Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board
P&T Meeting Notes
February 20, 2019

Amber Figueroa: Moving on to the oral breast cancer drugs. Becca, are you on the phone?

Rebecca Borgert: Yes.

Amber Figueroa: Okay. We're ready whenever you are.

Rebecca Borgert: So we're going to start with the slide that has the pie chart on it.

Amber Figueroa: Yes.

Rebecca Borgert: Let me know when you're on that slide.

Amber Figueroa: We're ready.

Rebecca Borgert: Okay. So, again, a quick overview of the disease state. Breast cancer is the most common site of cancer and the second leading cause of death in U.S. women, again, gonna make the disclaimer, we're not… you know, those statistics exclude non-melanoma skin cancers in terms of frequency and the numbers are there in terms of the estimated cases of diagnosis and number of deaths that are projected to occur in 2019. Death rates from breast cancer have steadily decreased since 1989 due to improvements in both early detection and in improvements in treatment. More than half of all breast cancers in the United States are diagnosed on screening mammography and you can see there the stage at diagnosis which is fortunate, you know, this speaks to the screening mammography program that 62% of all cases are diagnosed with localized disease, 31% of patients have lymph node extension and only 6% of patients have metastatic disease at time of diagnosis and that is related to early screening interventions. Next slide.

We are going to talk a little bit about the analysis of tumor markers, which is critical in terms of defining appropriate breast cancer

treatment options in both adjuvant setting as well as in patients with advanced or metastatic disease. There are basically three main subtypes. There are certainly additional sub classifications within that, but for the purposes of thinking about drug therapy I think we can just limit it to this. Basically you have hormone-receptor positive/HER2 negative. There… that hormone receptor includes both estrogen receptor and a progesterone receptor. HER2-pa… and so that's defined as basically an expression of either the estrogen receptor or the progesterone receptor is present in greater than or equal to 1% of tumor cells and if so that is considered hormone receptor positive. The second group… as you see there the hormone receptor positive HER2-negative that's the bulk of the group of patients with breast cancer that accounts for 70% at diagnosis. The second group is hormone receptor positive HER2-positive. HER2 is a transmembrane receptor tyrosine kinase in the EGR family. So patients who are hormone receptor positive and HER2-positive account for about 20% of patients at diagnosis and then the third group is referred to as triple negative because they lack expression of either hormone receptor positivity or HER2 positivity and that represents about 15% of patients at diagnosis. These are the patients, as you'll see on the next slide, with the worst prognosis.

So five-year prognosis is excellent for patients with non-metastatic disease. So of those three groups we just talked about for HER2-positive… excuse me, HR+/HER2-negative, I obviously left off the negative. I apologize about that. Five-year prognosis is 99% for patients that are HER2 positive and HR+ five-year prognosis is about 94% survival and even women with triple negative breast cancer have about an 85% five-year survival prognosis if they were diagnosed with non-metastatic disease. However, median survival in patients with metastatic disease is obviously much poorer in the neighborhood of four to five years for the best risk patients, hormone receptor positive, HER2-negative and hormone receptor positive/HER2-positive also now in the era of anti-… two new therapies that we have, have increased to about five years because HER2 is actually a negative prognostic indicator. However, since drug therapy has been developed to target that we've kind of reversed that trend and then women with the worst prognosis are women with triple negative metastatic breast cancer with

a life expectancy of only 10 to 13 months and that tends to be very young women that are diagnosed with triple negative breast cancer. It's a devastating diagnosis.

In terms of pharmacologic classes I just wanted to break these down because I think it will help us as we talk about the guidelines and the place in therapy. So we have your antiestrogens. Tamoxifen was obviously the initiator in this category and is the original gold standard drug. It's been around for a very long time, maybe 50 plus years. Toremifene is a very tamoxifen like molecule and then fulvestrant is an antiestrogen. Then we have three aromatase inhibitors all of which are available generically – anastrozole, exemestane and letrozole. Specific oral HER2 directed therapies include lapatinib and neratinib. And then the newest class of drugs to have a role in the treatment of breast cancer are the CDK 4/6 inhibitors and we now have three of those – abemaciclib, palbociclib and ribociclib. And then included in this TRC are two what I would call traditional cytotoxic agents – capecitabine, which is a derivative of 5VU, which is a drug that's given via IV and cyclophosphamide, also obviously has an IV formulation, but there are oral cyclophosphamide that can be used in some cases.

