your name. I'll start with Alex Park.

Alex Park: Good morning. Present.

Ginni Buccola: Good morning. Diane Schwilke. I think Diane's not here yet. I'll go to Jordan Storhaug.

Jordan Storhaug: I'm here.

Ginni Buccola: Nancy Lee.

Nancy Lee: Here.

Ginni Buccola: Leah Marcotte.

Leah Marcotte: Here.

Ginni Buccola: And Susan Flatebo.

Susan Flatebo Here.

Ginni Buccola: Catherine Brown.

Catherine Brown: Here.

Ginni Buccola: Kavita Chawla.

Kavita Chawla: Here.

Ginni Buccola: Michael Corsilles.

Michael Corsilles: Here.

Ginni Buccola: Tanks, committee members and good morning to you. The Health Care Authority members, Leta Evaskus.

Leta Evaskus: Here.

Ginni Buccola: Donna Sullivan.

Donna Sullivan: I'm here.

Ginni Buccola: Ryan Pistoressi.

Ryan Pistoressi: Here.

Ginni Buccola: Luke Dearden. Moving to Ryan Taketomo.

Ryan Taketomo: Here.

Ginni Buccola: And Marissa Tabile.

Marissa Tabile: Here.

Ginni Buccola: Amy Irwin. And I'll move to our Magellan Medicaid administration member, Umang Patel.

Umang Patel: Here.

Ginni Buccola: And our manage care organization representatives Greg Simas with Molina. Moving to Heidi Goodrich with Molina. Going to Petra Eichelsdoerfer with United Healthcare. Going to Omar Dode of Community Health Plan of Washington. Going to Jeffrey Natividad with Community Health Plan of Washington. Okay, good morning to everyone. Glad you're here. I'll let Leta go over the meeting logistics.

Leta Evaskus: Okay. There's Diane. [unrelated discussion] Okay, I'm just going over the rules for today. Thank you for being patient. We're using Teams for the first time and we have to move everybody over to presenter who's going to be speaking. And presenters can mute and unmute themselves. So please mute

yourself when you're not speaking to limit the background noise. Please share your webcam while you're presenting or for the committee while you're deliberating. The meeting is being recorded. So please state your name each time that you speak. For stakeholder participation, the chair will first read the list of stakeholder names who pre-registered to speak and I will unmute you after your name is called. You'll have three minutes to speak. After, the chair will ask if there's any other stakeholders. You can use the raise hand function and I can unmute you. You can also use the chat function to enter questions and we'll address those during the stakeholder time. Let's see. Yeah, I think that is it. Thank you for your patience, and this is yet again, a new platform. And so I will share my screen now for Umang's presentation.

Ginni Buccola: Thanks, Leta. So our first presentation by Umang is on antipsychotics and antimanic agents. Just a note for the committee, this is going to be one presentation and then it'll be broken into two separate motions for us to consider after we hear Umang and the stakeholders. Thanks.

Umang Patel: This is Umang Patel. Thank you very much. We'll go ahead and get started with the antipsychotic, antimanic agents. Just a reminder to the committee, what we've primarily done in the past is we highlight significant clinical updates. That being said, if there are any guidelines or anything pertinent that's over a year old, I generally do not go over it but I do my best to put it in the appendix so the committee can refer back to that if they would like. And we'll just go on to slide three. And then in this antipsychotics class, again, just a refresher, sometimes the classes that Magellan has and the classes in the Apple Health PDL aren't always one to one. The top title for antipsychotics is the Magellan class. The three subgroups are the specific lists, class names in the Apple Health PDL. And so this will encompass second generation antipsychotics, combinations, and Parkinson Psychotic Disorder as well. So on the next slide here, to go over the disease state and descriptions, schizophrenia is the most common psychotic illness, which affects 1% of the population. Between 25 and 50% of schizophrenic patients attempt suicide and 10% of patients succeed in their attempt. Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, negative symptoms, and at least one of these should be delusions, hallucinations, or disorganized speech. Again, the guidelines are roughly eight years old, so we will not be going over them. Since this practice parameter is over five years old, it is considered to be historical practice parameter. However, newer guidance is not available from the AACAP. On the next slide here, according to the American Psychiatric Association, just

last year, they had released guidelines stating schizophrenia is a chronic illness that afflicts all aspects of life. The goal of treatment is to stabilize the patient, which is defined as reducing acute symptoms, to return to baseline functioning, prevent recurrence of symptoms, and maximize functioning and quality of life. Goals may also be based on individual patient preference impacting school, employment, and other quality of life impacting components. The guidelines recommend that patients with schizophrenia be treated with an anti-psychotic, including monitoring for both safety and efficacy. An anti-psychotic should be continued in patients whose symptoms improved and the APA suggests that the same anti-psychotic be used. They recommend clozapine specifically be used in patients with treatment resistant schizophrenia and in patients with significant risk of suicide. And they also suggest clozapine for patients with aggressive behavior despite other treatments. A long acting injectable is suggested for patients who prefer this therapy or for patients with a history of uncertain or poor adherence. Notably, the guidelines state that an evidence based ranking or algorithm approach for anti-psychotic selection is not practical due to clinical trial heterogeneity and limited comparative trials. In addition, there's no preference for first generation antipsychotics or second generation antipsychotics, although clinical meaningful distinctions such as tolerability do occur. With the exception of clozapine, no anti-psychotic has demonstrated superior efficacy when compared to other agents in the class. They also state that there is no reliable strategy to predict response. Thus, initial treatment choice is often individualized and includes several patient specific factors. And lastly, the guidelines also detail management of adverse effects such as acute dystonia, parkinsonism, akathisia, and tardive dyskinesia, some of which may want to switch to an alternate anti-psychotic treatment. Moving over to bipolar disorder. For bipolar disorder, lifelong prevalence estimates a range from .9 to 2.1% of the population. It’s characterized by episodes of mania, depressed or a mixed state. Criterion used to diagnose bipolar 1 disorder is the presence of a manic episode defined as persistent, elevated, expansive, or irritable mood for at least one week with increased energy and activity, or mixed features specifier, which is rapidly alternating polarity of mood through sadness, irritability, and mania for at least one week, and three or more other characteristic symptoms. These symptoms include, there's a litany here, but self-esteem, inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual or pressured speech, flight of ideas or feelings of racing of thoughts, distractibility, increase in goal-directed activity or psychomotor agitation, and excessive involvement in risky pleasurable events. Again, the guidelines

are almost 20 years old, however, they're here just for reference. Moving over to Tourette's disorder. The prevalence of Tourette's disorder is unknown, but observational studies have suggested about 1% in school aged children. It's a genetic tic disorder characterized by motor and vocal tics. Generally, individuals have repetitive stereotype movement of vocalization, which could involve sniffling, muscle tension, or blinking. The DSM-5 criteria for Tourette's states multiple motor and at least one vocal tic being present during the illness, not necessarily simultaneously and have been present for one year or greater. Although they may wax and wane in frequency. Onset of the symptoms must occur prior to 18 years of age to be considered Tourette's. The peak severity typically occurs between ages 10 and 12 years of age and tics usually improve during adolescence, with 18% of those older than 16 years experiencing no tics and 60% having minimal or mild tics six years after initial examination. And we have the AAN guidelines from about two years ago regarding Tourette's as well. Alright, moving over to the next slide, we will go over our first clinically updated medication. We have a new medication here, Lybalvi. In June 2021, the FDA approved this combination medication of an atypical anti-psychotic and opioid antagonist indicated for the treatment of schizophrenia in adults and bipolar 1 disorder in adults for acute treatment of manic or mixed episodes as monotherapy and as an adjunct to lithium or valproate and maintenance monotherapy treatment. This new medication does come with black box warnings here. Elderly patients with dementia related psychosis treated with anti-psychotic drugs are at an increased risk of death. And Lybalvi is not approved for the treatment of patients with dementia related psychosis. There are additional warnings here with cerebrovascular adverse reactions in elderly patients with dementia related psychosis, as I mentioned a second ago. And precipitation of opioid withdrawal in patients who are dependent on opioids because this combination medication does have an opioid antagonist. The dosing is stratified by indication and the availabilities and tablets and again being combination strength, we have a variable combo tablet available here. On the next and the final slide for anti-psychotics we do have discontinuations, one being for Symbyax. In July 2020, Eli Lilly announced discontinuing Symbyax 6/50 milligram medications and 12/50 milligram combo capsules. The distribution would continue until end of December 2020. And the other discontinuation was for Saphris. In February 2021, Allergen had made a business decision to discontinue the five milligram sublingual tab presentation packaged in a box of 100. This was 10 blisters with 10 tabs, and the 10 milligram sublingual tablet package in a box of 100. Again, 10 blisters with 10 tabs. All other packaging configurations continue

to be available. I'll go ahead and pause right there for the committee as that is the end of anti-psychotics

Ginni Buccola: Thanks, Umang. Committee members, do you have any questions? Okay, I think we're ready then to go to our stakeholders. I have the following stakeholders listed and I'll call you in the order that I that I list, starting with William O'Neill with Sunovion, Ian D'Souza with Intra-Cellular, Paul Thompson with Alkermes, Margaret Olmon with Abbvie, Kerry Carroll with Telecare, and Payal Tejani with Indivior. So I'll call each of you. You'll each have three minutes to speak. If you can please state your name and your affiliation and if you're not clearly affiliated with a pharmaceutical company, can you please state if you have any financial ties to any pharmaceutical manufacturer? If you did not hear your name called, please raise your hand or sign in the chat to let us know that you're here and you want to be able to speak. Alright, so we'll start with William O'Neill with Sunovion.

William O'Neill: Well, good morning, thanks for the opportunity. I'm Bill O'Neil, Director of HUR with Sunovion Pharmaceuticals. And I'm here in support of retaining Latuda on the Washington State preferred drug list. Latuda is indicated for the treatment of adults and adolescents ages 13 to 17 with schizophrenia, and in adults and pediatric patients ages 10 to 17 with major depressive episodes associated with bipolar 1 disorder. This is as mono therapy. Lurasidone is also approved as adjunctive therapy with lithium or valproate in adults with major depressive episodes associated with bipolar 1. The safety and efficacy of Lurasidone in schizophrenia and bipolar depression has been established in multiple clinical trials. Now in some short term studies, treatment with Lurasidone was associated with minimal changes in metabolic parameters, including weight, glucose, and lipid levels. And I'd refer you to the full prescribing information for a complete list of warnings, precautions, and adverse events. Now, the evidence based guidelines from the 2018 [indistinct] and the International Society of Bipolar Disorders recommend Lurasidone among first line therapies as monotherapy or adjunctive therapy with lithium or divalproex for acute bipolar depression in adults. Now, Lurasidone is also the only first line agent recommended in children and adolescents with acute bipolar depression. In addition to the favorable clinical trial outcomes, Lurasidone also consistently demonstrated favorable comparative health outcomes and cost effectiveness in adult patients with schizophrenia and bipolar disorder. In a Medicaid claims database analysis, adult patients with schizophrenia after switching to Lurasidone monotherapy had numerically fewer all cause and mental health

related hospitalizations and significantly shorter length of stay compared to those who switched to quetiapine in a six month follow up period. Also, an independent Humana claims database analysis found that patients with schizophrenia on Lurasidone had substantially lower total medical costs, fewer hospitalizations and emergency room visits than Aripiprazole, Quetiapine, Risperidone, Olanzapine, and Paliperidone. So just in conclusion, Lurasidone addresses the need for a well-tolerated and cost effective agent for patients with schizophrenia and bipolar depression and I'd like to respectfully request that lurasidone be retained on the PDL. And thanks for the opportunity this morning to speak to you and I'd be happy to take any questions.

Ginni Buccola: Thank you, Bill. Any questions from the committee for Bill? Okay, thanks. And just again, this is Virginia Buccola, committee chair, just a word to Leta, thank you for putting the timer up on the shared screen. I do note that it doesn't seem to be on my view, it doesn't seem to be updating. So I don't know if others are noticing that. So maybe to our presenters, we'll be using this but I have a separate clock that hopefully will be more accurate. So I'm not sure. [unrelated discussion] Okay, next is Ian D'Souza with Intra-Cellular.

[unrelated discussion]

Ian D'Souza: Thanks. So good morning. My name is Ian D'Souza. I'm an executive director with medical affairs representing Intra-Cellular therapies. And thank you for the opportunity to speak with you today about Lumateperone, known by its brand name Caplyta, which is a typical anti-psychotic indicated for the treatment of schizophrenia in adults. As you know, and as Umang mentioned, schizophrenia remains a serious lifelong illness that continues to see unmet needs among current treatments. In fact, 2019 meta analyses by [indistinct] highlights that physicians must balance the risk of various motor, metabolic, and prolactin side effects that contribute to distress, non-adherence, and ultimately relapse which increase the overall social and economic burden of illness. So going to the clinical trials for Caplyta, Caplyta's approval for the treatment of schizophrenia in adults was based on two positive placebo controlled randomized studies of similar design. In both studies, Caplyta 42 milligrams statistically significantly separated from placebo on the primary efficacy outcome, [indistinct] total score. Efficacy was further corroborated by clinician related CGIS Global severity scale, including clinical relevant improvements by bands responded analyses. Improvements were also observed across bands positive negative and general psychopathology sub

scales. In the short term control trials, the most common adverse reaction [indistinct] versus placebo was [indistinct] and dry mouth. Metabolic changes from baseline and it shifts to higher levels of fasting glucose, total cholesterol and triglycerides was similar in patients with Caplyta or placebo. Changes in weight and prolactin levels are similar to placebo as were motor side effects. EPS rates were 6.7% or 3%, using broader narrow criteria and 2% for [indistinct]. Overall, 2 patients or .5% [indistinct] placebo discontinued due to adverse events. In an open label trial up to one year in patients with stable schizophrenia, the percentages of patients with shift normal to high levels but 8 % for total cholesterol, 5% for triglycerides, and 4% for LDL. The mean body weight decreased by approximately four pounds at six months and seven pounds at one year, with three times as many patients experiencing a clinically significant [indistinct] increase from baseline. [indistinct] 5.3% and .5% respectively and no new safety signals were observed. An additional six week open label study also demonstrated low levels in body weight, BMI, cardio, metabolic, and EPS related defects associated with Caplyta. Efficacy was maintained at the long open label studies beyond six weeks and up to one year. Like other drugs in the antipsychotic class, Caplyta has a box warning that it should not be used to treat dementia-related psychosis and other warnings and precautions associated with typical antipsychotics as described in the full prescribing information provided. [indistinct] milligrams is dosed once daily with food with a terminal half-life of 18 hours. It should be avoided with moderately strong [indistinct] and persons with moderate to severe [indistinct]. No difference was seen on the basis of gender, age, or race. Thank you for considering Caplyta without restriction [indistinct] and I welcome any questions.

Ginni Buccola: Thank you, Ian. Are there any questions from the committee? Okay, thank you. I'm also going to pause here just to be sure that the two stakeholders who have sent a message in the chat, Brandy Seignemartin and Hiten Patadia, I've noted both of those names and added them to the list. Our next stakeholder is Paul Thompson with Alkermes. Paul, are you there?

[unrelated discussion]

Paul Thompson: Okay, thank you. And thank you, Umang, for providing introduction to what I'm about to present today and thanks for the opportunity to provide testimony on Lybalvi. I'm Paul Thompson. I'm the psychiatric pharmacist and medical science liaison an Alkermes. Lybalvi is a combination atypical

antipsychotic olanzapine and opioid antagonist samidorphan administered orally by tablet. I have the full prescribing information available and would be pleased to address any questions you have about the points I'm highlighting today. First off, there's a box warning for more increased mortality in elderly patients with dimensionalized psychosis. Lybalvi is not approved for use in that population. Lybalvi's indicated for the treatment of schizophrenia or bipolar 1 disorder in adults. It is contraindicated in patients who are using opioids or who are undergoing acute opioid withdrawal. In patients who use opioids, delay initiating Lybalvi for a minimum of seven days after last use of short acting opioids and 14 days after last use of long acting opioids. Administer Lybalvi once daily with or without food. Do not divide tablets or combine strengths. The efficacy of Lybalvi in the treatment schizophrenia in adults, partly based on adequate and well controlled studies of orally administered olanzapine. In study one, adult patients who met DSM-5 criteria for schizophrenia were randomized in a one to one to one ratio daily to Lybalvi, olanzapine, or placebo for four weeks. The primary efficacy endpoint was the change in baseline positive negative symptoms scale total score week four. Patients treated with Lybalvi showed a statistically significant improvement compared to placebo from baseline to week four [indistinct] total score. In study two, adult patients who met DSM-5 criteria for schizophrenia were randomized one to one to daily Lybalvi or olanzapine for 24 weeks. The co-primary endpoints were percent change in baseline body weight and the proportion of patients who gained greater than or equal to 10% body weight at week 24. The least squares need change in body weight from baseline was plus 4.2% for Lybalvi and plus 6.6% for olanzapine. In the Lybalvi group, 17.8% of patients experienced weight gain greater than 10% of baseline body weight compared to 29.8% in the olanzapine group. In both instances, the differences in co-primary endpoints were artistically significant. In adults with bipolar 1 disorder, the efficacy of Lybalvi was established based on adequate and well controlled studies of orally administered olanzapine. The most common adverse reactions occurring greater than 5% or twice the rate of placebo for patients in schizophrenia were weight increase, somnolence, dry mouth, and headache. In bipolar 1 disorder, most common adverse events for dry mouth, constipation, increased appetite, dizziness across all groups. If Lybalvi is used as adjunct to lithium or [indistinct], additional adverse events included dyspepsia, weight gain, back pain, speech disorder, increased elevation, amnesia, or paresthesia. Now, samidorphan, which is a component of Lybalvi is an opioid antagonist and can precipitate with opioid withdrawal in patients who are dependent on opioids, which can lead to opioid withdrawal

syndrome, sometimes requiring hospitalization. Attempting to overcome Lybalvi's opioid blockade by administering high repeated doses of exogenous opioids can lead to life threatening or fatal opioid intoxication. Patients should be informed of the potential consequences of trying to overcome the opioid blockade and serious risks of taking opioids concurrently with Lybalvi or while transitioning off Lybalvi. Thank you for the opportunity today to provide testimony Lybalvi. I would like to see if the committee has any questions for me.

Ginni Buccola: Thank you, Paul. This is Virginia. Anything committee? Okay, thank you again.

Paul Thompson: And Virginia, this is Paul. I did have a second testimony, not to take up the committee's time. Should I do that later?

Ginni Buccola: Maybe Leta can guide us it. I think it depends on what the testimony is in regards to.

Leta Evaskus: Is it also on an antipsychotic?

Paul Thompson: Yes. Aristada Initio. Would now be the appropriate time to provide testimony on that?

Leta Evaskus: Yeah, I can give you another minute.

Paul Thompson: Okay, thank you. So it's still me and I definitely want to thank the committee for letting me provide testimony on Aristada Initio. Aristada Initio is an atypical antipsychotic and in combination with oral aripiprazole is indicated for the initiation of Aristada when used for the treatment of schizophrenia in adults. There's a box warning for increased mortality in the elderly patients with dementia related psychosis and the only contraindication of those hypersensitive aripiprazole. The main formulation difference between Aristada and Aristada Initio is the particle size of aripiprazole lauroxil crystals. Aristada Initio has much smaller sized particles and after injection releases aripiprazole faster than Aristada. Aristada Initio comes in one strength, 675 milligrams, and it should be given in conjunction with 30 milligram oral dose of aripiprazole to start the patient on Aristada therapy monthly every six weeks or every two months. Aristada Initio is only a single dose and not intended for repeated dosing, it needs to be injected intramuscularly by a healthcare professional and should be avoided to be injected in the same muscles as Aristada. Since there is a fixed dose for

patients that have never taken aripiprazole before, oral tolerability should be established first. And since it's a fixed dose, it should be avoided in patients with 2D6 poor metabolism or patients on a strong 2D6 3A4 inhibitors or inducers.

Ginni Buccola: Thank you, Paul. Thank you very much. So next is Margaret Olmon with AbbVie.

[unrelated discussion]

Margaret Olmon: Good morning. My name is Dr. Margaret Olmon with medical affairs at AbbVie. I'm excited to be here today to talk with you about cariprazine, brand name Vraylar. Vraylar is a once daily oral medication for adult patients approved for the treatment of schizophrenia, the acute treatment of manic or mixed episodes of bipolar one disorder, and the treatment of depressive episodes associated with bipolar 1 disorder, also known as bipolar depression. I would like to highlight three important points about Vraylar for you. First, Vraylar has established safety and efficacy in nine separate clinical trials, three trials for schizophrenia, three trials for manic or mixed episodes of bipolar 1 disorder, and three trials for bipolar depression. As such, and unlike most atypical anti-psychotics, Vraylar treats the full spectrum of bipolar 1 disorder: manic, mixed, and depressive episodes. The most common adverse events of Vraylar include ecastasia and extra parameters symptoms, although discontinuation due to these side effects was 2% or less in the pivotal studies. Vraylar has a neutral metabolic profile and minimal risk of weight gain, which is a common side effect with other anti-psychotics. Vraylar does have most of the same warnings and precautions as other atypical antipsychotics and I encourage you to review the full prescribing information at rxabbvie.com for complete safety and efficacy information. Second, I would like to bring to your attention Vraylar's unique pharmacologic profile. While the precise mechanism of action is not fully characterized, Vraylar is unique among the atypical antipsychotics for having the highest affinity for the D3 receptor. Vraylar is the only D3 preferring atypical antipsychotic available, which may have potential benefits on the difficult to treat symptoms of schizophrenia, such as predominant negative symptoms or cognitive defects. Lastly, Vraylar has an active metabolite, which contributes most of the antipsychotic activity, with long half-life estimated to be between one and three weeks. This long half-life suggests that some continued effect may persist after the discontinuation of treatment. I believe this should be important to you as it may be beneficial in

preventing rapid relapse in patients with intermittent adherence. In a 97-week schizophrenia relapse prevention trial where stable Vraylar patients were randomized to placebo or allowed to continue on Vraylar, the placebo group maintained prior treatment benefits over six weeks before increasing rates of relapse were seen. I'd like to close by respectfully asking that Vraylar be preferred for Washington Medicaid patients and I'd be happy to answer any questions that you have today.

