Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board
P&T Meeting Notes
April 18, 2018

Lisa Chew:	Welcome. We are going to convene the Washington State Pharmacy and Therapeutics Committee. A reminder that this is a recorded meeting so please be sure to speak into the microphone and state your name before you make your comments or have… ask questions. Let's start with introductions. Maybe on this far right here, please.
Amy Irwin:	Good morning. I'm Amy Irwin with the Health Care Authority.
Jose Zarate:	Jose Zarate with the Health Care Authority.
Jennifer Brown:	Jennifer Brown, Amerigroup, pharmacist.
Lorena Wright:	Lorena Wright from Coordinated Care.
Fran McGaugh:	Fran McGaugh, PHPW.
Audrey Heirs:	Audrey Heirs, Molina.
David Johnson:	David Johnson, Molina Healthcare.
Catherine Brown:	Catherine Brown, committee member.
Amber Figueroa:	Amber Figueroa, committee member.
Susan Flatebo:	Susan Flatebo, committee member.
Alex Park:	Alex Park, committee member.
Dale Sanderson:	Dale Sanderson, committee member.
Lisa Chew:	Lisa Chew, committee member.

Nancy Lee: Nancy Lee, committee member.

Virginia Buccola: Virginia Buccola, committee member.

Jordan Storhaug: Jordan Storhaug, committee member.

Leta Evaskus: Leta Evaskus, Health Care Authority.

April Phillips: April Phillips, Health Care Authority.

Donna Sullivan: Donna Sullivan, Health Care Authority.

Umang Patel: Umang Patel, clinical account manager from Magellan Medicaid Administration.

Ryan Pistoresi: Ryan Pistoresi, Health Care Authority.

Ray Hanley: Ray Hanley, Health Care Authority.

Lisa Chew: Thank you. Donna, any announcements? Okay. Great. Let's go ahead and dive in. Is Marian on the phone for biologic drugs for asthma and urticarial?

Marian McDonagh: Yes, I am.

Lisa Chew: Great. Go ahead and start when you're ready.

Marian McDonagh: All right. So this is the first report on these biologic drugs for both asthma and urticarial. If we go to slide 2.

This is a quick review of the mechanism of action of these drugs. For patients with eosinophilic phenotype of asthma the IL-5 drugs are the targets here. Eosinophils are found in the [inaudible] in the blood in these patients in elevated levels and are thought to contribute to the inflammation and then causing severe asthma symptoms. So IL-5 is the cytokine that is responsible for or involved in eosinophil growth differentiation, recruitment, activation and survival. So blocking the activity of IL-5 helps to reduce the effects of

the eosinophils. You can see in the diagram here that the IL-5 monoclonal antibodies reslizumab and mepolizumab both bind to IL-5 itself to inhibit its binding to the receptor whereas benralizumab actually binds to the receptor blocking the IL-5 from binding. So it has a slightly different effect in that the eosinophil reduction is greater with a little bit longer duration of effect. Next slide.

Looking at the biologic therapy for allergic asthma and chronic spontaneous urticaria here we have…. asthma tends to be… this type of asthma tends to occur in younger patients and they tend to have more severe symptoms. So here IgE mediates the allergic immune responses and omalizumab monoclonal antibody inhibits the effects of IgE. So for all of these drugs they are given injection either intravenously or subcutaneously, but they do need to be given under supervision because of concern for anaphylaxis. Next slide.

These were the key questions for our review. The first is, are there differences in benefits or harms of the biologic drugs compared with each other or placebo when added to either treatment? So these are given as a third line treatment added to other treatments for patients who are not responding. And so the… and the idea is that ultimately… ultimately the goal is to not only improve their control and reduce exacerbations, but also to be able to reduce the dose of oral steroids or even allow the patient to stop taking oral steroids all together. So here in this question we had a specific subgroup question about the eosinophil levels at baseline. So is there a threshold for which… with the eosinophil levels where patients could be selected for treatment and what is that threshold? And then the second question was, are there differences in, again, benefits or harms for the biologic drugs compared with each other or placebo for patients with chronic spontaneous urticaria? So these are patients who have failed prior treatments, which is primarily antihistamine treatments. Then here we also had subgroup questions, which were more the typical type of questions for subpopulations. Next slide.

Slide 4 is a summary of our review criteria and methods. So we used our drug effectiveness review project methods and here we were

including adults or children with either asthma or urticaria. We conducted our searches in December and we included all of the drugs… the four drugs we just talked about in the mechanism of action slide. We required that these studies be at least 12 weeks in duration and we were focusing on randomized controlled trials, but we included other study designs as well where needed. Next slide.

So this is the overview of what we found. We found 49 good and fair quality trials of over 13,000 patients. There were a couple of trials that we rated poor quality that are not included here. Most of the studies included patients age 12 and up and the range of duration of treatment of the studies was 12 to 60 weeks. The majority of those were shorter – either 12 to 14 week durations, but there were some longer studies in the mix. You'll see in the bar graphs here that there is also some off-label studies listed. So we wanted to include any studies we came across where these drugs were being used in asthma patients especially, but who did not fit the criteria. So not increased blood or [inaudible] or patients who did not have the allergic type of asthma, non-atopic asthma because that was also noted to be an area of concern for this report. Next slide.

Let's get into the evidence. So here we're looking at the anti-IL-5 drug benralizumab. We're starting with the most recently approved drugs and working our way back. So here there were five good quality trials of almost 3,000 patients. The patients included were moderate to severe asthma and here benralizumab was given every four to eight weeks whereas all the other drugs you'll see in the IL-5s are given every four weeks in these trials. So here the exacerbations were significantly reduced with benralizumab compared with placebo. So the definition of exacerbations varies. So when you're defining it by requiring oral steroids that's the first definition listed here. So the right ratio is 0.62. So the rate ratio is not a relative risk. It takes into account the variation in the duration of treatment. So you'll see above the durations of the trials were 28 to 56 weeks and within those patients had varying durations of treatment. And then the second definition listed here exacerbations that required an ER visit or a hospitalization. Now in this particular case this is a subgroup analysis that was done only in patients who had

eosinophils in the blood of greater than 300 cells per microliter. So in this one here… in this definition there was also a significant reduction with benralizumab compared to placebo. And you can see that… our confidence here is moderate in these findings. So we're pretty sure these findings won't change with future studies, but they could… the actual point estimates could change some. All right. And we've given the placebo rates for both of those different definitions of acerbations to show you the baseline rate. So for the exacerbations requiring oral steroids, for example, the placebo rate was .98 events per patients per year whereas the more severe form of exacerbations be rates only .11, so less frequent. Next slide.

So looking at oral steroid doses what happens to those there was a significant decrease in the benralizumab group. 75% decrease in the dose… mean dose across the groups and then that was compared with 25% reduction in the placebo group. For quality of life we're going to find some interesting findings across the board here. So here we're using the asthma quality of life questionnaire. There was a statistically significant reduction, a mean difference of 0.23 out of a scale that ranges from 1 to 7. So it's the clinical significance, you know, clinically important difference has been defined to be 0.5… a change of 0.5. So the 0.23 does not meet that definition. So we have high confidence that there is a statistically significant difference, but not a clinically important difference. So for adverse events here it is the rate of serious adverse events was actually lower with benralizumab than placebo, which may seem odd, but it is driven by the fact that exacerbations are included as serious adverse events here. So clearly with the low reduction in exacerbations that's what we are seeing here in the serious adverse events. No difference in withdrawals due to adverse events although the rate is slightly higher with the benralizumab group. And we're moderately confident in these findings, as well. Next slide.

So looking at these subgroup analyses then first we see a decrease in the exacerbation rates and in improvement in quality of life is significant for patients who have eosinophils of greater than 150 cells per microliter in the blood, but not those who have less than

150. So that threshold seems to be valid there. And then in a separate study the threshold of 300 cells per microliter in the blood did not make a difference. So greater than or less than 300 there was no difference in the rate of exacerbation. Next slide.

So we're moving on to the second drug, anti-IL-5 drug, reslizumab. So here there were four trials, two good and two fair. Fewer patients total, 1,270. Here the patients had moderate to severe asthma, again, similar to benralizumab. But all of the patients here were required to have elevated eosinophils and in fact they were greater than 400 cells per microliter in three of these studies. So here with exacerbations we have some different findings. The type of exacerbations that require oral corticosteroids were indeed statistically significantly lower with reslizumab. There's the rate ratio given again. However, the more severe form of exacerbations requiring ER or hospital visits was not statistically significantly lower. Our confidence here, again, is moderate so it could be with future studies, particularly that finding in the more serious form of exacerbation could change. Next slide.

So here again looking at quality of life we find similar findings as we did with benralizumab that the… using the same quality of life questionnaire there's a statistically significant improvement, but it does not meet the clinically important threshold. So for adverse event outcomes there were no differences here for serious adverse events or withdrawals due to adverse events. And for serious adverse events this may be driven again by the fact that there was not a statistically significant difference in the rate of the more serious form of exacerbation, those requiring ER or hospital visits. Next slide.

This is looking at the subgroup analyses or reslizumab. These are single small trials for each of these findings. So I do suggest caution in interpreting their findings. But symptoms in asthma control were improved significantly in patients who had greater eosinophil levels at baseline, greater symptoms at baseline, longer disease duration or who had nasal polyps. And patients who didn't have one or more of these did not have significant improvement. And then separately

another trial found that patients who did not have eosinophilic asthma did not show improved symptoms. Next slide.

This is the third of the IL-5 drugs, mepolizumab. So here we had a total of three good quality trials, a little over 1,200 patients. In this case the patients that were enrolled only had severe eosinophilic asthma and that was defined as more than 150 cells per microliter in the blood at screening or greater than 300 in the last year. So here the exacerbations of both definitions were significantly reduced. And you can see the rate ratios there that are similar to the other IL-5 drugs and here our confidence in these findings is high. Next slide.

This is looking at the secondary outcomes. So looking at baseline oral steroid dosages, these were also decreased. The odds ratio for the likelihood of a significant decrease was 2.39 and to give you some idea of what the actual change was, the median dose changed by 7 milligrams… sorry, this is for prednisone. A decrease of 7 milligrams in the mepolizumab group compared with 2.5 in the placebo groups. Now for quality of life outcome here we have a different finding to the others and the reason may be because this is a different quality of life scale. So the St. George's Respiratory Questionnaire and here the change was significant both from statistical viewpoint and also from a clinical importance viewpoint. Serious adverse events were not significantly different here and the withdrawals due to adverse events in both groups were very low in this… for this drug. So there was no difference between that either. Next slide.

This slide is looking at subgroup analyses in mepolizumab. Here we found that decreased exacerbations, improved symptoms and quality of life were seen with any threshold that they used for eosinophilia. And so this was anything above 150 cells per microliter in the blood. Separately then there was also an analysis showing that the improvement in exacerbations was not affected by the number of type of background controller drugs that were being used. Next slide.

Now we're moving to the other type of asthma, the allergic asthma and the drug omalizumab. Here all of the patients in these studies were confirmed to have allergic asthma using skin testing. So here we had 16 fair quality trials of over 5,000 patients. They had moderate to severe asthma and here the definitions used in these studies for exacerbation were a little different than what we saw in the IL-5 drug trials. So here overall exacerbations were decreased significantly with omalizumab and that included the ER or hospital visit, as well as the exacerbations requiring oral steroids. So 16% versus 26%. And then in separate analyses looking at just studies with longer durations. It was also significant looking at three studies that were done only in children. The reduction was significant. And then finally there was a couple of studies looking at seasonal pre-treatment. So this is in children who have a history of increased exacerbation rates during a particular season of the year; so fall or winter, depending on the study. And that pre-treating three months prior to that season you had a significant reduction of exacerbation rate during the season of… the target season. So our confidence in these findings is again moderate. Next slide.

These are subgroup analyses looking at omalizumab in allergic asthma. So subgroup analyses of exacerbations based on severity we see that the reduction is significant in patients who have moderate to severe asthma, but not in patients who have the more severe form. So only severe asthma not significant. Next slide.

Looking at quality of life measures we see improved both statistically and clinical difference is unclear here. The reason is because we have studies measuring this outcome in different ways. So we have the mean difference using the AQLQ scale, again. It is only 0.31 and again remember that change of .5 is required for clinical significance. So that doesn't meet the threshold, but then there's a newer study that was focused only on… that their primary outcome was looking at quality of life and they were measuring the proportion of patients who had met the threshold for clinical importance and found 72% versus 22% meeting this definition. So we have low confidence in these findings and this is a conflicting… these findings are somewhat conflicting. So here also there were significantly fewer serious

adverse events with omalizumab. Again, that is likely to be driven by the difference in exacerbations and particularly the serious forms. And then there's also been some concern about malignancy and arterial thromboembolic events with omalizumab. In part because this drug has been used for a number of years in many of these patients because, as I mentioned earlier, they tend to be patients who are younger when they are first started on the drug. However, there's only a couple of studies, one study on malignancy and one on arterial thromboembolic events. Neither of them were very good in terms of the quality and their findings were inconclusive. So we don't have any good answers for those serious adverse events at this time. Next slide.

Looking at omalizumab used in patients who do not have a proven atopic asthma. These are very small studies. So just to give you an idea of what's going on out there with these off-label uses. So for intermediate outcomes there were improvements in the levels of IgE in the blood and also lung function tests. But the exacerbation rates, asthma control and global impression while they improved, they were not statistically significant. Again, these are very small studies. So it could be that they would be significant in larger studies. And quality of life scores were not different between groups. And then separately there was a study looking at patients with nasal polyps and asthma and here the nasal polyps did improve and were reduced significantly. Asthma symptoms improved and lung function and quality of life were not improved. So just a hint since it is such a very small study. Now moving on to our next population.

This is looking at the evidence for omalizumab in chronic spontaneous urticaria. So these are mostly good quality studies, over 1,500 patients. It is adults or children. Again, as I mentioned earlier, these are patients who are refractory to mostly second generation antihistamines, usually within fairly high doses, sometimes in combination with other drugs such as H2 antagonists. So here the response and complete response, so complete response is resolution of symptoms was significantly better with omalizumab and it does seem to be dose dependent. So complete response was 11% greater with omalizumab at the 150 mg level and 30% better at

the 300 mg level. And our confidence here is high for those findings. Next slide.

On the next slide then looking at quality of life, similar to the findings we had with the other drugs, we see here that although this is a statistically significant improvement it was not a clinically significant improvement. And here there were no differences in the adverse events between the groups. So our confidence in the adverse event findings, however, was pretty low. Mostly because there aren't very many adverse events reported in the studies. Next slide.

So now moving on to the summary and conclusions. We have 49 placebo-controlled trials. They were mostly pretty good quality studies. There were no head-to-head comparisons. These are all placebo-controlled trials adding on to existing treatment. So for the anti-IL-5 drugs in patients with eosinophilic asthma the exacerbations for that require oral corticosteroids and are consistently reduced compared to placebo across the drugs. Exacerbations requiring ER or hospital visits are less consistently reduced. There is evidence for benralizumab and mepolizumab. Quality of life, as we mentioned, there's really not been… for benralizumab and reslizumab no evidence that they are clinically important changes although mepolizumab did have a significant improvement, again, using a different scale than the other two drugs. Serious harms, here at least was not worth with the IL-5 drugs and may be better when you include exacerbation rates. So evidence on the threshold for eosinophil… blood eosinophils is somewhat unclear. We can say that patients with less than 150 cells per microliter are unlikely to benefit. Next slide.

Looking at patients with allergic asthma there is low to moderate strength evidence that omalizumab does reduce exacerbations. Those with varying definitions, those requiring oral corticosteroids or ER or hospital admission. Exacerbations were also significantly reduced in moderate to severe asthma, but not in those with only severe asthma. So for chronic spontaneous urticaria we had high strength evidence that omalizumab does improve complete response.

Some final notes on the next slide. For quality of life across the drugs and indications we find that quality of life was improved statistically, but the difference didn't reach the clinical importance thresholds except for mepolizumab. Again, using a different scale. And then lastly adverse events, lower rates of serious adverse events are found with benralizumab and omalizumab, but no differences in the other drugs or patients with urticaria.

So that concludes the summary of our report.

Lisa Chew: Thank you, Marian. Any questions for Marian?

Nancy Lee: I just had a question about the symbol with the box and the X in it. What does that represent?

Marian McDonagh: Oh yes. So in the report there's a complete definition of what's in that table. So, yeah, on this slide here it means that there is not a statistically significant difference.

Lisa Chew: Any other questions for Marian? Marian, there doesn't appear to be any other questions. Thank you very much. Are we going to be doing presentations back-to-back or presentations and motions, presentations?

Leta Evaskus: We'll do the presentations back-to-back and then we'll go back to the P&T motion and then the DUR motion and we'll do stakeholders before the motions.

Lisa Chew: Thank you. Umang, I think you'll be presenting?

Umang Patel: Perfect. Thank you again. My name is Umang Patel from Magellan. I will be going over the first topic which is the biologic drugs for asthma and urticaria. Next slide, please.

Just to give a quick overview, the prevalence of asthma in the United States continue to rise. An estimated 7.8% or roughly 25 million Americans have asthma with approximately 10 to 20% in poor

control. The National Asthma Education and Prevention Program has defined asthma as a chronic inflammatory disorder of the airways in which many cells and cellular elements play a role. Asthma phenotypes have been identified by clinical and/or pathophysiological characteristics. It has been established that eosinophils play a role in the inflammatory process of asthma and eosinophilic asthma is identified as a phenotype of asthma. Generally, patients with eosinophilic asthma have severe disease with high eosinophil levels in the blood and sputum despite treatment with a glucocorticoid. Persistent levels of these eosinophils in sputum may also be an indicator of the disease severity. Next slide.

General overview of urticaria, as well the prevalence of chronic urticaria is estimated to be roughly .5 to 5% of the general population. Typically it presents as pruritic edematous red wheals of variable size and shape with surrounding erythema. It is defined as episodic or daily hives lasting for six weeks or more that impairs the quality of life. The majority of cases have an undetermined cause, also known as idiopathic; however, infectious and autoimmune conditions can be associated with it. Chronic urticaria may be associated with the presence of mononuclear cells such as CD4+, Th1 and Th2 lymphocytes, eosinophils, neutrophils, basophils, mast cells and activated macrophages. Next slide.