I want to go now to the page that is oncology oral breast cancer guidelines.

So [inaudible], you know, there are some other groups that publish guidelines for the treatment of breast cancer in addition to NCCN. So, again, I tried to put together a narrative here of the oral compilation guidelines. We will look at the NCCN guidelines, as well, but I think there is a fair amount of information we can share just in this format. So we'll start off with the general principles of adjuvant drug therapy. So the need for adjuvant… I'm sorry, I don't know the audience very well so I apologize if I'm speaking below you, but I just feel the need. Adjuvant therapy is basically therapy that is given after definitive treatment whether that's surgery, radiation, both to prevent recurrence, basically. So adjuvant therapy is given in the setting of basically no measureable disease and you're trying to prevent reoccurrence and I apologize if that… okay.

So principles of adjuvant therapy. The need for adjuvant therapy is based primarily on the risk of recurrence and some patients will not require adjuvant therapy. If the tumor is hormone receptor positive and the risk of recurrence is sufficiently high then adjuvant endocrine therapy will be utilized following… either following systemic chemotherapy or alone. Fulvestrant, although it is an antiestrogen type of drug there's no established role for that in the adjuvant setting at this time. Neratinib is the only HER2 directed therapy in this NTR that has a role in the adjuvant setting. As I mentioned oral cyclophosphamide is infrequently utilized as part of an adjuvant chemotherapy regimen and capecitabine has a few derivatives and has a recent established role in the adjuvant setting. Prior to just recently it was reserved for the metastatic setting, but now has a role in variable interest… specific role in the adjuvant setting, which we'll talk about.

So now I want to talk about the adjuvant endocrine therapy. So, as I mentioned, the original standard of care was five years of tamoxifen and that was established by the Early Breast Cancer Trailists' Collaborative Group. It was a huge meta-analysis of over 21,000 patients where they found that five years of tamoxifen versus control reduced the risk of recurrence by 50% at five years. And so that risk of recurrence decreases proportional to the patient's individual risk. So if for instance they had a 50% risk of relapse or recurrence then that's reduced to 25%. If they only had a 10% risk of recurrence then it's reduced to 5%. So you can see there where there's tradeoff in terms of, you know, who is it worth it for in terms of how high your risk is of recurrence? That is, you know, things that oncologists help patients work through and figure out. However, the standard of care being five years of tamoxifen has now changed and the current standard of care is inclusion of an aromatase inhibitor. I mentioned there are three of them on the market all available generically. This is the 2015 meta-analysis of tamoxifen for five years versus an AI for five years and they found that the 10-year breast cancer mortality was 15% lower with an AI versus tamoxifen.

As you'll see in a minute when we talk a little bit more about this, the combination of an AI and tamoxifen for… none [inaudible] at the same time, but sequentially is often used in clinical practice, which we'll talk

about in the guidelines. AI's definitely are considered standard of care now for adjuvant patients with hormone receptor positive breast cancer that require adjuvant therapy. In terms of the duration of adjuvant endocrine therapy that's also been an area of recent exploration. ASCO did publish a systematic review last November on this and they said that the use of AI beyond five years significantly reduces breast cancer recurrence and development of contralateral breast cancer compared to placebo despite the fact that they saw no improvement in overall survival. So, you know, the rationale for extending the duration of adjuvant therapy is that the risk of recurrence continues even multiple decades after the original diagnosis. So we are looking at how long should we give adjuvant endocrine therapy? As I said in the past the standard was five years and that is, you know, what the correct duration of therapy is, is a myriad currently under review.