Ginni Buccola: Thank you, Margaret. Committee, do you have any questions? Okay, thank you. Next is Kerry Carroll with Telecare. You'll have three minutes to speak. Go ahead.

Kerry Carroll: Good morning. I'm Kerry Carroll and I'm a psychiatric nurse practitioner and I'm the psychiatric provider here at telecare's Thurston Mason crisis and triage facility in Tumwater. And I'm here to speak about issues to access for the clients I serve here with obtaining the therapy for the Aristada two-month injectable. Most of the pushback I have experienced is with our contract with pharmacy has been with obtaining Initio product. I have difficulties. Either the pharmacy doesn't stock it or the prior authorization. But even after I've jumped through all those hoops, I get denials for the Medicaid and Medicare clients. And they give me the alternative of prescribing the 21 day [indistinct] instead of the initio. And I have an issue with that because the population I serve here are come in in crisis due mainly to poor medication adherence. These are homeless a lot of the time or have been incarcerated and they have difficulty keeping their meds due to loss or difficulty with access. And some of our younger clients struggle with the stigma and difficulty of taking a pill daily. And as we know poor medical compliance with these antipsychotics, with this diagnosis of schizophrenia results in poor prognosis and quality of life over their lifespan. Also, this results in repeated hospitalizations, which is expensive and disrupts their lives and the lives of their caregivers and family. So lowering the risk of relapse with improved medication compliance is why this option of access to Aristada Initio is a medical need for these clients I serve. And I asked the committee with any help to improve access for these patients based on medical need. Thank you for your time.

Ginni Buccola: Thank you, Kerry. Committee members, do you have any questions for Kerry? Okay, our next is Payal Tejani with Indivior. When you're ready, you have three minutes.

Payal Tejani: Okay, perfect. Thank you committee for letting me speak today. My name is Payal Tejani and I am a medical outcomes and value liaison with Indivior. Today I'll be sharing information on Perseris, which is an extended release injectable Risperidone product. Perseris is indicated for the treatment of schizophrenia in adults. It does come with a box warning related to increased mortality in elderly patients with dementia related psychosis. The most common adverse reactions for Perseris include increased weight, sedation, somnolence, and muscular skeletal pain. Perseris is administered once monthly via via an abdominal subcutaneous injection and it is available as a 90 milligram or 120 milligram dose. Those do correspond with a three milligram per day oral Risperidone dose for the 90 milligrams and four milligrams of oral Risperidone for the 120 milligrams. If patients haven't used Risperidone in the past, they should be established on oral Risperidone prior to treatment with Perseris to establish tolerability. Our pivotal phase three double blind randomized placebo controlled trial studied the change in positive and negative syndrome scale or pan score from baseline to end of the study, which is day 57. And also at a secondary endpoint looking at the change in clinical global impression severity or CGIS score from baseline to end of study. We evaluated men and women aged 18 to 55 years who had schizophrenia for DSM 4 criteria. And we found that they did have a statistically significant improvement from baseline to day 57. In the pans total score, there was a reduction that was statistically significant, as well as a reduction in CGIS from baseline to end of study. The most common adverse reactions were headache, injection site pain, and weight gain. And we had five subjects that withdrew from the study because of adverse events. And that was related to groin pain or paranoia. And some important adverse warnings and precautions related to Perseris include cerebrovascular adverse reactions, including stroke in elderly patients with dementia related psychosis, neuroleptic malignant syndrome, tardive dyskinesia, and metabolic changes. Thank you for your consideration of Perseris for your formulary. And if you have any questions, I'll open it up.

Ginni Buccola: Thank you very much. Committee, do you have any questions for Payal? Okay, thank you. The next list is Brandy Seignemartin with Washington State Pharmaceutical Association.

Brandy Seignemartin: Hello. Thank you so much. My name is Brandy Seignemartin. I'm a pharmacist and I represent pharmacists at the Washington State pharmacy Association. The WSPA opposes requiring prior authorizations for antipsychotic agents. WSPA is comprised of pharmacists in many practice

settings, including board certified psychiatric pharmacists, who provide care at in and outpatient settings, including in the HCA program of assertive community treatment program. These care teams often need to make rapid dose or anti-psychotic medication changes to manage acute symptoms and stabilize patients. Prior authorizations significantly limit their ability to rapidly address symptoms due to the delays that they pose. PAs may also cause delays in care when a patient has been released from an inpatient facility where they've trialed medications and stabilized the patient on an agent that is effective for them. But then on discharge, the patient and their family show up at the community pharmacy only to find that the medication they need requires a PA. This delays care and puts the patient at risk. Additionally, PAs need to be reauthorized every year. This also puts the patient at risk of destabilization, when perhaps all has been going well, but one month they go to refill their prescription and it requires a PA. Now the patient may have to go without medication for a period of time. This can be a critical time when patients may decide they don't need their medications at all. They're feeling stable and the cycle starts again. To address issues of mis prescribing with respect to antipsychotics, WSPA supports annual medication reviews and quality metrics that assess appropriate prescribing and care. Prior authorizations for anti-psychotic medications hurt patients, families, and our communities. We already have a major shortage of mental health care facilities and providers. Requiring PAs bogs down in already stressed system and poses undue barriers and risks for patients to get the treatment they need. Thank you so much for your consideration.

Ginni Buccola: Thank you very much. Any questions from the committee for Brandy? Okay, and our last stakeholder is Hiten Patadia with Otsuka.

Hiten Patadia: My name is Hiten Patadia. I'm a pharmacist by training. I'm a manage market liaison with Otsuka Pharmaceutical development and commercialization. Thank you for the opportunity for me to provide testimony on Abilify, Maintena to the Washington Medicaid. I believe you've all received or have reviewed the full prescribing information, so I would just like to highlight a few clinical points. Schizophrenia is a heterogeneous disorder with a wide range of potential genetic, environmental, and psychosocial factors that may impact its clinical course. Also several studies suggests that there's substantial interpatient variability in responses to different antipsychotic medications. Mental health professionals agree that it is very important to match anesthetic agents to the individual patient needs. Drug utilization management policies that hinder access to medications and continuity in

care may interfere with treatment. One study by Wes et al examined medications among psychiatric patients in ten state Medicaid plans to evaluate adverse events associated medication access issues. Results show that patients with access issues had 3.6 times greater likelihood of adverse events including ER visits, hospitalization, homelessness, suicidality, or incarceration. Based on these findings, it was concluded that the access to full range of medication facilitates optimal disease management for psychiatric patients. Bipolar disorder is also a serious lifelong episodic illness characterized by the occurrence of one or more manic episodes. Episodes of mania are recurrent and commonly associated with negative outcomes, including decline in cognitive function and increase in hospitalizations. Bipolar 1 disorder is associated with significant medical and psychiatric comorbidity, premature death, functional disability, and reduced quality of life. Long term pharmacological treatment is necessary to prevent recurrence of symptoms and relapse. The chronic nature of bipolar 1 disorder and the negative consequences of unremitted or recurrent symptoms emphasize the need for effective long term treatment. Otsuka pharmaceutical development and commercialization supports an open access policy to allow for individualized and appropriate treatment of patients with serious mental illness. Abilify Maintena is an extended release injectable suspension. It's an atypical antipsychotic and it's indicated for the treatment of schizophrenia and for the maintenance monotherapy of bipolar treatment for bipolar 1. On July 29, 2017, Abilify Maintena was approved by the FDA as once first month monthly long acting injectable for maintenance monotherapy of treatments of bipolar 1 disorder in adults. In fair balance, I'd like to call your attention to the box warning for Abilify Maintena: increased mortality in elderly patients with dementia related psychosis. For the complete box warning and additional information, please refer to the PI for Abilify Maintena. Abilify Maintena activity is presumably due to the parent drug Aripiprazole to a lesser [indistinct] Aripiprazole.

Ginni Buccola: I'm sorry to interrupt. Your three minutes are up.

Hiten Patadia: Okay. Thank you so much.

Ginni Buccola: Thank you very much. Are there any questions from the committee? Okay, thank you. Are there any stakeholders that were missed?

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

Ginni Buccola: Okay, I see actually Kavita has a question.

Kavita Chawla: Hi there, Kavita Chawla. May I ask a question to Brandy? My question is does WSPA have any metrics to share about what percentage of antipsychotic prescriptions are rejected up front and require a prior auth? Are there any metrics that track this?

Brandy Seignemartin: I don't have that information at this time, but I can definitely do some research and get back to you with that.

Kavita Chawla: Thank you.

Ginni Buccola: Thanks, Kavita. Okay, so I think we're ready to move to our motion. We have two motions. The first is on second generation antipsychotics and combination products. And then we'll do a separate motion for Parkinson's. What's written on our agenda is Parkinson's psychotic disorder but I don't know if there's meant to be a slash there. Alright, so team if you want to bring your cameras up, so we can see each other.

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

Ginni Buccola: This is Virginia Buccola and I second that motion. All those in favor please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? Okay, the motion carries.

[unrelated discussion]

Ginni Buccola: Can we return to that after the break? Okay, so then we'll go back to Umang to review cytokine and CAM agents.

Umang Patel: Alright, we'll pivot over to cytokine and CAM antagonists. Before we dive right into it, just to inform the committee, as you can imagine, there are a lot of different disease states and medications that fall under here that can have dual, triple indications for various disease states. I've done my best to give background on all the disease states in which there are significant clinical updates for medications in the last year. And so we'll be going through the umbrella of disease states and then will pivot over to new clinical information. On the next slide, just a little bit of background, cytokine and cell adhesion molecules or CAMs are chemical mediators involved in the inflammatory process throughout the body. Cytokines are small proteins secreted in response to an immune stimulus for the purpose of mediating and regulating immunity, inflammation, and hematopoiesis. The actions of the individual cytokines are widely varied and they contribute to fibrosis and tissue degeneration associated with chronic inflammation primarily by inducing the proliferation of fibroblasts and collagenase The proinflammatory cytokines, TNF and IL-1 are involved in tissue destruction in many chronic inflammatory diseases affecting various organs. On the next slide, the cell adhesion molecules are cell surface proteins involved in binding of cells, usually leukocytes to each other, endothelial cells, or the extracellular matrix. Specific signals produced in response to wounds and infections control the expression and activation of these molecules. Most of the CAMs categorized fall into three general families of protein. There's the IG superfamily, the integrin family, and the selectin family. Other proteins that are functionally classified as CAMs are involved in strengthening the Association of T cells with antigen presenting cells or target cells and T cell activation and recirculating lymphocytes back to the circulation via the lymphatic system. And different CAMs have been implicated in inflammatory, fibrotic, and autoimmune diseases. On the next slide here, we'll pivot over to juvenile idiopathic arthritis. There are guidelines from 2019. Again, it is over a year old. I've kind of bolded the relevant and updated information regarding DMARDs for polyarthritis. Methotrexate is usually recommended over leflunomide or sulfasalazine. And sub q, methotrexate is conditionally recommended over oral methotrexate. For biologic DMARDs in patients with polyarthritis, combination therapy with a DMARD is conditionally recommended over biological monotherapy when initiating treatment with a biologic. I know there's a lot of information here. Because it being over one year old, I just wanted to highlight some of the significant points here. Continuing on to the next slide, in terms of the ACR Arthritis Foundation, for initial therapy in polyarthritis patients, they recommend all patients have initial therapy with the DMARD over NSAID monotherapy. And in patients

without risk factors, which are things such as positive anticyclic citrullinated peptide antibodies, positive rheumatoid factor, or presence of joint damage, they recommend initial therapy with a DMARD conditionally over a biologic. For subsequent therapy and low disease activity patients defined as clinical juvenile disease activity score, they recommend escalation of therapy. And this is, for example, intraarticular glucocorticoid injection, DMARD dose optimization, methotrexate trial, and adding a changing biologic. And that is recommended over no escalation. For subsequent therapy in moderate or high disease activity, patients receiving DMARD monotherapy, the group conditionally recommends adding a biologic to the original DMARD over changing to a second DMARD or a triple. For subsequent therapy in moderate or high disease activity in polyarthritis patients receiving a TNF antagonist with or without a MDARD, they recommend switching to a non TNF antagonist over switching to a second TNF antagonist. However, a second TNF antagonists may be appropriate in patients with good initial response to a TNF antagonist, who have experienced secondary failure. And if the patient is receiving their second biologic use of a TNF antagonist, abatacept or tocilizumab is conditionally recommended over rituximab. Continuing onward, for patients with juvenile idiopathic arthritis and sacroiliitis, guidelines strongly recommend treatment with an NSAID over no NSAID therapy. In those who already are on NSAIDs with continued active disease, they recommend a TNF antagonist over NSAID mono therapy, the group strongly recommends against the use of methotrexate monotherapy. Bridging therapy with a limited duration of oral corticosteroids in select conditions and adjunct use of intra articular glucocorticoid are conditionally recommended. For those with juvenile idiopathic arthritis and enthesitis, the group strongly recommends NSAID treatment over no NSAID treatment with a TNF antagonists conditionally recommended over methotrexate or sulfasalazine. And bridging therapy with a limited duration oral corticosteroid in select conditions also is conditionally recommended. And there are additional recommendations on specific glucocorticoids. Moving over to pediatric psoriasis, the American Academy of Dermatology and National Psoriasis Foundation published guidelines for this and they recommend ongoing assessment of psoriatic arthritis, uveitis, obesity, CV risk factors, dyslipidemia, insulin resistance, and mental health conditions and the body surface area plus children's dermatology life quality index should be used to assess severity. In terms of treatment, they recommend topical treatments and there's a litany of medications here. For systemic treatments, they include medications such as methotrexate, cyclosporin, systemic retinoids, biologics, etanercept, infliximab, adalimumab, and

ustekinumab. And lastly, guidelines recommend treatment of physical and psychosocial wellness, quality of life in pediatric patients with pediatric psoriasis as well. Pivoting over to ankylosing spondylitis. So axial spondylarthritis is an inflammatory condition generally affecting the spine and can be further subdivided into ankylosing spondylitis and non-radiographic ankylosing spondylitis. The American College of Rheumatology, the Spondylitis Association of America, and the spondylarthritis research and treatment network published 2019 updates on the treatment of ankylosing spondylitis and non-radiographic axial spondylarthritis. In general, the recommendations for ankylosing spondylitis and non-radiographic ankylosing spondylitis are similar. TNF antagonists, not a specific agent, are recommended as first biologics over a second TNF. Excuse me, I apologize. TNF antagonists are recommended as first biologics over Cosentyx or Tremfya, which are then recommended over a second TNF antagonist if first dose does not produce a response. All prior mentioned agents are recommended over Xeljanz. Concurrent low dose methotrexate with TNF antagonist is not recommended. They recommend against a strict treat to target strategy. If a patient's disease is stable guidelines recommend against discontinuing or tapering of biologics and sulfasalazine provides a viable option for select patients who cannot take a TNF antagonists. [unrelated discussion] Next we have periodic fever syndrome. Now these are rare hereditary syndromes that are characterized by short recurrent severe localized inflammation and fever attacks that are not otherwise explained by routine childhood or adult infections. It is defined as three or more episodes of unexplained fever in a six month period, occurring at least seven days apart. These can occur periodically or irregularly and undergo spontaneous remission. CAPS is a family of syndromes associated with mutation in cryopyrin, now known as nucleotide binding domain and leucine rich repeat containing family. CAPS include Muckle-Wells Syndrome, familial cold autoinflammatory syndrome, chronic infantile neurologic cutaneous articular syndrome, which is also known as neonatal onset multi system inflammatory disease. Now, in terms of treatment, Kinneret, Ilaris, and Arcalyst are approved for the treatment of CAPS in select ages. Kinneret is only approved for patients with CAPS associated with NOMID and Arcalyst and Ilaris are approved more generally for patients with CAPS including FCAS and MWS. Ilaris is also approved for the following other periodic fever syndromes such as tumor necrosis factor receptor associated periodic syndrome, hyper immunoglobulin D syndrome, and familial Mediterranean fever. On the next slide, we have giant cell arteritis or temporal arthritis is a systemic inflammatory vasculitis of unknown etiology that is classified as a large

vessel vasculitis, but typically also involves small and medium arteries. Most commonly it affects the occipital, ophthalmic, posterior ciliary, proximal vertebral, and vertebral arteries. While the incidence ranges from .5 to 27 cases per 100,000 people in those 50 years of age or older, the incidence is higher in the northern areas of the US, and it occurs in older people and can result in a wide variety of neurologic ophthalmologic and systemic complications. In terms of treatment, high dose corticosteroids although clinical studies on various dosing protocols are limited, steroids are generally continued until resolution of symptoms and then maybe tapered slowly to the lowest dose that adequately suppress symptoms. And Actemra is the only non-corticosteroid drug FDA approved for the treatment of giant cell arteritis. Next, we have hidradenitis suppurativa. This is a chronic condition that affects the terminal follicular epithelium in the apocrine gland bearing skin, such as the armpits or the perianal area. It typically occurs in adolescence generally after puberty and adults is generally diagnosed clinically and affects approximately one to 2% of the US population. Select signs and symptoms include erythema, raised bumps or lesions, painful lesions, local arthritis, or arthralgia. In addition to non-pharm treatments, pharmacological treatments include anti-inflammatories, antibiotics, anti-androgens, biologics such as Remicade. And surgery may also be considered in some patients. Terms of guidelines, they are somewhat outdated. The European dermatology forum from six years ago released guidelines for the treatment and are limited but guidelines from the European dermatology forum recommended either adalimumab or infliximab in severe or refractory disease, stating adalimumab appears to be better tolerated. However, only adalimumab is approved by the FDA for this use. And in terms of uveitis, it is a non-infectious intermediate and posterior uveitis inflammation of the immediate and posterior uvea while pain uveitis is inflammation of the anterior chain chamber, the vitreous humor, the choroid, and the retina simultaneously. Together, these represent the most severe and highly recurrent form of uveitis. And the incidence of all cases of uveitis is approximately 15 per 100,000 patients per year. And the anterior uveitis is the most common form. On the next slide here, in terms of treatment, the ACR and Arthritis Foundation in 2019 published guidelines. I'll do my best to kind of summarize with the underlined information. But they published guidelines on the recommendation of uveitis associated with juvenile idiopathic arthritis, one of the most common extra articular manifestations of JIA. And the group recommends select topical glucocorticoids in patients with JIA and active chronic anterior uveitis for short term control. But for those who are unable to control symptoms with short term therapy, they

recommend adding systemic therapy in order to taper topical glucocorticoids. For juvenile idiopathic arthritis patients who develop new chronic anterior uveitis despite stable systemic therapy, they recommend topical glucocorticoids prior to changing or escalating systemic therapy. Regarding specific agents, they recommend subcutaneous methotrexate conditionally over oral methotrexate. However, use of a TNF antagonist with methotrexate in severe active disease and site threatening complications is conditionally recommended over methotrexate monotherapy. If starting a TNF antagonist, they conditionally recommend a monoclonal antibody over etanercept. Abatacept and tocilizumab as biologics, and mycophenolate, leflunomide, or cyclosporin as non-biologic options are conditionally recommended in patients who have failed methotrexate in two monoclonal antibody TNF antagonists. For pediatric patients with spondylarthritis who develop acute anterior uveitis, the group conditionally recommends topical glucocorticoids prior to a change in the systemic therapy. And notably, the only agent approved for uveitis in this class, is adalimumab. On the next slide, we have cytokine release syndrome and that can occur following select immunotherapies and result in a large rapid release of cytokines in the blood. This manifests as fever, nausea, headache, rash, tachycardia, hypotension, dyspnea, and can be life threatening. Actemra is approved for the treatment of CAR T-cell induced severe or life threatening cytokine release syndrome in adults and pediatric patients two years of age or older. Now, to pivot over to the role of biosimilars In 2017, the ACR published a white paper regarding the use of biosimilars in treatment of rheumatic diseases and provides a comprehensive overview of the scientific, clinical, economic, and prescribing issues pertaining to biosimilar use, including efficacy and competition. They note that available real world studies have demonstrated efficacy for extrapolated indications and state that healthcare providers should incorporate biosimilars where appropriate into treatment for patients with rheumatologic diseases. An internal multidisciplinary taskforce issued a consensus based recommendation on the use of biosimilars for rheumatologic diseases focusing on multiple factors including extrapolation of indication and switching between originator and biosimilar. They state treatment is a shared decision between patient and clinician and patients and providers must be educated on biosimilars. In addition, they are not considered superior or inferior to the originator product and biosimilars should be considered safe and effective for all the originators products approved indications. Notably, the guidelines recommend against interchangeability without consultation with a prescriber. Next slide, here we have ulcerative colitis. And so this is a chronic inflammatory disease

primarily affecting the colon and rectum. It affects approximately a million people in the US and the incidence continues to increase worldwide. The CDC estimates the current prevalence of ulcerative colitis is 238 per 100,000 adults, and it may present at any age, but onset typically peaks between 15 and 30 years of age. The disease is characterized by superficial infiltration of the bowel wall by inflammatory white cells, resulting in multiple mucosal alterations and crypt abscesses. The predominant symptom is diarrhea, which is usually associated with blood in the stool. Additional symptoms may include pain in the lower quadrant or rectum along with systemic features, including fever, malaise, weight loss, which is more common if a greater portion of the colon is affected. The initial attack may be fulminant with bloody diarrhea, but the disease more commonly begins indolently with non-bloody diarrhea progressing to bloody diarrhea. It can present initially with any extent of anatomic involvement ranging from disease confined to the rectum to the whole large intestines, and that is defined as pancolitis. And most commonly, this follows a chronic intermittent course with long periods of quiescence interspersed with acute attacks lasting weeks to months. However, a significant percentage of patients suffer a chronic continuous course. On the next slide, the American Gastroenterology Association last year released guidelines. For moderate to severe ulcerative colitis, they recommend considering patients with moderate to severe disease to be those who are dependent on or refractory to corticosteroids, exhibit ulcers upon endoscopic assessments, or at high risk of the colectomy. Long term management can include medications from the following classes: TNF alpha antagonists and immunomodulators, the anti-integrant agent vedolizumab, and JAK inhibitors. If the agent selected for inducing remission is effective, it is usually continued as maintenance therapy. The exception to this would be when corticosteroids or cyclosporin are used for indication of remission. The following agents are recommended over no treatment for adults, outpatient with moderate to severe ulcerative colitis listed in order of FDA approval: infliximab, adalimumab, golimumab, vedolizumab, tofacitinib, and ustekinumab. In patients who are biologic naive, infliximab or vedolizumab are suggested rather than adalimumab or induction or remission. However, patients with less severe disease who value the convenience of self-administration over the relative efficacy of therapy may select adalimumab instead. For induction of remission, thiopurine monotherapy suggested against use however, it is suggested over no treatment for maintaining remission. Methotrexate monotherapy is suggested against use for induction as well as maintenance of remission. The combination of TNF alpha antagonists such as vedolizumab or ustekinumab is suggested with