We'll discuss the four medications, three of which are interleukin-5 antagonists and one of which is an IgE antibody. Just to give you a little bit of background, Marian did go over it in much more detail, but essentially eosinophils circulate in the peripheral blood and are found in peripheral tissues and respiratory mucosa and the levels increase when there's acute inflammation. These eosinophils are recruited into the airway in allergic asthma by the action of cytokines and chemokines such as IL-5, which is a potent eosinophil activator that facilitates recruitment. So the first three medications, Fasenra, Nucala and Cinqair are all IL-5 antagonists so they block the IL-5 from binding to the eosinophils which results in the inhabitation of eosinophil growth and differentiation recruitment activation. So as you can see the first three are all indicated for add-on maintenance

treatment for patients with severe asthma. Fasenra and Nucala are for patients aged 12 years of age or older with an eosinophilic phenotype. Cinqair is for patients aged 18 years of age or older with the same eosinophilic phenotype. The second class are IgG antibodies, specifically Xolair. Xolair in the treatment of a… it inhibits the binding of IgE to high affinity IgE receptors on the surface of mass cells and [inaudible] and this in turn decreases the release of the allergic response. It is indicated for moderate to severe persistent asthma in patients 6 years of age or older with a positive skin test or in vitro reactivity along with being indicated for chronic idiopathic urticaria in adults and adolescents 12 years of age or older who remain symptomatic despite antihistamine treatment. Next slide, please.

Here you can see the dosages. The dosage and administration comments and the dosage forms. I won't go over them specifically, but please note that Fasenra, Nucala and Xolair are all administered subcutaneously whereas on the third row, Cinqair is for IV infusion only, again, infusion not for IV push or bolus. And all four are indicated to be administered by a healthcare professional. In terms of warnings there is a box warning for Xolair and Cinqair for anaphylaxis. For Xolair it is reported to occur after the first dose and up to one year after beginning. The time to onset is reported to be about 90 to 120 minutes after administration. For Cinqair anaphylaxis was reported roughly… can be reported up to 20 minutes after infusion completion. And although labels for Fasenra and Nucala do not contain boxed warnings, hypersensitivity reactions can occur within hours to days of dosage being given. And please note that none of these agents should be used to treat accused asthma symptoms or asthma exacerbations. Just to give a little bit more clinical background in terms of pediatric safety and efficacy have not been established for Fasenra and Nucala patients in less than 12 years of age or Cinqair patients less than 18 years of age. And if you refer back to the indication slide previously, Xolair is indicated for patients 6 years of age or older to treat moderate to severe persistent asthma. There is insufficient data for all four of these agents in patients who are pregnant. And in terms of renal and hepatic insufficiency there have been no pharmacokinetic

studies performed to assess the impact of Fasenra, Nucala or Cinqair. Renal and hepatic impairment was not addressed in Xolair labels, as well. Next slide.

To recap over guidelines, the American Thoracic Society and European Respiratory Society in 2014 stated severe asthma is defined as asthma that requires treatment with high-dose inhaled corticosteroids plus a second controller and/or systemic corticosteroids to prevent it from becoming uncontrolled or that remains uncontrolled despite this therapy. The guidelines suggest a trial of Xolair in adults and children aged 6 years of age or older with a confirmed IgE-dependent allergic asthma despite optimal drug and non-drug therapy. If there is no response within four months of beginning, then it is unlikely that continued treatment will be of benefit. Please note that Fasenra, Nucala and Cinqair were not available at the time these guidelines were published. That's why they are not mentioned. Next slide.

Here we have the Global Initiative for Asthma, the GINA guidelines. I'm not going to go over these row by row, but as you can see these guidelines recommend and stratify treatment of asthma in a stepwise approach depending on the patient's specific case. If you note, the immunomodulators are not recommended until step 5 where there is a higher level of care and/or add-on treatment needed. Next slide, please.

In terms of urticaria the American Academy of Allergy Asthma and Immunology, the American College of Allergy Asthma and Immunology and the Joint Council of Allergy Asthma and Immunology all in 2014 recommend a stepwise approach to treat chronic urticaria. Treatment should begin based on the patient's level of severity and previous treatment history. At each level medication should be evaluated for efficacy and patient tolerance and stepdown should be considered when consistent control is achieved. Step 1 is recommended monotherapy with second generation antihistamines which are considered to be first line in addition to avoidance of triggers. For example, NSAID drugs, food allergens and relevant physical factors. In Step 2 if the chronic

urticaria is not controlled, antihistamine dose can be increased if it is appropriate for that particular agent. If not, one of the following can be added – another second generation or first generation antihistamine, an H2 antagonist, or a LTRA. Step 3 if control I still not achieved dose advancement of a potential antihistamine such as hydroxyzine or doxepin may be considered as tolerated. And finally chronic urticaria that is refractory to maximal antihistamine therapy in Step 3, alternative agents such as Xolair can be sued; other anti-inflammatory, immunosuppressant, or biologic agents may be considered, but have a lower level of supporting evidence. Any questions?

Lisa Chew: Thank you, Umang. Any questions for Umang? We have two stakeholders, Brian String and Don Moran. If you guys could make your way up to the podium. Please state your name and who you represent and you will have three minutes for comments.

Brian String: Good morning. Can you hear me okay? Great. Well thank you for the opportunity just to present a few brief comments. My name is Brian String. I'm in health outcomes with GlaxoSmithKline, GSK. I just want to focus my comments just briefly in two areas. One, on the comprehensive review that was just reviewed and then also just going back to the transcript of your February meeting where there was some commentary on this class and I just wanted to point out one thing that looked like a type-o. So I'll mention that in here as well.

First off, for this comprehensive review I did want to acknowledge, just appreciate the fact, I think all the manufacturer's do that were solicited to make comments ahead of time on the evidence if anything is missed or corrections or that, so really appreciate that opportunity. So for Nucala or mepolizumab really represented all of the key Phase 3 evidence—the exacerbation trials, the corticosteroid reduction, and the comment in there about the level of evidence for health-related quality of life using the St. George's Respiratory Questionnaire that was an additional Phase 3 six-month study that we sponsored after the main pivotal studies with that SGRX St. George's Respiratory Questionnaire as a primary endpoint, so that

really led to the higher quality evidence within that. So, again, very clinically important.

And then also the oral corticosteroid reduction trial, the SERIUS trial, you know, with these agents obviously the big focus is on reducing clinically-important exacerbations. One of the other key clinical objectives is these are severe patients, many of them on maintenance or oral corticosteroids so the goal that I think all of the data is trying to look at as well, in some trials specifically is to stabilize the patient and methodically try to reduce that oral maintenance corticosteroid dose while maintaining asthma control. So with mepolizumab or Nucala that was the SERIUS trial. So again, that was all represented in here, as well.

The second point I want to… this looked like a type-o to me so let me just put it out there. So it's your February meeting when this was discussed. It mentioned Nucala second indication that we received late last year in December and that's for a rare vasculitis and that is eosinophilic granulomatosis with polyangiitis, EGPA. And so in the comments it mentioned it was for patients 12 years of age and older. So this is different than severe asthma. This is patients 18 years of age and older. So if you were developing a policy and you were to include that second indication I just wanted to make sure you were aware that is adults with EGPA. So that's 18 years of age and older relative to the severe asthma with eosinophilic phenotype, which is 12 years of age and older. Those are my brief comments and if there's any questions I'm happy to take them. Thank you very much.

Lisa Chew: Thank you, Brian. Any questions for Brian?

Don Moran: Good morning. My name is Don Moran and I'm a member of the medical affairs department at Teva. I'm filling in today for a colleague who normally attends these meetings on behalf of Teva. So I guess [inaudible] set your expectations he may also look at me as Plan B for your meeting today. On behalf of the company I want to also say that the work done by the Oregon group I thought was well performed, very accurate. I think a very fair balance. I concur. I think with the overall and over-arching conclusion that these biologic

agents are successful in being able to reduce the frequency of severe adverse events or severe adverse exacerbations by at least half, at probably a very acceptable rate of safety. Now in reviewing the document that you had in front of you today in terms of the report and from Marian's remark, there are three publications that were not included or covered. There are various sub analyses, which were performed by Teva in the latter half of 2017. So it could very well be that they didn't fulfill the criteria for inclusion in the report. Nonetheless one of the three reports, one of the three publications is probably very pivotal to the conclusions you'll make today.

So in respect to the work our Phase 3 studies were allowed to be continued in open label fashion with enrollees out to two years after participation in the trial. So we have long-term safety and efficacy data now out to 24 months of experience in patients who are enrolled in the Phase 3 trials and allowed to continue in an open-label fashion. And I'll just share with you the findings of that long-term study. This was published in the Journal of Allergy and Clinical Immunology Practice, again, in the latter half of 2017, 1,051 patients for whom we now have 24 months' worth of infusion experience, continuous exposure, constantly again for about 740 of those patients with 250 patients having exposure out to 24 months or two years. The most common adverse events were worsening of asthma, which by FDA is considered an adverse event in this protocol and nasal pharyngitis. Serious adverse events effecting about 7% of the patients, 2% of the patients discontinued from that open long-term study because of adverse events, and there were three deaths, and these deaths were all concluded to be not related to the administration of drug. So in retrospect and looking at this data overall in patients with moderate to severe eosinophilic asthma, intravenous reslizumab displays favorable long-term safety and sustained long-term efficacy in the initial improvements in lung function and asthma control were maintained for up to two years. Hopefully that will be reassuring as you go look at the deliberations of your meeting today and look at reslizumab as one of the options that the allergists and immunologists have for treatment of patients.

On that note are there any questions or comments that I can address before moving on?

Lisa Chew: There doesn't appear to be questions. Thank you, Don.

Don Moran: Okay.

Lisa Chew: I think we're going to move to the first motion. For the committee members it's in your binder right after Marian's slides, the P&T motion. If you want to take a minute to review the materials and then if someone feels comfortable to make a motion or have a discussion about the motion.

Amber Figueroa: I think the question here being the therapeutic interchange and whether or not they can be subject to that. It seems that they are all equally effective and as long as, in my opinion, as long as they are with the differing age range and for the correct indication I would think that it would be all right. But I'd be interested to hear what everybody else thinks.

Lisa Chew: I would agree with that. I think one of the drugs has a different mechanism of action, the omalizumab and whether or not that can be exchanged with others, but I would appreciate others' thoughts.

Alex Park: I agree with Dr. Chew. It seems like omalizumab is the only drug that's indicated for the IgE mediated allergic asthma so I would not consider that for therapeutic exchange, at least in exchange with the IL-5 antagonists.

Amber Figueroa: I'm going to make a motion here. After considering the evidence of safety, efficacy and special populations for the treatment of asthma, I move that benralizumab, mepolizumab, omalizumab and reslizumab are safe and efficacious for the treatment of their approved indications. Benralizumab, mepolizumab and reslizumab can be subject to therapeutic interchange in the Washington Preferred Drug List.

Lisa Chew: I second. Nice pronunciation of those medications. All in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Now we're going to move on to the second motion, which are on the slides after Umang's presentation. April, will you be running through those?

April Phillips: So for the Apple Health PDL our recommendation is that all products are considered safe and efficacious and are eligible for preferred status and grandfathering at the discretion of HCA. And 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.

Man: [inaudible]

Umang Patel: I believe that question is for me. Yes, it is.

Susan Flatebo: I'll go ahead and make the motion. I move that the Apple Health Medicaid Program implement the limitations for the antiasthmatic monoclonal antibody drug class listed on slide #11 as recommended.

Jordan Storhaug: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. So we'll move forward with the asthma rescue medication scan. Ian? Ian, are you on the phone? Great. Your slides aren't up quite yet. Hang on just a moment. Okay. Your slides are up. Go ahead. Anytime you're ready.

Ian Blazina: So these are the slides for the quick-relief medications for asthma preliminary scan 7. Next slide.

Leta Evaskus: Ian, this is Leta. Are you on a speaker phone? It's kind of hard to hear you.

Ian Blazina: Is that better?

Leta Evaskus: A little bit. If you could speak a little bit louder.

Ian Blazina: Okay. I'll try my best.

Leta Evaskus: Thanks.

Ian Blazina: So for history the last update report was update number 1 in 2008 and the last update scan was scan number 6 in January of 2017. The present scan the searches of MEDLINE and Cochrane ran through December 2017. Next slide.

This slide just shows the key questions. The comparative efficacy and effectiveness of quick-relief asthma medications to treat outpatients. The comparative incidence and severity of harms and subgroup differences. Next slide.

We included adults or children with asthma including exercise-induced bronchospasm. The interventions are inhaled short-acting beta2 agonists, short-acting anticholinergics and combination products. And the settings we were looking at outpatient settings, urgent care and ER. Next slide.

So we did not identify any new drugs in the current scan. Previously we identified new formulation of albuterol, the PROAIR RESPICLICK. We have also not identified any new serious harms or new relevant comparative effectiveness reviews. Next slide.

This slide shows a table of the relevant head-to-head trials including the one newly identified Donohue 2016. Next slide.

This slide shows the head-to-head delivery method trials. Next slide.

So since the last update report we identified one newly-approved drug which is the new formulation of albuterol sulfate. Cumulatively there are nine new head-to-head trials including one new this scan and five dose… sorry. I mean delivery method comparisons. We have not identified any new boxed warnings or comparative effectiveness reviews in the current or previous scans since the 2008 report. Are there any questions?

Lisa Chew: There doesn't appear to be any questions and there are also no stakeholders for these drugs. The committee members direct your attention to the page just after these slides for the motion. I guess our options are we either make a motion that the scan is adequate or ask for a more thorough update. Is that correct? Okay.

Amber Figueroa: I move that we accept the scan as adequate for the inhaled short-acting beta2 agonists.

Lisa Chew: I second. And then I think we need to either… we have to reiterate the prior motion or is…

Leta Evaskus: You can make changes or you can reiterate.

Lisa Chew: So let's review the prior motion and if someone wants to make changes we can do that.

Diane Schwilke: I move that we reiterate the prior motion.

Catherine Brown: I second.

Lisa Chew: All in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. So let's move onto the statin scan. Ian, we're still in the process of pulling up your slides so just a minute.

Ian Blazina: All right.

Lisa Chew: Ian, your slides are up so any time you're ready.

Ian Blazina: Great. These are the slides for the statins scan which was update scan #5. The last report was update five in November 2009. Next slide.

So this is more of the history. The last scan was an expanded scan in January 2016 following preliminary update scan in April 2015 and the searches of the current scan run through February of this year. Next slide.

This slide is the key questions about how the statins compare in their ability to reduce LDL-C, raise HDL-C, reduce risk of clinical health outcomes, as well as subgroup differences in effectiveness and harms. And a question on specific populations and drug/drug interactions. Next slide.

We included outpatients targeted for primary or secondary prevention of coronary artery disease or non-coronary forms of atherosclerotic disease with or without hypercholesterolemia. We are also including inpatients with ACS or those undergoing revascularization, as well as outpatients with familial hypercholesterolemia and we included both adults and children. Next slide.

This table is the included statin interventions given as individual drugs. Next slide.

This is the fixed dose combination products. Next slide.

Since the last scan we identified no new drugs, pitavastatin and the combination of atorvastatin and ezetimibe were previously identified. We also identified no new boxed warnings and no new comparative effectiveness reviews. There was one identified previously. Next slide.

In this scan we found 11 potentially relevant head-to-head trials, 3 of pitavastatin and 5 of the atorvastatin/ezetimibe combination and one new secondary publication. Cumulatively that results in 55 head-to-head trials, 6 of which report clinical outcomes, 17 of these trials are of pitavastatin and 8 trials of the atorvastatin/ezetimibe combination, and 17 secondary analyses, 8 of which are reporting clinical outcomes. Next slide.

Since the last report we've identified one new drug, pitavastatin; one new combination, the atorvastatin/ezetimibe; one new formulation is an oral suspension, simvastatin; one comparative effectiveness review; 55 head-to-head trials, 11 new this scan and 17 secondary analyses, 1 new this scan. Next slide.

This is the recommendation for updating the report and it's not relevant here. Are there questions?

Nancy Lee: I have a question about the head-to-head studies with pitavastatin. What were the comparison drugs?

Ian Blazina: That is a good question. I would have to look back into the report. If you can give me a minute I can do that.

Nancy Lee: As you're looking could you also comment on the head-to-head comparisons for the combo atorvastatin/ezetimibe?

Ian Blazina: Yeah. Give me one minute.

I'm sorry. I have the table now. So it looks like the pitavastatin studies… looks like none of them reported clinical health outcomes. We have comparisons to rosuvastatin, simvastatin, atorvastatin. It looks like the majority of the pitavastatin trials compared to atorvastatin. And for the combination product it looks like the comparisons for the combination product are mostly to the individual components. So atorvastatin/ezetimibe compared to atorvastatin alone or ezetimibe… I'm sorry, just atorvastatin alone.

Nancy Lee: Thank you. So just to re-emphasize that none of the studies looked at the clinical outcomes except the six that you had reported in terms of your accumulative summary.

Ian Blazina: Yes, that's correct. So the clinical health outcome studies are mostly the older—atorvastatin compared to rosuvastatin, pravastatin compared to atorvastatin, and there's one trial of atorvastatin/ ezetimibe combination compared to atorvastatin. Sorry, actually two trials of that comparison reporting clinical health outcomes, but none for pitavastatin.

Lisa Chew: Any other questions for Ian? Okay. There are no stakeholders. So let's move to the motion here. I believe it's, again, similar to the last class of drugs where we, you know, make a motion to accept the scan as adequate or not adequate and we want a more thorough review. So…

Catherine Brown: I move to accept the scan as adequate.

Dale Sanderson: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. And now I'm asking the committee remembers to review the prior motion and see whether that's… we want to approve that or make any changes.

Amber Figueroa: I move that we carry over the prior motion or whatever that wording is. Do we need to state the motion? No? Okay.