This next slide talks specifically about ASCO's adjuvant endocrine therapy guideline which they updated last November and specifically for post-menopausal. The reason that's important to designate between post-menopausal and pre-menopausal is that pre-menopausal women should not get AI's unless they are receiving concomitant ovarian suppression therapy, which we'll talk a little bit more about in a few minutes. Just based on the mechanism of action the fact that it is not a direct estrogen-regulator modulator. So this gets broken down between post-menopausal and pre-menopausal women. So post-menopausal women with hormone receptor breast cancer they recommend that an AI should be included at some point during adjuvant therapy either as upfront or as sequential treatment after tamoxifen. And they list all of the following options as acceptable as compared to five years of tamoxifen. Either they get AI as their initial endocrine therapy, they do sequential therapy using both the tamoxifen and an AI in either order or they get extended AI where they get an aromatase inhibitor after they receive the five years of tamoxifen. The important point is that they get an aromatase inhibitor at some point in the adjuvant regimen. Tamoxifen and AIs differ in their adverse effect profile and these differences may help to inform these treatment preferences that patients go through. Tamoxifen tends to have more, you know, [inaudible] type of adverse effects and

AI's more bone toxicity associated with them, weakening of bones and that sort of thing. Where tamoxifen actually enhances bone health. So these are things that have to be taken into consideration when considering, you know, how long you'll be on an AI or tamoxifen. ASCO now says that none-positive patients should be offered extended aromatase inhibitor therapy up to a total of 10 years of adjuvant aromatase therapy. So 10 years post-surgery if they were node positive at time of surgery. If they were node negative they may be offered. So there would be a difference there you can see is node positive patients should be offered and node negative patients may be offered and that's where the nuance of the toxicity versus the benefit has to come into play between the oncologist and the patient. And then premenopausal women with hormone receptor positive breast cancer, the most recent update here is about three years old where they came out and said that ovarian suppression plus endocrine therapy should be given to women with stage 2 or 3 disease. So a little bit more advanced disease. They should receive ovarian suppression and ovarian suppression is typically accomplished, again, with a [inaudible] releasing hormone such as Lupron or Leuprolide or [inaudible] or one of those types of drugs. It can be considered in lower risk women with stage 1 breast cancer not… but women who don't warrant chemotherapy should not receive ovarian suppression with their endocrine therapy nor should women with tumors less than 1 cm who are node-negative. So again it's that stratification by risk versus the toxicity of the drug. They recommend that ovarian suppression should be administered with either tamoxifen or an AI. It has to be administered with an AI, but they recommend it be administered with tamoxifen as well and again kind of the theme here is that clinicians should discuss potential benefits and risk profiles with their patients.

Next slide is the ASCO guidelines for adjuvant therapy. This is some fairly new data. This was updated last may looking at women with early breast cancer who in particular are triple negative. So as they said for capecitabine, again, available generically. Previously limited to a [inaudible] metastatic disease, but now the guidelines say that patients with HER2-negative disease and pathologic invasive residual disease at the time of surgery following anthracycline and taxane-based preoperative therapy so in other words neoadjuvant therapy they got

chemotherapy and then they went to surgery, may be offered up to six to eight cycles of adjuvant capecitabine. And that's a moderate recommendation. You can see they phrase it as "may be offered". However, you can see there at the very bottom the ASCO expert panel preferentially supports this use of adjuvant capecitabine in women with triple negative breast cancer and that's the information there on the trial is listed. You can see that it had an impact regardless in HER2-negative women it favored capecitabine over nothing, but in triple negative disease free survival was 69.8% versus 56.1% with the hybrid ratio of .58. So I would go out on a limb and say probably standard of care to give women with triple negative breast cancer adjuvant capecitabine if they did not have a couple pathologic response. So they got chemotherapy, they went to surgery, they basically still had evidence of residual disease. We know those people are extremely high risk for disease recurrence and that's the role of capecitabine in those triple negative patients.

Neratinib is… it's FDA approved indication and the… ASCO gave it a moderate rating for extended adjuvant therapy in patients with early stage HER1-positve breast cancer. I list there the trial that the FDA approval was based on. It demonstrated an evasive disease-free survival of 94.2% at two years versus 91.9% at two years that favored neratinib. Extended follow-up showed a five-year disease-free survival of 90.2% versus 87.3% with a hybrid ratio of .73 and to date no overall survival benefit has been demonstrated. There's a drug called pertuzumab, which is an IV drug and it is now considered standard of care and I think at the time that neratinib was studied it was not studied in conjunction with pertuzumab so there is no data on the added benefit of neratinib in patients who also receive pertuzumab in the neoadjuvant or adjuvant setting. And neratinib causes substantial diarrhea and diarrhea prophylaxis must be utilized in patients who are on neratinib. So that's, I think, the gist… the genesis of the moderate recommendation even though it's an FDA approved indication. The ASCO expert panel did preferentially support the use of neratinib in patients who were node-positive, as well. So if they were HER2-positive and they were found to have positive nodes at time of surgery they would feel like those patients would probably benefit the most from neratinib.