thiopurines or methotrexate over biologic monotherapy or thiopurine monotherapy. Early use of biologics with or without immunomodulator therapy is suggested rather than gradual step up to these agents following the failure of 5-ASA. And additional recommendations for adult outpatients with moderate to severe ulcerative colitis are provided regarding the use of tofacitinib and management of non-responders to infliximab. And for those who achieve remission with biologic agents and/or immunomodulators or tofacitinib, it is suggested against using 5-ASA for induction and maintenance of remission. On the next slide, the AGA published guidelines this year for the management of moderate to severe luminal and fistulizing Crohn's disease in adult outpatients as well and they recommend anti TNF alpha therapy over no treatment for induction and maintenance of remission. Ustekinumab is recommended and vedolizumab is suggested over no treatment. They recommend against natalizumab over no treatment for induction and maintenance. And infliximab, adalimumab, or ustekinumab are recommended over certolizumab pegol and vedolizumab is suggested over certolizumab pegol for induction in patients naive to biologics for Crohn's disease. Okay, now we will pivot from background and guidelines over to new clinical updates and medications. First, we have Stelara. In July 2020, FDA approved expanded indication for patients moderate to severe plaque arises who are six years of age or older. Previously, it was indicated only in patients 12 years of age or older. Just to remind the committee, when there are expanded indications, new formulations, things such as that I tried to bold the relevant information on the slide. So you can kind of go immediately to what is new. So, as I mentioned, Stelara's indication for pediatric patients increased from 12 years of age down to six years of age. All other information remains the same. Limitations: dosing is stratified by indication and that can be found in the TCRs or the package insert and availability. In terms of pregnancy, patients who are pregnant with this medication, there's limited available human data for use in pregnant women and there's insufficient data to form a drug associated risk. And there are no formal trials of this medication on patients with hepatic or renal impairment. On the next slide here we have the medication Hulio. In July of 2020, FDA approved this medication which is a biosimilar to Humira. It is a TNF antagonist approved for the treatment of adults with moderate to severe active rheumatoid arthritis, juvenile idiopathic arthritis in patients four years of age or older, psoriatic arthritis in adults, active ankylosing spondylitis in adults, moderate to severe active ulcerative colitis, moderate to severe active Crohn's disease, and moderate to severe plaque psoriasis. In terms of limitations, there are black box warnings. Again, it is a biosimilar to Humira. There's an increased

risk of severe infections, leading to hospitalizations or death, including TB, bacterial sepsis, invasive fungal infections, and infections due to other opportunistic pathogens. A second black box warning for lymphoma and other malignancies, some fatal have been reported in children and adolescent patients treated with TNF blockers including adalimumab products. There's a warning for serious infections. So do not start this medication during an active infection. If an infection develops, monitor carefully and stop if the infection become serious. The dosing is stratified by its various indications and that can again be found in the TCR NPI. And the availability are injection. There are prefilled plastic syringes in 40 milligrams and 20 milligrams as well. In terms of special population, for patients who are pregnant, there are limited available human data with Hulio for use in pregnant women. So there's insufficient data to inform a drug associated risk. And again, no formal trials of this medication on patients who are hepatic and renally impaired. Next, we have Tremfya. This medication in July 2020, FDA approved a new indication for psoriatic arthritis. As you can see, it already had an indication for the treatment of adult patients with moderate to severe plaque psoriasis were candidates for systemic therapy or phototherapy. All of their information remains the same. No changes in limitations or availability. And as you can see, the dosing for active psoriatic arthritis is the same as for plaque psoriasis here. Similar to some of the other biologics, no available data in pregnant women to inform a drug associated risk. There has been no safety and efficacy in pediatric patients younger than 18 years of age. And again, no specific studies in patients were renal or hepatically impaired. Next we have Ilaris. In September 2020, FDA approved Ilaris for active Still's disease, including adult onset Still's and systemic juvenile idiopathic arthritis in patients two years of age or older. As you can see, it does have a list of other indications as well. No changes in limitations. The dosing again is stratified by indication and the availability or injections in single dose vials. Identical to the previous medications listed, insufficient information to inform a drug associated risk in pregnant women and no formal trials for hepatically or renally impaired patients. Alright, next we'll go on to Enspryng. In August 2020, the FDA approved Enspryng, which is an IL-6 receptor antagonist for the treatment of neuromyelitis optica spectrum disorder in adult patients who are anti aquaporin-4 who are antibody positive. In terms of limitations, there can be infections. Delay administration in patients with active infections until the infection is resolved. Vaccination with live or live attenuated vaccines is not recommended. It is recommended to monitor ALT and AST during treatment as it can elevate liver enzymes, and to monitor neutrophil count during treatment as it can decrease the patient's

neutrophils. In terms of dosing, there are, as I mentioned prior to the infections Hep B, tuberculosis, and LFT screenings need to be done before the first dose prior to every use to determine if there's an active infection. The recommended loading dose for the first three administrations is 120 milligrams by sub q injections at week zero, two, and four followed by a maintenance dose of 120 every month. The availability comes in 120 milligram per mil single dose prefilled syringe. And similar again to the previous medications, there is insufficient data to develop a risk in pregnant women and no formal trials for hepatic and renal impairment. And safety and efficacy has not been established in pediatric patients yet. On the next slide here we have Xeljanz and Xeljanz XR. Now in September 2020, FDA approved Xeljanz one milligram per ml oral solution and Xeljanz tablets for the treatment of polyarticular course juvenile idiopathic arthritis in patients two years of age or older. As you can see, Xeljanz and Xeljanz XR already have a number of other indications. No changes to any of the warnings including the box warnings of infection, thrombosis, or lymphoma. The dosing here is stratified by indication and again, there was a new oral solution of being one milligram per ml. The XR tablets and tablets already exist. Okay, next we have Simponi Aria. Now, in October 2020, there were two different changes, first being the FDA approved and Simponi Aria for the treatment of active polyarticular juvenile idiopathic arthritis in patients two years of age or older. Additionally, they also expanded indication for the use in psoriatic arthritis to include children as young as two years of age or older. Previously it was only adults. So as you can see, it also has other indications such as rheumatoid arthritis and ankylosing spondylitis. No changes in limitations whatsoever or availability, just the two new indications were added in. And again, no adequate studies in pregnant women to assess a drug interaction and no formal studies for hepatically or renally impaired patients. Next, we have Kineret, where in December 2020, FDA also expanded the indication for use in treatment of deficiency of interleukin receptor antagonist. It already has other indications for rheumatoid arthritis and cryopyrin associated periodic syndromes: CAPS. No changes in warnings or availability whatsoever. And the dosing is stratified by indication. Now in terms of pediatric use, this medication does have pediatric indications for NOMID and DIRA. In terms of geriatric population, because there's a higher incidence of infection in elderly population in general, caution should be used in treating the elderly. This drug is known to be substantially excreted by the kidney and the risk of toxic reaction to this drug may be greater in patients with impaired renal function. So clinicians should monitor renal function as well. And patients with hepatic impairment, there were no formal studies to show

hepatically impaired patients on Kineret. Moving on to Arcalyst. Arcalyst received two new updates, the first being in December 2020. The FDA expanded indication for the use and treatment of deficiency of interleukin 1 receptor antagonist. And then in March of 2021, FDA expanded indication for the use in treatment of recurrent pericarditis and reduction in risk of recurrence in adults and children 12 years of age or older. As you can see, there were already a list of other indications primarily surrounding CAPS and the subgroups that fall under CAPS. No changes in the warnings of serious infections, hypersensitivity reaction, or immunizations. Again, dosing is stratified by indication here and no changes in availability for Arcalyst. For Arcalyst, no studies have been conducted to evaluate PK differences in hepatically and renally impaired patients. However, based on animal data, this medication could cause fetal harm in patients who are pregnant. Okay, moving onward to Humira. So in February 2021, FDA expanded the indication for treatment of moderate to severely active ulcerative colitis to include patients as young as five years old. It already has a lot of other indications, as you can see here. And similar to all the other medications with expanded indications, no changes to their warnings or their availability here, just the expanded indication and the dosing is stratified by indication, age, and weight, which can be found in the TCR or the package inserts. Okay, moving onward we have Actemra. And so in March 2021, FDA issued the emergency use authorization for tocilizumab, an IL-6 blocking monoclonal antibody for the treatment of hospitalized adults and pediatric patients two years of age or older for COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extra corporeal membrane oxygenation: ECMO. Actemra is already approved for the treatment of select patients with rheumatoid arthritis and interstitial lung disease, giant cell arteritis, and juvenile idiopathic arthritis. No other changes in warnings or availability and dosing is stratified again by indication, age, and weight. Alright, on the next slide we have our last medication update. And so in June 2021, FDA expanded the use for Cosentyx for moderate to severe plaques arises in patients who are candidates for systemic therapy or phototherapy to include patients six years of age or older. Previously, this was only in adults. No other changes to warnings which include infections, TB, which stems off of infections, inflammatory bowel disease, and immunizations. No changes to availabilities, which can be found in injection form. And the dosing again, similar to its three predecessors on this slide deck are stratified by indication, age, and weight. On the next and last slide for cytokine and CAM antagonists, we have just some updates in terms of discontinuations, FDA

communication, and REMS updates. So in terms of discontinuation, in July 2020, Abbvie reported to the FDA plans to discontinue the 10 milligram per .2 milliliter and 20 milligram per .4 milliliter prefilled syringe presentations of Humira based on market assessment and product demand. For FDA communication, in February 2021, Xeljanz and Xeljanz XR, FDA alerted the public that preliminary results from the safety clinical trial show an increased risk of serious heart related problems in cancer compared to TNF inhibitors. FDA advises patients should not stop taking prescribed medication without consulting their physician and FDA will communicate final conclusions and recommendations once the review is complete. In February 2021, for Siliq, there was a REMS update. Various updates to the REMS material including conversion of the REMS document to a new format and removal of the program from titles of the REMS material. Additionally, changes were made to the stakeholder enrollment form and patient enrollment form as well as to the REMS material to align with changes to the new REMS documents. I'll go ahead and pause there for the committee.

Ginni Buccola: Thanks, Umang. Thanks very much. That was really thorough. Did I give enough time for the committee to formulate any questions or turn their cameras on? If there aren't any questions, then we have two stakeholders. Margaret Oman with Abbvie and Carrie Johnson with Amgen. If you did not hear me call your name, please go ahead and raise your hand or in the chat let us know that you are requesting stakeholder time. Alright, so Leta when you're ready, let's go ahead and start with Margaret Olmon with Abbvie. You'll have three minutes to present. Thanks.

Margaret Olmon: Hello, my name is Dr. Margaret Olmon for medical affairs at Abbvie. Thank you for the opportunity to speak with you today. Abbvie now has three targeted immunomodulating medications available. I'd like to briefly review Skyrizi, Rinvoq, and Humira and answer any questions you might have. Please see the full prescribing information for all three products at rxabbvie.com for comprehensive safety and efficacy data. Skyrizi is an IL-23 inhibitor indicated for the treatment of moderate to severe plaque psoriasis in adults and is given as a subcutaneous injection at week zero, four and every 12 weeks, which means four doses per year for maintenance treatment. In the four phase three clinical trials that met all primary and ranked secondary endpoints, Skyrizi showed superior efficacy to Stelara in both passing 90 and passing 100 responses at 16 and 52 weeks. After two doses, 75% of patients had at least a 90% improvement in their PASI score, increasing the 83% of patients after one year of treatment. Skyrizi also

showed a statistically significant difference versus Humira in passing 90 at week 16 and after a switch from Humira in intermediate responders. The incidence of adverse reactions in the integrated analysis were similar for Skyrizi, Humira, and Stelara. In both long and short term, there were no unexpected safety findings and there are no contraindications for treatment. Rinvoq is an oral jack inhibitor indicated for the treatment of adults with moderately to severely active rheumatoid arthritis, given as a 15 milligram oral tablet once daily. In the phase three clinical program, Rinvoq met all primary and ranked secondary endpoints in all five clinical trials and significantly more patients achieved DAS 28 remission and low disease activity versus controls in each trial. Rinvoq is the only approved JAK inhibitor to demonstrate inhibition of joint damage in its approved patient population of methotrexate IR patients. it is also the only targeted immunomodulator to show clinical support superiority to Humira plus methotrexate. The most common adverse reactions in the [indistinct] trials were upper respiratory tract infections, nausea, cough, and fever. As you recall, Humira has ten currently approved indications with long standing safety data, 71 clinical trials, 18 years of market, and experience in over 1 million patients exposed. Humira has a well-defined published benefit to risk and database. In summary, I respectfully urge the committee to maintain preferred status of Humira on the PDL and to add Skyrizi and Rinvoq as available treatments for your state Medicaid patients. Thank you and I'd be happy to answer any questions you might have.

Ginni Buccola: Thank you, Margaret. Committee members, do you have any questions for Margaret? Okay, next is Carrie Johnson with Amgen.

Leta Evaskus: This is Lita. She may have stepped away. Shirley Quach, could you please raise your hand? Thank you. Alright. Go ahead, Shirley.

Ginni Buccola: Go ahead, Shirley. Your three minutes will start now.

Shirley Quach: Good morning, Washington P&T committee members. My name is Shirley Quach and I am a population health MSL with Novartis pharma. I just want to first thank you for the thorough and thoughtful review of the targeted immune modulators class. And just for this opportunity to provide some updates regarding Cosentyx Secukinumab, the first and only fully human interleukin inhibitor that's indicated for plaque psoriasis, psoriatic arthritis, ankylosing spondylitis, and non-radiographic axial spondylarthritis. And these are a group of related diseases driven by interleukin 17A. So on May 28

of this year, the FDA approved Cosentyx for the treatment of moderate to severe plaque psoriasis in patients six years and older who are candidates for systemic therapy or phototherapy. Cosentyx was evaluated in a 52 week randomized double blind placebo and active controlled trial in 162 pediatric patients that were six years of age or older with severe plaque psoriasis. And these patients were candidates for systemic therapy. The study met the coprimary endpoints. Both Cosentyx doses were superior to placebo with respect to the POZI 75 response and IGA 01 response at week 12. The study also met the key secondary endpoints. Both Cosentyx doses were superior to placebo with respect to POZI 90 response at week 12. And the safety profile for Cosentyx was consistent with the adult phase three studies with no new safety signals that were identified. To date, Cosentyx has been prescribed to over 500,000 patients worldwide since launch, with over five years of consistent long term efficacy and safety data and over 100 clinical studies and a comprehensive head to head clinical trial program. Thank you for your time and consideration and I'd be happy to answer any questions you have for me. Thank you.

Ginni Buccola: Thank you, Shirley. Committee, do you have any questions for Shirley? Okay, I see that Carrie Johnson is here. Carrie, your three minutes will start now.

Carrie Johnson: I'm Carrie Johnson. I'm a pharmacist with Amgen medical affairs. Thank you for the opportunity to speak in support of Otezla or apremilast. Reminders, Otezla was approved in 2014 for adult patients with active psoriatic arthritis and adult patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy. In July 2019, Otezla became the first FDA approved therapy for oral ulcers associated with the [indistinct] disease. Warnings and precautions include diarrhea, nausea and vomiting, depression, and weight loss. Please see the full prescribing information for further details. I want to provide a few key reminders about Otezla. Otezla is an orally administered small molecule. It is not a biologic. It works intracellularly to inhibit [indistinct] for which results in an increase in cyclic adenosine monophosphate. This modulates the production of pro inflammatory and anti-inflammatory cytokines. It's a very distinct mechanism of action. Importantly, when considering this class, Otezla has no black box warning, no warnings or precautions related to infection or malignancy, no laboratory monitoring or pre medication screening requirements, and does not elicit the production of anti-drug antibodies as it is not a protein. Otezla has fully published long term safety data five years in psoriatic arthritis and three years in moderate to severe psoriasis. I want to

provide three relatively recent updates, the first in moderate to severe plaque psoriasis of the scalp, which is considered a difficult to treat area causing a lot of quality life issues for the patients that experienced this, which is the majority of psoriasis patients at some course in their disease state, Otezla 30 milligrams twice daily demonstrates significantly greater improvements in scalp psoriasis, scalp and whole body itch, and quality of life compared to placebo during a 16 week double blind placebo controlled phase three study. It was a style study. These improvements were maintained in patients continuing Otezla out to 32 weeks. Most common adverse events through week 16 included diarrhea, nausea and headache, and vomiting. Most common adverse events out to week 32 were diarrhea and nausea., And these data are fully published and were added to the label in April 2020 and represent an option for patients with scalp condition. Second, recent published analyses from claims data demonstrate that biologic naive patients with psoriatic arthritis who initiated Otezla had switch rates similar to biologic users and significantly lower healthcare costs, regardless of treatment switching. Thirdly, the joint American Academy of Dermatology and national psoriasis foundation guidelines for care management of psoriasis with systemic non biologic therapies were just published in 2020 and recommended Otezla for the treatment of moderate to severe psoriasis and adults. In summary, Otezla's not a biologic, has no black box warning, has published long term safety data. I would respectively ask the committee to consider adding Otezla to the PDL as an oral option for patients with active psoriatic arthritis and moderate to severe psoriasis. Thank you.

Ginni Buccola: Thank you, Carrie. Committee members, do you have any questions for Carrie? And are there any stakeholders that did not get the opportunity to speak?

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

Ginni Buccola: Okay, great. So we'll go to the motion for cytokine and CAM antagonists. Committee members if you're able to bring your cameras on so we can see one another.

Susan Flatebo: This is Susan Flatebo. I move that all products in the cytokine and CAM antagonists 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 require prior authorization for

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

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

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

All: Aye.

Ginni Buccola: Are there any opposed? The motion carries.

Leta Evaskus: Ginni, this is Leta. Since we have a little bit of time before the break, can we go back to the Parkinson's motion?

Ginni Buccola: Yeah, that'd be great. I was just going to ask about that.

Kavita Chawla: This is Kavita Chawla. I move that all products in the anti-psychotics/antimanic agents, Parkinson Psychotic Disorder drug class are considered safe and efficacious for their medically accepted indications and are eligible for their preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, non clinically appropriate, or only one product is preferred.

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

Ginni Buccola: This is Virginia Buccola, committee chair, all those in favor please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. And that brings us to a break.

Leta Evaskus: This is Leta. Great, thank you. Let's take ten minutes so we'll come back at 10:51. And please mute your microphones on the break.

Ginni Buccola: Hi everybody, this is Virginia Buccola, committee chair. We're just reconvening after our break. And when Umang is ready, we're going to go to movement disorder agents.

Umang Patel: Hi there, this is Umang. So the next class we'll be reviewing are movement disorder agents. Moving on to the next slide. The first kind of sub topic that kind of encapsulates movement disorders is Huntington's disease. Chorea, an abnormal involuntary twisting or writhing movement is a characteristic feature of Huntington's disease, which is a rare and fatal genetic disorder resulting in neuro degeneration of the brain, which affects over 35,000 people in the US. As Chorea becomes more severe, it can interfere with patient's function. As the disease progresses, Chorea is replaced by dystonia and parkinsonism. Chorea affects approximately 90% of patients with Huntington's and it often develops early, gradually worsens, and plateaus in late stages. Symptoms may be aggravated by stress and anxiety. No current therapy exists to delay the onset of symptoms or prevent the progression of disease. However, symptomatic treatment may improve the quality of life and prevent complications. Xenazine, a VMAT 2 inhibitor was the first approved agent in 2008 by the FDA to treat Chorea associated with Huntington's. A deuterated formulation allowing once daily dosing, Austedo was approved to treat chorea associated with Huntington's in 2017. Other therapeutic options that are used but lack FDA approval for this use or known as off label include dopamine depleting agents and dopamine receptor antagonists. However, long term use of these medications may carry a high risk of adverse effects. At the bottom here, you can see according to the AAN, there is a guideline here that is about nine years old, so I won't be reviewing it. But again, it is here for completeness sake. On the next slide, in terms of tardive dyskinesia, which is the second subgroup that encapsulates under movement disorders, this consists of involuntary movements of the tongue, lips, face, trunk, and extremities that occur in patients treated with medications with dopamine antagonists properties. It may consist of movements classified as bradykinesia or hyperkinesia. Dopamine transporter dysfunction and chronic central dopamine blockade have been hypothesized to play a role in the development of tardive dyskinesia, although multiple other pathophysiologic mechanisms have been proposed. Tardive dyskinesia differs from acute movement disorders, often referred to as extra pyramidal symptoms or EPS, which commonly occur in patients treated with dopamine antagonists. DPS most commonly occurs early in therapy and during dose increases. These acute movement disorders include akinesia, acute dystonia, parkinsonism, and other hyper kinetic dyskinesias.

Tardive dyskinesia generally occurs after long term treatment with the dopamine antagonizing medication, but the timeline onset varies extensively. Once a patient develops tardive dyskinesia, it may be irreversible. And then on the next and final slide here for movement disorders just in terms of clinical updates, there's a medication, Ingrezza, where in April 2021, FDA expanded the formulation to include 60 milligram capsule strengths. It was already available in 40 and 80 milligram. And in terms of indications, warnings, and dosage, it remains undeterred. For specialized populations, there is no dosage adjustment in this medication for renally impaired patients. And if patients are moderate to severely hepatically impaired, then there are dose adjustment recommendations. That is all for movement disorders. I'll pause right there for any questions from the committee.

Ginni Buccola: Thanks, Umang. This is Virginia again. Any questions from the committee? We have several stakeholders and I'll go ahead and list them now. If you don't hear your name called, please raise your hand or drop a message in the chat so that we know that you would like some time.