Jordan Storhaug: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Okay. Then we're back to Marian on the next topic of PCSK9 inhibitors. So Marian, we're still in the process of pulling up your slides so we'll let you know.

Marian McDonagh: Okay.

Lisa Chew: Marian, your slides are up so any time you're ready.

Marian McDonagh: All right. Let's go to slide 2 then.

So the history of this report the original full report was done in July of 2015. We did a preliminary update scan… the last one we did was in March of last year and we had done a broader expanded scan following that in April of last year. So this is the first regular scan since then. So the date of the searches for this scan are up through February of 2018. So next slide. We have a series of questions for this report looking at benefits and harms of the PCSK9 inhibitors in different populations and then also looking at some subgroup questions. Next slide.

The inclusion criteria will make all of that more clear. So the populations included are patients with heterozygous or homozygous familial hypercholesterolemia, patients with hypercholesterolemia who are unable to use statins for a variety of reasons, and then patients with non-familial hypercholesterolemia who have not achieved specific targets. These are people who have varying levels of risk for cardiovascular events. So the two drugs included in this report are alirocumab and evolocumab. Next slide.

Our findings for the scan, there are no new PCSK-9 inhibitors approved at this time. And the only one that was in develop previously was the… just the development was discontinued. So new boxed warnings, none for this scan. Comparative effectiveness review really none. The only report we found was a report from the Canadian agency for drugs, technology and health. And they limited… their criteria was head-to-head studies only so they found one study that was not a randomized controlled trial.

The next two slides are just introducing a couple of drugs that are in the pipeline that are related to this class. So they're not approved yet. So just to give you a head up. The first is inclisiran and that is a [inaudible] nucleotide inhibiting that inhibits PCSK-9 synthesis in the liver. And so the advantage here is that it… although it is an injection it is only given two or three times a year. There are three Phase 3 trials that are projected to end… finish by the end of 2019. So not that far away. There is a Phase 2 study that has been published.

On the next slide looking at another drug in the pipeline, a little further out, [inaudible] and this is a monoclonal antibody that is for angiopoietin like protein 3. So this angiopoietin like protein 3 inhibits the enzymes that break down lipids, so blocking it with the antibody should help elimin… with the body's elimination of lipids. This is, of course, not a PCSK-9 mechanism, but just another biologic mechanism. So this drug has been given breakthrough therapy designation by the FDA for familial hypercholesterolemia and it also lowers triglycerides. There are two Phase 3 trials ongoing, but these are not expected to finish until 2020 and 2022. Next slide.

So for the PCSK-9 inhibitors since the last scan there are five new trials that we've identified for this scan. All of them however only report lipid outcomes, five of them… these are all in alirocumab. So they're looking at specific subpopulations. So patients with diabetes specifically, patients with diabetes were certainly included in the previous studies, but this is just focusing only on diabetics, Asian patients, alternative dosing meaning stretching out the dosing to be less frequent and see if that still has the advantages. Statin-intolerant so defining that in different ways and then heterozygous familial hypercholesterolemia looking at the subpopulation of these patients who are getting lipoprotein apheresis and seeing if the PCSK-9 inhibitor can reduce the [inaudible] apheresis. And then there are also additional subgroup populations… or subgroup analyses, sorry, and additional durations of follow-up for previous trials in secondary… six new secondary publications. So cumulatively there are now 17 trials, and then the 6 secondary publications since the report was done originally. So there's only one with

cardiovascular outcomes, however, and that is the four-year trial of evolocumab. We included that in the expanded scan last April. There is another trial, the Odyssey Outcomes Trial for alirocumab that will report cardiovascular outcomes and that is pending meaning that the trial is completed and is in analysis. We assume that that publication will be out sometime in the next six months or so. And the remainder of these studies only report lipid outcomes.

Quick summary on the next… well, I guess if we skip to the summary slide since the original report there are no new drugs or boxed warnings, 17 new trials, only one with cardiovascular outcomes. And that concludes the scan if there are any questions.

Lisa Chew: Thank you, Marian. Any questions for Marian? There doesn't appear to be any questions. And there are no stakeholders. So let's move to the motion and it's really the same whether we want to accept the scan as adequate or not adequate and requesting more thorough update.

Woman: I move to accept the scan as adequate.

Alex Park: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. And the motion carries. So committee members, please review the prior motion and see if we need to make changes to that or whether we can reiterate the prior motion.

Amber Figueroa: I move that we reiterate the prior motion.

Susan Flatebo: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. And the motion carries. Thank you. So I think we are now adjourning the P&T Committee and we'll take a 15-minute break. So maybe 10:30? And then we'll convene the DUR Board. Thank you.

Leta Evaskus: Is anyone still on the phone? Okay. Thank you.

Lisa Chew: Okay. We are going to go ahead and get started and we're going to be convening the Drug Utilization Review Board. So I'm going to turn it over to Umang to do presentations on lipotropic statins in PCSK-9 inhibitors.

Umang Patel: Okay. Next we will go over lipotropic statins and then lipotropic PCSK-9 inhibitors, specifically. Next slide.

Cardiovascular disease or CVD is one of the leading causes of death and disability in the Western world, and has been estimated to be the cause of one out of every three deaths in the United States. Hypercholesterolemia constitutes a major risk factor for the development of atherosclerosis and consequently ASCVD, especially coronary heart disease. Approximately 15.5 million Americans have coronary heart disease defined as a history of an MI, angina, heart failure, stroke, and congenital cardiovascular defects. The National Health and Nutrition Examination Survey reported in 2015 to 2016 approximately 12.4% of adults had high total cholesterol which was defined as greater than or equal to 240 mg/dL and 18.4% had low HDL or less than 40 mg/dL. It was found to be higher in women, approximately 13% compared to men about 11%. Many clinical trials have demonstrated that a high serum creatinine of LDL and low HDL levels are major risk factors for CHD. And there is a high level of evidence supporting the use of statins for secondary prevention and moderate to high level of evidence for their use in primary prevention. As a class it is found they can lower LDL up to 60% in a dose-related fashion. Statins typically have relatively minor effects on triglyceride and high… excuse me, and HDL reducing triglycerides by 6 to 30% and increasing HDL by 2 to 16% on average. Next slide.

Just to brush over the availability of statins, as you can see here, all formulations… we have all the formulations available. Note that all are available in generic aside from Altoprev and pitavastatin. And note that there is one new formulation of simvastatin which is Flolipid, which is an oral suspension. Next slide.

Now the next two slides you can see that statins have numerous indications. We're not going to go over each of these specific indications; however, it is here for an overall completeness sake. Just to give a brief clinical background in terms of mechanism of action these statins competitively inhibit HMG-CoA reductase, which is the enzyme that catalyzes the conversion of HMG-CoA to mevalonate, which is an early rate-limiting step in cholesterol biosynthesis. The inhibition of this reduces cholesterol in the hepatic cells, which in turn stimulates the synthesis of LDL receptors and increases the uptake of circulating LDL particles. Additionally, the statins work to reduce LDL by inhibiting the synthesis of VLDL which is very low density lipoprotein which is considered the LDL precursor. And HMG-CoA reductase inhibitors decrease LDL, VLDL, triglycerides and increase HDL. The other beneficial effect of statins in reducing the risk of cardiovascular events maybe through an independent anti-inflammatory effect unrelated to LDL reduction. The reduction in C reactive protein levels may lead to a decrease in cardiovascular event risk. In the statins marked response usually occurs within two weeks with maximum response occurring in about four to six weeks. Next slide.

Again, just a carryover from the previous slide indicating the indications for all the formulations available. Next slide.

Here you can see the U.S. Preventative Task Force in 2016. Their final recommendation on the use of statins for primary prevention of CVD in the adults. They recommend a low to moderate dose statin for prevention of CVD events and mortality in adults age 40 to 75 years of age with no history of CVD, one or more CVD risk factors and a 10-year calculated CVD event risk of 10% or greater. Since the likelihood of benefit is small, they recommend that clinicians may consider a low to moderate statin… dose statin, excuse me, in adults

age 40 to 75 with no history of CVD, one risk factor, or a 10-year calculated risk score of 7.5 to 10%. There is insufficient evidence at this point to assess adequately the risk versus benefit of statin in older adults defined as greater than or equal to 76 years of age without any CVD history. The American Association of Clinical Endocrinologists and American College of Endocrinology recommend aggressive lipid-modifying therapy to lower LDL with statins as the drug of choice. The recommended LDL goals of less than 55, 70 and 100 and 130 mg/dL for individuals at extreme, very high, high/moderate and low risk of cardiovascular events respectively. They support the use of apolipoprotein in evaluating lipid status, as well, and these guidelines address the unique challenges associated with atherosclerosis and heart disease in women and recommend pharmacotherapy preferably a statin for all women at high risk regardless of LDL level and for those at intermediate risk with an LDL of greater than 130. Any questions?

Lisa Chew: Any questions for Umang? So I think we'll move on and do the next presentation. Okay.

Umang Patel: We're continuing lipotropics. Next we'll discuss PCSK-9 inhibitors. Next slide.

Again, a quick overview to carry over from the previous topic. While hypercholesterolemia is common among the general population, it is even more prevalent in patients with familial hypercholesterolemia, a genetic disorder that leads to accumulation of LDL particles in the plasma and it is a premature cardiovascular disease. The more severe form, homozygous familial hypercholesterolemia, you'll see it throughout with the acronym HoFH is rare occurring in about 1 out of 1 million people in the U.S. In this disease LDL receptor activity is nearly absent and LDL levels commonly range between 400 to 1,000 mg/dL. Severe and widespread atherosclerosis affects all major arteries and children are at risk for early coronary events and valve abnormalities, particularly aortic stenosis. Historically, treating patients with this disease state has been very difficult since it is resistant to diet modifications and most medications indicated for lowering cholesterol. The less serious heterozygous familial

hypercholesterolemia occurs in about 1 in 500 people in the U.S. CAD symptoms begin to manifest in the fourth or fifth decade of life in men and women respectively. Additional risk factors such as genetic, metabolic or environmental can lead to variations in the clinical manifestations and severity of atherosclerotic disease in heterozygous familial hypercholesterolemia. And the accumulation of cholesterol in nonvascular tissue such as cornea, skin, tendons and joints also commonly occurs in children with homozygous familial hypercholesterolemia and heterozygous familial hypercholesterolemia. Next slide, please.

Here we have the two medications in this class, Praluent and Repatha. Just to kind of take a step back clinically for the mechanism of action how Praluent and Repatha work are they are human monoclonal antibodies that bind to PCSK-9. PCSK-9 binds to the LDL receptor at the surface of hepato sites and it targets internalized LDL receptors for lysosomal degradation. These drugs, by inhibiting the binding of PCSK-9 to the LDL receptors they have an increase in the number of LDL receptors available to clear the LDL particles, thereby lowering LDL. Both of these are indicated for Praluent is indicated for the treatment of adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease who require additional lowering of LDL as an adjunct to diet and maximally tolerated statin therapy. For Repatha it does have two indications. First, the treatment of adults with heterozygous familial hypercholesterolemia or ASCVD who require additional lowering of LDL as an adjunct to diet and maximally tolerated statin therapy and it is indicated for the treatment of patients with homozygous familial hypercholesterolemia who require additional lowering of LDL as an adjunct to diet and other LDL lowering therapies. Next slide, please.

Here, as you can see, the availabilities are similar with both Praluent and Repatha being available as subcutaneous pens. However, please note that the Repatha is also available as an on body infusion device named Pushtronex. This allows a once monthly dose of 420 mg of Repatha delivered to the patient. This is indicated for… it should be only used in children that are age 13 to 17 years of age or older, and

in children it should be used under adult supervision as instructed by a healthcare professional. In terms of pediatrics the safety and efficacy of Praluent in pediatric patients has not been established. The safety and efficacy, as I mentioned a second ago, for Repatha in pediatric patients is for 13 years of age or older if they have heterozygous familial hypercholesterolemia. In terms of hepatic and renal impairment no dose adjustment is necessary for patients with mild to moderate hepatic or renal impairment using either of these medications and neither of these have been studied in patients with severe hepatic or renal impairment. Next slide.

In terms of guidelines the American Association of Clinical Endocrinologists and the American College of Endocrinology in 2017 dictated the guidelines for the management of dyslipidemia and prevention of CVD are for adults 20 years of age or greater, should be assessed annually for dyslipidemia. Children should be screened who are at risk for familial hypercholesterolemia. They recommend fibrates for treatment of triglycerides greater than 500 mg/dL. Omega-3 fish oil can be used as adjunct to fibrates or niacin to achieve satisfactory triglyceride levels. Recommend bile acid sequestrants for reducing LDL and apo B and mostly increasing HDL. Ezetimibe is effective monotherapy in reducing LDL and apo B. They maintain statin is primary therapy and recommends ezetimibe in addition to statins. And finally PCSK-9 inhibitors may be considered in patients with clinical CVD who are not at goal with maximally tolerated statin or in those with familial hypercholesterolemia. The American Diabetes Association in 2017 recommend moderate to high intensity statin therapy in patients with diabetes based on patient's age and presence of their risk factors. They recommend ezetimibe as add-on moderate intensity… add-on to moderate-intensity statin therapy in patients with ACS or LDL over 50. And similar to the ACE PCSK-9 inhibitors are recommended to maximally tolerated statin doses in those that are at high risk for CVD events who require additional LDL reduction or who are intolerant to high intensity statin therapy. Any questions?

Lisa Chew: Thank you, Umang. No questions? Okay. Great. We do have one stakeholder, Dr. Sylvia Churchill. If you could make your way to the

podium. Please state your name and who you represent and you will have three minutes.

Sylvia Churchill: Good morning. My name is Sylvia Churchill. I'm a pharmacist here in Washington State and I work for Amgen as a health outcomes and pharmacoeconomic specialist. Thank you for the opportunity to say a few words today about evolocumab or Repatha and the PCSK-9 class in general.

The Magellan scan didn't mention some major changes that occurred with Repatha in the past year. So I do want to bring these up. Repatha now has published outcomes data in 27,500 patients with ASCVD which showed that the decrease in LDL from Repatha translates to a significant reduction in the incidence of MI, stroke, and coronary revascularization. That's basically want. I mean we've shown for a while that we can decrease LDLs, but what we really want to see is that that decrease in LDLs is going to translate into a decrease in cardiovascular events. We have that with statins. Now we have that with the PCSK-9s. This outcomes data was significant enough that in December of 2017 the FDA did add this as an additional indication in the Repatha PI.

In addition, Repatha is now approved in the PI for primary hyperlipidemia and it can be given alone or with diet or with other lipid lowering therapies. So for those patients who are unable to tolerate a statin, Repatha is now an FDA approved option.

The other recent changes to the PI relate primarily to safety… better safety data. As a result of additional clinical trial data and long-term safety follow-up they removed the following adverse reaction sections from the PI. The risk of neurocognitive events was removed from the adverse reaction section and this is due to data from the Ebbing House Trial, which showed that Repatha is non-inferior to placebo and cognitive function domains over a median follow-up of 19 months. The risk of musculoskeletal events was also removed from the adverse reaction section. The risk of low LDL levels was also removed from this section and that's based on… in our 27,500 patient [inaudible] trial, 76% of those patients achieved an LDL of

less than 25 mg/dL and these patients had a similar safety profile as those patients that had LDL levels over 40.

We also have some data in severe renal impairment. So the PI was changed to state that no dosing adjustment is needed in mild, moderate or severe renal impairment. In summary, the PCSK-9 inhibitors have a significantly different mechanism of action. They are able to decrease LDLs to a much greater magnitude than many of the other non-statin lipotropics. Repatha is the only PCSK-9 with published outcomes data and an FDA approved indication of decreasing the incidence of MI, stroke and coronary revascularization.

We certainly agree with the current guidelines that patients should always be started and optimized on statin therapy before considering the addition of a non-statin. But for those patients who are already on maximally tolerated statins and yet skill require an additional significant reduction in their LDL, healthcare providers should be able to add Repatha to their current regimen to achieve their goal LDL and decrease the risk of MI and stroke. Thanks. Are there any questions?

Lisa Chew: Thank you. Any questions for Dr. Churchill? Great. Thank you. Okay. So let's go ahead and move towards the motion of the statins.

April Phillips: So our recommendation is that all statin products are considered safe and efficacious and are eligible for preferred status and grandfathering at the discretion of HCA. All non-preferred products require a trial of two preferred products with the same indication and different active ingredients before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Nancy Lee: I move that the Apple Health Medicaid Program implement the limitations for the statin drug class listed on slide 19 as recommended.

Alex Park: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Now we'll move on to the PCSK-9 motion.

April Phillips: Our recommendation is all PCSK-9 products are considered safe and efficacious and are eligible for preferred status and grandfathering at the discretion of HCA. 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.

Diane Schwilke: I move that the Apple Health Medicaid Program implement the limitations for the PCSK-9 drug class listed on slide 26 as recommended.

Catherine Brown: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. And the motion carries. Great. So we'll move on to the Apple Health Policy. April?

April Phillips: Okay. So our first policy is for the PCSK-9 inhibitors for the indication of both Praluent and Repatha. Heterozygous familial hypercholesterolemia in adults is defined by one of the following listed on the slide.

The next indication for both products is clinical atherosclerotic cardiovascular disease in adults including at least one of the following.

The next two indications are for Repatha only. The first one is homozygous familial hypercholesterolemia for 13 years and older and is defined by one of the following listed below. And it looks like on the slide it is a history of untreated LDL at least 500 per dL with either xanthoma before 10 years of age or evidence of heterozygous familial hypercholesterolemia in both parents, and genetic typing confirming the presence familial hypercholesterolemia genes in both parents. And the second indication is myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease.

And with both products a trial of highest tolerated statin regimen for at least 12 weeks and LDL has not achieved at least 50% reduction from baseline. I was also noted that it hadn't… it missed it on the slide. It was or remains at least 100 mg/dL. The definition for highest tolerated dose of statins is listed below. Are there any questions?