The last thing about the ASCO guidelines now we're going to switch gears and think about advanced or metastatic breast cancer. So for hormone receptive positive, HER2-negative disease, endocrine therapy is recommended as first line in nearly all patients except maybe patients who have various symptomatic disease that might… you might go straight to chemotherapy, but for most patients first line therapy is going to be oral endocrine therapy. For hormone receptor positive HER2-negative patients the NCCN guidelines, which we'll see in a minute, preferentially recommend fulvestrant plus a CDK4/6 inhibitor. Excuse me, there's a type-o there, or an AI with the addition of a CDK4/6 inhibitor for patients who have had no prior endocrine therapy within the past year. Recommendations for pre-menopausal women with hormone receptor positive HER2-negative disease mimic those for post-menopausal women except they add with the… you add ovarian suppression to pre-menopausal women. Endocrine therapy may be utilized in hormone receptor positive, HER2-positive patients with metastatic or advanced breast cancer who have not received prior endocrine therapy in the last year. The CVK4/6 inhibitors are not recommended in HER2-positive patients. They have not been studied in that setting.

In the past, for a long time, the guidelines recommended that patients basically progress through three lines of endocrine therapy before moving on to systemic therapy where they have metastatic disease, but that's changed somewhat. Now that the CDK4/6 inhibitors have come along and are being utilized in the first line setting of metastatic breast cancer. The CDK4/6 inhibitors are dealing more with the resistance issues that we used to see and lessening those so that moving on with subsequent endocrine therapy is not going to have as much benefit as what it might have had in the past.

And then finally… sorry, second to last bullet there. If there is disease progression while on a CDK4/6 inhibitor there are no data to support an additional line of therapy with another CDK4/6-containing regimen. So you wouldn't go from, you know, whatever. And then finally the last bullet there lapatinib, with or without capecitabine, is an option for patients with HER2-positive disease, but it's considered third line

because there are other parenteral HER2-directed therapies. That has shown to be more effective than lapatinib.

All right. Any questions? If not we'll go to the breast cancer… NCC and breast cancer guidelines and we'll start on page 49.

Leta Evaskus: We're there.

Rebecca Borgert: You're there. Hello?

Leta Evaskus: Yes, we're there.

Rebecca Borgert: Oh, sorry. I thought we got cut off. So, again, this reiterates some of the things that we just talked about in that with adjuvant endocrine therapy you can basically start with either tamoxifen or an AI, but nearly all patients should receive an AI at some point regardless of how you, you know, if you give it for two to three years, even five years and you switch, but women… at the very bottom there women with a contraindication to aromatase inhibitors or decline aromatase inhibitors or are intolerable to aromatase inhibitors may just receive tamoxifen, but basically all other patients should receive an AI as part of their adjuvant regimen.

Then if we go to page 50 I just want to point out here what we talked about. This is HER2-negative patients. So if they are triple negative. So if they are HER2-negative and hormone receptor negative and they have residual disease after their preoperative therapy with a taxane [inaudible] based chemotherapy [inaudible] is recommended. And that's a fairly new recommendations as I mentioned. Let's go to page 14.

So the ones I want to point out here on the very last column at the very bottom there we're talking here about patients… we're still talking about adjuvant therapy. We're talking about these are hormone receptor positive or hormone… excuse me, HER2-positive. So they are positive for both markers and in the patients who… you can see get stratified that are node positive at the very option there or either option really, adjuvant chemotherapy with _____.

Now go to page 61 and look at the recommendations for therapy for patients with… here it says at the top recurrent or stage 4. So these are patients with metastatic disease. You can see over here on the left HER2-negative and… so these are all hormone receptive positive patients, this whole page. So if they are HER2-negative then a postmenopausal you can see there the recommendations and the category 1 recommendations are either fulvestrant or AI with a CDK46 inhibitor. So the CDK46 inhibitors or fulvestrant alone has a category 1 recommendation, as well. But the CDK46 inhibitors have moved into first line therapy of metastatic disease. And then over on the right column you can see for HER2-positive patients that are postmenopausal you can see lapatinib. That's kind of the role for oral lapatinib in combination with other drugs in the setting of women with hormone [inaudible] positive HER2-positive postmenopausal metastatic breast cancer. That's all I have for breast cancer. Any questions?