Leta Evaskus: And Ginni, this is Leta. Again, when your name is called, if you can raise your hand so that I can easily unmute you, that would be helpful.

Ginni Buccola: Thanks, Leta. We have John Deason with Neurocrine. We have Jennifer Shear with Teva, William O'Neal with Sunovion, Kerry Carroll with Telecare, Dr. Mathew Bogoyas with Comprehensive Healthcare in Yakima. And as I've said before, but just to reiterate, each presenter has three minutes and at the beginning of your time, could you please acknowledge any affiliation you have with a pharmaceutical company even if you're not employed directly by a pharmaceutical company? So that said, first up is John Deason with Neurocrine.

John Deason: Hello, my name is John Deason and I am a manage care liaison from Neurocrine Biosciences medical affairs department and appreciate the opportunity to speak to you today about Ingrezza or generic valbenazine capsules. This is indicated for the treatment of adults with tardive dyskinesia or TD. TD is an often persistent and disruptive condition associated with prolonged exposure to dopamine receptor blocking agents including anti-psychotic and antiemetic drugs. Recommendations from a recent systematic review include V-mat 2 inhibitors as first line treatment for TD. And in addition, the 2020 APA schizophrenia guidelines recommended V-mat 2 inhibitors for the treatment of TD as well. Ingrezza has no box warnings and

is only contraindicated in patients with a history of hypersensitivity to valbenazine or either components of Ingrezza and has three warnings and precautions including somnolence, potential for prolongation of QT interval, although the degree is not clinically significant at concentrations expected recommended dosing, and parkinsonism in patients with TD with all three of these having been observed with other V-mat 2 inhibitors as well. Now the efficacy and safety of Ingrezza were established in multiple clinical trials in adults with TD and stable schizophrenia, schizoaffective disorder, or a mood disorder, with the most commonly reported adverse reaction greater than or equal to 5% and twice the rate of placebo being somnolence. Out of respect for the committee's time, I will refer you to the Ingrezza PI for a comprehensive overview of the clinical and safety data and I'm happy to answer any questions that you may have. Although there's no direct head to head studies comparing Ingrezza or generic valbenazine and deuterobenzene, there was a study using the Buker indirect treatment comparison or ITC method that compare the efficacy and safety of valbenazine and deuterobenzene that was recently published, where ITC is using pooled data for both valbenazine and deuterobenzene randomized placebo controlled trials displayed that regardless of the time point analyzed, the reductions in aim scores favored the pooled valbenazine trials, where the differences in effects were statistically significant for comparisons of the pooled valbenazine time points versus the deutetrabenazine time points except for the six week valbenazine versus 12 week deutetrabenazine time point comparison. And this represented an additional AIMS reduction for valbenazine of .92 to two points. The analysis also showed no significant differences with regards to safety outcomes. So in summary, Ingrezza is an effective once daily treatment for adults with TD with long term safety and efficacy data up to 48 weeks. And I really appreciate the committee's time and respectfully request that the committee would add Ingrezza as a preferred agent to the PDL for the treatment of TD in adults. Thank you.

Ginni Buccola: Thank you very much, John. Any questions from the committee for John? Okay, next is Jennifer Shear with Teva.

Jennifer Shear: Good morning. My name is Jennifer Sheer. I am a medical outcomes liaison with Teva Pharmaceuticals and today I'm here to provide information about Austedo, deutetrabenazine. Austedo is a V-mat inhibitor and is the only FDA approved therapy indicated for the treatment of TD or tardive dyskinesia in adults and chorea associated with Huntington's disease. A box warning exists for the use of Austedo in patients with Huntington's disease. However, this

warning is not associated with patients using Austedo for tardive dyskinesia. In December 2020, Austedo labeling was updated to reflect the following: at the maximum recommended dose, Austedo does not prolong the QT interval to any clinically relevant extent. Labeling no longer requires assessment of the QT interval before and after increasing the dose of Austedo to greater than 24 milligram in patients who are at risk of QT prolongation or in patients using other drugs known to prolong QT. In TD patients, the most common adverse reactions occurring in greater than 3% of Austedo treated patients and greater than placebo were nasal pharyngitis and insomnia. In patients with HD, the most common adverse events occurring in greater than 8% of Austedo treated patients were somnolence, diarrhea, dry mouth, and fatigue compared with tetrabenazine, deutetrabenazine was associated with significantly lower risk of moderate to severe adverse events and neuropsychiatric adverse events including agitation, akathisia, depression, drowsiness, somnolence, insomnia, and parkinsonism. Austedo provides response driven dosing options with six milligram, nine milligram, and 12 milligram oral tablets administered total daily doses of 12 milligrams or above in two divided doses. In analysis based on real world data, the main daily dose of Austedo was determined to be 25.6 milligrams and 28.5 milligrams in TD and HD respectively. The REM TD study is an ongoing three year open label extension study to evaluate the long term safety and efficacy of Austedo in patients with TD. 343 patients were titrated using response driven dosing up to 48 milligrams per day and patients treated with Austedo experienced sustained improvements in AIM score over time, with a main change in AIM score of -6.6 at week 145. And the percentage of patients who achieved 50% or greater and 70% or greater improvements in aim score from baseline increased over time, with the majority of patients 67% experiencing 50% or greater improvement by week 145. 73% of patients achieved treatment success based on the CGIC And deutetrabenazine was generally well tolerated across 723 patient years of exposure through week 158. And this concludes my comment today. I thank you for your time and I'm happy to answer any questions from the committee.

Ginni Buccola: Thank you very much, Jennifer. Are there any questions? Okay, next is William O'Neill with Sunovion.

William O'Neill: Hi Virginia and Leta. I think that our impression was that under this movement disorder, there would be some inclusion of the anti-Parkinson's products. And so if that's not the case, I didn't want to waste the committee's

time by giving my testimony. So if you can confirm that that's an inappropriate topic for this particular subject and I'll just get my time back.

Ginni Buccola: Let me ask Leta. And what agent were you going to speak to?

William O'Neill: Kynmobi.

Leta Evaskus: Umang, that was not a drug under movement disorder agents, correct?

Umang Patel: Can you repeat the drug name?

William O'Neill: Kynmobi.

Umang Patel: I don't believe so.

William O'Neill: It's to treat off episodes in Parkinson's disease.

Umang Patel: Okay, then Leta, yes, I would go ahead and class it under here.

Leta Evaskus: Okay. William, go ahead.

William O'Neill: Okay, thank you. Well, thanks for the opportunity to speak. I am here talking on behalf of Kynmobi. Currently, Kynmobi is a non-preferred and subject to a prior authorization with approval criteria requiring a trial and failure of two preferred products with the same indication. So Kynmobi is a sublingual film indicated for the acute intermittent treatment of off episodes in patients with Parkinson's disease. This indication is distinctly different from other dopamine agonists, which have the same mechanism of action but different indications. You can think of Kynmobi as an on demand treatment or a rescue when Parkinson's patients are experiencing particularly troublesome off episodes, which can include different combinations of actually several types of off episodes like morning offs, when patients wake in the morning with virtually no blood levels of the medication they took the night before and are having trouble getting started in the morning, delayed ons, which is the delay between the time the patient takes their medication and when they start to receive satisfactory improvement in their motor symptoms, the wearing offs, which is the predictable occurrence of patient motor symptoms before the next scheduled dose of medication, and then of course, unpredictable offs is when a patient randomly and abruptly transitions from an on to an off state. Of these off episodes, morning offs and unpredictable offs tend to be the most

troubling to Parkinson's patients. Morning offs tend to be very deep. They can delay getting out of bed, the ability to use the bathroom, and simple things like changing clothes. All of these types of off episodes can be treated with an on demand therapy, such as Kynmobi, however, not all off episodes can effectively be treated with current adjunctive treatments which can extend on time but cannot move a patient from off to on. We would like the committee to consider moving Kynmobi to preferred status with the trial and failure of levodopa carbidopa. And we would suggest the committee have a separate on demand category under movement disorder agents. Forcing a patient to step through an on extender when they really need an on demand agent only opens the patient up to increased risk for side effects, increased costs of the patient and the plan, and doesn't actually resolve the problem that the patient is experiencing. Neurologists do a good job of interviewing their patients around the type of off episodes they are experiencing and know which treatments to prescribe. So, due to the progressive nature of Parkinson's disease in some Parkinson's patients, it may be necessary over the course of treatment to need carbidopa levodopa and on demand treatment and an on extender all at the same time to control their motor symptoms. So, our ask is that you just please create a criteria that allows the neurologists the opportunity to choose the order in which they add medications to their patients' drug regimen. And I thank you for the time to speak today. And if you have any questions, I'd be happy to answer those.

Ginni Buccola: Thank you, William. Any questions? Okay, and to Kerry Carroll with Telecare.

[unrelated discussion]

Leta Evaskus: This is Leta. Again if you can raise your hand. Alight, Kerry, I have unmuted you. She's not responding. Maybe she stepped away. Let's go to Matthew Bogoyas.

[unrelated discussion]

Leta Evaskus: I can read it out loud just so it's on the record. So Matthew Bogoyas has said: "I've worked with both of these agents that have been discussed - Austedo and Ingrezza. Both work well on helping patients with TD, but there are some issues I've noticed working at comprehensive mental health center as the medical director."

Ginni Buccola: I'm wondering if that's an incomplete comment. I don't know, Matthew. Maybe you can raise your hand if there's more coming. His hand is raised.

Leta Evaskus: Okay, so Matthew has said: "I've used both of these agents but there are some advantages to Ingrezza in regards to Austedo. Austedo has a dose titration that is difficult for many patients. It also requires twice daily dosing. If the patient stops Austedo for more than a week, you need to re-titrate. Previously, I worked in Florida, where Austedo and Ingrezza were the same level of preferred. I think it would be nice to consider both of these agents at the same level as they both work well." Okay and Matthew, when you're done with your testimony, if you could just type "end" so that we know that you're done. "But most of our psychiatric clients do well on Ingrezza because it begins working with one dose and doesn't require a difficult increase in dose. I have no drug company affiliation. I'm happy to answer your questions. Sorry the mic isn't working. End."

Ginni Buccola: Thank you, Matthew. Committee members, do you have any questions for Matthew? Okay, looks like we can go to the motion.

Leah Marcotte: This is Leah Marcotte. I move that all products in the movement disorder agents drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class require prior authorization for medical necessity. All nonpreferred products require a trial of two preferred products with the same indication before a nonpreferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred. And can I just clarify one thing actually? Before it usually it says products in this class may require prior authorization. Is this class, all products require? Is that accurate that all products require prior auth?

Marissa Tabile: Hi, Leah, this is Marissa. Yes, so in this class, all the products have a prior authorization on them.

Leah Marcotte: Okay, that sounds good. I just wanted to make sure that that was accurate before moving on.

Jordon Storhaug: This is Jordan Storhaug. I second.

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

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. That takes us to up ophthalmic agents. Whenever you're ready, Umang.

Umang Patel: Perfect. Thank you. This is Umang. Next we have up the ophthalmic agents. Just a quick note for the committee. The next two topics are going to be under, I believe, one motion, which is the ophthalmic agents. So I will be going through glaucoma agents and then immediately into immunomodulator agents where I will pause for the committee. On the next slide here, for glaucoma agents, a little bit of background. Approximately 2.7 million people in the US suffer from glaucoma. It is the second most common cause of permanent blindness in the US and most common cause of blindness among African Americans and Hispanics. Risk factors for the development of glaucoma include elevated intraocular pressure, advancing age defined as greater than 40 years, family history of glaucoma, and African American or Hispanic descent. Increased intraocular pressure is common in glaucoma and is believed to contribute to the damage to the optic nerve, which can lead to the loss of visual sensitivity and field. However, some patients with glaucoma have normal IOP and many patients with elevated IOP do not have glaucoma. It alone is no longer considered a diagnostic criterion for glaucoma. Two major types of glaucoma have been identified as open angle and closed angle. In open angle, there is reduced flow through the trabecular meshwork. Open angle glaucoma accounts for the majority of cases. In closed angle, the iris is pushed forward against the trabecular meshwork blocking fluid from escaping. Reduction of IOP may be achieved either by decreasing the rate of production of aqueous humor or increasing the rate of outflow of aqueous humor from the anterior chamber of the eye. Topical ocular hypotensive agents can delay or prevent the development of primary open angle glaucoma in some patients. On the next slide here, we do have guidelines for glaucoma agents, first being the American Academy of Ophthalmology in 2018 and an update for 2020. Normally, I wouldn't go over the ones that are greater than a year, but because they're from the same academy, I'm going to for completeness sake here. The goal of treatment is to maintain the IOP in a range at which loss of visual field is unlikely to significantly affect the patient's health related quality of life over their lifetime. And initial target pressure is at least 25% lower than pretreatment IOP. However, target pressure is an estimate and should be individualized based on disease course. Lower IOP targets are reasonable in patients with more severe optic

nerve damage. Medical therapy is the most common initial intervention to lower IOP. Medication classes used in the management of glaucoma include beta blockers, miotics, sympathomimetics, topical, and oral carbonic anhydrase inhibitors and prostaglandin F2 analogs. Monotherapy or combination therapy may be used to treat glaucoma and delay the need for surgery and prevent functional vision loss. At an update in 2020 by the same academy, preferred practice patterns prostaglandin analogs are the most frequently prescribed eyedrops to lower IOP due to their efficacy, safety profile, and once daily regimen. Sufficient management of glaucoma is dependent on a high level of adherence to therapy. Data has suggested the addition of a second medication can lead to reduced adherence therefore fixed dose combinations may potentially increase adherence and decrease exposure to preservatives. Although fixed dose combinations are not usually recommended as initial therapy, a fixed dose combination agent may be warranted in patients requiring a greater IOP reduction than available with a single agent. On the next slide, in terms of clinical updates for the medications under glaucoma agents, there was a discontinuation notice here for phospholine iodide in October 2020. The FDA announced the discontinuation of this medication in 6.25 milligram package. Pfizer expects the product will remain available through May 1, 2021. In terms of a new generic, brinzolamide in December 2020, the FDA approved the first generic for Novartis' Azopt medication. That concludes the glaucoma agents. I'll continue forward with immunomodulators. For the ophthalmic agents immunomodulators, a little bit of background here for keratoconjunctivitis sicca. KCS is defined as dry eye disease related to either decreased tear volume, aqueous tear deficiency, or rapid evaporative loss and evaporative tear deficiency due to poor tear quality. Both of these conditions may be present in dry eye syndrome. The term dry eye syndrome, dry eye disease, keratoconjunctivitis sicca or keratitis sicca are often used interchangeably with the term keratoconjunctivitis sicca being an older term. There is considerable overlap with other ophthalmic conditions such as meibomian gland dysfunction. DES or KCS affects approximately 10 to 30% of the US population that occurs more commonly in patients over 50 years of age with approximately twice as many women as men affected. However, due to increased use of soft contact lenses and frequent smartphone and computer usage, the prevalence of DES is increasing among young adults aged 18 to 34 years of age. Patients with KCS and DES may have the following complaints: sensation of ocular dryness, grittiness, a foreign body or irritation, hyperemia, mucoid discharge, excessive tearing, photophobia, and blurry vision. On the next slide here, for updates to clinical information in

medications, in October 2020, FDA approved Eysuvis. And this is a corticosteroid indicator for the short term, defined as up to two weeks treatment of signs and symptoms of dry disease. In terms of warnings and precautions it is contraindicated in most viral disease of the cornea and conjunctiva including epithelial, herpes simplex keratitis, vaccina, and varicella and also in mycobacterial infections of the eye and fungal diseases of ocular structures. There is a delayed healing and corneal perforation. The initial prescription and each renewal of the medication order should be made by physician only after examination of the patient with the aid of magnification such as slit lamp biomicroscopy and where appropriate, fluorescent staining. And lastly, prolonged use of corticosteroid may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields division. Renewal of the medication order should be made by physician only after examination of the patient and evaluation of the IOP. For dosing, it is simply one to two drops into each eye four times daily. And the availability, as you can imagine, is an ophthalmic solution containing two and a half milligrams per milliliter of said medication. On the next and final slide for immunomodulators we have Verkazia. And in June 2021 the FDA approved Verkazia, which was a calcineurin inhibitor immunosuppressant for the treatment of Vernal keratoconjunctivitis in children and adults. In terms of warnings and precautions, to avoid the potential for eye injury and contamination, advise patients not to touch the vial tip to the eye or other surfaces. It is one drop four times daily and they define that morning, noon, afternoon, and evening in each affected eye. And as you can imagine, it is an ophthalmic emulsion and so it's 0.1% cyclosporin. I'll go ahead and pause there and just remind the committee that both glaucoma and immunomodulators will be under ophthalmic agents.

Ginni Buccola: Thanks Umang for that reminder. We have one stakeholder and that is Margaret Olmon with AbbVie. If there any other stakeholders, can you please raise your hand or write your name in the chat so we know you're here. And I see that Margaret's hand is raised already.

Margaret Olmon: Hello. I'm Dr. Margaret Olmon still with medical affairs of AbbVie. Thank you for the opportunity to talk with you today about Lumigan, the brand name for bimatoprost 0.01% ophthalmic solution. [indistinct] glaucoma, a chronic progressive disease is the leading cause of irreversible total vision field blindness. So far, the only approach proven to be effective in preserving visual function is lowering intraocular pressure. Every millimeter of mercury elevation translates to 19% increased risk of progression of disease. No

single IOP level is ideal for every patient. Guidelines recommend each patient's treatment be individualized. Lumigan is a prostaglandin analogue indicated for the reduction of elevated inter ocular pressure in patients with open angle glaucoma or ocular hypertension. I'd like to highlight three important points about Lumigan for you. First, Lumigan has two modes of action, unlike other prostaglandin analogues such as latanoprost. While the precise mechanism of action is not fully characterized, it is believed to lower interocular pressure by including increasing outflow of aqueous humor through both the trabecular meshwork and uveoscleral roots. Acting in this way, Lumigan selectively mimics the effects of naturally occurring postumides. Second, I would like to bring your attention to a comparison of Lumigan 0.01% solution with bimatoprost 0.03% drops in a study by Katz and Associates. Lumigan, with its lower concentration, produced equitable IOP lowering effective across the 12 months of this study while cutting the treatment related adverse effects by one-third. The discontinuation over time due to ocular adverse events was also significantly lower with Lumigan arm. Lastly, Lumigan may work in patients who do not respond to other prostaglandin analogs. I'd like to share information from a study by Meyers and Associates. For patients previously treated with latanoprost and switch to Lumigan, a lowering of an additional four millimeters of mercury was observed. Switching within this class may be valuable for patients who are not reaching their treatment goal with their initial therapy. The most common adverse events of Lumigan were conjunctival hyperemia. In the pivotal study, approximately 1.6% of patients discontinued therapy for this reason. For comprehensive safety and efficacy data, please see the full prescribing information at rxabbvie.com. I want to close by respectfully asking that Lumigan 0.01% solution be considered as a preferred option for Washington Medicaid patients and I'd be happy to answer any questions you might have at this time.

Ginni Buccola: Thank you, Margaret. Are there any questions from the committee? Okay, so we're going to go to the motion. And again, this is one motion for two presentations.

Michael Corsilles: This is Michael Corsilles. I move that all products in the drug classes listed on slide 11 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All nonpreferred products require a trial of two preferred products with the same indication before a nonpreferred drug will

be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Alex Park: This is Alex Park seconding that motion.

Ginni Buccola: This is Virginia Buccola, committee chair, all those in favor, please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? The motion carries. And we go to respiratory agents next.

Umang Patel: So this is a quick one, this topic. As I mentioned earlier, I include pertinent, significant clinical information or updates in the last year. And for this subclass, there were no clinical updates. And so I'll pause right there for the committee.

Ginni Buccola: Thanks Umang. We have one stakeholder for respiratory agents and that's Michael Horton with Boehringer Ingelheim.

Michael Horton: Thank you to the committee for allowing me a few minutes to address this. The only thing I would add since he did not offer any additional comments and I can't remember if this was covered last year, is just to point out that with [indistinct] we actually do have three approved indications. All three were based on very robust phase three trials. The two additional ones were of course in systemic sclerosis ILD and then the chronic fibrosing ILD with a progressive phenotype. And so I just wanted to make sure everybody was aware of that. And I really have nothing else to add unless there are any other questions. And if there are not, I will give back this time to the committee.

Ginni Buccola: Thank you, Michael. Are there any questions? Okay, we can go ahead and look at the motion for respiratory agents.

Kavita Chawla: Hi, Ginni. Kavita Chawla here. Just wondering, how do we decide, like, for some of these, as Leah had pointed out earlier, all ages will require prior authorizations, whereas other ones, they may require prior auth. Is this a decision that HCA makes in a separate setting?

Ginni Buccola: I don't know if I can address the question as to what the history is in terms of what's presented to us. But I know that we can, as a committee, discuss if there's any language changes we'd like to make in the motion.

Donna Sullivan: Hi, Ginni, this is Donna. So the way we say “may” is it’s more permissive for HCA to, at our own discretion, put it on prior authorization or not put it on prior authorization. If you think that there are drugs that should not be on prior auth, or we can discuss what that might look like if we were to remove it. And typically, we try to get policies developed as soon as possible when they are on PA and we bring those to the board for review.

Ginni Buccola: Thanks, Donna. Kavita, does that help to clarify that for you?

Kavita Chawla: Yes, it does. I suppose when we're looking at the language here, we're not really addressing any specific agents to call them out for they should or should not be under prior auth. This is more just a group of agents discussion. And then if we do a separate policy discussion then maybe there it is up for discussion. Not sure I'm making myself very clear.

Ginni Buccola: I think you're clear. I'm understanding what you're asking. That's my interpretation also. So if there's any clarification, Donna, that needs to come from you, we’re all ears.

Donna Sullivan: I was just messaging. I just noticed that this is missing some of our standard language that we talked about, you know, the preferred, have to try and fail and that they may require prior auth. Is the question more about why is this motion different than the others that you've currently read? And should it be more similar to the others?

Kavita Chawla: No, my question was, in general, you brought up earlier that the language in these motions is up for discussion at these meetings. And I was trying to sort out when it's an individual drug level discussion, is that at this part of the meeting or is that when we are discussing specific policies for the drugs?