Amber Figueroa: I have a couple questions. On slide 4 in our pack, but the one that says Repatha only. I think the wording of that is not… it says with either a xanthoma, but it has already said above defined by one of the following. So something about that needs to be cleared up.

April Phillips: That was a type-o on the slide. It missed… it's history of… with either the xanthoma before age 10 or the evidence of heterozygous familial hypercholesterolemia in both parents.

Amber Figueroa: Or the genetic…?

April Phillips: Yes. Or the genetic test.

Amber Figueroa: Since you've already said up above by one of the following I think you should just take out "either" before xanthoma, because you've already said they only need to have one of those three things. Then we don't need to put "or".

April Phillips: There's technically only two. That middle bullet there should actually be up with the first one.

Amber Figueroa: Okay. And my other question was on the next slide where it says concomitant therapy with the highest tolerated statin regimen for at least 12 consecutive weeks and LDL has not achieved. And we heard from… I think it was Umang's presentation that maximum effect of statin usually is reached by four to six weeks. So do we want to make them do 12 weeks?

April Phillips: I believe when this policy was originally presented in 2015 it was eight weeks. Would you like to go back to eight weeks?

Amber Figueroa: I just think if the evidence shows that the maximum is going to be reached at four to six weeks that I don't know if there is any clinical benefit and there could be potential harm of forcing them on a high dose, especially if they aren't tolerating it very well. I would vote for going back down to six or eight weeks.

Donna Sullivan: You really need to pick one because otherwise it is six. If you want it to be eight weeks you should say eight weeks. If you want it to be six weeks say six weeks. If you say six to eight weeks it will always be six weeks.

Amber Figueroa: If we're going evidence-based let's do six weeks.

Donna Sullivan: Okay.

Amber Figueroa: And then did you guys want to make sure it says "or remains greater than or equal to 100" at the end of that?

Leta Evaskus: I changed it to six weeks here, as well.

Amber Figueroa: I guess I have another question on that last bullet point of the last slide. The statin intolerance is defined as the inability to tolerate, due to muscle symptoms. There are other things that make people not tolerate statins. I don't know that we specifically want to say they have to have muscle symptoms.

April Phillips: Do you have a recommendation of how it states?

Amber Figueroa: I would recommend just taking it out. I mean I feel like clinicians have a pretty good grasp on what makes… I mean patients have a pretty good grasp on what they can't tolerate. They tell us, "I stopped it because I was puking."

Donna Sullivan: This is what we… on the previous policy it says that statin intolerance defined as documented trial and failure of at least two statins after ruling out hyperthyroidism, changes in physical activity and exercise, potential drug/drug interactions due to pre-specified intolerant symptoms that began or increase during statin therapy and stopped once statin therapy was discontinued. And so the pre-specified intolerant symptoms are myopathy or myalgia (muscle pain ache/weakness without CK elevation and then myositis, which is muscle symptoms with increased CK levels.

Amber Figueroa: That's obviously more loaded than muscle… I guess I'm not saying that they don't cause that, but I'm saying that I think if we say that their intolerance… it's almost like limiting it. Like due to muscle symptoms. So…

Donna Sullivan: What the intent is just to say is to… to make sure that it is really an intolerance as opposed to a preference. So we're trying to frame it up more in this policy. I would recommend that we kind of go back to the way it is stated in this policy. I think it's on our website that Ryan had presented back in 2015.

Nancy Lee: I agree. I think in your… what you read you also mentioned resolution of intolerant symptoms aside from the muscle aches and pains after stopping. So I think that includes the other potential intolerances that patients may report.

Leta Evaskus: Should I make a note in here then to reference the previous policy. Is that from 2015?

Donna Sullivan: Yes.

Leta Evaskus: Okay.

Amber Figueroa: Is there a way that we can pop that up or can you read it again, Donna?

Donna Sullivan: It's not online so I can read it again. So statin intolerance is documented trial and failure of at least two statins after ruling out hyperthyroidism, changes in physical activity and exercise, and potential drug/drug interactions due to pre-specified intolerant symptoms that began or increase during statin therapy and stopped once statin therapy was discontinued. Qualification of at least two statins is one statin must be the lowest starting daily dose and a different statin may be at any dose. If patient is on combination therapy such as fibrate or niacin tapering a fibrate or niacin while maintaining statin therapy is required to establish statin intolerance. Rhabdomyolysis is determined to be caused by any statin at any dose after ruling out all other potential causes including drug/drug interactions will be considered as a contraindication to statins as a class. Patients with history of rhabdomyolysis caused by statins must be managed by a lipid specialist and may be considered eligible for PCSK-9 inhibitors on a case-by-case basis. And then patients who have failed to meet criteria in three… in medical policy may be managed on non-daily statin therapy if able to demonstrate that they are maximally tolerated therapy can maintain the dose while on PCSK-9 inhibitor. And then it has the pre-specified intolerant symptoms of myopathy or myalgia, which is defined as muscle pain, ache or weakness without a CK elevation and then myositis, which is muscle symptoms with increased CK levels. I can pass this around so people can glance at it.

Amber Figueroa: So a couple of things in there that would change it from three statins to two statins. So we need to be clear if we want to do that. Like tried and failed or intolerant. And then that policy lists that they need to be seeing a lipid specialist. I'm not… is that an endocrinologist or a cardiologist or a family practice doctor? What is a lipid specialist?

Donna Sullivan: I would have to ask Ryan what the intention was on that. It's probably, I would imagine, something of that nature. I don't think there is a particular specialty for lipidology.

Amber Figueroa: I would just, you know, thinking of rural populations where somebody might have this familial thing or end up meeting all the criteria would not have access to a lipidologist or anything like that. I don't know that that is… my opinion is that I wouldn't be prescribing something outside of my scope without talking to a specialist on the phone anyway, but I don't know that the patient would be under their care. I don't know if we want to take that out or not. Just a couple points.

Leta Evaskus: I could put a note in here just saying that the patient can be seen by their primary care physician. Does that make sense?

Donna Sullivan: Sure.

Leta Evaskus: Okay.

Donna Sullivan: I have the policy. Can we put it up there or…

Woman: Oh yeah, yeah, yeah.

Donna Sullivan: Sorry, I found it. You probably can't read it, but…

Let me know if you want me to scroll down.

Alex Park: My reading of the definitions that are being passed around is that the pre-specified intolerance is still primarily muscle symptom related. So I just want to be sure that if we are referring to that, that that satisfies the concerns that Amber has addressed here. Because it seems to me that her concern was that intolerance can be broader than muscle symptoms alone and I tend to agree with that.

Amber Figueroa: I mean we can't really list out all the things that make… all the symptoms that would define intolerant. Right? But I think this does a good job of addressing the muscle issue and looking at the

utilization stuff. It looks like this stuff is about $1,000 a prescription. I understand that, you know, not every street corner needs to offer this, but the issue, in my mind, is that there are other intolerances that are not related to muscle symptoms. And I don't really know exactly how to do that except for "intolerant including" add in the policy.

Donna Sullivan: What I was thinking is… what I just added here is that "so documented trial and failure of at least two statins after ruling out hypothyroidism, changes in physical activity and exercises, potential drug/drug interactions, pre-specified intolerant symptoms or other adverse effects that began or increased during statin therapy and stopped when statin therapy was discontinued". So that kind of throws it all in there.

Lisa Chew: I agree. I think the symptoms and adverse effects that began or increased during statin therapy, I think Nancy mentioned this, I think it is pretty broad and would cover a lot.

Alex Park: I agree. Adding the other affects line I think satisfies our concerns.

Susan Flatebo: Do we need to remove the lipid specialists?

Donna Sullivan: Yeah. Did you guys say family practice doctor, or…?

Amber Figueroa: I think we should just remove that. Patients with a history of rabdo caused by statins may be considered eligible on a case-by-case basis.

Lisa Chew: Is there a motion then that we would make on these or…?

April Phillips: We don't have a slide specific for it, but if you want to make a motion.

Leta Evaskus: On policies you don't usually make motions. That's why there are no motion slides.

April Phillips: Are there any other questions before… So moving on to the next policy, the apolipoprotein B synthesis inhibitors specifically Juxtapid

and Kynamro. Sorry about that. Indication of homozygous familial hypercholesterolemia confirmed by one of the following: genetic confirmation of two mutant alleles of the following; documentation DNA testing for the functional mutation in both LDL receptor known to affect functionality; and untreated low density… or LDL cholesterol greater than 500 and triglyceride less than 300 in both parents with documented untreated triglyceride at 250.

Amber Figueroa: I think that's total cholesterol, not triglyceride.

April Phillips: Oops. Sorry. Yeah. For this one the indication… it's only for adults and prescribed by or in consultation with a specialist in lipid management. Are there any questions or comments on this policy?

Lisa Chew: Any comments about the policy for the apolipoprotein B synthesis inhibitors? Everybody comfortable with the last bullet based on the conversation we had with the previous medication?

Donna Sullivan: We can remove lipid specialist.

Lisa Chew: I actually like the way it is worded and it provides some limitations and making sure there is expertise when prescribing these sort of very highly specialized drugs. Open to other people's thoughts.

Jordan Storhaug: I think especially a consultation can just be calling a specialist describing the history and documenting that for the Health Care Authority and [inaudible] unnecessary burden.

Lisa Chew: I think we actually have a stakeholder, Dr. Sylvia Churchill.

Woman: [inaudible]

Lisa Chew: Can we go back to that? Okay.

Sylvia Churchill: Again, Sylvia Churchill, pharmacist working with Amgen. A really good conversation about the criteria and most of those were addressed. So that's great. The one thing that wasn't discussed was the requirement for the step through of Zetia on top of the

maximally tolerated statin as a step through before the PCSK-9. I think it's like the second bullet point from the bottom. I just want to point out that Zetia, or ezetimibe and the PCSK-9s are drastically different drugs. They work in very different mechanisms of action. Ezetimibe works by inhibiting cholesterol absorption in the gut and it only gives you an additional 15 to 20% decrease in LDLs whereas the PCSK-9s are monoclonal antibodies. They are very effective and will decrease your LDL by 50 to 60% on top of statins. So because of the two differences… the two major differences in efficacy, I would prefer to leave it up to the physician to determine, based on where that patient is, and how much lower they need to go whether that patient should be placed on ezetimibe and get a 15 to 20% additional decrease or if he thinks that the patient needs a bigger decrease and wants to put them on a PCSK-9, but to make them step through ezetimibe knowing that it is not going to get them to goal just adds another medication and more time.

I can give you an example. If you had a patient whose baseline LDL was 300 you give them a high intensity statin, you're expecting that that LDL is going to decrease by 50%. So LDL goes from 300 to 150 and they still are not at goal. The healthcare provider wants them lower than 150. So if you added Zetia to that patient you could get that down 15 to 20%. You'd still have an LDL of 120 to 125 and you're not where you want to be. So then the doctor needs to add yet something else. Whereas instead of Zetia the provider adds a PCSK-9 and you'll decrease your LDLs by 50 to 60% and that will get you down to the 60 to 70 LDL range and everybody is happy. The 2017 ATC Consensus Guidelines, the most recent ones from last year, they do recommend adding either ezetimibe or a PCSK-9 depending on the magnitude of addition of additional LDL decrease needed for that patient to reach goal. So if you could consider maybe removing that Zetia requirement or saying that if the patient needs more than a 20% additional decrease then waive that step for Zetia. Any questions?

Lisa Chew: Thank you very much.

Sylvia Churchill: All right. Thank you.

Lisa Chew: Any last comments about the PCSK-9 inhibitors and the apolipoprotein B synthesis inhibitor policy before we move forward?

April Phillips: We actually would like you to make a motion on the policies.

Nancy Lee: I do want to comment on the… just looking at the NLA guidelines, as well, they do put plus/minus Zetia and I think part of it, as mentioned, kind of depends on whether or not it is treatment of homozygous versus heterozygous familial hypercholesterolemia. So with homozygous it's really difficult to get that additional lowering with the addition of the ezetimibe versus maybe in the heterozygous patient population depending on where their LDL levels are. It may or may not… I mean… it's going to depend on I guess the underlying how bad their cardiovascular lipedema is. So plus/minus instead of and that would encompass both hetero and homozygous patient populations.

Lisa Chew: Any other comments about this policy? You've gonna have to give us the words to make the motion without the slides in front of us.

Leta Evaskus: If you can look back at the last motion under the last tab. So I guess you could just word it like that. It says I move the Apple Health Medicaid Program implement the limitations for…

Amber Figueroa: I move that the Apple Health Medicaid Program implement limitations for the PCSK-9 drug class listed on slide 3 through 5 in our packet. Right? Oops, none, 2 through 5, as recommended.

Jordan Storhaug: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. So let's move on to the apolipoprotein B synthesis inhibitors.

Amber Figueroa: I move that the Apple Health Medicaid Program implement the limitations for the apolipoprotein B synthesis inhibitors drug class listed on slide 6 as recommended.

Susan Flatebo: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Okay, the topic dermatitis.

April Phillips: For the atopic dermatitis agents specifically Elidel and Protopic require a diagnosis of dermatitis or eczema, history of failure or contraindication or intolerance, clinically inappropriate to two topical corticosteroids with daily treatment for a minimum of 14 days. With this one failure is defined as inability to achieve or maintain remission of the disease greater than age 2… or at least age 2 and dose limits as follows: Elidel and tacrolimus 0.33% for aged 2 or older and tacrolimus 0.1% for age 16 or older unless the prescriber is a dermatologist.

For the Eucrisa diagnosis, once again, atopic dermatitis, history of failure (unable to achieve or maintain remission), intolerance, contraindication or clinically inappropriate to both of the following: topical corticosteroid steroids and topical calcineurin inhibitors and at least age 2.

And then the final one is the Dupixent. Diagnosis of severe chronic atopic dermatitis involving at least 10% of the body surface area, clinical documentation of functional impairment due to the atopic dermatitis, history of failure, intolerance, contraindication, or clinically inappropriate to the following therapies: corticosteroids, calcineurin inhibitors or systemic treatment such as immunosuppressants or phototherapy. And age 18 and older and prescribed by or in consultation with a specialist in dermatology.

Amber Figueroa: I think you can just change that to dermatologist.

David Johnson: My concern is that there's lots of dermatology practices. Like everybody else, they are adding mid-level practitioners. So you get PAs and ARNPs working in a dermatology practice and they are not dermatologists. So if you specify to that then I'm going to end up denying all of those. That is the reality. That is the reality of that.

Amber Figueroa: Change specialist to provider. Does that work? Because in mind a specialist is someone who has done residency training in a specific area. Provider is more generic and you wouldn't have to deny it. Right?

Lisa Chew: Are there other questions or comments for April?

Amber Figueroa: I'm sorry. I should have been a newspaper editor. The way that all of these read doesn't…

Donna Sullivan: I'm sorry. I was going to go back to the specialist issue. I mean you can have a nurse practitioner, I believe, that has a dermatology specialty. Am I correct?

Virginia Buccola: Yes, that's correct. There would be no residency, but you would certainly be a specialist if you were an FNP and had an established practice in a focal area.

Donna Sullivan: Right. So I agree with not saying dermatologist because that is a physician and to David's point then a nurse practitioner or physician assistant wouldn't meet that description, but a provider in dermatology… I think somebody that actually has a specialty, you know, some sort of specialty training in dermatology whether it be board certified or otherwise is what we're trying to say here with a specialist.

Amber Figueroa: So do you feel like that doesn't address it?

Donna Sullivan: I think it does the way it does here… I think leaving it the way it is written is what we're… what I would prefer as opposed to… I'm not sure what you had recommended changing it to.

Amber Figueroa: Maybe I'm the only one here that thinks this, but when I read "specialist" to me it means like they have some specific advanced training. I don't think mid-levels there is advanced training where they get some kind of special certificate saying that they are now specialists in dermatology. They have worked with a dermatologist for two years. There's nothing on their wall that says that they are a specialist. It is maybe just semantics.

Virginia Buccola: I would… my opinion would be that that would be semantics that, you know, as an advanced practice provider there would be a level of specialty that would be assumed if they are working in a specialty office usually in conjunction with a board certified dermatologist who is an M.D. I would just be worried about limiting clients' access in any way. If we were to back away from acknowledging the specialty work of PA or ARNPs in practices such as those. That might be too much to say about provider versus specialist. But…

Dale Sanderson: The understanding is that the PA or the ARNP would have delegated responsibility from the dermatologist. Personally I think this qualifies.

Amber Figueroa: We have bigger fish to fry so I don't care. Put it however you want. Good discussion.

Lisa Chew: So are we leaving it with provider or do we want to change it back to specialist?

Donna Sullivan: I'm okay with leaving it with provider.

Lisa Chew: Amber, did you have additional comments?

Amber Figueroa: Always. I just… the way that each one of these slides reads doesn't make grammatical sense to me. So the second bullet point, "history of failure, (take out the parenthesis for a second) contraindication,

intolerance or clinically inappropriate to". Clinically inappropriate to prescribe? It just doesn't flow to me and it's not quite exactly clear. Or maybe it is just me.

Emily Transue: What about if… it seems like it is the "clinically inappropriate" that doesn't belong. So if it was "history of failure, intolerance or contraindication to, or clinical inappropriateness of,"? Also raised by an English professor so I'm always getting people hung up on…

Alex Park: I guess I don't quite understand what we mean by clinically inappropriate.

Donna Sullivan: I think when you're talking about clinically inappropriate it is summarizing. You've tried and failed it already or you're contraindicated to it, you know, you're allergic to it. It caused really bad rash the last time kind of stuff. So I think clinical inappropriate is really summarizing everything else that we're saying before we say clinically inappropriate.

April Phillips: If you were using a topical steroid it may not be clinically appropriate to use it around the eye or on the face in general.

Donna Sullivan: Or on kids.

April Phillips: It doesn't necessarily mean it is contraindicated. It is just potentially not appropriate to use it.

Emily Transue: Put a comma after the of.

Lisa Chew: Thank you, Emily, for the punctuation. Any other comments about this policy? We do have one stakeholder for this, Dr. Arthy Bake.