Amber Figueroa: There don't appear to be any questions. Thank you for demystifying that somewhat.

Rebecca Borgert: I did my best.

Amber Figueroa: All right.

Ryan Pistoresi: We are on to the breast cancer Apple Health Policy. Same order as before, abbreviations, then the list of drugs, then the proposed criteria and then the list of the FDA approved indications for each of those drugs so that way you're able to kind of look and see, okay, what criteria are we proposing that apply to some of these drugs. There is a lot of criteria to be reviewing for this meeting today. And then also the quantity level limits are included in the Magellan slide. So if you do want to go back and see what some of those limits are those are included there as well. You may start to notice that we do have some drugs overlap between drug classes. So some drugs that were approved for hematologic disorders may appear in some of these. So just keep that in mind that you may see certain drugs and certain indications listed here that are not necessarily related to breast cancer and that's because we have included some of the other ones. So I do

believe there are some like the cyclophosphamide, yeah, there's the lymphoma's that we already covered. So just letting you know that you may be seeing some drugs, again, in some of these other drug classes that we reviewed earlier today, but for the purposes of this motion these would apply to the breast cancer indications.

Amber Figueroa: I have a question for Dr. Santana-Davila. Do you feel that the differences between the three AIs are sufficient enough that they should all be covered?

Rafael Santana-Davila: [inaudible]

Ryan Pistoresi: Do you mind speaking into the microphone?

Rafael Santana-Davila: So that's… there is no randomized controlled study that I'm aware of that compares the three together. So we don't know which one is better than the other.

Amber Figueroa: Do you feel that they are equally used?

Rafael Santana-Davila: I don't have data if they are equally used, but I would guess so.

Amber Figueroa: Are there any other questions for Rebecca or our subject matter expert? Okay. I'm going to call our stakeholder, Kelly Kirsch.

Kelly Kirsch: Hi. I'm Kelly Kirsch from Eli Lilly & Company and I'm just going to provide a couple comments on abemaciclib or marketed as Verzenio. So Verzenio is part of the [inaudible] dependent [inaudible] inhibitors. So that's the CDK4 and 6 class. It fits along with [inaudible]. You've heard of them or what she mentioned a few minutes ago. But it has three indications along the hormone receptor positive HER2-negative advanced metastatic breast cancer population. So it has three indications and one in combination with a [inaudible] inhibitor in the first line setting if you will with endocrine therapy, as well as a second line setting with fulvestrant. It also has a single agent indication after patients have progressed on endocrine therapy as well as chemotherapy. Verzenio is 14 times more potent towards the CDK4 rather than 6. CDK4 is more commonly expressed in GI tissue, as well

as breast neoplasms and CDK6 is more commonly expressed in bone marrow. So the reason why I point that out is because Verzenio is dosed differently than the other CDK46's. As well, it has a little bit of a different of a safety profile, as well.

So from a dosing perspective it is dosed twice a day every day. So when in combination with aromatase inhibitor or fulvestrant it is 150 mg twice a day every day. And when used as a single agent it is dosed at 200 mg twice a day.

Verzenio was studied in Phase 2 and Phase 3 trials. In a single-arm Phase 2 trial in patients that have progressed [inaudible] and chemo the overall objective response rate was 19.7% and in the Phase 3 trials in combination with fulvestrant as well as in combination with an AI there was a 45 to 46% reduced risk of progression in that patient population. Now I mentioned about the safety profile. So what you're going to see with abemaciclib is diarrhea, abdominal pain, nausea and fatigue, as well as neutropenia and infections. Five percent of patients have reported DTE's as well. I'm going to comment on the diarrhea as that is probably the most significant as far as the patient felt symptom on abemaciclib. And with that diarrhea is 80 to 90% common in patients. Eighty to 90% of that is in a low grade, so grade 1 or grade 2, and it resolves fairly quickly within 7 to 10 days with supportive care such as hydration or Loperamide or with dose reduction. And so with that thank you for your time. In summary, Verzenio is the only CDK46 with a continuing dosing schedule and it does have a single agent monotherapy indication, as well. So if there are any questions I'll take those now. Thank you.