Donna Sullivan: I think you can do it at any time. It really probably depends what you’re trying to accomplish. If you feel there’s evidence that shows a drug clearly is superior to another and you want it to be preferred, you could say that. Or if there’s a drug that clearly has a safety concern or an adverse event profile, you would want it to not be a preferred drug. You could say that as well. Or you could more differential and we can make those decisions. What we do

now is this is more permissive information and then we look at our utilization. We look at the net cost for the drugs. And based on your recommendation, we will then choose the preferred products after the committee makes their recommendation.

Kavita Chawla: Okay, that is helpful. Yeah, I think those are my questions for now.

Leta Evaskus: Donna, could I just clarify to your earlier question? Why is this motion much shorter than usual?

Donna Sullivan: I think that was just an oversight on our part. And we should probably go back to one of the other motions and copy and paste that additional information and put it in here.

Marissa Tabile: This is Marissa. Yeah, it would be just that section right there. I apologize for that oversight.

Alex Park: This is Alex Park. Donna, I was just looking at the Excel sheet that got sent out with the PDL. There are only two drugs in this class and they are all preferred. Is that right?

Donna Sullivan: I would have to double check.

Marissa Tabile: Hi, Alex, this Marissa. So yeah, I can confirm that's correct. There's only two agents and they're both preferred in this class with PA.

Alex Park: Kavita, did you have a concern about one or the other drug, in terms of feeling that one shouldn't be preferred?

Kavita Chawla: No. The timing of my question does not have anything to do with this particular class of agents. I was trying to understand just the protocol of when a discussion is to be had. Because I know there's also that difference between the [indistinct] and then the DUR part. And so this is actually more rumination about some of the other drug classes that we did approve. I believe one of them was anti-Parkinson's medications where the language did say that all medications require a pre auth. And so in my mind, I was trying to figure out why would all of those agents require pre auth while other ones may require a pre auth? So I was trying to understand the protocol here, and when does it get discussed one way or the other?

Donna Sullivan: And Kavita, this is Donna, again. I would say that that particular motion probably should have said “may” and not all.

Kavita Chawla: That would make me feel more comfortable too because for those patients, I don't know what their option would be if everything is pre auth.

Donna Sullivan: I don't know. I'm not sure if that's even an accurate statement to say that they all require prior authorization, I'd have to go back and look at the particular drug class, unless it was a subclass and there was only the one drug in it.

Ginni Buccola: I think That was for movement disorders.

Leta Evaskus: Okay, so this is Leta. What do you want me to remove?

Donna Sullivan: Nothing on this slide.

Leta Evaskus: Oh, okay.

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

Leta Evaskus: This is Leta. I couldn't hear who seconded. Leah.

Ginni Buccola: I didn't hear it either. This is this is Virginia, Committee Chair. All those in favor, please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. Do we need to return to the movement disorder agent motion and correct language before we go forward?

Donna Sullivan: That would be helpful, yeah.

Leta Evaskus: Can you tell me what the change is?

Donna Sullivan: Just put “may require prior authorization”.

Leah Marcotte: And I made that motion. Can I just say agree with edits and correction that the class may require prior authorization?

Ginni Buccola: Thank you, Leah. Any opposed to the change in that language? Leta, not to rush ahead, but I'm wondering, should we go ahead and do smoking deterrence before lunch?

Leta Evaskus: Yeah, we can do that.

Kavita Chawla: Ginni, did the ophthalmic agents also have required prior auth?

Ginni Buccola: Gosh, I don't know.

Kavita Chawla: No, that was incorrect. Sorry.

Donna Sullivan: Ginni, if you want, we can go back through with your approval and direction and make sure that they all say “may” so that we don't have to go back and redo each particular motion.

Ginni Buccola: That would be great. And thanks to Kavita for noticing that that wasn't consistent.

Donna Sullivan: So yeah, it looks like it was just a couple of them that didn't have “may” in there.

Leta Buccola: Umang, are you on?

Umang Patel: Next we'll go over to smoking deterrence. On the next slide here, smoking cessation agents. Cigarette smoking is the leading preventable cause of death and is responsible for about one in five deaths annually, or about 480,000 deaths per year in the United States. Approximately 70% of smokers have a desire to quit completely and 55% have made a quit attempt in the last year. Discontinuing smoking often requires multiple attempts. Most attempts aren't successful because they're unaided. Relapse is often caused by stress, weight gain, and withdrawal symptoms. And examples of common nicotine

withdrawal symptoms include irritability, anxiety, difficulty concentrating, and increased appetite. According to the American Thoracic Society last year, they published new clinical practice guidelines on initiation of pharmacotherapy for tobacco dependence in adults. The guidance maintains all patients who are using tobacco should receive treatment for dependence and not only be encouraged to discontinue tobacco use. Strong recommendations in the guidelines include preference for Chantix over a nicotine patch, preference for Chantix over bupropion, use of Chantix rather than a nicotine patch in adults with comorbid psychiatric conditions, starting Chantix in adults even if they're not ready to quit, and using controller therapy for an extended duration of more than 12 weeks. Conditional recommendations include the combination of nicotine patch with Chantix over use of Chantix alone and use of Chantix over electronic cigarettes. On the next slide, the US Preventive Services Task Force this year recommended that clinicians ask all adults about tobacco use and to advise current users to stop using tobacco and provide behavioral interventions including approved pharmacotherapy for tobacco use cessation. This was a level A recommendation. Clinicians should also advise pregnant women to stop using tobacco and provide behavioral interventions. However, evidence is not sufficient to assess benefits versus risk of pharmacotherapy use in pregnant women. In April 2020, the USPSTF issued a recommendation for school aged children and adolescents who have not started to use tobacco, stating that primary care clinicians are recommended to provide interventions such as education or brief counseling in order to prevent tobacco use initiation in these individuals. However, for school aged children and adolescents who use tobacco, it was concluded the current evidence is inadequate to determine the benefits versus risks of primary care feasible interventions regarding tobacco cessation. That is the only update in this class. Due to the two new guidelines within the last 12 months, I wanted to highlight those. There is no drug specific clinical update in the last year. So I'll go ahead and pause there for the committee.

Ginni Buccola: Thanks, Umang. We don't have any stakeholders unless there's somebody that has not signed up. I also want to take a moment, I don't think I asked specifically after the last two topics, if there were any stakeholders that were waiting to be heard and were not recognized. Okay, I don't hear or see anybody. So we can go to the motion.

Kavita Chawla: Hi, Ginni. I just had a quick question for Umang.

Ginni Buccola: Go for it.

Kavita Chawla: Do does the USPSTF guideline specify a preference of Chantix versus Wellbutrin for the treatment of smoking cessation?

Umang Patel: No. The update was primarily around more so prevention. So the 2021 update was just about that not about treatment options.

Kavita Chawla: Thank you.

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

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

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

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. And that looks like that brings us to a lunch break.

Leta Evaskus: This is Leta. Yes. Let's take half an hour. So we will return at 12:20. Please mute your microphones while on break.

[break]

Leta Evaskus: Hi, this is Leta. Ginni, I want to see if the committee is back. Okay, we have a quorum, so why don't we get going and Jordan, if Ginni isn't back by the time we're ready for stakeholders, et cetera, I'll have you lead. Alright, go ahead, Umang.

Umang Patel: Perfect. This is Umang Patel. We'll go ahead and get started with the next sub classes. Just to inform the committee, essentially what will be happening for

the next part as you can see, the next and final part of my clinical presentation has a lot of different subcategories for oncology medications. Previously, I mentioned how Magellan therapeutic classes and Washington State's isn't always a one to one. Ours are sometimes broken down by systems of oncology, for example, prostate, breast cancer, renal cell carcinoma, et cetera. I believe on the Apple Health PDL, it is by mechanism of action. And as one can imagine, one medication that has a certain mechanism of action can be used for different oncology, different cancers. And so I will be going over all oncology agents with the mechanism of actions that are listed here. And we will be doing the motion, I believe, at the end. And Leta and/or Marissa, please correct me if I'm wrong on that.

Leta Evaskus: This is Leta. You're correct.

Umang Patel: So the first class we'll be looking at is prostate cancer. This encompasses the androgen biosynthesis inhibitor and the anti-androgens, both oral medications. On the next slide here, a little bit of overview. In the United States prostate cancer is the most commonly diagnosed cancer in men, excluding non-melanoma skin cancer, with an estimated of a little bit short of 200,000 cases projected to be diagnosed in 2020. While prostate cancer accounts for the largest percentage of diagnosed cases in the US, roughly 20% of males, it only accounts for about 10% of all cancer deaths in this population, far behind lung cancer, the leading cause of cancer death, which accounts for 24% of US male cancer deaths. Prostate cancer is rare in men under the age of 40 years, but the risk increases with each subsequent decade of life. Overall, one in nine US men will develop prostate cancer during their lifetime. Aside from age, the risk factors most strongly associated with the development of prostate cancer include race, ethnicity, and family history. Prostate cancer mortality in non-Hispanic African Americans is more than twice that of the US Caucasian population. And prostate cancer may represent an indolent disease in some patients and highly aggressive disease and others. On the next slide here we have an overview, continuing on for the overview. Androgens specifically testosterone are a known growth signal for prostate cancer and the majority of prostate cancers are hormonally dependent. Due to the hormone responsiveness of the tumor. androgen deprivation therapy, ADT, is a cornerstone of prostate cancer treatment. ADT is utilized at the backbone of therapy in advanced or metastatic disease as well as in combination with radiation therapy for clinically localized disease. ADT can be accomplished by utilizing either a surgical approach, bilateral orchiectomy, or a medical

approach with the administration of a luteinizing hormone releasing hormone agonist or an LHRH antagonist to suppress the serum testosterone concentrations to castrate levels defined is less than 50 nanograms per deciliter. IV chemotherapy options such as docetaxel, and Jevtana, as well as immunotherapy options for certain patients include Provenge or Keytruda and a radiopharmaceutical option Xofigo may be utilized in the treatment of metastatic prostate cancer. Additionally, the use of oral poly polymerase inhibitors in select prostate cancer patients is included in a separate TCR. The use of docetaxel, cabazitaxel, Provenge, Keytruda, and radium 223 for the management of metastatic prostate cancer is beyond the scope of this review and will not be discussed. And again, it's specifically for the sub mechanism of actions. On the next slide here we have Xtandi and I apologize for some of my pronunciations here. In August 2020, FDA approved a new tablet formulation of Xtandi in 40 milligrams and 80 milligrams strengths. Like the previously approved 40 milligram capsule, it is approved for the treatment of patients with castration resistant prostate cancer and metastatic castration sensitive prostate cancer. Again, it is just a new tablet formulation. So it was just 40 and 80 milligram tablets. It already is here available in 40 milligram capsules. On the next slide, in December 2020 FDA approved Orgovyx, which is a GNRH receptor antagonist indicated in the treatment of adult patients with advanced prostate cancer. It does carry some warnings with it, first being a QTC interval prolongation. So it is important to monitor a patient's QT interval along with monitoring for any other medications that may increase QT interval. And the second being embryo fetal toxicity. This can cause fetal harm and loss of pregnancy. Advise males with female partners of reproductive potential to use effective contraception. The dosing for this is a loading dose of 360 milligrams on the first day of treatment, followed by 120 milligrams taken orally once daily at approximately the same time each day. And it is again in tablet form of 120 milligrams. This medication, there's no recommendations for renal or hepatic impairment. Now, as I mentioned before, we'll just be going over all oncology medications and then the final vote will occur. On the next slide we have oncology oral and this is specific to hematologics and I will define what medications break down into this. So for hematologics as one can imagine, there are various cancer types that fall under this. The first being marginal zone lymphoma. MZL accounts for approximately 10% of all NHLs and are generally divided into three subtypes: nodal MZL, splenic MZL, and the most common subtype mucosa associated lymphoid tissue. Lenalidomide plus rituximab is an NCC and category two B as in beta recommendation for the first line therapy of MZLs. For elderly or infirm patients, chlorambucil with or

without rituximab may also be utilized in the first line setting. Both lenalidomide with or without rituximab, and ibrutinib as a single agent are NCCN v4.2020 category 2A preferred recommendation for second and subsequent line therapy of MZL. Idelalisib or dubelisib may be used in second and subsequent line of marginal zone lymphoma in patients who are relapsed refractory after two prior therapies. The next being acute myeloid leukemia or AML. Most common form of acute leukemia among adults estimated 5930 cases diagnosed and 1500 deaths in the US in 2019. in patients who obtained a CR, three years survival is 45%. Remission rates are inversely proportional to age. Cytogenetics does play a large role in determining prognosis and treatment options, and acute Promyelocytic Leukemia is a subtype of AML with distinct features and treatment. For the third sub cancer type, we have diffuse large B cell lymphoma. DLBCL are the most common types of lymphoma and account for 30% of all NHL. There are several subtypes of DLBCL including DLBCL arising from follicular lymphoma. Some patients with follicular lymphoma may undergo conversion to more aggressive lymphomas such as DLBCL. And this risk increases over time. About 30% of follicular lymphoma patients convert to more aggressive lymphoma at 10 years post follicular lymphoma diagnosis. The B cell lymphoma NCCN guidelines list Xpovio as an option for DLBCL not otherwise specified, including DLBCL arising from follicular lymphoma after at least two prior systemic therapies. On the next slide, we have the fourth and final subtype. And as the committee may remember, I tried to encompass the relevant background disease states for the new clinical updates in this section. So the fourth disease state we have is Kaposi sarcoma. It is a malignancy of the endothelial cells and is characterized by cutaneous red or brown papules often seen on the lower extremities. There are four types. Classic presents with cutaneous lesions but follows an indolent course. It is most common in elderly patients of Mediterranean, Eastern European, Middle Eastern, and/or Jewish descent. Endemic Kaposi sarcoma tends to be more aggressive than classic and it occurs in younger patients, less than 40 years of age, as well as children in Equatorial Africa. The third type is iatrogenic and occurs in the setting of patients taking immunosuppressive therapies such as organ transplant recipients. And the fourth and final subtype is seen in patients infected with HIV. In these patients, Kaposi sarcoma is considered to be an AIDS defining cancer. The risk for developing Kaposi sarcoma is estimated to be approximately 498 fold higher in HIV positive patients compared to the general US population. Due to the improved treatment options available to AIDS patients, the incidence of this cancer has been declining. The NCCN 2020 guidelines for AIDS related Kaposi

sarcoma lists Pomalyst as a preferred systemic therapy option for patients with relapsed refractory disease. And note that Pomalyst has been FDA approved for the treatment of adult patients with AIDS related Kaposi sarcoma after failure of highly active antiretroviral therapy. On the next slide here, we have guidelines from the American Society of Hematology from last year. They published guidelines for the treatment of newly diagnosed AML in older adults. The guideline examined questions around the role of treatment for adults with AML and the intensity and length of treatment in this patient population. The general conclusion of the panel of experts was that for older adults, treatment is recommended over best supportive care and more intensive therapy is recommended over less intensive therapy when it is tolerable to the patient. Specific recommendations pertaining to patients who are not appropriate for intensive anti leukemic therapy but who are able to receive treatment include a recommendation of monotherapy over combination therapy. And lastly, the guidelines further note that when these patients choose combination therapy, there's evidence to support the use of LDAC in combination with venetoclax. Okay, so on the next slide here we have the subclasses by Apple Health Organization. And so for this, we have antineoplastic miscellaneous combination. And that includes Inqovi. We have hedgehog pathway inhibitors, oral and that includes Daurismo. Multikinase inhibitors, oral. That would be Rydapt or Ukoniq. TKIs, Tyosine Kinase Inhibitors and that has Bosulif, Brukinsa, Gleevec, Iclusig, Imatinib, Imbruvica, Sprycel, Tasigna, and Xospata. And lastly, retinoids oral, which is Tretinoin. Of these, the ones I have bolded are the ones that do have recent updated clinical information that I'll be sharing with the committee. So the first of three will be Inqovi. On the next slide, in August 2020, FDA approved Inqovi, a combination decitabine, which is a nucleoside metabolic inhibitor and cedazuridine, which is a cytidine deaminase inhibitor indicated for the treatment of adult patients with myelodysplastic syndrome, MDS, including previously treated and untreated de novo and secondary MDS with the following French American-British subtypes: refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blast, and chronic myelomonocytic leukemia and intermediate one, two, and high risk international prognostic scoring system groups. Now in terms of warnings and precautions, first one being myelosuppression. As one can imagine, fatal and serious myelosuppression infectious complications can occur with this medication. Obtained complete blood cell count prior to the initiation of treatment, prior to each cycle, and as clinically indicated to monitor for response and toxicity. Delay the next cycle and resume at the same or reduced dose as recommended. The next being embryo fetal toxicity. This

can cause fetal harm. Advise patients of the potential risks to a fetus and use of effective contraception. And lastly, drugs metabolized by cytidine deaminase. It is recommended to avoid coadministration with Inqovi. The dosage is one tablet taken orally once daily on days one through five of each 28 day cycle. In terms of availability, it is found in a tablet formulation of 35 milligrams of decitabine and 100 milligrams of cedazuridine. In terms of this medications for special populations, its safety and efficacy has not been studied in pediatric patients and there's no dosage adjustment required and mild to moderate hepatic impairment. And it has not been studied in severe hepatic or renal impairment. On the next slide, we have Iclusig. In December 2020 the FDA approved a new indication for the treatment of adults with chronic phase chronic myeloid leukemia with resistance or intolerance to two or more prior kinase inhibitors. As you can see, there are other indications here. This medication does have a black box warning along with other warnings and precautions. However, these are not new, and therefore are not highlighted here. The dosage for this new indication is 45 milligrams orally once daily, with a reduction to 15 milligrams once daily upon achievement of less than or equal to 1% BCR-ABL1IS. In terms of special populations, no safety or efficacy has been established in pediatric patients. Again, no dosage adjustment required in mild to moderate renal impaired patients and not studied in severe. In terms of hepatic impairment. There is dosage adjustment for patients with child Pugh score A, B or C.. On the next and final slide for this subclass, we have Ukoniq. In February 2021, the FDA granted accelerated approval to Ukoniq a kinase inhibitor for the treatment of adults with relapsed or refractory marginal zone lymphoma who have received one or more prior anti-CD20 based regimen or relapsed or refractory follicular lymphoma who have received three or more prior lines of systemic therapy. The indications are approved under an accelerated approval based on overall response rate. Continued approval for these indications may be contingent upon verification and description of clinical benefit in a confirmatory trial. In terms of warnings and precautions, infections being the first, it is important for clinicians to monitor for fever and any new or worsening signs and symptoms of infection. Evaluate promptly and treat as needed. Neutropenia monitor blood counts during treatment, diarrhea, noninfectious colitis. And lastly hepatic toxicity, which requires monitoring LFTs and hepatic function. The recommended dosage is 800 milligrams daily. And it is very important to manage toxicity using treatment interruption, dose reduction, or even discontinuation. And it is available in 200 milligram tablets. I'll go ahead and pause right there. We'll pivot over to oncology oral - breast. I did want to ask the committee if they

have any questions. I can pause under each subclass instead of waiting until the end.

Ginni Buccola: This is this is Ginni. Thanks Umang for offering that. Committee members, do you have any preference? I guess we'll just keep going, Umang.

Umang Patel: Okay, no problem.

Ginni Buccola: Thank you for pausing.

Umang Patel: No, that's okay. It selfishly it gave me a chance to get some water. Okay, the next being breast cancer on the next slide here. Breast cancer is the most common site of cancer for women in the United States, accounting for 30% of all cancer diagnosis and is second only to lung cancer as a cause of cancer death in American women. It is estimated that there will be 281,000 new cases of breast cancer diagnosed in the US in 2021. And there will be an estimated 43,000 deaths. The incidence of breast cancer in US women continues to increase by about .5% per year. Known risk factors that may be contributing to this increased incidence include a decline in fertility rates and an increase in body weight. Despite this increasing incidence, death rates from breast cancer have declined by 41% 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 localized disease have a 98.9% five year survival rate. However, prognosis for patients presenting with distant metastatic disease is much poorer with a five year survival rate of only 28.1%. Breast cancer is most frequently diagnosed in women between the ages 55 to 64 with a median age of diagnosis being 62 years. Rarely breast cancer may be diagnosed in men. Other risk factors include various endocrine, genetic, environmental, and lifestyle factors. And some of these risk factors are modifiable, some are not and the impact of these factors are variable. On the next slide here, we'll pivot over to the guidelines. In terms of neoadjuvant treatment of breast cancer, historically, the role for neoadjuvant chemotherapy was limited to breast cancer patients with inoperable locally advanced disease, but contemporary breast cancer treatment protocols now often include neoadjuvant therapy. There are several reasons for this expanded role of neoadjuvant therapy. First, it can increase the likelihood of patients being able to undergo breast conserving surgery. Second, studies have shown that patients with triple negative breast cancer and those with a HER2 positive disease who achieve a pathologic complete response defined as the absence

of invasive disease in the breast and lymph nodes following neoadjuvant therapy have an improved prognosis. And recently published research has focused on response to neoadjuvant treatment as a predictive marker any guide for selecting subsequent adjuvant therapy. In terms of the ASCO guidelines this year, regarding neoadjuvant chemotherapy, endocrine therapy and targeted therapy, the guidelines recommend neoadjuvant therapy with any of these modalities if the patient has inflammatory breast cancer or if the patient has unresectable or locally advanced disease at presentation such that the disease may be rendered resectable with neoadjuvant treatment. Furthermore, the guidelines state neoadjuvant systemic therapy should be offered to patients with a high risk TNBC in whom the finding of residual disease at the time of surgery would guide recommendations related to adjuvant therapy. Regarding neoadjuvant endocrine therapy, the guidelines state that postmenopausal patients with an HR positive or HER2 negative disease may receive a neoadjuvant aromatase inhibitor to increase local regional treatment options or if there's no intent for surgery, endocrine therapy may be used for disease control. However, for premenopausal patients with a HR positive HER2 negative early stage diseases, neoadjuvant endocrine therapy should not be routinely offered outside of a clinical trial. On the next slide here we have subclasses. So as you can see, here's an overview of all the subclasses for the Apple Health Organization. They consist of antineoplastics, miscellaneous combinations, which include Kisqali and Femara. We have cyclin dependent kinase inhibitors, I brands Kisqali and Verzenio. We have poly polymerase inhibitors such as Talzenna. And we have again TKI such as lapatinib, Nerlynx, Tukysa, and Tykerb. And again, we have two medications here with significant recent clinical information. The first on the next slide being Nerlynx. In August 2020, FDA approved for use in combination with capecitabine for the treatment of adult patients with advanced or metastatic HER2 positive breast cancer, who have received two or more prior anti-HER2 based regimens in the metastatic setting, already indicated as a single agent for the extended adjuvant treatment of adult patients with early stage HER2 positive breast cancer to follow adjutant trastuzumab based therapy. Again, this is an expanded indication, so no changes in the warnings or availability. And as you can imagine, due to different indications the dosing is stratified by indication. In terms of special population for this medication, safety and efficacy is not established in pediatric patients and there's no dose adjustment required in mild to moderate renal impairment. But there is a dose adjustment required for severe hepatic impairment. On the next and final slide we have Talzenna. In October 2020, FDA approved this medication for the use in patients with

severe renal impairment, defined as a creatinine clearance of 15 to 29 milliliters per minute. Just so one knows, the indications for this medication or treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated HER2 negative locally advanced or metastatic breast cancer. Select patients for therapy based on FDA approved companion diagnostic for Talzenna. No other changes. It is expanded to, as I mentioned, severely renally impaired patients. No changes to dosage or availability. I'll pause right there. We'll be going on to renal cell carcinoma, but I'll see if anyone has any questions.