Amber Figueroa: Can we just make sure that that carries through to each one of the slides because they are all worded that way. Thanks.

Lisa Chew: Please state your name and who you represent and you have three minutes for comments.

Arthy Bake: Good morning. My name is Dr. Arthy Bake. I am a licensed pharmacist and a field medical director for Pfizer. I appreciate your time today to talk about Eucrisa. It is a non-steroidal ointment for the treatment of mild to moderate atopic dermatitis in patients 2 years of age or older. I support… I do this in support of Pfizer's request to consider inclusion of Eucrisa on the PDL. Atopic dermatitis is a common chronic inflammatory skin disease that occurs most frequently in children. About 18 million children and adults in the U.S. have atopic dermatitis and approximately 90% of these people are mild to moderate in their condition.

Treatment can be a lifelong commitment. Eucrisa is the first topical prescription treatment for atopic dermatitis in more than a decade. It is the first and only steroid-free topical treatment that inhibits PDE4 enzyme within the skin. There are no limitations on duration of use for the package insert. Eucrisa can be applied twice daily to the skin anywhere on the face and body. The product is for external use only and is not to be used ophthalmically, orally or intravaginally. The safety and efficacy of Eucrisa was established in two identical pivotal… I'm sorry, two identical double-blind randomized vehicle controlled trials of 1,522 patients. The patients were 2 to 79 years of age with about 86% of these patients being under the age of 17. And the body surface area that was treatable was anywhere from 5 to 95%. 40% of these patients had a mild disease and about 60% of these patients had moderate disease per the investigator static global assessment score.

The primary efficacy endpoint was the proportion of patients at day 29 who achieved success, which was a two grade improvement in their ISG score to be clear or almost clear. Approximately 32.8% of these Eucrisa patients had this result with 25.4 of the vehicle in trial 1 and 31.4 versus 18% of the vehicle achieved the primary endpoint within the 28 days of this trial. They also did additional evaluations with regard to time to success. About 14.7% of these patients received that two grade improvement in the Eucrisa arm versus the vehicle about 5.4 as early as day 8. The same trend showed throughout at days 15, 22 and 29. Significantly more Eucrisa patients achieved a score of clear or almost clear regardless of the

two point change by day 29 at 50.7% of the Eucrisa arm versus 40 of the vehicle in Trial 1 and about 48.5 of the Eucrisa arm versus 29.7 of the vehicle in Trial 2. The most common adverse events of it occurring in greater than 1% of the patients was application site pain of 4% in the active arm and 1% in the vehicle even though discontinuation rates for both groups were 1.2.

The reason I wanted to come by and share particular information with you was long-term data. We have longer term safety data available with Eucrisa in which they were looked at for 48 weeks. There were 517 patients to 72 years of age that were included in this trial and the majority of the treatment of urgent adverse events, which were seven, were mild to moderate in severity and not related to treatment. The mean number of treatment cycles was 6 with a mean duration of 28 days per cycle across all age groups and there were no reports of application site cutaneous adverse reactions such as atrophy or telangiectasia. There is a contraindication with Eucrisa for hyper sensitivity or any… to Eucrisa or any component of the formulation and it is instructed to discontinue use immediately and initiate therapy if this occurs. Again, the most common adverse event was application site pain such as burning and stinging as stated earlier.

In summary, this is the first and only steroid-free PDE4 inhibitor for mild to moderate atopic dermatitis in patients greater than 2 years of age. It is… the active ingredient is crisaborole and it inhibits the PDE4 enzyme within the skin. There are no limitations on duration of use per the package insert. Patients apply a thin layer twice daily to the affected areas, including face and it is not for ophthalmic, oral or intravaginal use. I appreciate your time in listening to me and considering our request to be included in the PDL. I'd be happy to answer any questions for you.

Lisa Chew: Any questions? Thank you very much.

All right. Let's turn back to the atopic dermatitis agents. Any last comments or edits to that?

Catherine Brown: This is not my area, but I have a question on the Dupixent. I'm just wondering did the guidelines recommend the systemic treatment before something like Dupixent?

April Phillips: Sorry. I am not aware of what the guidelines say at the moment. I just know with the Dupixent it says subcutaneous injection usually for severe atopic dermatitis.

Woman: [inaudible]

April Phillips: Thank you. I guess the Eucrisa and the Dupixent aren't in the guidelines.

Catherine Brown: I'm just wondering why you would want to go with a systemic immunosuppressant first.

Amber Figueroa: I think it's prednisone.

Catherine Brown: All right. All right.

Alex Park: Referring to slide 8 I would like to recommend that we change the wording on the bullet point… the second bullet point to read, "daily use of one or both of the following". And I say that because I would not necessarily think that a patient should have to be on both those agents before moving to Eucrisa. I think that… my understanding of the cost data between the calcineurin agents and Eucrisa is that it is fairly similar and I think there are some benefits to Eucrisa over the calcineurin agents in that dose adjustments are not necessary and there… there's less safety concern with regard to some of the more obscure reports of lymphoma and other malignancies that you see with calcineurin. So I would like to see one or both. That would be my recommendation.

Donna Sullivan: So going back to the point about the systemic immune modulators. They are in the guideline that states systemic immunomodulator agents are indicated for the subset of adults and pediatric patients in whom optimized topical regimens or phototherapy do not adequately control the signs and symptoms of the disease. They are

indicated when the patient's skin disease has a significant negative physical, emotional or social impact in that they should be adjusted to the minimal effective dose once response is obtained and sustained and adjunct therapy should be continued. Cyclosporine is effective and recommended as a treatment option for patients with AD refractory to conventional topical treatment. Strength of recommendation is B with level of evidence 1 or 2. So azathioprine, methotrexate, mycophenolate and interferon gamma and systemic steroids all have the same level of recommendation and evidence.

Catherine Brown: Thank you.

Donna Sullivan: You're welcome.

Amber Figueroa: So they would need to try one of those systemic treatments?

Donna Sullivan: Correct.

Amber Figueroa: And fail? Okay.

Nancy Lee: I just had a question for Donna. You have to remind me, was there a DERP report looking at… I know that there were DERP reports looking at like topical calcineurin inhibitors and topical corticosteroids. Has there been one that looked at the treatment of atopic dermatitis and kind of did a different drug class comparison like including the Eucrisa and now the Dupixent? Or if there is any plan to do that kind of report? I think that might help guide…

Donna Sullivan: I think that report might actually be in process. For some reason I was thinking that we had reviewed… that we were going to be reviewing it this week, now that you mention it, or this month, but I believe it is either in draft form or it is in process.

Nancy Lee: Should we wait until we review the findings from that to kind of help guide this process?

Donna Sullivan: Let me double check and make sure that it is actually being reviewed. And April is telling me she thought we had already reviewed it in December. So I'm going to go back and look.

Nancy Lee: I remember we talked about Eucrisa before, but I can't remember if it was just in isolation like separate with, you know, a separate drug class rather than kind of the disease state and the different drug therapies within that disease state.

Donna Sullivan: I don't have the agenda on the website. So I'll have to look.

April Phillips: I believe… I'm not 100% sure, but I believe we reviewed the DERP report and the Magellan information in December, but I may be incorrect so we're going to check real quick.

Donna Sullivan: We did review it in December. So what was the question, again that you were wanting to look at?

Nancy Lee: In terms of what we reviewed could the information… I can't remember, could that help us guide us in terms of… I guess the question is, because the question goes into the one or both of the following. I guess where did this stepwise recommendation come from? Did it come from those two reviews?

Donna Sullivan: As far as I can tell it seems to be in line with what the guidelines are minus the… with the… the guidelines basically say use the topical treatments and then the immune modulators and phototherapy. These drugs haven't been added to the guideline so I think what we're trying to say is follow the guideline and if those recommendations don't work that's when these come into play. I can pull up the guideline. Hang on.

Nancy Lee: I have it up too. The American Academy of Dermatology?

Donna Sullivan: Uh huh.

Nancy Lee: Yeah.

Amber Figueroa: So yeah, the issue is saying one or both of the following for the Eucrisa and do you… Alex, do you feel like that if you didn't want to use the calcineurin inhibitor that you would be able to justify it under one of those either intolerance, contraindication or clinically inappropriate? Or do you feel like it needs to say one or the other?

Alex Park: I think I misunderstood the reading there. I think I was interpreting it as saying that we were requiring patients to have tried both those agents, but reading it again it looks like we are saying that we're asking for intolerance or contraindication or clinically inappropriate status to… well, let me look at the verbiage again here.

Donna Sullivan: We changed it.

Alex Park: Oh we did? I think I remember. So we had changed it to one or both. So you're asking should we go back to just saying "both" based on…

Amber Figueroa: I'm just feeling Donna and the crew are trying to fit it into the current recommendations that don't even address Eucrisa and how… Donna, what do you think about that?

Donna Sullivan: About…?

Amber Figueroa: Or maybe the planned pharmacy pharmacists… about having it be just one of those instead of both of them.

April Phillips: Just a comment. For the calcineurin inhibitors they have to have tried either or contraindicated to the topical steroid. So that's kind of where…

Nancy Lee: To be consistent I would recommend sticking with what the current guidelines recommend, which is stepwise therapy both. Since we don't have additional data to inform us if… like we don't have comparative information.

Alex Park: I recognize your point. I agree. Thanks.

Amber Figueroa: But if you have to try two rounds of steroids before you can get approved for the calcineurin then that doesn't really make sense. Right?

April Phillips: And you would have already had a history of failure of the topical corticosteroid.

Woman: I think the question is kind of do we want this to be a step two choice or do we want it to be a step three choice? Is that how you would interpret it at the plan level?

David Johnson: Yes.

Donna Sullivan: I'm sorry. I'm pulling up the Eucrisa, which we haven't brought to you. So for Eucrisa we have the diagnosis of history of failure, intolerance, contraindication or clinically appropriate to topical steroids and topical calcineurin inhibitors. So I don't think we have a policy for the topical calcineurin inhibitors. Do we? Oh, okay. So I think what we're trying to say is the policy for atopic dermatitis really you start with trying two different topical steroids and then you go to a calcineurin inhibitor before you go to one of these other drugs. So this would be step three.

Amber Figueroa: Then we should either take out the topical corticosteroids knowing that you would have had to have done two rounds of those to even get on the calcineurin inhibitor or it needs to say two different steroid rounds, 14 days each, or something like that. Do you see what I'm saying? It doesn't make sense that we say only one round, but you have to have two rounds even to get the calcineurin based on the previous slide.

Jordan Storhaug: I mean I can imagine a situation where maybe that's not the case like someone had commercial insurance before and then it's coming onto this plan and so maybe that had that opportunity before. I think I'm comfortable with the way that it is even though most of them will not have done it that way. I think we might be getting just caught up on details that aren't actually changing what we're going to implement here.

Donna Sullivan: I don't see how… I'm not sure what you're interpreting this, but we're saying here that you have to have tried a corticosteroid and you have to have tried a calcineurin agent. And so it's not that we're going back and making you try them again if you haven't, you know, try them again and fail them again. It's that if the doctor say, "Yeah, we tried that. They didn't work." Then they would be approved. So I'm not sure… I'm not sure what you're trouble is.

Amber Figueroa: I'm just saying in order for the plans to approve the calcineurin what would they have had to try and fail?

Donna Sullivan: Two topical steroids.

Amber Figueroa: Right. So here we're saying they only have to do one. But I don't… again, it's semantics. We can leave it that way. It's okay. It's all right with me.

Woman: [inaudible]

Amber Figueroa: It doesn't matter to me because it's going to… they are going to have to have done that anyway to get the calcineurin.

Donna Sullivan: Right.

Amber Figueroa: For consistency…

Donna Sullivan: Okay. It does say topical steroids.

Lisa Chew: Going back to the whole policy are people comfortable with the way it sits and ready to make a motion?

Amber Figueroa: Did you want to eat lunch?

Lisa Chew: I'm sorry.

Alex Park: Not to further our hypoglycemia here, but on slide 9, you know, I would consider Dupixent a systemic treatment. So I would wonder if

we should change that third bullet point to read, “other systemic treatments or alternative systemic treatments”.

Donna Sullivan: So say that first part leading up to that one more time.

Alex Park: I see Dupixent as a systemic treatment so I don’t think we would want to say you’re going to use this if you have clinical inappropriateness or a contraindication to using systemic treatment. I think we would want to say you use this if you have clinical inappropriate [inaudible] and other systemic treatments.

Donna Sullivan: Yeah. So I think what we want to say is systemic treatment with immunosuppressive agents or phototherapy. Since the systemic treatments in the guideline was referring to things that were systemic prior to these new drugs being approved and now that they are approved that reference… the way that they reference it in the guideline, you’re know, it conflicts with the new products that are actually systemic.

Alex Park: Right. Right. That’s how it reads now.

Amber Figueroa: I move that the Apple Health Medicaid Program implement the limitations for the atopic dermatitis agents drug class listed on slides 7 through 9 as recommended.

Susan Flatebo: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries.

Donna Sullivan: I do have an announcement. We are not going back. Before you adjourn for lunch I wanted to jump in. I forgot to announce it earlier this morning that Ray Hanley is actually moving on to new adventures outside of the Health Care Authority or outside of the Prescription Drug Program so today is his last meeting. So I just

wanted to thank Ray for the 14 years that he's been working in the prescription drug program and all of the help and support that he's given us for the P&T Committee, the DUR Board, and the Washington PDL. So thanks Ray.

[Applause]

Lisa Chew: Thanks, Ray, for everything. It's great. We could go through another class or…

Woman: No, no, no, no, no.

Lisa Chew: All right. Do we take the full hour for lunch? Okay. All right. So we will take a break and come back at 1:00.

We will reconvene the DUR Board and I think we left off at bone density regulators. Is that correct? I guess one question while we're setting up. Is there a way that… if it's been presented by Magellan whether we could have those referenced documents? Just sometimes it's helpful to refer back to them with some of these drugs. I don't know if other people on the committee would find that helpful.

Donna Sullivan: So have me pull them up now or give them to you later? Is that what you're meaning?

Lisa Chew: Not for today but in the future if we could have those documents readily available.

Donna Sullivan: Sure. Absolutely.

Lisa Chew: Thank you.

April Phillips: Sorry about that. I lost my place. So we're going to review the bone density regulators. The first product is Tymlos. So diagnosis of osteoporosis in postmenopausal women at high risk for fracture and then defined by one of the following listed below: with a history of failure, contraindication, or intolerance to at least one of the

following: two oral bisphosphonates or one oral bisphosphonate and one selective estrogen receptor modulator, and then not to be used for more than two years total.

The next one is for Prolia. This is the policy that was reviewed in 2016 and one of the following listed below: men or postmenopausal women diagnosed with osteoporosis as defined there, or men who are receiving androgen deprivation therapy for non-metastatic prostate cancer, or women who are receiving adjuvant aromatase inhibitor therapy for breast cancer, with a history of failure, contraindication or intolerance to at least one bisphosphonate and one IV zoledronic acid with none of the following listed below.

And for the next product a diagnosis of one of the following: postmenopausal women with osteoporosis and high risk of fracture, to increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture, or treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at risk for fracture. And high risk of fracture is defined below. History of failure, contraindication or intolerance to at least one of the following: two oral bisphosphonates, or one oral bisphosphonate and one selective estrogen receptor modulator greater than or equal to 18 years of age with closed epiphyses and a total combined duration of parathyroid analog use not to exceed two years. That is including both Tymlos and Forteo.

Are there any questions or comments?

Amber Figueroa: Slide 12 it says diagnosis of osteoporosis one of the following. To include or in addition to or…? What does…? Or as defined by?

April Phillips: Another type-o. It should read diagnosis of osteoporosis in postmenopausal women with osteoporosis at high risk for fracture as defined by one of the following and then list the…

Amber Figueroa: That's not going to work because the second bullet point says men.

Jordan Storhaug: I have concerns about requiring that patients have to have treatment failure of two bisphosphonates. These are medications that take a long time for them to fail and so it would be many years potentially before they would be able to get onto these other treatments. I'm kind of unaware of any evidence to suggest that if one of the bisphosphonates was ineffective at improving their bone density that it would be actually reasonable to think [inaudible] would.

April Phillips: Sorry. I was looking to Ryan. He's the one that originally created the policy in 2016. Donna, do you know anything?

Donna Sullivan: I didn't quite hear the question.

Jordan Storhaug: I'm fine with the contraindication or intolerance to at least two bisphosphonates, but asking people to fail two bisphosphonates of which case they would need to be on each one of those medications for a couple of years before I would really be able to call it a failure by repeat DEXA scan and so I'd be, you know, six years of receiving inadequate treatment before they would be able to get on one of these stronger agents. So I guess I would ask that we do just failure of one oral bisphosphonate.

Donna Sullivan: So basically we could say failure of one oral bisphosphonate and one selective estrogen receptor modulator. Is that what you're thinking?

Jordan Storhaug: I think it would be an or would be the part of that because in general I mean in my practice I would probably not use a [inaudible] because the bisphosphonates have kind of better evidence for most people who don't have an alternative for doing that. But I would… what I would expect from my practice is to do an oral bisphosphonate if they are not getting adequate improvement in their bone mineral density guidelines, as far as I know, then would then suggest I should use something like Forteo stronger for doing that and not necessarily subject them to bleeding or a long enough period for a trial to have another failure.

Donna Sullivan: And so you're saying a trial would be several years.

Jordan Storhaug: By this date I think you'd be doing that because you'd have to be getting another DEXA scan and then… there's some good data that it takes a number of years before you're able to see a difference in bone marrow density.

Donna Sullivan: Okay. So we could say a two-year trial of either an oral bisphosphonate or selective estrogen receptor modulator.

Jordan Storhaug: That would appease me.

Donna Sullivan: Any other comments from committee members?

Amber Figueroa: I'm okay with that.

Leta Evaskus: Then the first bullet do you want to leave as it was or to two oral bisphosphonates or keep it as changed to one?

Jordan Storhaug: It might be best to do a contraindication or intolerance to at least such and such and then another main bullet point, you know, that would then be a history of failure and a history or two years or something along those lines.