Susan Flatebo: Yeah, hi, this is Susan. So back on your slide where you listed the various drug classes, you have the Tinzaparin under PARP inhibitors. But I believe Olaparib is also a PARP inhibitor that has the same medication that the Talzenna does for metastatic BRCA-mutated breast cancer. So shouldn't Olaparib or Lynparza also be in that category under PARP inhibitors?

Umang Patel: This is Umang. Give me one second. I'm just looking that up right now.

Susan Flatebo: Okay. I wasn't sure if this was -- because it was a newer agent out that you didn't include the other one.

Umang Patel: I believe Marissa may have stepped away. I think I saw a message. But I may need to confer with Marissa about this because I believe I pulled these from the specific Apple Health PDL. I can circle back and once I get a chance to look in there to see if I do see Lynparza listed on there. But I don't believe I did when I was creating these slides.

Marissa Tabile: Hey, Umang. This is Marissa. I'm back. Lynparza is included in the PARP inhibitors drug class. So we have Zajula, Lynparza, Rubaka, and Talzenna all in that inhibitors class.

Umang Patel: Okay, then then you are correct. It should be listed here. However, it wouldn't be bolded or reviewed as there was no significant information for that medication for I believe at least three years.

Susan Flatebo: Okay, sounds good. Thank you.

Umang Patel: Thank you. Okay. Hearing no other questions, we'll continue onward to renal cell carcinoma. On the next slide, cancers of the kidney and renal pelvis account for approximately 4% of all newly diagnosed cancers in the United

States, with a 5% incidence in males and 3% in females. The median age of diagnosis is 64 years, and over 75% of cases are diagnosed in patients 55 years of age or older. The overall five year survival for patients diagnosed with renal cell carcinoma was about 76% from the period of 2011 to 2017. If the disease is localized at the time of diagnosis outcomes are excellent with a five year survival of approximately 93%. However, patients diagnosed with advanced metastatic disease accounting for approximately 16% of diagnoses have much poorer outcomes with approximately 14% survival rate at five years. About 85% of kidney tumors are renal cell carcinoma and approximately 70% of all renal cell carcinoma have a clear cell histology. Other less common histologies are usually grouped together as nonclear cell tumors. The incidence of renal cell carcinoma in men is more than twice than that of women in the US. The most common presenting triad of symptoms include hematuria, flank mass, and flank pain. However, as the use of routine imaging has become more widespread, the frequency of incidental detection of RCC has increased and only about 30% of patients are now diagnosed on the basis of symptoms. On the next slide, we did have new guidelines this year from the NCCN. For first line systemic therapy of favorable risk clear cell histology relapsed or stage four renal cell carcinoma. The guidelines recommended TKI plus an immune checkpoint inhibitor as a category one preferred option. Specifically, Inlyta plus Keytruda or [indistinct] plus Obdivo or Lynvima plus pembrolizumab are the three TKI CPI regimens included. Other recommended regimens for the same group of patients include monotherapy with Sutent, Votrient, or Inlyta plus [indistinct]. Axitinib monotherapies and NCC and category 2B recommendation listed as useful in certain circumstances. For the same group of patients with poor or intermediate risk rather than favorable risk, the same three TKI/CPI regimens are listed as category one preferred along with single agent [indistinct] being a category 2A preferred option. Other options for these patients with poor or intermediate risk largely mirror the favorable risk options defined above. For subsequent therapy of RCC with clear cell histology category one preferred options include [indistinct] plus Affinitor. Additional options include axinitinib as either a single agent defined as a category one or in combination with pembrolizumab category 2A. [indistinct] plus nivolumab, Lenvatinib plus pembrolizumab or single agent [indistinct] as a single agent is included as a category 2A, useful in certain circumstances. For patients with nonclear cell histology single agent [indistinct] are all category 2A recommendations, though [indistinct] and sunitinib are the preferred regimens. Importantly, sorafenib is now only indicated in the NCCN guidelines as a category 3 recommendation for subsequent therapy

that may be useful in certain circumstances. Now, on the next slide here, we have the subclasses here broken down into the MTOR kinase inhibitors, the multi-kinase, inhibitors and the TKIs. For the MTOR kinase inhibitors, we have Afinitor and Everolimus. Then we have for the multi kinase inhibitors, we have Fotvida, Nexavar, and Sutent. And for the TKIs we have Cabometyx, Inlyta, Lenvima, and Votrient. And so we'll move on to the first of the four medications that were bolded there, Inlyta. In June 2020, there was a new indication in combination with avelumab or pembrolizumab for the first line treatment of patients with advanced renal cell carcinoma. Previously approved as a single agent for the treatment of advanced renal cell carcinoma after failure of one prior systemic therapy. As you can see, they already had a list of other indications. There are no updates to the warnings and precautions of their cardiac failure, hypertension and hypertensive crisis, VTEs or embryo fetal toxicity. The dosage for this medication is stratified by indication. And the availabilities are unchanged as well by this expanded indication. There's no safety or efficacy data for pediatric patients. And those studies are conducted for renally impaired patients. For patients who do have moderate hepatic impairment, there is a dose adjustment that is recommended for this medication. On the next slide, we have Fotivda. In March 2021, FDA approved this medication for the treatment of adults with relapsed or refractory advanced renal cell carcinoma, following two or more prior systemic therapies. The warnings and precautions are very similar with cardiac failure, hypertension/hypertensive crisis, VTEs and embryo fetal toxicity. The recommended dose here being 1.34 milligrams once daily with or without food for 21 days on treatment, followed by seven days off treatment. And this is a 28 day cycle until disease progression or unacceptable toxicity. It is available in capsule form being 1.34 milligrams or .89 milligrams. Similar to the previous medications, safety and efficacy has not been established in pediatric patients. There's no dosage adjustment needed in renally impaired and if patient has hepatic impairment, it is recommended to adjust the dosage in patients with moderate hepatic impairment and to avoid in patients with severe hepatic impairment. The next slide here, in terms of a new generic, sorafenib. In September 2020 the FDA approved sorafenib by Mylan as the first AB rated generic for Nexavar. And in terms of Cabometyx or Opdivo, in January 2021, FDA approved expanded indication for Cabometyx and Opdivo for use in combination for first line treatment of patients with advanced renal cell carcinoma. On the next slide, we'll pivot over to skin cancer. I'll pause there for any questions. Hearing none, I'll continue onwards to skin cancer. On this slide, we have an overview of subclasses by Apple Health Organization for what we define as

skin cancer. This includes the BRAF kinase inhibitors such as Braftovi, Tafinlar, Zelboraf. We also have the hedgehog pathway inhibitors, which is Erivedge and Odomzo. And lastly the MEK inhibitors, which is Cotellic, Mekinist, and Mektovi. In this class with these three sub classes, there were no significant clinical updates within the last year in this class. So we'll pivot right over to the next cancer class, which is lung cancer. Again, pause there for any questions for skin cancer. On the next slide, we have a little bit of an overview. So lung cancer is the leading cause of cancer death in both men and women in the US. In 2021, an estimated 235,000 new cases of lung cancer will be diagnosed and 131,000 deaths are estimated to occur. Currently, the five year survival is estimated to be 21%, an increase from 18%. Declines in lung cancer mortality in the US have been accelerating in recent years. From 2009 through 2013, lung cancer mortality declined at 2.4%. From 2014 through 2018, this decline more than doubled, resulting in a 5% decline. Additionally, there have been a steady decline in the incidence of lung cancer diagnoses in the US. The number of diagnosis declined 2.3% in the most recent measurement. And despite these encouraging trends, there are still more US lung cancer deaths annually than deaths from breast, prostate, and colorectal cancer combined. The primary risk factor for the development of lung cancer is smoking tobacco, accounting for approximately 85 to 90% of all cases of lung cancer. The carcinogenic chemicals in cigarette smoke are responsible for most lung cancer related deaths while exposure to secondhand smoke also results in an increased relative risk of developing lung cancer. While chemo prevention agents are not yet established, lung cancer screening using low dose computerized tomography is recommended by the US Preventive Services Task Force, who expanded their lung cancer screening guidelines in 2021. The guideline is now recommended annual screening for patients 50 to 80 years of age who are current smokers with at least a 20 pack year smoking history and former smokers who have quit within the past 15 years. On the next slide. In terms of guidelines, so EGFR sensitizing mutations. The guidelines have been updated to incorporate the use of Tagrisso an adjuvant setting of earlier stage non-small cell lung cancer. The guidelines recommend the use of Tagrisso for patients with stage 2B or 3A disease who have undergone complete resection or for patients with high risk stage 1B or 2A EGFR mutation positive disease who received previous adjuvant chemotherapy or are ineligible to receive platinum based chemotherapy. This year, the ASCO in the Ontario Health Cancer Care Ontario guidelines stated regarding stage four non-small cell lung cancer with driver mutations, they indicate that Osimertinib should be offered in the first line setting for patients with the

following mutations: T790M, L858R, or exon 19 deletion EGFR mutations. If Osimertinib is not available in the first line setting, gefitinib with chemotherapy or dacomitinib may be offered. Other options listed by the guidelines include afatinib or erlotinib and bevacizumab; erlotinib and ramucirumab; or gefitinib, erlotinib, or icotinib, not available in the US, as single agents. In terms of BRAF V600E point mutations, for patients with advanced metastatic lung cancer who are found to have BRAF V600E mutations, a combination of dabrafenib, which is Tafinlar plus Mekinist is recommended as preferred first line therapy by NCCN, while single agent vemurafenib may be an option if the combination is not tolerated. According to the ASCO guidelines, patients with stage four non-small cell lung cancer and BRAF V600E mutations should be offered the combination in the first line setting. For patients who receive targeted therapy in the first line setting, second line therapy should consist of standard non driver mutation guideline recommendations. Continuing on with guidelines on the next slide, we have MET exon 14 skipping mutations. Both Tabrecta and Tepmetko are listed as NCCN category 2A preferred options. While Xalkori is classified as category 2A, useful in certain circumstances recommendation. ASCO guidelines recommend offering capmatinib or tepotinib in the first line setting. And if the patient does not receive one of these therapies in the first line setting, they may be offered in the second line. In terms of ALK rearrangements, ASCO 2021 updated guidelines regarding patients with stage four non-small cell lung cancer who harbor an ALK rearrangement recommend that alectinib or brigatinib be offered in the first line setting. The guidelines recommend that if either of these medications are not available, patients should be offered a ceritinib or crizotinib. The guidelines also outline drug choices for the second line setting. Lorlatinib in the second line setting is recommended if the patient received alectinib, brigatinib, or ceritinib in the first line setting. If the patient received crizotinib in the first line setting then alectinib, brigatinib, or crizotinib can be offered. And in the third line setting, lorlatinib may be offered. Moving to ROS1 rearrangement mutations, ASCO guidelines recommends crizotinib or entrectinib in the first line setting. Other options include certinib or lorlatinib. And if targeted therapy was given in the first line setting than ASCO recommends that the standard treatment based on non-driver mutation guidelines should be followed. Moving onward to the mutations. On the last slide of the mutations we have RET rearrangements. Both Gavreto and Retevmo are listed as NCCN category 2A preferred first line options. The guidelines state that selpercatinib or standard therapy based on non-driver mutation guidelines may be offered in the first line setting. At the time of the ASCO publication,

prelsetinib recommendation in the first line setting was provisional pending confirmatory data. And recommendations for second line setting for RET rearrangements are dependent on the therapy received in the first line. If targeted therapy with prelsetinib or selpercatinib were not given in the first line setting, they may be offered a second line therapy. And lastly, we have NTRK fusions. Both Rozlytrek and Vitrakvi are NCCN category 2A preferred options in the first line setting. ASCO guidelines also recommended entrectinib or Larotrectinib in this setting. And these drugs also may be offered in second line setting for patients with NTRK gene fusions who did not receive them in the first line setting. Okay, on the next slide, we have the subclasses by Apple Health Organization that fall under lung cancer. First being multi kinase inhibitors and that medication being Tepmetko. We have topoisomerase inhibitors such as Hycamtin. Tropomyosin receptor kinase inhibitors, Razlytrek. We have TKIs. And the main ones we'll be focusing there are Gavreto, Lorbrena, Tagrisoso, and Xalkori. Moving to the first medication, we have Gavreto. In September 2020, FDA approved Gavreto, kinase inhibitor indicated for the treatment of adult patients with metastatic RET fusion positive non-small cell lung cancer as detected by an FDA approved test. Continued approval may require a demonstration of benefit in confirmatory clinical trials. Patients should be selected for treatment based on the presence of an RET gene fusion. Additionally, in December 2020, FDA granted accelerated approval for new indication for adult and pediatric patients 12 years of age or older with advanced or metastatic RET mutant medullary thyroid cancer who requires systemic therapy and adult and pediatric patients 12 years of age or older with advanced or metastatic RET fusion positive thyroid cancer who require systemic therapy and who are radioactive iodine refractory. The dosing on this for adults and again pediatric patients 12 years of age or older is 400 milligrams once daily. I apologize for the warnings. There is warnings for interstitial lung disease or pneumonitis, hepatic toxicity, embryo fetal toxicity, and pediatric use. And this medication is available in 100 milligram capsules. On the next slide here we have Tagrisso. In December 2020, a new indication was approved for the use as adjuvant therapy for tumor resection in adult patients with non-small cell lung cancer whose tumors have epidermal growth factor receptor exon 19 deletions or exon 21 L858R mutations as detected by an FDA approved test. Again, it does have additional indications. No changes to warnings and precautions or dosage and the availability are 80 and 40 milligrams here. This medication, the safety and efficacy has not been established in pediatric patients and there is no dose adjustment for renal or hepatically impaired patients. Continuing onward we have Xalkori where in January 2021, FDA

approved a new indication in pediatric patients one year of age or older and young adults with relapsed or refractory systemic anaplastic large cell lymphoma, that is anaplastic lymphoma kinase positive. Its safety and efficacy have not been established in older patients with relapsed or refractory systemic ALK positive ALCL. It was already approved for metastatic non-small cell lung cancer whose tumors are ALK or ROSS1 positive as detected by an FDA approved test. Similar to the previous medication, this medication has additional indications but no changes to those or the warnings and precautions. In terms of the new systemic ALCL, the recommended dose is 280 milligrams per meter squared orally twice daily. And there's no adjustment in the availability as well. Okay, continuing to the next slide here we have Tepmetko. In February 2021, FDA granted accelerated approval for Tepmetko, which is a kinase inhibitor indicated for the treatment of adults with metastatic non-small cell lung cancer harboring mesenchymal epithelial transition exon 14 skipping alterations. Again, the syndication is approved under accelerated approval based on the overall response rate and duration. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. Very similar warnings and precautions such as interstitial lung disease and pneumonitis, hepatic toxicity, so it is important to monitor LFTs, and embryo-fetal toxicity. The dosage is 450 milligrams once daily with food until disease progression or unacceptable toxicity and it is available in 225 milligram tablets. In terms of additional populations, it is safety and efficacy has not been studied in pediatrics, and no dose adjustments for renal or hepatically impaired patients. On the next slide for the lung cancer class, we have Lorbrena. In March 2021, the FDA approved indication was expanded from the initial accelerated approval for use in the second or third line setting to the following full approval. The treatment of adults with metastatic non-small cell lung cancer whose tumors are anaplastic lymphoma kinase, or ALK positive, as detected by an FDA approved test, patient should be selected for treatment of metastatic non-small cell lung cancer based on ALK positivity in tumor specimens. In terms of warnings and precautions, there is a risk of serious Hepatotoxicity with concomitant use of strong CYP3A inducers. Similarly, interstitial lung disease and pneumonitis warning exists here as well, along with embryo fetal toxicity. The recommended dose for this medication is about 100 milligrams orally daily and there's a dose reduction for patients who are severely renally impaired. And the availability being in 25 or 100 milligram tablets. I'll go ahead and pause right there to see if there's any questions before moving on. Okay, hearing none, we'll continue on to the next class. Magellan

health defines this class as other oncology medications. And the other is due to the large quantity of subclasses. The background and various guidelines won't be reviewed but they can be found in the TCR that's on the SharePoint. Under other, some of the oncology classes that fall under here are bladder cancer, central nervous system cancer, colon geo carcinoma, colon cancer, epithelioid sarcoma, follicular lymphoma, gastric cancer, GI stromal tumors, hepatocellular carcinoma, neuro fibro mitosis, ovarian cancer, pancreatic cancer, prostate cancer, soft tissue sarcoma, and thyroid carcinoma. So on the next slide here, we have all the subclasses by Apple Health Organization. And we have anti neoplastic or miscellaneous combinations being Lonsurf. We have FGFR kinase inhibitors, which include Balversa, Permazyre, and Truseltiq. We have MEK inhibitors, being Koselugo. Multi kinase inhibitors being Stivarga. PARP inhibitors such as Lynparza, Rubraca, and Zejula. Tropomyosin receptor kinase inhibitors such as Vitrakvi. And Tyrosine kinase inhibitors such as Ayvakit, Caprelsa, Cometriq, Qinlock, and Turalio. On the next slide, we have Tazverik here. So in June 2020, FDA approved Tazverik for the treatment of adults with relapsed or refractory follicular lymphoma, whose tumors are positive for an EZ H2 mutation, as detected by an FDA approved test, and who have received two or more prior systemic therapies, as well as for the treatment of adults with RR follicular lymphoma who have no satisfactory alternative treatment options. Both indications of follicular lymphoma are approved based on accelerated approval and continued approval may be contingent on results of additional clinical trial data. As you can see, this medication does have other indications and no changes to those indications or their warning such as secondary malignancy and embryo fetal toxicity. The recommended dosage is 800 milligrams twice daily and it is available in 200 milligram tablets. In terms of patients who have hepatic or renal impairment, there is no dosage adjustment here. On the next slide, we have Qinlock. In July 2020, FDA approved Qinlock, which is a TKI indicated for the treatment of adults with advanced gastrointestinal stromal tumor who have received prior treatment with three or more kinase inhibitors including imatinib. In terms of warnings and precautions, Palmar-Plantar Erythrodysesthesia Syndrome, new primary cutaneous malignancies. Hypertension and embryo fetal toxicity do exist with this medication. The recommended dosage is 150 milligrams once daily, with the availability being in 50 milligram tablets. The safety and efficacy have not been established in pediatric patients and there are no dosage adjustments required for hepatic or renal impaired patients. On the next slide we have Truseltiq. In June 2021, FDA granted accelerated approval for this medication which is a kinase inhibitor for adults with previously treated

unresectable locally advanced or metastatic cholangiocarcinoma with the fibroblasts growth factor receptor 2 fusion or other rearrangement as detected by an FDA approved test. The presence of an FGFR2 fusion or rearrangement should be confirmed before starting therapy. Again, warnings include hyperphosphatemia and soft tissue mineralization and embryo fetal toxicity as well. In terms of dosage, it is necessary to confirm the presence of an FGFR2 fusion or rearrangement prior to the initiation of treatment and the recommended dose is 125 milligrams orally once daily for 21 consecutive days followed by seven days off therapy in a 28 day cycle and is available in 25 and 100 milligram capsules. Similar to the predecessor medications in this subclass, safety and efficacy has not been established in pediatric patients and there is dosage adjustment for mild to severe hepatic impairment and mild to moderate renal impairment. On the next slide here we have Ayvakit, where in June 2021, FDA approved an expanded indication for the treatment of adults with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm and mast cell leukemia. As you can see it already had an indication for gastrointestinal stromal tumor. There's no changes to the warnings and precautions such as intracranial hemorrhage or embryo fetal toxicity. And the dosing for this new indication that Ayvakit has received is 200 milligrams orally daily with various availabilities from 25, 50, 100, 200, 300 milligrams. Again, safety and efficacy has not been established in pediatric patients. No dosage adjustment needed in hepatic or renally impaired patients. On the next and final slide here, just miscellaneous but yet still relevant information for the committee. First is a new diagnostic medication, Vitrakvi. In October 2020, the FDA approved a companion diagnostic for Vitrakvi. The companion diagnostic is a next generation sequencing based foundation 1 CDX test that can be used to identify fusions in neurotrophic receptor tyrosine kinase genes, ,NTRK1, 2, and 3 in DNA isolated from tumor tissue specimens from patients with solid tumors eligible for treatment with Larotrectinib. In October 2020, as well, regarding Rubraca, the PA was updated to instruct to select patients for metastatic castration resistant prostate cancer therapy based on FDA approval companion diagnostic. If result is negative for BRCA mutation, consider further genomic testing using tumor specimens. And lastly, there being a REMS update for Turalio. In February 2021, the REMS documents were updated to list GGT, ALP elevations and direct bilirubin elevations as a trigger for liver adverse event reporting suggestive of serious and potentially fatal liver injury and to align with the product label. I'll go ahead and pause right there and see if there's any questions.

Alex Park: Hi, Umang. It's Alex here. Can I ask about two drugs? I'm just trying to figure out where certain of these new drugs that you discussed fit into the Apple Health rubric, the Tazverik, I can't figure out which category that goes into. And then the new prostate cancer drug, the GNRH antagonist, I can't figure out where that goes into.

Umang Patel: Okay. So Tazverik is for advanced epithelioid sarcoma not eligible for complete resection. And as I stated before, Apple Health PDL is broken down essentially by mechanism, not disease state specifically, whereas Magellan does it by disease state. And so I think that's why we had it under other whereas Apple Health would just have it by its mechanism, which I'm trying to pull up.

Marissa Tabile: Hi, Alex, this is Marissa. I'm looking at our PDL right now and it looks like Tazverik doesn't have the Apple Health preferred drug list class assigned yet. So that will need to be updated. That will probably need to be added. Which class it would be, I'm not quite sure. I would need to make that determination. But thank you for pointing that out because that is definitely something we would want on the PDL

Alex Park: Yeah okay. I was searching in the excel sheet that you guys attached. That and the prostate drugs were the only ones I couldn't find.

Marissa Tabile: What was the name of the other one, Alex?

Alex Park: Orgovix.

Marissa Tabile: So it looks like Orgovix is on the oncology agents gonadotropin releasing hormone receptor antagonists oral drug class on the AH PDL.

Alex Park: Okay. Does that class include drugs like leuprolide and the other ones?

Marissa Tabile: Let me double check, I believe the leuprolide, yeah, so that's the only product in that class. I believe the leuprolide is in another class. I don't have off the top of my head, which class that is. But I do know that that is on our AH PDL. It's just in another class.

Alex Park: Okay. Today the motion's going to say androgen biosynthesis inhibitors and then anti androgens. So this new drug wouldn't be part of either of those categories then?

Marissa Tabile: No. Let me double check which class. No, it wouldn't be in any of those classes. But I don't know. I would have to double check if it's scheduled for a future meeting because we do break up the oncology classes. I believe we reviewed some last meeting. And I don't know. We might have some reviewed for the next meeting in October. So it could fall under those classes that either have already been reviewed or are scheduled to be reviewed.

Alex Park: Okay. Sounds like it's either come up or going to be coming up.

Marissa Tabile: Exactly. Yep.

Umang Patel: And Alex, this is Umang. Just to kind of pivot on the question you had about leuprolide. The subclass of Apple Health PDL is luteinizing hormone receptor analogues. So it's yes for prostate cancer but in the Apple Health, PDL, it's just a different subclass based on mechanism.

Kavita Chawla: Kavita here. To kind of piggyback on what Alex just asked, there were a couple of ones that I couldn't find either on our PDL and Umang didn't list them -- he listed them as first line for the specific cancer. So one was the [indistinct] sarcoma. I couldn't find it anywhere on the PDL.

Marissa Tabile: Hi, this is Marissa. So the Pomalyst is actually in the immune modulators thalidomide analogs. So the PDL that you guys got, the Excel spreadsheet only includes the classes that are being reviewed at this meeting. So you don't have the complete, comprehensive PDL. It's just for the classes that we'd be reviewing. So that's probably why you may not find it, but we do have that on our AH PDL. Just in different class.

Kavita Chawla: Okay, so could you also confirm one more for me, Marisa? Keytruda.

Marissa Tabile: Keytruda is not assigned to any AH PDL class. It looks like the reason why that's not included on the PDL is because it's an IV drug. So typically, we only include oral or maybe subcutaneous formulations or products that have that route of administration on the PDL. If it's an IV, it's on a case by case basis. But typically, we don't include those on the PDL. So it is not included on the PDL at this time.

Kavita Chawla: And if it's not included on the PDL, does that mean that it is not one of the options that patients would have on Medicaid or what does that mean?

Marissa Tabile: It is still one of their options. It would just be billed through the medical benefit. So any request that we get would be really more on the medical side. Drugs that are included on the Apple Health PDL, you'll typically see come through like a pharmacy point of sale service. So that's really kind of the key difference. So even though it's not included on the PDL it most likely if anything will probably be covered on the medical benefit. So it is still an option. It is still available for patients.

Kavita Chawla: Thank you. That distinction is helpful.

Leta Evaskus: This is Leta. Ginni, are you on?

Ginni Buccola: I am here. My apologies.

Leta Evaskus: Okay, we do have two stakeholders.

Ginni Buccola: Yes, I see Marjan Massoudi and Amy Stanford. So Marjan, when you are unmuted, then you will have three minutes to speak and just as a reminder to our stakeholders, if you can go ahead and give us your affiliation with any pharmaceutical company. Thank you.

Marjan Massoudi: Thank you. Yes, I'm Marjan Massoudi. I'm Senior Director of field health economics and outcomes research at Beigene and I'm going to provide public comment on Brukinsa or zanubrutinib, which is a Bruton's tyrosine kinase inhibitor indicated for the treatment of adult patients with mantle cell lymphoma, who've received at least one prior therapy. This indication is approved under accelerated approval based on overall response rate. I'll review some of the recent updates first with the NCCN treatment guidelines inclusion of zanubrutinib. The first one is for mantle cell lymphoma. So zanubrutinib has been included as a second line therapy option for mantle cell lymphoma in the guidelines and this is a category 2A recommendation consistent with other BTK inhibitors for this indication. And then next we have inclusion for a chronic lymphocytic leukemia and small lymphocytic lymphoma. And the NCCN version four point 2021 was updated to reflect the addition of zanubrutinib. And so zanubrutinib was added for patients regardless of deletion of 17P or TP53 mutational status and was added to the

second line option for patients with intolerance or contraindication to other BTK inhibitors as a category 2A recommendation. And then also for patients with the del 17P or TP53 mutations, zanubrutinib was added as a first line options for patients with the similar contraindication again as a category 2A recommendation. Third, we see addition of zanubrutinib for marginal zone lymphoma. So the NCCN updated it in version four point 2021 to reflect the addition of zanubrutinib and it's now listed as a category 2A recommendation as an alternative to ibrutinib, which is the preferred regimen in the second line and subsequent lines of therapy. And [indistinct] follows consider alternate BTKI acalibrutinib or zanubrutinib patients with intolerance or contraindication to ibrutinib. And fourth, we see inclusion for Waldenstrom macroglobulinemia and the NCCN updated its guidelines for inclusion here as a category 1 recommendation for both primary therapy and therapy for previously untreated Waldenstrom. We also finally see that there was supplemental NDA acceptance for both Waldenstrom and for marginal zone lymphoma. So Waldenstrom, the the Paducah date is October 18 of 2021. And for marginal zone, it is September 19, 2021. And note that we don't currently have these indications. So thank you so much for your consideration and time.

Ginni Buccola: Thank you, Marjan. Are there any questions from the committee? I see that our next stakeholder is Amy Stanford with Pfizer.

Amy Stanford: My name is Amy Stanford. I'm a pharmacist with Pfizer oncology medical affairs. I'm here to provide the committee with updated efficacy and safety information for Ibrance, the first oral CDK46 inhibitor. Ibrance is indicated for the treatment of adult patients with HR positive HER2 negative advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine based therapy in postmenopausal women or in men, or with fulvestrant in patients with disease progression following endocrine therapy. In Paloma 2 a phase three trial of postmenopausal women with ER positive HER2 negative metastatic breast cancer treated in the first line setting, Ibrance plus letrozole demonstrated median PFS of 24.8 months versus 14.5 months with placebo plus letrozole. Hazard ratio was .58, 95%confidence interval of .46 to .72. Overall survival data was not mature at the time of the final PFS analysis for that study. In Paloma three of phase three tribal women with HR positive HER2 negative metastatic breast cancer whose disease progressed following endocrine therapy, Ibrance plus fulvestrant demonstrated median PFS of 9.5 months versus 4.6 months with placebo plus fulvestrant. Hazard ratio was .46, 95% confidence interval was .36 to

.59. In the final analysis the secondary endpoint of OS was 6.9 months longer in patients treated with Ibrance plus fulvestrant versus placebo plus fulvestrant. Median OS was 34.9 versus 28 months respectively. Hazard ratio was .814, 95% confidence interval was .64 to 1.029. This did not reach statistical significance. In a post hoc analysis of updated OS with longer follow up, patients treated with Ibrance plus fulvestrant still demonstrated a numerically longer median OS versus placebo plus fulvestrant. Median OS was 34.8 versus 28 months respectively. Hazard ratio was .81 with the 95% confidence interval of .65 to .99. Neutropenia was the most frequently reported all grade adverse reaction in Paloma two and Paloma three trials. 80 and 83% respectively. Febrile neutropenia has been reported in 1.8% of the patients exposed to Ibrance across the trials. One death due to neutropenic sepsis was observed in the Paloma three trial. Severe life threatening or fatal interstitial lung disease [indistinct] pneumonitis can occur in patients treated with CDK46 inhibitors including Ibrance. Ibrance can cause fatal harm. Advise patients of potential risk to the fetus and use effective contraceptive. For the full side effect profile, please view the complete prescribing information. And with that, in conclusion, Ibrance is an oral inhibitor of CDK46. Thank you so much for your time and attention to provide testimony this afternoon.

Ginni Buccola: Thank you very much, Amy. Committee, do you have any questions? And are there any other stakeholders?

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

Ginni Buccola: Okay, thanks. So we'll go to the motion.

Michael Corsilles: This is Michael Corsilles. I move that all products in the drug classes listed on slide 16 and 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 non-preferred products require a trial of two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Leta Evaskus: Hi, Michael. This is Leta. Sorry, I had to update the slide numbers to 18 and 19 since that other motion was added in. So just noting for the record that the slide numbers are 18 and 19.

Susan Flatebo: This is Susan Flatebo. I second the motion.

Ginni Buccola: And this is Virginia Buccola, committee chair. All those in favor, say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. We have on the agenda a break here. I just want to check in with Leta and everybody else around timing.

Leta Evaskus: Yeah, this is Leta. We were going to break at 2:30. We came back at 12:20 so it's up to you guys if you feel like you want a break now or if you want to wait another hour.

Ginni Buccola: I'm up for waiting. How does everybody else feel?

Leta Evaskus: Keep going? Okay, I'm going to stop sharing my screen and Marissa, you can take over.

[unrelated discussion]

Marissa Tabile: Okay, so good afternoon, DUR board. This is Marissa. I will be going through the GLP-1 agonist policy that we have drafted today. So just to give you some background, we didn't go over GLP-1 agonist in any of the drug reviews so I'll be giving a pretty high level overview, just a really brief overview of the background of these. So glucagon-like peptide 1 GLP-1 receptor agonists are a class of medications that are indicated for the treatment of type two diabetes. GLP-1 agonists worked by mimicking the functions of natural incretin hormones in the body that help lower post meal blood sugar levels and it is a noninsulin medication. So this policy that you see before you was really created to help guide patients to an equally effective, less costly alternative. So currently, on our Apple Health PDL, we do have Victoza and Byetta preferred without prior authorization. So this policy really only applies to the nonpreferred GLP-1 agonists that are currently on the Apple Health PDL. So I'll go through the policy now. So we did change a little bit of language for our policies you'll see in upcoming meetings. So instead of listing the indications here in the medical necessity box, they'll all be on the side in the actual criteria itself. And we have updated the policy now to just say GLP-1 agonist, or whatever drug class may be considered medically

necessary in patients who meet the criteria described in the clinical policy below. And then I have also added a note here for this policy that it only applies to really the non-preferred products in the Apple Health PDL, like I said before, and then the link is here as well. So getting into the criteria for the nonpreferred GLP-1 agonist. The criteria is pretty straightforward. One, they would just need a diagnosis of type two diabetes, the patient is 18 years of age or older, the documentation of their hemoglobin A1C or HBA1C is greater than 6.5%. And it's measured within the past 12 months. And the last criteria is history of failure defined as inability to achieve glycemic control, intolerance, contraindication, or clinically inappropriate to all of the following listed below. And those medications can be used separately or simultaneously for a minimum of 90 days. So the four medications essentially that we would want patients to really try are Metformin at the maximum or highest tolerated dose, a preferred SGLT2 inhibitor, one preferred DPP4 inhibitor, and then of course, one of the preferred GLP-1 agonists that we have on the PDL. And this and right here, I apologize is a mistake that should be removed. So looking at the criteria, if they meet all that criteria, the request will be approved for 12 months. We do have our blanket statement here that if the clinical reviewer sees that they don't meet the criteria, but in their professional judgment, these products, the nonpreferred GLP-1s can still be approved on a case by case basis. And then the reauthorization criteria is pretty simple. It's just documentation showing that their A1C is improved from baseline. And if it's reauthorized, it will be approved for an additional 12 months. And then we have the same case by case statement below. And here are the quantity limits for those GLP-1s. And then the references. And then I will go ahead and move over to the forms. Let me pull that up. So this is the form much like the other forms you've seen at previous meetings to help click the providers when they're doing prior authorizations for these medications. Same demographic information up here. Their information, medication and strength directions, quantity day supply, asking if it's a continuation of existing therapy. We asked for their A1C at baseline, what's their diagnosis. And then here for four, we have the section where the provider will list out all of the tried and failed medications that the patient has tried before. So I'll go ahead and stop here for any questions from the board.

Nancy Lee: Hi, Marissa, this is Nancy. I was wondering. I know you put the generic semaglutide? Where would Wigovi Fit in? Would it fall under here or would it fall under a different policy? Is it in here?

Donna Sullivan: Is that the one that was recently approved for weight loss?

Marissa Tabile: Yeah, but it's still semaglutide. It's just under a new name.

Donna Sullivan: We don't cover weight loss medication. So it's a non-covered. benefit.

Marissa Tabile: Got it. Okay, I just wanted to clarify that because it's still a GLP-1.

Donna Sullivan: And it's marketed under a different brand name, and I think it's even a different strength.

Marissa Tabile: Yes, correct.

Nancy Lee: Okay, thank you.

Kavita Chawla: Kavita here. I just had a more of the top part of the form, which is common to all forms, a general question about that. I've never seen a pharmacy NPI number. Is there a reason that that is usually requested or that providers are supposed to know that?

Amy Irwin: Hi, this is Amy from pharmacy section. This form is specific to the fee for service program. And so our process works slightly different than some of the other payers where we've actually had a claim rejected and we send this form directly out to the provider. So we do have a claim already. And we populate that information already with the pharmacy's NPI and things like that. So it's not that the prescriber is expected to have that information. We have it because we're basing that off of our claim that we've already received.

Kavita Chawla: Okay, thank you.

Michael Corsilles: Hi, Marissa, this is Michael Corsilles. I had a question on the clinical policy. I might be reading it wrong. But it says for the four criteria for the number four, history of failure, it says use separately or simultaneous for a minimum of 90 days. So is this saying that they have to try the medication for 90 days? What if they have adverse reactions and something like that right from the get-go?

Marissa Tabile: Yeah. Hi, this is Marissa. So Michael, if they have an adverse reaction to that medication, then that can still be reviewed on a case by case basis. So that's kind of where that statement goes in. Of course, we would take that into

consideration. So if they have an adverse reaction to Metformin and they didn't take it for the 90 days then we wouldn't hold that against them because they didn't tolerate it or they had some kind of contraindication to that medication.

Catherine Brown: Hey, Marissa, this is Catherine. Is there a separate policy for pediatric patients?

Marissa Tabile: Hi, this is Marissa. I didn't drop the policy specifically for pediatric patients.

Catherine Brown: Okay, because I know at least one or more of them are approved for the 10 to 17 age group.

Marissa Tabile: Okay. I didn't see that in my review. I might have missed it. Do you happen to know which ones off the top of your head?

Catherine Brown: Victoza is the one I'm thinking of off the top, That may not be the only one.

Donna Sullivan: Marisa, maybe we can go back and make sure that we have the right patient ages in here.

Marissa Tabile: Okay, I can't do that.

Leah Marcotte: This is Leah. I have a question if you can scroll down. So this is requiring 90 days of all A through D. I'm just wondering the decision with the DPP-4 inhibitor, just because they have fairly inferior evidence in terms of diabetes outcomes as compared to both GLP-1 and SGLT-2. So understanding that liraglutide is preferred and does not require prior auth but I can definitely think of situations where I would want to have someone on a GLP-1 instead of a DPP4 in the case that they didn't tolerate liraglutide for whatever reason. Just curious about conversations and discussions about including DPP4s.

Marissa Tabile: Yeah, hi, Leah. This is Marissa. So I included DPP-4s just because when I was looking at the guidelines, it wasn't not recommended that they be used. And like you said, they still do help with diabetes treatment. So I did include it just to be all inclusive of those. And we do have some equally effective, less costly DPP-4s that are approved that I think patients could try. So that was really the rationale of why I included DPP-4s in the criteria. But of course, to piggyback off of what Michael said, if a patient does have some kind of adverse reaction to them or any of the products that I listed in A through D, if

they don't work then we could offer exceptions or it could still possibly be approved on a case by case basis if they have some adverse reaction to some of these other products or the ones that I listed.

Leah Marcotte: Okay, thanks. Especially the SGLT-2s and the GLP-1s, a lot of considerations in terms of comorbidities, where some of these agents are such more favorable outcomes that I'd maybe just like to consider striking the DPP-4 just because it seems like a hurdle substantive benefit. I only use DPP-4s in practice when I can't use an SGLT-2 or GLP-1. And so I don't know. I welcome other people's experience too. But in this setting, I just think that the evidence behind GLP-1s and SGLT-2s are just so much better that it may be worth considering taking out the hurdle of the DPP-4. Again, I'm okay with it because there is a preferred GLP-1 and people can prescribe liraglutide without the prior auth. But I'd be curious to hear others' impressions and experience with that.

Nancy Lee: This is Nancy. I would concur with your observation and comments that the DPP-4, blood sugar lowering effects are not as good. And if they're already on a GLP-1, they require, in practice, something that provides more than what a DPP-4 can provide. And so having to select the DPP-4, which is really not going to do a whole lot, just I think further hinders the processes from clinical practice perspective. I mean, it is an option and it is in the guidelines. But if you're going to a GLP-1, the A1C lowering of GLP-1 is definitely greater than a DPP-4 can offer.

Kavita Chawla: Kavita here. I would third that motion. I really end up using DPP-4s if there is just not possibility of getting GLP-1 and SGLT-2 because of the inferior performance. And separately, I heard Donna state that obesity treatment is not something that is a covered benefit, I think was the term you used. But I'm almost wondering - and this is more just for discussion - is there a way to put in language here that if we know that semaglutide's effect in lowering weight is far superior to liraglutide's. And so is there any way we can frame the language here that even if the A1C is okay but we are just not getting enough weight lowering, just because the obesity's so significantly associated with diabetic outcomes, whether that could be a reason to get the semaglutide authorized. So it's not specifically, A1C hasn't been lowered enough. But it's that there hasn't been adequate weight loss along with the A1C achieved.

Nancy Lee: And this is Nancy. I guess one additional thing that came to mind is on the flip side, the dosing for Wakovi offers a higher dosage. And for some patients that have coexisting uncontrolled diabetes and morbid obesity, they may require higher dose of semaglutide and the Ozempic form, so that Ozempic dosage may not also -- there may be instances where a higher dose of semaglutide would be applicable for a patient who has uncontrolled diabetes and is morbidly obese.

Donna Sullivan: So this is Donna. We wouldn't be able to cover semaglutide or even Ozempic for weight loss. This is where it gets complicated. When a manufacturer has two products with the same medication with different dosages with different indications, it starts to impact rebates and we'll start getting disputes on whether or not we're using Ozempic instead of the newer product for treating weight loss as a way to get around not paying for the new product. So that's one of the concerns that I have with allowing the higher dose. Totally understand where you're coming from about obesity. It is a conversation that we're having within the Health Care Authority. And we don't even we don't cover bariatric surgery or any of the other weight loss products. And bariatric surgery probably has the best evidence to have long term outcomes. So, it is a conversation but it's just not something that we can do even with the higher dose of Ozempic. We're just in a sticky situation here.

Marissa Tabile: Hi, this is Marissa. Did any other DUR board members have any feedback? I did take down on my end to make sure that the age indications are appropriate. So I will double check that. I put Victoza as an example for the pediatric indication. And then considering removing the DPP-4 inhibitors from the criteria, which I do completely understand the rationale for that. So I can definitely take that back and see if we want to consider removing that.

Ginni Buccola: This is Ginni. I don't have any questions about the form. I was just coming online to -- it sounds as if we might be at a pause or at a place where we're ready to go to the motion. So I wanted to make sure.

Donna Sullivan: Marissa, I think we can go ahead and remove the DPP-4 inhibitor requirement with the knowledge that we're going to include the appropriate ages under number two for the appropriate products. I just want to be able to move forward with the policy so that we can get it approved and not have to come back again.

Marissa Tabile: This is Marissa. Okay, I made that note on here, Donna. We will remove the DPP-4 inhibitor criteria on the policy. So Ginni, whenever you're ready.

Ginni Buccola: We do have a stakeholder, Mark Borns with Eli Lilly before we entertain the motion. Mark, I see your hands up. So whenever you're unmuted you'll have three minutes to share.

Mark Borns: Alright, thanks. Well, good afternoon, everyone. This is Mark Borns. I'm the evidence and outcomes liaison here on behalf of Eli Lilly and company. And Lilly is seeking an upgrade to preferred status for dulaglutide, also known as Trulicity. So I'm here to highlight the medical value and help ensure you all are aware of the latest data to make the most informed decisions for Washington Medicaid patients. As a reminder, Trulicity is a once weekly GLP-1 receptor agonist indicated for adults with type two diabetes and it was first approved for use in 2015. It's available as an auto injector with a hidden attached self-retracting needle and requires no constitution or mixing. Recently Trulicity does have a new indication to reduce the risk of major adverse cardiovascular events or MACE in adults and adults with type two diabetes or patients with established CV risk factors. So Trulicity is the only GLP-1 indicated to reduce the risk of MACE events for both patients with established CV disease and for patients at risk for CV disease. Also, more recently, there are two approved higher doses of Trulicity, 3 and 4.5 milligrams, so additional glycemic control can be achieved without the need to switch or add additional therapy for patients previously maintained on Trulicity. Real world evidence studies show Trulicity initiators have significantly higher adherence, are more persistent, and have lower discontinuation rates compared to once weekly Bydureon or Victoza. Additional RWE has shown that patients prefer the Trulicity device over both the Victoza and Ozempic devices. And finally, real world evidence shows all costs and diabetes related costs per 1% A1C reduction are lower for Trulicity initiator as compared to basal insulin initiators. So, Trulicity has a proven safety and tolerability profile. It's similar to the class. I'd asked for you guys to please be sure to see that prescribing information for safety details. And thank you for this time to address the board. And I'll be happy to stay on the line and attempt to answer any questions you may have.