Leta Evaskus: So are you saying get rid of the first bullet, leave the second and then put a new second one saying history of failure.

Jordan Storhaug: Yeah. So I think the contraindication or intolerance needs to be one bullet point and then some verbiage referring to a length.

Donna Sullivan: How about this. So a history of a contraindication or intolerance to both oral bisphosphonates and a selective estrogen receptor modulator or failure of a two-year trial of either an oral bisphosphonate or a selective estrogen receptor modulator. Is that what you're trying to get at?

Jordan Storhaug: Uh huh.

Donna Sullivan: Okay.

Leta Evaskus: So then the oral would be a second bullet point because you're… under this first one, history of a contraindication intolerance to one of the following, leave both of those and then do…

Donna Sullivan: I think that first bullet, Leta, you would change the… where it says "at least one" it would be to both.

Leta Evaskus: Are you saying in the main bullet or the sub bullet?

Donna Sullivan: In the main bullet. So intolerance to both of the following and then get rid of the one in the first bullet. Leave the oral bisphosphonates. And then it would say or you can copy and paste the selective estrogen receptor modulator. And paste it… that should say and instead of or. Sorry. And then delete… just copy that second or cut that second sub bullet and make it a main bullet. And then paste it there. And say or history of failure… at the beginning. Sorry. Just insert it in front of the A. History or failure of a two-year trial of… and then change that to two-year trial of one bisphosphonate and change the big and to an or. I think that does it. Yeah, that or goes after the first sub bullet.

Lisa Chew: So are we saying… because I think intolerance and failure are two different things. Are we saying then if somebody is intolerant to one oral bisphosphonate they can jump to a higher potency agent or are we saying for intolerance they should have at least two?

Donna Sullivan: That's a great point. We could say for intolerance that you have to try two, meaning, you know, if you… it gives you a headache or it makes you throw up. That's intolerance as opposed to it is not working. So if you're comfortable saying intolerance… so contraindication or intolerance to two oral bisphosphonates and a serum or history of failure of one or the other.

Lisa Chew: I think… I agree with the failure that it should be one. But I think intolerance should be two. Do other people have comments on that?

Donna Sullivan: So Leta, I would put, in front of the sub bullet put two oral bisphosphonates.

Nancy Lee: For that first bullet history of "or not effective" do we take that out? Because you have that on the second bullet point. Yeah. So history of contraindication or intolerance to both of the following or… should we… history or… history of contraindication or intolerance to the following two oral bisphosphonates and/or a selective…

Donna Sullivan: I don't think we need "the following". I think you can say history of contraindication or intolerance to two oral bisphosphonates and one selective estrogen receptor modulator. And then get rid of "both of the following". Keep the "two". Yep. It doesn't really need to be a sub bullet, but it can be.

Lisa Chew: Any other comments? We do have one stakeholder.

Alex Park: Can I clarify? So we are saying that a patient must have tried two oral bisphosphonates and a serum and had intolerance before they can move on to Forteo? Am I ready that right?

Donna Sullivan: Correct. Yeah. So they don't have to have been on it… each one for two years. They take it for a month, they break out in hives, you know, you try another one. They break out in hives then you can go to Forteo.

Alex Park: Okay.

Amber Figueroa: That's not what that says. It says you have to take one, break out in hives, take two, break out in hives, then take a serum.

Donna Sullivan: Correct.

Amber Figueroa: And then get Forteo.

Donna Sullivan: But you don't have to do each one for two years is what I'm trying to say.

Lisa Chew: Is Dr. Sylvia Churchill here for our stakeholder? All right. Any other comments about the policy?

Jordan Storhaug: I think you guys… I like this verbiage a lot more. But then I think with Tymlos as well kind of changing… that also had kind of similar verbiage and this verbiage, I think, is better.

Donna Sullivan: So does that mean we are going backwards?

Jordan Storhaug: It's the same category. We went back some slides.

Donna Sullivan: We can't go back… we can make them consistent.

Amber Figueroa: I also think that when you read it, April, you said like total combined duration of use not to exceed two years, but that's not how it reads. So can you make sure that that…

Donna Sullivan: I think that is the Forteo. It cannot be used for more than two years.

April Phillips: It's on the parathyroid hormone analogs. The labeling is they shouldn't be used a combined total. So if you're using one for six months and you switch to another you should only use it for 18 months, for a total of 24 months.

Alex Park: Should we add that to your duration statement to Tymlos as well then?

Donna Sullivan: Yes.

April Phillips: Sorry.

Lisa Chew: Other comments about the policy?

Alex Park: So the contraindications and failure information for Tymlos and Forteo I think should be the same. Is that right? Take the stuff from the Forteo and move it over to the Tymlos.

Lisa Chew: Are we ready? I move that the Apple Health Medicaid Program implement the limitations for the bone density regulators, a drug class listed on slides 10 through 13, as recommended.

Nancy Lee: I second the motion.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Okay, now on to amylin analogs.

April Phillips: There is only one drug in this drug class – the Symlin or the SymlinPen. So diagnosis of Type 1 or Type 2 diabetes and failed to achieve desired glycemic control despite optimal insulin therapy. And they are currently receiving optimal mealtime insulin therapy. And then none of the following listed below: so diagnosis of gastroparesis, hypoglycemia unawareness, poor compliance with current insulin therapy, poor compliance with self-blood glucose monitoring, and hemoglobin A1c greater than 9% within the last three months.

Amber Figueroa: I'm going to make the motion unless anybody says…

Lisa Chew: I don't know if there are stakeholders for this.

Leta Evaskus: There's not. I only gave you the sheets that we have stakeholders for.

Lisa Chew: Okay. Sorry, Amber. Go ahead.

Amber Figueroa: I move that the Apple Health Medicaid Program implement the limitations for the amylin analogs as listed on slide 14 as recommended.

Lisa Chew: I second. All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Okay. Afrezza.

April Phillips: The next one is Aprezza, an inhaled insulin. So the diagnosis of Type 1 in combination with a basal insulin or Type 2 diabetes, history of failure, contraindication or intolerance to an injectable insulin regimen containing prandial insulin, documentation of the inability to self-inject medications such as physical or visual impairment, lipohypertrophy or needle phobia. An FEV in the last 60 days of greater than or equal to 70% of predicted and then none of the following: chronic lung disease or current or recent… recently quit smoking. I believe the last six months is the definition.

Diane Schwilke: Could we say just quit smoking within the last six months? Because that's really all over the place.

Donna Sullivan: And currently smoking.

Leta Evaskus: Do you want me to add it or make another bullet?

Diane Schwilke: At the beginning "current smoker or quit smoking cigarettes within the last six months".

Lisa Chew: Can I ask a question? Is that goal-reducing A1c goal to less than 7% is that correct or is it 9? It's an aggressive… it looks like it is indicated for both 1 and 2, but…

April Phillips: I believe it is 9 and I just mistyped it.

Dave Johnson: What are we doing about people smoking weed? I mean if we're putting up cigarettes that means you can smoke your weed and still get this and I'm guessing that's not the… the studies were done with cigarette smokers, but in other states that may be the case, but we know that's not the case here. Do we want to make it "the smoking" more general?

Virginia Buccola: I would add vape pens. I don't know if the risk would be equivalent with using vape pens, but that might be something to consider.

Leta Evaskus: Smoking… and just say smoking?

Nancy Lee: Instead of cigarettes just put smoking. That will fulfill a broad enough… encompassing other products that could limit lung function for inhaled insulin.

Dave Johnson: Do we just want to say smoking/vaping?

Donna Sullivan: I would like to do that because I don't want to get into an argument whether or not using a vapor is the same as smoking.

Virginia Buccola: I don't prescribe these types of medications so I don't know in terms of the pediatric population if it would be applicable in terms of causing great anxiety in a young person to have this as an option.

Woman: [inaudible]

April Phillips: I don't believe so.

Donna Sullivan: So delete it?

Nancy Lee: I would propose just leaving it in there. These are examples of inability to self-inject medication. There are cases of patients who have significant issues.

Woman: [inaudible]

April Phillips: Would you like to specify severe needle phobia as defined by like the DSM5 or something?

Virginia Buccola: Just as a suggestion would they need a letter from a specialist?

Donna Sullivan: Amber, is it the word "severe" that you're hung up with or just needle phobia?

Amber Figueroa: It's needle phobia. [inaudible]

Susan Flatebo: Back to the smoking. Is there a reason why we wouldn't just say it's contraindicated for current smokers? Why are we putting or recently quit within the last six months? If you look at the package insert it says it is just not recommended in current smokers. It doesn't say anything about if they recently quit and if you're concerned about their pulmonary function I mean the package insert says they have to meet certain criteria with pulmonary function test. So that would be addressed. So I'm not sure if we need that "recently quit within the last six months". I don't know. That's just my opinion.

Diane Schwilke: Just a clarification. Are each of these bullets "ands"? They have to meet all of these to qualify?

April Phillips: Yes, that was the intention.

Woman: [inaudible]

Donna Sullivan: Is that the verb versus the…

Alex Park: Do we need to provide examples of inability to self-inject medication or could we just leave that statement on its own without providing the examples.

Donna Sullivan: That's kind of what I was thinking if we just say they can't inject. It could include somebody that might be… they can't inject because they are needle phobic.

Alex Park: I would also say that lipohypertrophy to me would not be inability to self-inject. I mean I usually just have people rotate their injection site if they have that. And then we have Amber's concerns as well about the needle phobia, but that looks good.

Lisa Chew: How are we doing? Any other comments or thoughts or edits to the policy? I'll make the motion if that's… I move that the Apple Health

Medicaid Program implement the limitations for the inhaled Afrezza inhaled insulin listed on slide 15 as recommended.

Alex Park: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Okay. Next one.

April Phillips: So our next policy is regarding Ampyra. Diagnosis of MS, concurrent use or documented intolerance for contraindication to a disease modifying agent for MS, currently 18 years old or older, and then none of the following: history of seizures, moderate to severe renal insufficiency, non-ambulatory and prescribed by or in consultation with a neurology specialist, and maximum dose of 20 mg per day.

Susan Flatebo: I make the motion that the Apple Health Medicaid Program implement the limitations for Ampyra as listed… with the limitations as listed on slide 16 as recommended.

Diane Schwilke: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Next?

April Phillips: The next policy is regarding Makena. Diagnosis of a singleton pregnancy, prior history of singleton pregnancy delivery before 37 weeks, to be initiated after 16 weeks and before 37 weeks, and maximum dose is… for the vial is 250 mg once weekly and the recent approval of the auto-injector is 275 mg once weekly, and at least 16 years of age.

Amber Figueroa: I'm not super familiar with it, but is it contraindicated under age 16?

April Phillips: It's only been studied to age 16. I take that back, the labeling studies were down to age 16. I don't know if it has other studies.

Amber Figueroa: I move the Apple Health Medicaid Program implement the limitations for Makena listed on slide 17 as recommended.

Susan Flatebo: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries.

April Phillips: And this policy is for Midazolam as a seizure rescue agent. So a diagnosis of seizure disorder or epilepsy, administered intranasally as a rescue agent for prolonged seizures, prescribed by or in consultation with a neurology/epileptologist and documentation of patient and/or caregiver has been provided proper training on administration and follow-up, documentation that patient or caregiver has been counselled on risks of the use of Midazolam and maximum dose of 10 mg per dose.

Susan Flatebo: On the second bullet point shouldn't it just say longer than three minutes? Should it have that range?

April Phillips: So the reason why it has that range is it was studied by five… after minutes. We have had this policy for about a year going and we have noticed that neurologists have a tendency to do three minutes or longer because often times it is children and they don't want to see them having a grand mal seizure for too long.

Donna Sullivan: I think we could just change it to three.

Lisa Chew: I move that the Apple Health Medicaid Program implement the limitations for Midazolam listed on slide 18 as recommended.

Catherine Brown: I'll second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries.

April Phillips: For our final policy Dronabinol, which includes Marinol and the recent product Syndros. For indication of anorexia associated with weight loss in adults with AIDS with one of the following listed below: history of failure, contraindication, or intolerance to conventional therapies, and a dose limit of Marinol 20 mg per day or Syndros 8.4 mg twice a day, prescribed by or in consultation with an HIV specialist.

And the second indication for Dronabinol is nausea or vomiting associated with chemotherapy in adults. So current diagnosis of cancer or history of diagnosis in the last year, currently receiving chemotherapy or a history of chemotherapy in the last year, history of failure, contraindication or intolerance to conventional therapies, and dose limits are listed below. Prescribed by or in consultation with an oncology specialist.

Diane Schwilke: Just a little type-o in that first bullet point, current diagnosis "of" cancer, not "for cancer".

Susan Flatebo: I move that the Apple Health Medicaid Program implement the limitations for Dronabinol listed on slides 19 and 20 as recommended.

Amber Figueroa: Sorry, just a second. The top slide the first bullet point says in adults with AIDS. But then the second dot it says can't have concurrent illness or medical condition other than HIV. Is that okay? I think they are saying AIDS as it has progressed to a certain extent and HIV as a diagnosis, but I'm just… it's a little incongruent there. So can we just change HIV to AIDS?

Alex Park: I think in the FDA indication they use AIDS.

Leta Evaskus: So change it to an AIDS specialist or HIV specialist?

Amber Figueroa: HIV. Uh huh. Okay. Carry on.

Susan Flatebo: I move that the Apple Health Medicaid Program implement the limitations for Dronabinol as listed on slides 19 and 20 as recommended.

Nancy Lee: I second that motion.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. Okay. Good job! Donna?

Donna Sullivan: Okay. So similar to what we did last month these are the remaining drug classes, subclasses that are going to be implemented July 1st. And so you have the stack of slides and the slide… there's like 189 of them, but some of them are just really short. They have like one drug in them. So I think we can go through them pretty quickly and then again you have the accompanying spreadsheet that has utilization data. So, again, it will go as fast or as slow as you guys want it to go. So just keep that in mind and we can go ahead and get started. So the first slide is analgesics – opioids and this is the partial agonists. The long-acting partial agonist, the only drug in that class is the buprenorphine patches and the generic patch is preferred and the brand is not.

The next slide is the short-acting partial agonists. And so we are preferring Belbuca. You'll notice that Belbuca is the only one here. You might say what about suboxone and buprenorphine and all of those others. Those are all listed under the substance use disorder so these are categorized by their actual indication. The other drugs

are not indicated for analgesia so they are listed under substance abuse disorder.

So the next slide we go to the antianxiety agents and so Dale, I think to your question at the last meeting, this is where we have the rest of the antianxiety medications that are non-benzodiazepine. So the Buspirone, Droperidol, Hydroxyzine, hydrochloride Pamoate are all preferred and then the Meprobamate and Vistaril are not preferred.

The next slide is antibiotics. Question? Go ahead.

Dale Sanderson: Vistaril is… crosses the blood/brain barrier much more readily than the hydrochloride.

Donna Sullivan: That's the hydroxyzine pamoate. Right? So the generic is preferred. The brand Vistaril is not preferred.

Dale Sanderson: I got it. Thank you. Sorry.

Donna Sullivan: So the aminoglycosides basically any generic is preferred and if there is a brand it is not preferred.

Antibiotics – the aminopenicillins, they were missing from last month's slide so the amoxicillin generics and ampicillin generics are preferred.

Moving on to the cephalosporins we didn't have the fourth generation last month. So the cefepime is preferred, as well as the dextrose injection and the maxipime. And you might be saying a lot of these are injectables. We are preferring them… we are allowing them to be covered under the pharmacy benefit because we have a lot of outpatient or home healthcare that goes to the pharmacy benefit that's not necessarily being filled under the medical benefit. So we are allowing many of the injectables to be processed. So we are assigning preferred status to them.

Going to the next slide is anticonvulsants. Specifically the succinimides. So the Ethosuximide, Celontin, Zarontin are all preferred.

The next slide are the antidiabetics specifically the alpha-glucosidase inhibitors. So we're just preferring the generic Acarbose, so Glyset, Miglitol and Precose are not preferred.

The next slide is the biguanides. So this is the class, if you remember, for those of you who that were here several months ago we referred the metformin class. And so we're preferring the generic metformin that is generic for Glucophage and the generic metformin extended release, specifically the generic for Glucophage XR. All of the other long-acting metformin products are not preferred and so that's the distinction there.

The next slide for diabetes other these are just the glucagon and glucose products that are preferred. And those that are not preferred is the Korlym and the Proglycem.

The next slide is the amylin agonists that we talked about earlier. So Symlinpen is preferred.

The next slide are the combinations – the Glyxambi, Qtern and Steglujan are preferred, but are on prior authorization. So many times when… if everything was going to be not preferred we swapped it to preferred and put a prior authorization on it because the end result is the same. They have to try the preferred products first before they can get the combination. This way we don't have to try to assign the preferred drugs that we have listed in a different subclass. Just to let you know if you were wondering why those are preferred. Any questions?

So the next slide is the incretin mimetics, the DPP4 inhibitor TZD combination is the generic preferred and the brand is not preferred.

And then the DPP4 inhibitors individual products we are preferring Janumet and Janumet XR, Januvia, Jentadueto and Tradjenta and the others that are listed are not preferred.

For the antidiabetics GLP1 agonists and insulin combinations, again, we have them listed as preferred, but they will be on prior authorization.

The GLP1 agonists on the next slide, Bydureon, Byetta and Victoza will be preferred and the Adlyxin, Tanzeum, Trulicity and Ozempic will not be preferred.

For the meglitinides analogs Nateglidine, Repaglinide, and Repaglinide/metformin will be preferred and then Prandin and Starlix are not preferred.

Going to the SGLT2 inhibitors we are preferring Farxiga, Invokamet, Invokana, Jardiance, and Xigduo XR. And not preferred will be Invokamet XR, Segluromet, Steglatro and Synjardy.

So the next slide is the sulfonylureas. So traditionally the old generic Glimepiride, Glipizide, Glipizide-Metformin, Glyburide and the Glyburide Metformin combinations are all preferred and then the brands listed there are not preferred.

For our TZDs the Pioglitazone is preferred and then all of the other TZDs and their combinations are not preferred.

Moving to antiemetics and antivertigo. So we're on slide 22. We are preferring Diclegis, the Meclizine, Metoclopramide tablet solution and injections, the Prochlorperazine injection, suppository, syrup and tablet, Promethazine injection, suppository and tablets, and Scopolamine. And then the others that are listed on the right are not preferred.

Dave Johnson: Will the Diclegis… we had talked about having a requirement of diagnosis of pregnancy on there. Are we still having that since it doesn't say anything about PA required?

Donna Sullivan: Correct. Yes. None of these, I think, indicate PA required, but on these slide… but yes, Diclegis is on prior authorization for pregnancy.

Dave Johnson: Thank you.

Donna Sullivan: Injectable antifungals is on the next slide. So I don't expect much use in these in the pharmacy benefit, but we are just allowing them to be processed through the pharmacy benefit, especially if they are used in any type of compounding.

And then the next slide are the oral antifungals. So the Clotrimazole Troche, Fluconazole suspension and tabs, Griseofulvin suspension and tabs, Ketoconazole tablets, Nystatin suspension and tablets, and then the Terbinafine tablets and then those products that are listed on the right hand side will all be not preferred.

So the topical antifungals…

Dave Johnson: I don't want to be difficult. We had talked about the Ketoconazole tablets being non-preferred due to their increased risk profile on our phone call. Has that changed?

Donna Sullivan: Um, I'd have to go back and check. If that's what we agreed on then it probably just didn't get fixed in the file. So the file that Joey was going off of just might not have been accurate. So I'll double check our file that we sent to you and see what it says.

Dave Johnson; Thank you.

Donna Sullivan: Topical antifungals. Ciclopirox cream, shampoo, solution preferred, Clotrimazole and then the Clotrimazole with betamethasone, the Ketoconazole cream, Miconazole, Nystatin, Nystatin Triamcinolone, Terbinafine cream and Tolnaftate are preferred and the others are not preferred.

Going to the next slide the difference on these two slides is that the preferreds are duplicated and then the non preferreds on the right hand side are just additional non-preferreds.

So on the slide 27 is the vaginal antifungals. So they are all preferred except for the Terazol cream 7, but we have the Terconazole cream and suppositories are preferred as the generics.

Under the antiparasitics the anthelmintics, the Biltricide, Ivermectin and Stromectol all preferred, Albenza, Benznidazole and Emverm are not preferred.

And the antimalarials Atovaquone, Chloroquin, Coartem, Daraprim, Hydroxychloroquin, Melfloquine, Primaquin Phosphate and Quinine are all preferred. And then Malarone, Plaquenil and Qualaquin are not preferred.

So Amy checked the Ketoconazole and it is preferred with prior authorization. So thank you, Amy. But we'll double check on that one.

Going to the scabies and pediculicides, the Eurax, the nit remover gel, Permethrin products, the Pyrethrin combination are also preferred and then the Sklice product and then the Elimite, Lindane, Malathion, Ovide, Natroba and Spinosad are not preferred.

Parkinson agents Carbidopa is preferred, the brand is not.

The next one, Benztropine and Trihexyphenidyl generics are preferred.

Slide 33 the Entacapone is preferred and the brands are not preferred. Henidyl generics are preferred.

Slide 34 the dopaminergics agent so Amantadine, Carbidopa-Levodopa, Pramipexole, and Ropinrole and the products to the right are not preferred. So the Amantadine tablet is not preferred, but the capsule and the syrup is. That was intentional.

Slide 35 the monoamine oxidase inhibitors so Selegile is preferred and then the brands listed to the right are not preferred.

Moving to antipsychotic antimanic agents specifically the antimanic agents we're preferring the generic lithium products and then Lithobid is not preferred.

Going to the first generation so the intention here was to make the first generation antipsychotics the generic products preferred and the brands not preferred and then not preferring the combination of the Perphenazine amitriptyline tablet that they can take those individually.

The second generation antipsychotics is based on the… when we reviewed them the last time. So all of the individual products are preferred that have been reviewed. Anything that was new, that came out to market since the last review is not preferred. I do not think there are any that have come out since you've last…

Virginia Buccola: I just had a question about the Haloperidol injection. Is that going to be… any chance that will be grandfathered for people who are already on that?

Donna Sullivan: Brand name Haldal or Haloperidol?

Virginia Buccola: Am I not seeing the Haloperidol?

Donna Sullivan: The Haloperidol Decanoate is there. It's the second… I actually made that and double checked it too. So yes, it will be. And if the generic goes away then we would cover the brand. I believe to answer your question, anybody that's on these I think we grandfather anyways because they have already probably gone through a prior authorization process to get a brand if a generic was available. Dave?

Dave Johnson: It looks like with the Haloperidol Decanoate listed on both the preferred and the non-preferred sides.

Donna Sullivan: No. The one side it says Haldol and the other one is Haloperidol. It just gets confusing because the brand name is so similar. I did that double-take too. Thanks.

So the second generation agents, moving on to the miscellaneous. So Equetro and Vraylar are preferred.

The CMV antivirals pretty much just consistent with preferring the generics, not preferring the brands.

The hepatitis B agents, again kind of sticking with the generics, other than the Epivir HBV oral solution, we're covering that. And then the brands that are listed on the right hand side are not preferred.

Then moving to the herpes agents. So preferring the Acyclovir injection, tablet, suspension, Famciclovir, Valacyclovir and not preferring the Acyclovir capsules or ointment or the other brands that are listed there.

And then the influenza agents sticking with the generic Oseltamivir and Rimantidine are preferred and then the brands Flumadine, Relenza and Tamiflu are not preferred.

Moving to slide 44 asthma and COPD the leukotriene modifiers. This is consistent with the Washington PDL that have Montelukast, Zafirlukast being preferred and the other agents being not preferred.

Slide 45 the COPD agents, the long-acting muscarinic agents, Stiolto Respimat is preferred and Anoro Ellipta, Bevaspi and Utibron not preferred.

Slide 46 long-acting muscarinic. So preferring the Spiriva Handihaler, the Spiriva Respimat will not be preferred as well as the other products that are listed.

And then moving to the phosphodiesterase inhibitors under asthma and COPD the Daliresp will be preferred on prior authorization.

And slide 48 the xanthine products. So essentially preferring the generic Theophyline products and then not preferring the branded products.

Moving to 49 the antihyperlipidemics preferring the Ezetimibe and not preferring the Kynamro, Lovaza, Omega-3 products, Vascepa and Zetia, the brand.

Moving to 50 the bile acid sequestrants so again the generic Cholestyramine and Colestipol are preferred and their respective brands will not be preferred.

Slide 51 Fenofibrate we're looking at the fibric acid derivatives. So Fenofibrate tablets and Gemfibrozil are preferred and the products listed on the right are not preferred.

Cardiovascular agents. So specifically the anti… the statins and their combinations. So preferring Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, Simvastatin and the products listed on the right under non-preferred are all not preferred. So we're not preferring any of the combination products. The patients can take the individual products that are less costly than the combination product itself.

Going on to the nicotinic acid derivatives we're preferring the Niacin ER and Niacor and Niaspan is not preferred.

Cardiovascular agents with PCSK-9 inhibitors that we reviewed earlier today consistent with the Washington PDL, the Repatha/Sureclick and the Repatha Pushtronex system will be preferred.

Slide 55 the angiotensin modulators specifically the ACE inhibitor combinations. So we are preferring the Benazepril Amlodipine combination, the Benazepril HCL combination as well as the Enalapril, Fosinopril, Lisinopril and Quinapril HCTZ combinations and then the other products on the right hand side are not preferred.

And then consistent with the previous slide and just the ACE inhibits were preferring the individual ACE inhibitors and I do need to make a correction to the Captopril HCTZ combination. I need to go back and check that one from the previous slide. Any questions?

So moving to the angiotensin receptor blocker combinations. We are preferring the Losartan Amlodipine combination and then the Irbesartan, Losartan, Olmesartan and Valsartan HCTZ combinations. And then all the other combination angiotensin receptor blockers will be not preferred.

Slide 58 the angiotensin receptor blockers, the individual drugs. So again sticking with the combination products of the ARB that is in the combination product is also preferred so Irbesartan, Losartan, Omesartan, Valsartan are preferred and the others are not.

And then looking to the direct renin inhibitor combinations, Tekturna is preferred. Tekturna HCT is preferred and then the Tekturna is preferred and I believe these two are both on prior authorization.

So moving to slide 61 Entresto is preferred and on prior authorization.

Moving to the next slide the antiadrenergics, Clonidine, Doxazosin, Guanfacine, Methyldopa, Prazosin and Terazosin preferred and then the associated brands are not preferred.

Looking at the beta-adrenergic combinations the Atenolol-Chlorthalidone is preferred and then the Bisoprolol, Metoprolol and Propranolol HCTZ combinations are preferred and the others listed are not.

Slide 64 the beta-adrenergics so these are the beta blockers. So the products that are listed in the first two columns are preferred. I'm not going to read them all off. The products in the second two columns are not preferred.

Slide 65 is the combination calcium channel blocker combos. So the amlodipine-atorvastatin is preferred as is the Caduet.

And then the next slide, 66 the calcium channel blockers themselves. So the first column is the preferred products. And the two columns to the right are not preferred. So again sticking with mostly preferring generics with the exception of the Isradipine, Nicardipine, Nimodipine will be not preferred and then [inaudible]. Just to point out with the Nifedipine, which isn't quite apparent here, the immediate release capsules are preferred (in case you ever had that question).

And then the calcium channel blockers on the next page is just continuing the two… the Verapamil ER is not preferred. The capsule… the tablets are preferred, the capsules are not.

And then other anti-hypertensives listed on this slide are Eplerenone, Hydralazine, Minoxidil, Phenoxybenzamine and Phentolamine are preferred and their brands are not preferred.

The next slide is the cardiotonics. So Digoxin is preferred and the brand Lanoxin not preferred. And then Nitroglycerin should actually be on a different slide. We'll keep going.

So slide 70 we're getting into the diuretics. So the Acetazolamide and Methazolamide are preferred and their brands are not preferred.

And then the combination products we have the Amiloride, Spironolactone and Triamterene HCTZ combinations preferred. The generics and their brands are not preferred.

The next slide is the LOOP diuretics. So the generic LOOP diuretics are preferred and their brands are not preferred.

Slide 73 the potassium sparing diuretics Spironolactone preferred. The Aldactone, Carospir and Dyrenium are not preferred.

And then we have the thiazide and thiazide-like diuretics. The generics are preferred. The brands are not preferred.

Moving to antianginal agents. Specifically the nitrates. So we have the generic Isosorbide are preferred, as well as the nitroglycerin capsule, sublingual tablets and patch, the Nitro-Bid ointment and the Nitrostat products are preferred.

Antianginal agents – other. So Ranexa is preferred and on prior authorization.

The antiarrhythmic on slide 77. Again, generics preferred, brands are not preferred with the exception of Quinidine, which is also not preferred.

Slide 78 Letaris and Tracleer are preferred in the endothelin receptor antagonists for pulmonary hypertension and Opsumit is not preferred.

Slide 79 the pulmonary hypertension the phosphodiesterase inhibitors Adcirca and Sildenafil are preferred and then the brand Revatio not preferred.

And slide 80 the prostacyclin receptor agonists for pulmonary hypertension Uptravi is preferred on prior authorization. Actually all the pulmonary hypertension drugs I think are on prior authorization with maybe the exception of the phosphodiesterase inhibitors.

So moving to 81 the Tavaso, Ventavis are preferred and Orenitram is not preferred.

And the last pulmonary hypertension Adempas is preferred, as well.

Corlanor for the sinus node inhibitors is also preferred.

Moving into the contraceptives we're just going to kind of blast through these because what we did is we put any generic and single-source branded contraceptive is preferred and then any multi-source

brand contraceptives are not preferred. Just so you know we're pretty much covering everything except for something that has a generic equivalent. So we can just kind of blast through those. If you have any questions about that let me know. And that kind of aligns with the utilization if you switch to the utilization tab that most of these recommendations, or I should say all of them are really in line with where the utilization already is because the plans have had… we've all had pretty consistent formularies even before we went through making this a formal single preferred drug list. So I think we skipped to slide 98.

Diane Schwilke: Just a quick question then. Are these IUDs going to be covered on the patient's pharmacy plan?

Donna Sullivan: We allow them through the pharmacy benefit because some doctors do not like to buy and bill. And so if they are covered under the pharmacy plan often they are dispensed out of a specialty pharmacy and delivered to the doctor's office for insertion. But because sometimes the doctors don't want to have to keep those in stock they… we allow it through the POS as well as medical.

Diane Schwilke: At any pharmacy or just at a specialty pharmacy?

Donna Sullivan: It's just the specialty pharmacies, I believe.

Dave Johnson: Yeah, at least Bayer has restricted distribution. They won't even sell to a retail pharmacy like they used to.

Donna Sullivan: Okay. So the cough and cold class is kind of a special class. In this particular class it's an optional covered class by CMS meaning that the state has the prerogative to cover or not cover any cough and cold product regardless if there are federal rebates for it. So you might think that this is pretty limited or you'll see things that are not preferred. So generally if it's an over-the-counter product and it's not preferred it's not going to be covered. And if it's a prescription product that is covered and not preferred it's most likely listed here. So if you see that things are missing kind of in this class that's the reason. So if it's not covered over-the-counter or a not covered

cough and cold prescription product I don't think we listed it here or we might not have. So just giving you that warning. So for the antitussives the Dextromethorphan this actually has been corrected. It's the specific to the 15 mg dose for the suspension and then the Dextromethorphan-Guaifenesin I think is the 15 100 or 5 100. There are specific doses that are actually preferred and covered and then the Benzonatate will… the OTCs will not be covered and then the prescription Benzonatate will not be covered either and that's how it currently… the current state for the cough and cold.

For the next slide, slide 99, we will covered the Pseudoephedrine products, I believe the immediate and the long-acting acting products.

Slide 100 is the expectorants. So the Guaifenesin syrup.

Slide 101 is some miscellaneous. So Acetylcysteine, Sodium Chloride Nebulizer solution and the Vick's Vapo Steam. I'll have to double check that one if it was listed as preferred. I would think it is probably not.

Amber Figueroa: Can I break in? The [inaudible] the Benzonatate that has not historically been covered because it shows that…

Donna Sullivan: Well, the managed care plans, if they are covering it, they shouldn't be because it is a non-covered cough and cold product. So that… it's probably why there is little utilization that we're only supposed to be covering the cough and cold products that are listed on the fee-for-service website. So they are not covered. So they won't be covered going forward.

Amber Figueroa: On this, the big thing, for Benzonatate capsules it says 47,000 claims. So that was all a mistake?

Donna Sullivan: Yeah, I think. Yeah, to put it… the managed care plans are only supposed to be covering the cough and cold products that are approved cough and cold products. So they should not have been

covering the Benzonatate because it's not a covered cough and cold product.

Amber Figueroa: Is that available over-the-counter?

Donna Sullivan: It is available over-the-counter.

Dave Johnson: Not at all. I mean Benzonatate is not part… I believe what you're referring to is the OTC stuff and Benzonatate is prescription only.

Donna Sullivan: Okay. But it's not covered. It's never been a covered cough and cold for many, many years. It's not listed on our list.

Amber Figueroa: I'll take that off my template.

Woman: You have until July 1st because it's getting covered right now.

Dave Johnson: Yeah, codeine won't change until July.

Donna Sullivan: And if we looked at the other file where I broke out the utilization between managed care and fee-for-service it is that… it is all managed care. There is no claims for the Fee-For-Service Program. I think the decision was made that there's not a lot of evidence that it actually works. So we don't cover it for that reason.

Amber Figueroa: So just clarifying too… none of the codeine cough syrups are going to be covered either?

Donna Sullivan: Correct. And they haven't been. They aren't now. Which means that they can pay for it. So if it's not a covered benefit then the pharmacies are allowed to let the members pay cash for it because it's not a covered Medicaid benefit. And this stuff… these decisions are in the Washington administrative code and they are very specific down to the strengths. So if we want to change anything we will have to go through a rule making process and budget out whether or not we can actually cover, you know, afford to cover the additional strengths of the products. It's not to say we can't do that, but I'm

just… that's why this is so rigid is it's actually in the Washington State Administrative Code.

Amber Figueroa: I just think a lot of times we prescribe and then we don't know if it's not… if the patient paid cash for it and we just assumed it was covered because nobody called us back and said, "Hey, can you switch it to something else." So I think that's helpful. I think this is helpful to go over.

Donna Sullivan: I'm sure Joey appreciates that because he made all these slides. So the dermatologics on slide 102 is the topical acne products. So Azelex, Clindamyacin gel, lotions, solution, swabs, Differin, Epiduo, Erythromyacin pads and solution and Tretinoin cream and gel are preferred and all the others are not preferred.

Going to the next slide it just duplicates the preferred drugs and then there are more non-preferred products. I'll give you a second to absorb that because I know there are differences in what kinds of acne products to cover.

Going down to the next slide then is 104, again, it's duplicating the preferred drugs and then there are a few more not preferred drugs.

Then moving on to slide 105 are the antipruritics. Doxepin, Prudoxin and Zonalon are preferred and there are no non preferreds in this particular class and I believe those are… the Doxepin cream is on PA.

Dave Johnson: Is there a reason we have both brand and generic Doxepin listed as preferred?

Donna Sullivan: Probably not and I'll have to go back and see. It could be that the brand might be the same price as the generic. So I'll go back and double-check.

Dave Johnson: I don't know if it makes a difference, but back on the acne topical slides we have oral Isotretinoin listed on the non-preferred on a couple different places.

Donna Sullivan: Okay. We'll double check that one. And if it's wrong it's because it is wrong in the PDL file that I sent you. Good to double check.

On the next slide…

Amber Figueroa: Back to that though. For patients who are going to get on Isotretinoin that will be covered with a prior auth or?

Donna Sullivan: Yes.

Amber Figueroa: Okay.

Donna Sullivan: Which slides did you say Isotretinoin was listed?