Ginni Buccola: Thank you, Mark. Are there any questions from the board?

Leta Evaskus: Ginni, this is Leta. I just wanted to state for the record that in the chat, Roy Wang wrote: “Does the cost benefit of switching from a preferred GLP-1 to non-preferred GLP-1 outweigh utilizing a DPP-4 inhibitor?”

Ginni Buccola: Thank you, Leta. Does there need to be an answer for the record to the question?

Leta Evaskus: No. That was Ryan. He's one of our pharmacy students just asking a question.

Ginni Buccola: Okay. Thank you. Alright. So we will go ahead and look at our motion here.

Nancy Lee: This is Nancy. I move that the Apple Health Medicaid program implement the clinical criteria listed on policy 27.17.00-1 as recommended with the two amendments to remove the DPP-4 inhibitor criteria and to consider adding the age appropriate indication criteria for pediatric population approved GLP-1 agonist.

Jordan Storhaug: This is Jordan Storhaug. I second.

Ginni Buccola: All those in favor say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. And we'll go to the next policy. That's serotonin modulators, anti-depressants.

Ryan Taketomo: Good afternoon, everyone. This is Ryan Taketomo and I'll be presenting the antidepressant serotonin modulators policy this afternoon. Serotonin modulators are one of our classes of antidepressants and work by altering the activity of various postsynaptic serotonin receptors in addition to inhibiting the uptake of serotonin. For this policy, we're including three of the serotonin modulators drugs which include nefazodone, vilazodone, and vortioxetine. We don't include trazadone in this because it is not used for major depressive disorder as common now. And so with that, I think we can move to the clinical policy. So there's only one indication which the policy will cover it. And again, that's major depressive disorder. So going through the criteria, serotonin modulators may be authorized when all of the following are met or when the client is already established on the medication and the request is a continuation of therapy. For continuation of therapy samples do not count towards the established requirement. So with criteria

one, clients 17 years of age or younger may require a second opinion review with the agency designated mental health specialist from the second opinion network. And so if they're 17 or younger then it goes to the SON network or else they have to meet the following criteria, which includes the client is 18 years of age or older, they have a diagnosis of major depressive disorder, and they must try and fail three preferred antidepressant which are from at least two different Apple Health anti-depressant subclasses, for example, two SSRIs or selective serotonin reuptake inhibitors, and one norepinephrine dopamine uptake inhibitor, Apple Health anti-depressant subclasses eligible to meet clinical criteria include the following: Alpha-2 receptor antagonists, MAOIs, mono amine oxidase inhibitors, norepinephrine, dopamine reuptake inhibitors, selective serotonin reuptake inhibitors, selective serotonin norepinephrine reuptake inhibitors, and tricyclic agents. So as long as they've trialed and failed, three different products that come from two different Apple Health antidepressant subclasses listed and the rest of the above criteria, then it will be approved for as long as the patient or client shows a history of medication use within the last 60 days. So with that statement, there's no reauthorization. And then we just have the dosage and quantity limits.

Ginni Buccola: Ryan, hey, this is Ginni and I have a question about that 60 day treatment within the last 60 days just to clarify. If somebody was off medications for two months but had a history that met criteria of failure of other agents, is that stating that because they weren't actively on medication within the past two months, they would have to retry an additional three agents? I'm trying to figure out how that would work in real life.

Ryan Taketomo: I think it's more of a configuration with our system. The authorization will be allowed to continue to be refilled as long as the client has those fills within the past 60 days. But let's say they go off medication, then they just have to meet the criteria again, which they will since they have a history of trial and fail.

Ginni Buccola: Okay, so they don't need an additional three new agents to try and fail. Got it?

Ryan Taketomo: That's correct. Yeah. They don't have to try and fail three more.

Ginni Buccola: Okay, thank you.

Ryan Taketomo: Now we can to the form unless you want to stay on this.

Kavita Chawla: I just wanted to piggyback off what Jenny said. I'm just wondering if there's a way to clarify what you just said, Ryan, in the language there because, yeah, as a prescribing provider, that's how I would read that as well is that my patient, if they haven't been on medicine in the last two months then any of the previous med trials won't work. So is there any way we can clarify the language here since it will be part of it?

Ginni Buccola: And this is Ginni. I had an idea and then it floated out of my head for what we might suggest. It was something along the lines of and then review of previous authorization would be conducted or I don't know. I'm not the best with the word smithing.

Amy Irwin: This is Amy. Since the whole idea is kind of built around the configuration, something that you might want to consider is stating, if all of the above criteria are met, the request would be approved. And [indistinct] and say the medication will continue to be covered within the last 60 days. And then a statement that says if there is a break in treatment, a new authorization would be required, because that's really what we're trying to get at. It wouldn't be a whole new criteria would have to be met. It's just going to stop and require you to fill out that form and give us that information again,

Ginni Buccola: That sounds much more direct and easier for me to follow.

Marissa Tabile: Hi, this is Marissa. Amy, can you repeat that one more time so I can just get that documented?

Amy Irwin: I probably can't say it exactly the same way but I can try. I would say after approved and then as long as the client shows no break in medication use within the last 60 days.

Donna Sullivan: Marissa, this is Donna. I think a shorter way to say that would be saying reauthorization is required if the patient has a 60 day or greater gap in treatment.

Amy Irwin: Perfect. I like what Donna said.

Marissa Tabile: And this is Marissa. I just want to make sure. I tried typing and listening at the same time so hopefully I captured that correctly.

Donna Sullivan: I think so. And then just delete everything after approved up until reauthorization.

Ryan Taketomo: I can just read the revised wording. So if all of the above criteria are met, the request may be approved. Reauthorization is required if the patient has a 60 day or greater break in treatment. If there are no questions with the revised language, we can move to the form to review that. Okay and so here's the form, which just helps to supplement the prior authorization process. This form doesn't specifically dictate whether or not the termination is yes or no. But it makes the process for our review more efficient. So I'll leave a few minutes to have the committee to review the document and if there are any questions, feel free to ask them.

Kavita Chawla: Kavita here. Just regarding question four, I want to make sure, it asks about the length of time tried in the policy. I'm not sure I'm seeing any language in there where there's any kind of requirement for the length of time a medication was tried. So if there is any kind of criteria that we are using for the pre auth, I wanted to make sure I understood that.

Ryan Taketomo: Right now we don't have a specific duration that a client needs to have tried these medications. But if you think that adding a duration is appropriate, we can certainly do that.

Ginni Buccola: This is Ginni and I as a psychiatric prescriber, I would prefer to stay away from any prescriptive length of treatment simply because people can have pretty significant reactions even with short trials. So I would hope as long as we were documenting that and what the reaction is that that would qualify as a trial.

Kavita Chawla: I would agree with that. I just wanted to make sure if it's on the form, are we looking for something in particular if we're asking the question.

Jordon Storhaug: This is Jordon Storhaug. The other thing that I run into often is people have transitions of care and I'll be able to get old notes that say that they failed a medicine, but it may not actually have the dates. And I would want to trust that the providers if they said they failed it, I think they failed it.

Amy Irwin: Ryan, this is Amy, again. I think we can easily remove that from the form.

Woman: Thank you. I want a fourth that. Just trying to go through the record and find the dates of treatment is really painful. So if it's not very meaningful, I really think we can take that out. Thank you.

Ryan Taketomo: Alright, if there any last minute questions, looks like you might have a question.

Alex Park: Yeah. Ryan, Alex here. I'm feeling good about the policy and the form and great suggestions from the committee so far, but I just have a general question. Is there an intent behind the policy in terms of cost or safety or efficacy concerns? Just because I'm looking at the list of drugs that we're asking people to have tried first and MAOIs I rarely use now. And it's not a class that we tend to feel is terribly effective or safe. So this idea that we're going to have people go through those and then move to these drugs, I just want to make sure I'm understanding the reason behind this policy.

Donna Sullivan: This is Donna. I think I can jump in here. One, I would agree with Alex. We should probably remove the MAOIs because there's a lot of times contraindications with starting a new anti-depressant within a certain amount of time of ceasing an MAOI. Really, the intent of this policy is that we have -- on the PDL, we broke the anti-depressants up into their subclasses based on their mechanism of action. And so the tried and failed policy, they try and fail two SSRIs before they can get a preferred SSRI doesn't make a lot of sense. Because if the some SSRIs fail, what's the likelihood a third one's going to work. And so you would generally choose a different mechanism of action. And I know that there's certain side effects with some of the drugs that even within the same class, others don't have. So what we're trying to do is have a mechanism for us to have try and fail across the difference subclasses in order to get a non-preferred drug. And this is really the only the only way for us to have a coherent policy to share with the plan so that everybody's doing it the same way. I don't know if that makes sense or not.

Alex Park: No, it does. I guess I wanted to make sure there was not an epidemic of serotonin modulators being used or serotonin syndrome problems that I wasn't aware of because these are old drugs and they're not that expensive, as far as I know. But it sounds like they are non-preferred. So you have to have certain pathways around your process, which I can understand.

Ginni Buccola: Well, and this is Ginni, Alex and the two of them - Viibryd and Trintellix are very new and not with any improved efficacy rates compared to, you know,

when we compare them sort of head to head to SSRIs or SNRIs, which, everybody's more commonly using. So, that's just another little piece to consider. They're newer. With the exception of the nefazodone, I believe. That's not one that's commonly used in practice.

Alex Park: Well, if what we got out of my aside here is taking MAOIs out then I'm satisfied.

Ginni Buccola: Yeah, I appreciate that. I think I agree with that observation as well.

Ryan Taketomo: I agree with MAOIs but removing it would give patients less options if they have used in the past. I'm just throwing that out there. Keeping it there doesn't necessarily hurt because regardless, they still have to trial and fail two the different classes. Having that there just gives them an additional option if, for some reason they wanted to go down that route.

Donna Sullivan: Ryan, this is Donna. So again, yeah, now that you mention it, it does make sense. So they're not required to try an MAOI but if they did previously try one and it didn't work, it would count as one of their three products. Does that make sense?

Alex Park: I see. Yeah, that's another way to look at it. Yeah. I can appreciate that.

Catherine Brown: This is Catherine. Maybe you could reorder them and put it last? There's some kind of subliminal idea that maybe it ranks up higher because it's listed second? I don't know.

Donna Sullivan: They're just in alphabetical order.

Catherine Brown: Ah, okay.

Donna Sullivan: With the exception of four and five now that I say that.

Kavita Chawla: Kavita here. Just kind of playing devil's advocate on this. What is the probability that there could be patients who maybe 15 years ago, they tried only some of the older class agents, so like a TCA and an MAOI but they're coming in with severe symptoms. And so somebody wants to try them on one of the newer agents right away. Is that a scenario that would come up even often. Basically, what I'm just trying to avoid is that there are three here like one, two, and six, which are not really typically used because they don't have

great evidence for depression. And so I'm just wondering the value of leaving them on there. Because there are multiple classes that are not very effective.

Ginni Buccola: This is Ginni and I'll just give my two cents from practice is that even somebody who's presenting say, they've been out of treatment for a decade or more and have documented med history, it would have to, in my experience, it would have to be 20 or 30 years old for an MAO or a tricyclic to be the primary agents that they were treated with. I think going back to maybe the early 90s, most people have the first wave of treatment would be an SSRI. So it'd be very uncommon. I don't know if that's helpful or not. I don't disagree with having those agents there just because it may capture the few people that have worked with a psychiatric prescriber who is still using MAOIs but they're extremely uncommon. I don't think I've seen one in maybe in over 10 years. I don't think I've seen a person on one. That doesn't mean that they're not out there.

Jordan Storhaug: This is Jordan Storhaug. I think what we all kind of agree on is that this criteria is virtually for everybody going to mean that they take two SSRIs and one SNRI. And then and then they're going to be freed out for their -- that's going to be the clinical part for that. And it sounds like we're debating whether or not we want to put that into specific words that they have to do the exact pathway. Or if we're allowing for this small percentage of people who might take a different pathway than that.

Ginni Buccola: This is Ginni. I would say leaving the language as is at least allows us to capture that small group of people. And it doesn't seem to limit the larger group of people. Do we feel ready to move to emotion?

Leta Evaskus: This is Leta. For the record, no stakeholders signed up ahead of time but if anybody would like to speak, please raise your hand. Okay, I'm not seeing any stakeholders.

Ginni Buccola: Thank you, Leta.

Jordan Storhaug: This is Jordan Storhaug. I move that the Apple Health Medicaid program implement the clinical criteria listed on policy 58.12.00-1 as recommended, including the updated reauthorization criteria language and removal of the trial duration language from the form.

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

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

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. And we will move next to armodafinil modafinil, Apple Health Policy.

Ryan Taketomo: It's Ryan Taketomo. Thank you, Marissa. Now we'll be going over the armodafinil modafinil policy. Modafinil and armodafinil are wakefulness promoting agents FDA approved to improve wakefulness in patients with excessive sleepiness associated with narcolepsy, shiftwork disorder, and obstructive sleep apnea. The purpose of this policy is to provide just the criteria for the two FDA indications for which we cover these products. Shift work disorder is not a medically necessary indication. And so that's one of the reasons why we created this policy. We can move down to the clinical criteria. So first with narcolepsy, armodafinil or modafinil may be authorized when all the following are met. Again, this is another second opinion network drug. So if decline is 17 years of age or younger then it automatically goes to a mental health specialist from the SON network. Or else they'll have to meet the following criteria, which is they need to be 18 years of age or older and they have to have a diagnosis of narcolepsy with excessive somnolence confirmed with a sleep study and multiple sleep latency test and for armodafinil, trial and failure of modafinil for a minimum of 60 days. So if they meet those criteria, the request will be approved for 12 months and for reauthorization as long as documentation is submitted demonstrating a positive response then they can continue to be approved for an additional 12 months at a time. Moving on to the second indication, which is obstructive sleep apnea. Armodafinil or modafinil may be authorized when all of the following are met. Again for criteria one we have the second opinion network language, or else they have to meet the following with criteria two being client is 18 years of age or older and they have a diagnosis of obstructive sleep apnea with residual excessive somnolence confirmed with the sleep study and there's clinical documentation demonstrating the following: that the client has achieved normalized breathing and oxygenation with continuous positive airway pressure - CPAP therapy and that there is documentation within the past six months demonstrating that the client is adherent to CPAP therapy, client is determined to be adhered when CPAP is used for 70% of nights for a minimum of four hours per night. That adherence language comes from CMS. And then for armodafinil, specifically,

they have to have a trial and failure of modafinil for at least 60 days. So, for this indication, if all criteria are met then they will be authorized for six months at a time. We can move to the reauthorization criteria. So the products may be reauthorized when all the following criteria are met. One is documentation is submitted demonstrating a positive response and then also documentation within the past six months demonstrating the client continues to be adherent to CPAP therapy. So if they meet those then they will be granted an additional six months authorization. That wraps up the clinical criteria. And then we have the dosage and quantity limits. It looks like Marissa pulled up the form, which is fine. So this form, again, is to help facilitate the prior authorization process. I'll give the committee a few minutes and open it up for questions. Thank you.

Kavita Chawla: Hi, Ryan, Kavita here. For the sleep apnea indication, I'm wondering why that approval is for six months only instead of the usual 12 months.

Ryan Taketomo: I think for this one, usually our clinical reviewer has approved it for six months at a time. And CPAP I think is usually assess annually, I think in this case it's because with obstructed sleep apnea, the CPAP isn't fully improving their wakefulness. And so they're acquiring this controlled substance as an addition. Granted, as a [indistinct] this drug is not super prone to abuse.

Woman: One question on the form and policy. Would it be appropriate under the OSA diagnosis to say or cannot tolerate CPAP therapy? Just because there's a number of people who just are not able to tolerate and so that would exclude all of them. And I welcome feedback on that. I don't prescribe this medication very often. So there may be reasons why you want to require CPAP.

Donna Sullivan: This is Donna. Describe to me what it means to you is to not tolerate CPAP. I know some people are unable to sleep because the machine is annoying to them. Or is it the positive pressure?

Woman: And there's a variety of different things. Some people just can't keep the mask on, whether it's claustrophobia or they've tried a number of masks. Sometimes it's so drying even with a humidifier that people just can't tolerate it. So I have a number of patients, for example, who have very clear indications for CPAP because of uncontrolled atrial fibrillation and they've worked with sleep medicine very diligently and just have not been able to use CPAP. I recently had a patient who just got am Inspire device because of his inability to tolerate CPAP. And I guess that would be the other question is

some people use dental appliances which don't have as good of evidence but sometimes is an option if their CPAP really isn't working. And there are these newer interventions like the Inspire device that can be used as well. So I'm just wondering whether limiting to CPAP therapy precludes some people who truly don't tolerate the therapy from being able to be treated.

Kavita Chawla: Kavita here. I guess one of my concerns with that might be that if they are not tolerating CPAP, which I definitely have quite a few of those patients, I always worry about how much cardiovascular risk they have inherently because their sleep apnea is not treated. And then if we are adding a stimulant medication on top of that, I don't have the numbers off the top of my head, but I understand that stimulant medications do increase cardiovascular risk, arrhythmia risk specifically. So I'm just wondering, clinically, whether that would be safe not being on CPAP and then adding a stimulant.

Woman: l would have to review evidence. I'm not sure. I guess my question would be, should we expand the definition of OSA treatment or therapy. And I don't know the data on this inspire device. But this came up in clinic recently. And it's at least very effective for this particular patient. So with newer therapies for sleep apnea, I'm wondering whether that should be expanded. And maybe this is something that just needs a literature review and/or expert input. And also happy to keep as is if everyone feels like that's appropriate

Ryan Taketomo: I guess when I think of this, it makes sense that there might be a subset of patients who can’t tolerate CPAP therapy. I just wonder if using this medication will prevent them from actually further going in to get alternative treatments to treat the root cause, which is their OSA and that might have to be surgery. So those are some of the things I'm balancing while thinking about this topic.

Kavita Chawla: Kavita here. I just wanted to make sure the question I asked earlier whether the request will be approved for six months. So I wanted to make sure I understood that correctly. So you're saying that there's a separate clinical reviewer who decides that time interval for approval intervals? I'm just trying to understand why six months with this and 12 months for narcolepsy?

Ryan Taketomo: Yes. So the feedback least for our fee for service reviewer was that in the past before this policy existed, they've typically approved it for six months at a time. And whenever there's a [indistinct] they typically requested just to

ensure that the CPAP is being used. Because if they're not using the CPAP then that can be an alternative reason for why they need this wakefulness medication. I think we'd be okay. I'm okay with keeping the CPAP therapy and it should hopefully incorporate a majority of patients. I think the important thing is that their OSA is being treated adequately, which is CPAP. Modafinil is not a therapy to actually treat OSA. It's more to just address if they're continuously sleepy. And then we do have the language at the bottom saying that this drug can be approved on a case by case basis if they are not able to tolerate CPAP. And maybe they have a potential reason that they don't want to seek alternative therapies such as surgery. Any thoughts on that?

Woman: I am okay with that. And I'd be interested just from a sleep medicine specialist perspective of whether there's something for C of kind of an effective non positive airway pressure therapy, whether that might be reasonable. Because I do think that hypoglossal nerve stimulation is an option and has some evidence with significant improvement. So I could see someone in that category potentially still being a reasonable option for modafinil. And then the other thing that I would just recommend is a I think we should change this to positive airway pressure therapy to incorporate BIPAP. Because as it's written, it's actually excluding BIPAP

Donna Sullivan: So this is Donna. So what I think what we'll need to do if we're going to add any other therapies outside of CPAP, we'll have to go back and make sure that they're covered before we can recommend that we add them. Out of the abundance of caution, I don't want to agree to put something in the policy and then it's something that we don't cover. So we'll have to consult with our healthcare services folks within the agency and just make sure that we're inserting the right therapies.

Ginni Buccola: This is Ginni. Just checking in if there are any more questions on that policy. Ryan, you probably want to go to the form. I didn't let you do that. And were there any questions here? Does everybody feel satisfied with where we are? Okay, sounds like we're ready to look at the motion then.

Leta Evaskus: And Ginni, this is Leta. Just for the record, no stakeholders signed up. If anybody would like to speak, please raise your hand.

Donna Sullivan: So I this is Donna again. I have a question. So if we consider the BIPAP and the other non-positive airway pressure treatments, are you okay with us just moving forward without bringing it back? Or would you like us to bring it

back? My question is, if you want us to bring it back, there's no need to pass a motion.

Ginni Buccola: This is Ginni. Leah, do you mind responding to that?

Leah Marcotte: Of course. Yeah. I'm totally fine with that.

Ginni Buccola: With not bringing it back?

Leah Marcotte: With not bringing it back.

Ginni Buccola: So you are in agreement with us going to the motion unless there's anybody else that would like to see it come back another time. Okay. We're good. I think Marissa, though, that should say not positive airway pressure. Thank you.

Susan Flatebo: This is Susan Flatebo. I moved that the Apple Health Medicaid Program implement the clinical criteria listed on policy 61.40.00.AA-1 as recommended with the addendum to consider adding BIPAP and non positive airway pressure devices of covered by Apple Health.

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

Ginni Buccola: And this is Virginia Buccola, committee chair. All those in favor please say aye.

All: Aye.

Ginni Buccola: Are there any opposed? And the motion carries. And it looks like that is the end of our agenda for the DUR board for August 18. So we can go ahead and adjourn. Leta, do you have any announcements for us?

Leta Evaskus: I do not have any announcements but thank you all. I'm glad we ended early.

Ginni Buccola: Thanks, everybody. Good to see you. Have a good rest of the summer.

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