Dave Johnson: So on 102 the brand Absorica is listed there and then on 103 generic Isotretinoin is listed on the far right column.

Donna Sullivan: So are you asking why the brand and the generic are both not preferred?

Dave Johnson: No. Well, they are not topicals, number one.

Donna Sullivan: Okay. Got it.

Dave Johnson: I guess you could rub in on your skin.

Donna Sullivan: Okay. Thank you for that clarification. So was that the only question other than the Doxepin brand?

Dave Johnson: Yes. I reserve the right to have more questions later.

Donna Sullivan: And I reserve the right to refuse. Getting late. So dermatologics, the antipsoriatics – the orals, the Acitretin is preferred. The Methoxsalen, Oxsoralen or Soriatane are not preferred. And if you're thinking where's methotrexate? I believe it is listed in a different class. So generic methotrexate is also available for psoriasis.

And then the topical antipsoriatics on 107, the Calcipotriene cream ointment solution is preferred and the others are not.

Slide 108 with the antiseborrheics. So Pyrithione, Selenium, Sulfacetamide sodium, liquid, cleansing gel, shampoo are preferred and the brands on the right are not.

Slide 109 immunomodulating agents Imiquimod cream is preferred and then the Aldara and Zyclara is not preferred.

Slide 110 the immunosuppressive topical agents Elidel is preferred, Protopic and Tacrolimus are not preferred.

Slide 111 the rosacea agents the Finacea foam and gel and then the Metronidazole cream, gel and lotion are preferred and then the other products listed to the right are not preferred.

Slide 112 topical steroid combinations so the Calcipotriene-Betamethasone Dipropionate are preferred, Hydrocortisone-Pramoxine preferred, Hydrocortisone aloe maximum strength is preferred with the question mark next to it and then the Triamcinolone-Dimeth cream and silicone tape are preferred. Not preferred are listed to the right.

The next slide is 113. It is the high potency steroids so Betamethasone Valerate cream and ointment, Triamcinolone Acetonide cream and ointment are preferred and all the others are not preferred.

Slide 114 high potency steroids Betamethasone Valerate cream and ointment and then the Triamcinolone Acetonide cream and ointment are preferred. And then the others listed are not preferred.

Slide 115 topical steroids low potency the Alclometasone, Hydrocortisone cream and then the Micort HC are preferred. The others listed to the right are not.

Medium potency topical steroids are the Fluticasone cream and ointment and then Mometasone Furoate.

And then the very high potency we have the Clobetasol cream, solution and ointment and then the Halobetasol Propionate cream and ointment. And the products to the right are not preferred.

Moving on to the wound care products Regranex is preferred and it's on prior authorization.

Moving to endocrine and metabolic agents for the anabolic steroids Oxandrolone is preferred and the brand Anadrol is not.

The other adrenergic agents on slide 120 the Danazol is preferred and the Androxy is not.

Moving to the testosterone products on slide 121 we're preferring Androderm, Testosterone gel, patch, the Testosterone Cpionate injectable and the Testosterone Enanthate. Then the products listed to the right are not preferred. These do have the… they'll be subject to the same PA policy that you have previously approved, as well.

Moving to the bone density regulators. So on slide 122 preferred is Alendronate tabs and solution, Calcitonin solution, Ibandronate sodium tablets, Prolia, Raloxifene and Xgeva are all preferred. And then the products on the right are not.

And then moving to slide 123 Zometa is also not preferred in the bone density regulators.

For the estrogens I'm not going to read all through these, but we have a variety of patches, the orals, the combinations, and the patch, as well as the vaginal estrogens as preferred.

And moving to the next slide is the same. It's just the actual combination agents in addition to some of the other preferred products.

Slide 126 is the progesterone agents. So Makena is preferred, as well as the Medroxyprogesterone, Megestrol, Norethindrone and Progesterone. The Makena auto injector that was recently released will not be preferred, as well as the others that are listed on the right.

Susan Flatebo: Can we go back to slide 123? Instead of Xgeva shouldn't that be Prolia and then…

Donna Sullivan: Yeah. I mean Xgeva is actually the one for…

Susan Flatebo: Bone cancer.

Donna Sullivan: Yeah, I think they got sucked in because they have the same DPI number. So yes, Xgeva should just be removed and Prolia is already there.

Susan Flatebo: Okay. I think Zometa shouldn't that be reclassed? Again, it's the same drug but it's not the same approval.

Donna Sullivan: Yes, I believe so.

Susan Flatebo: Okay.

Donna Sullivan: Any questions about the progesterones?

Okay. 127 prolactin inhibitors the Cabergoline is preferred and on PA, I believe.

The next slide is the thyroid agents. So we're preferring, from your comments from last time, Armour Thyroid, Levothyroxine and the Levothyroxine/Liothyronine combo. And the products on the right hand side are not preferred.

Nancy Lee: I thought we were taking it off – Armour Thyroid and making that non-preferred.

Donna Sullivan: I thought the comments that we had were that it was… that you guys use it and… because we originally, I think last time, had it as non-preferred.

Amber Figueroa: I think you better check. I thought we took it off, too.

Donna Sullivan: I'll double check.

Amber Figueroa: I think we decided that if wanted that they could pay cash.

Donna Sullivan: It has a federal rebate and so it is a covered drug. I think that that was the question that it's not FDA approved, but it has a federal rebate. It's one of these weird… it sits in a weird space, but it is coverable by Medicaid. If you want us to make it not preferred we can. I have no dog in this fight.

Nancy Lee: I think according to the guidelines the preferences to use Levothyroxine as first line anyway.

Donna Sullivan: I'm just going back to the utilization. So we have 1,500 people using it. If you'd like we can make it not preferred and just grandfather everybody in or make them all switch. It doesn't matter to me. I'll go back and check the transcript from last time and we'll make sure that it aligns with what the transcript says.

129 antacids. So the calcium carbonate is preferred. The proton pump inhibitors and H2RAs are in their own category. They are listed separately.

Antidiarrheals, the Bismuth Subsalicylate, Diphenoxylate, generic Lomotil, Loperamide are preferred and then the others listed there are not preferred.

Amber Figueroa: The opium tincture is not preferred?

Donna Sullivan: Yes. So the next slide, 131, the gallstone solubilizing agents Ursodiol is preferred and all of the others listed are not preferred.

Moving to 132 the inflammatory bowel agents Apriso, Balsalazide, Canasa, Delzicol, Lialda, Mesalamine, Pentasa and Sulfasalzine are preferred. The others are not.

The next slide for irritable bowel syndrome for IBS for GI motility agents the Amitiza, Dicyclomine, Glycopyrrolate, Hyoscyamine, Linzess and Movantik are preferred. And the Linzess, I think, and Movantik are on PA. Everything else is not preferred.

Moving to laxatives on 134. So the Bisacodyl suppositories, tablets are preferred, as well as the PEG products. Basically the bowel prep products, castor oil and it should be Docusate sodium not Docusate calcium, I think. And then the glycerin suppositories.

The next page is just adding a couple more – the Sennosides and the Psyllium.

And then moving to slide 136 some GI agents that are miscellaneous that are also covered are Cromolyn sodium, Ipecac, Simethicone and Xermlo. And the Cromolyn sodium has a strange indication. So it's not the same Cromolyn sodium that you inhale. I specifically looked this up and the indication is… I forget exactly what it was, but that's why we're just lumping it in with the miscellaneous products. It seems out of place, but it does have a GI indication.

Slide 137 phosphate binder so looking at calcium acetate, Calphron, Fosrenol, Phoslyra, Renagel and Renvela. And the other products listed are not preferred.

And then for 138 short bowel syndrome Gatex is preferred.

Dave Johnson: Donna, on 137 is that correct that the brand Renvela is preferred and the generic is not?

Donna Sullivan: I'll double check, but it is likely. Sometimes the brands are cheaper than the generics. So it is possible.

Moving to 139 the Pylera is preferred and all the others are H. Pylori products or kits are not preferred. We prefer that they just get the individual prescriptions. These kit products are extremely expensive compared to just prescribing to individual products by themselves.

Emily Transue: Just the oral Cromolyn is for GI symptoms and [inaudible] for anyone who is curious.

Donna Sullivan: Okay. Thank you. I appreciate it.

Emily Transue: I did not know that. I looked it up.

Donna Sullivan: I thought it was strange being in there. It was different. So moving onto slide 140 are the H-2 antagonists. So Famotidine tablets and injection are preferred, as well as the Ranitidine tablets, injection and syrup. Cimetidine, Nizatidine are not preferred, as well as the multi-source brands.

Slide 141 are just some miscellaneous drugs. So Methscopolamine, Misoprostol, Propantheline and Sucralfate tabs and suspension is preferred. The other ones listed to the right are not preferred.

Moving to 142 the PPIs, proton pump inhibitors, Omeprazole capsules, Pantoprazole, Pantoprazole suspension and the Protonix IV solution will be preferred and all of the other products are not preferred.

Moving to slide 143 the alkalinizers so potassium citrate extended release, and the potassium citrate citric acid and sodium citrate acid are preferred and the others are not.

Slide 144 overactive bladder agents so preferring Bethanechol, Flavoxate, Oxybutynin immediate and extended release, Tolterodine extended release, Toviaz and Trospium immediate and extended release are preferred and the others are not preferred.

Slide 145 the prostatic hypertrophy agents preferring Alfuzosin, Dutasteride, Finasteride, Tamsulosin and the brands and those

products listed to the right are not preferred. So the combination product we're preferring the individual agents over the combo.

Moving to 146 the urinary analgesics Phenazopyridine is preferred and the branded products including Pyridium are not preferred.

In the gout agents Allopurinol, Colchicine, Colchicine-Probenecid and Probenecid are preferred and the others Colcrys, Duzallo, Krystexxa, Mitigare, Uloric, Zurampic and Zyloprim are not preferred. To make the distinction here we're preferring the Colchicine capsules over the Colchicine tablets just because of the cost.

Hematologic agents for platelet aggregation inhibitors so Anagrelide, the aspirin-dipyridamole combo, Brilinta, Cilostazol, Clopidogrel and Dipyridamole, the single agent are preferred and the brands that are listed to the right are not preferred.

Then moving into the sedative hypnotic products the barbiturates Pentobarbital elixir, injection and tablets will be preferred. And that will be whether they are used for hypnotics or for seizures. And then the products to the right will be not preferred.

Moving into the benzodiazepine sedative hypnotics Temazepam, Triazolam preferred and then the Estazolam, Fluroazepam, Midazolam and the brands will be not preferred.

Slide 151 is the non-bezo products. So we're preferring the Zolpidem immediate and extended release and then the other products in this particular class are not preferred.

And then moving to the selective melatonin receptor agonists the Rozerem and Hetlioz are preferred with prior authorization required on those particular ones.

One page 153 the Belsomra and Silenor are preferred with prior authorization as well.

Moving to 154 immunosuppressive agents so the Azathioprine, Cyclosporine, Mycophenolate, Rapamune, Sirolimus and Tacrolimus are all preferred. And the products listed to the right are not.

The fluoride products so pretty much generic fluoride products are preferred and the over-the-counter and the branded products are not. That's slide 155.

Going to skeletal muscle relaxers on slide 156 we're preferring Baclofen, Cyclobenzaprine, Methocarbamol and Tizanidine. The products on the right are not preferred and I want to point out that the Carisoprodol products will have a prior authorization on them and it's a… this goes back to probably the beginning of the PDL for Washington and for the Medicaid fee-for-service that the committee at the time didn't feel that Carisoprodol really had a place in treatment and that it was more likely to be abused and so the policy that was implemented was that Carisoprodol is indicated for the acute skeletal muscle issues and so the policy requires them to try each of the preferred products and then it gets denied because by the time they've tried five preferred products it is no longer an acute condition. That's essentially the policy. So if you're wondering why it is even listed as covered we have to cover it under federal rules, but we have a pretty tight policy around it and for fee-for-service we haven't had utilization or even requests for it in many, many years. The managed care plans on the other hand, I think, have had it on their PDLs and so we'll be transitioning out of that and watching the PDMP to see if people start paying cash for it.

Amber Figueroa: There's 2,600 people on here.

Donna Sullivan: Yeah. Any questions about skeletal muscle relaxers? Okay.

Moving to 157 which is the neuromuscular agents specifically for ALS so the Riluzole is preferred and Rilutek is not preferred. I think this is on PA just to make sure that it is ensuring the diagnosis.

Now moving to ophthalmic agents. Specifically the antiallergic ones. So the Cromolyn sodium, Ketotifen Fumarate and Pazeo are preferred and the ones listed to the right are not.

159 the artificial tears. So the generic artificial tear ointment, the Carboxymethylcellulose gel and solution, the preservative free and the non-preservative free and then Polyvinyl alcohol and the Refresh Optive sensitive are preferred and Lacriserts are not preferred.

Moving to the next slide, 160 which is glaucoma agents. We are preferring the Alphagan P, Azopt, Brimonidine, Combigan, Dorzolamide, including Dorzolamide and Timolol, Latanoprost and Levobunolol, Latanoprost and Levobunolol, Simbrinza, Timolol, and then Timoptic XE and Travatan Z and then the not preferred ones are listed.

The glaucoma agents continuing on are just catching up the other not preferred products on slide 161.

Then we have this miscellaneous ophthalmic product on 162, Cystaran. So it is preferred on prior auth, I believe.

And then 163 is the nonsteroidal anti-inflammatory ophthalmic agents. So Diclofenac, Flurbiprogen, Ketorolac and Ilevro are preferred. And the others are not preferred.

Slide 164 are the ophthalmic antibiotics. So Ciprofloxacin, Erythromycin, Gentamicin, Moxeza, Ofloxacin, Polymyxin B with the Trimethoprim, Tobramycin and Vigamox are preferred. And the others listed there are not preferred.

And then the next slide, 165 is just the sulfonamide antibiotics, the Sulfacetamide is preferred and the Bleph-10 is not preferred.

It looks like one of the notes slides got notes pages from the slide. Flip the page over and we get to 166, which are the antibiotic steroid combinations. So the Neomycin/Polymyxin/Dexamethasone prefer, the Sulfacetamide/Prednisolone preferred, Tobradex ointment, and

Tobramycin/Dexamethasone drops preferred. And then the ones listed to the right are not preferred.

Moving to 167 is the antifungals. Natacyn is preferred.

168 the antivirals the Trifluridine is preferred and Viroptic and Zirgan are not preferred.

Slide 169 the decongestants. So Nahcon-A is preferred and the Phenylephrine is not preferred.

170 the ophthalmic immunomodulators Restatis and the multi-dose are preferred and Xidra are not preferred.

171 the ophthalmic steroids Dexamethasone, Durezol, Fluorometholone, and Prednisolone are preferred and the products listed to the right are not preferred.

So 172 the miscellaneous otic agents are acetic acid, acetic acid with aluminum and then the carbamide peroxide are preferred products.

Then 173 the otic anti-infectives. Cipro HC, Ciprodex, Neomycin/Polymyxin/Hydrocortisone and the Ofloxacin products are preferred and their brands are not preferred.

The otic steroids so going to Acetasol, Fluocinolone and Hydrocortisone/acetic acid are all preferred otic steroids and Dermotic is not preferred.

Skipping to slide 175 kind of switching gears here now into ADHD drugs. So the non-stimulants we have the Atomoxetine, Clonidine immediate release and extended release preferred, Guanfacine immediate release extended release preferred and their brands are not preferred.

Moving to the stimulants specifically the amphetamines preferring the amphetamine-dextroamphetamine combination, as well as the

dextroamphetamine sulfate extended release capsules and Vyvanse are preferred.

177 the methylphenidates Aptensio XR, Dexmethylphenidate immediate release and extended release, Methylin, Methylphenidate CDs, ER and immediate release, and then Quillichew and Quillivant XR are preferred. And the products listed to the right are not preferred. Just to point out the generic for Concerta is not preferred.

Moving to slide 178 these are the miscellaneous stimulants. So Armodafinil, Modafinil preferred on prior auth and Nuvigil, Provigil are not preferred. I think these are on prior auth, but I can't remember for sure.

And then the analeptics on the next page, 179, are Cafcit and caffeine citrate. They are on prior authorization. They are listed as preferred because they kind of sit out in this weird different class… subclass that didn't fit with the others. Any questions on those?

Okay. Slide 180, psychotherapeutics and neurologic agents. Donepezil generic, Galantamine, Memantine tablets and ER capsules, Rivastigmine and Rivastigmine TD is preferred. And the other products are not preferred.

And then slide 181 movement disorders so Austedo, Ingrezza and Tetrabenazine are preferred and then Xenazine is not preferred. These are all on prior authorization. I think you reviewed them last month.

And then the miscellaneous neurological agents the Addyi, Ergoloid Mesylates, Pimozide are preferred and these other products are not preferred.

Moving to the slide 183 are the smoking deterrents. So we are preferring the nicotine gum and the patch and then the nicotine lozenge and nasal spray and inhaler are not preferred.

The next slide, 184, smoking deterrents preferring the Bupropion SR, the generic for Zyban as well as Chantix.

Moving into the respiratory agents cystic fibrosis so preferring Kalydeco, Pulmozyme, Orkambi and Symdeko as preferred and on prior authorization.

The next slide substance use disorder, specifically alcohol deterrents, Acamprosate and Disulfiram are preferred. And then the Antabuse is not preferred and we… just so you know we have Vivitrol the injection classified in the opioid substance abuse disorder. So it is preferred it's just not listed in duplicate under this particular slide even though it is indicated for that. And then the Naltrexone oral is also classified in that same class. They are listed and available.

And our final slide are just vaginal anti-infectives. So the Fem PH is preferred. We made it and we're two minutes early.

Any questions? Now we're moving to January of 2019. July is behind me. No. Any questions? Okay. So can I just get a motion for you guys to approve the July PDL drug classes?

Man: [inaudible]

Susan Flatebo: I second.

Lisa Chew: All those in favor say aye.

Group: Aye.

Lisa Chew: All those opposed say no. The motion carries. I think we are adjourned.

Donna Sullivan: We are adjourned and thank you for all your work and approving this for us.