Amber Figueroa: Thanks.

Rafael Santana-Davila: So the other thing weird about this is that although they have the same mechanism of action and they are similar, patients tend to tolerate the drugs different so it is reasonable to switch from one to the other, which is probably [inaudible], which you don't see in other drugs.

Nancy Lee: I had a question for Health Care Authority. Do we have a DERP report that looked at the AIs at all? I can't remember?

Ryan Pistoresi: No. For the DERP reports we have not actually looked at any oncology drug classes. So I don't think that we have any type of information that we've shared with you before about oncology.

Alex Park: Just a question for our subject matter expert. Are any of the combination drugs particularly clinically useful in terms of compliance or side effect reduction?

Rafael Santana-Davila: It depends on… there are some that are going to be better for patients… for some patients and some for others.

Diane Schwilke: I move that the Apple Health Medicaid Program implement the clinical criteria listed on slides 81 through 83 as recommended. The breast oncology drugs listed on slides 79 and 80 are considered safe and efficacious for their respective FDA indications. All drugs are preferred for their FDA labeled indications.

Jordan Storhaug: I second.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: Okay. The motion carries. I had a question about the class name. Do we want it to be adjunctive or adjuvant? Or do we care?

Ryan Pistoresi: So this is just how we have the drug names… the drug classes how their names are populated in our files. And so that's how it's written kind of in the pharmacy programming systems. So that's the reason that the names are as they are.

Donna Sullivan: But we can change them.

Ryan Pistoresi: We can change? Oh, but we can change it.

Amber Figueroa: It didn't seem to… it's called adjuvant therapy in all the stuff that we reviewed. I don't really care either way. I just want to make sure there's not a mixed message or that that doesn't mean something else.

Ryan Pistoresi: That's just how we have the drug names populated for the file.

Amber Figueroa: Okay. We can just leave it the same then. Okay. Lunch break, half an hour.

Leta Evaskus: So for Rebecca on the phone I'll just shut down the phone. Can you call back at 12:30? And then if the stakeholders can leave the room to give the committee and the rest of us half an hour to eat and then you can come back in. Thank you.

Amber Figueroa: Sounds good.

Okay. Let's reconvene.

Leta Evaskus: I don't think Rebecca is on yet because it just said I'm the first caller.

Amber Figueroa: Okay. Rebecca, are you there?

Rebecca Borgert: Yes, I am.

Amber Figueroa: Okay. Let's go to renal cell carcinoma.

Rebecca Borgert: Okay. All right.

Leta Evaskus: I'm sorry. Hang on just a second. Okay. Go ahead, Rebecca.

Rebecca Borgert: Okay. Again, you have there the incidents… predicted incidence of the disease. About 90% of all tumors of the kidney are renal cell carcinoma. So obviously the predominant malignancy seen in the kidney and about 70% of those are clear cell carcinomas, which is the most common histology. So most of the drug therapy that we're going to talk about… well, all the drug therapy that we're going to talk about today has to do with renal cell carcinoma that have a clear cell histology. We know that smoking, obesity and hypertension are risk

factors for the development of renal cell carcinoma. We also know there is a genetic disorder, von Hippel-Lindau disease that predisposes patients to developing renal cell carcinoma. The median age at diagnosis is 64 years and it is twice as common in men as opposed to women. Presenting symptoms include hematuria, flank mass and flank pain. That used to be kind of the classic triad of how patients were diagnosed. However, now more than half of all renal cell carcinomas are diagnosed based on incidental findings associated with routine imaging. Surgery involving either a partial or radical nephrectomy is usually performed, particularly in patients without metastatic disease. Renal cell carcinoma demonstrates a very poor response to traditional cytotoxic agents. It was one of the first disease states where we had some success with immunotherapy, interferon and interleukin-2 prior to the introduction of the TKIs. We're kind of the standard of care because traditional cytotoxic agents basically have almost no response. So targeted therapies are now used in first and second line setting of advanced renal cell carcinoma. And the first approval of the targeted therapy used in the adjuvant setting post-nephrectomy for high risk patients was granted in late 2017.

Now let's go to the NCCN guidelines. We will start on page 6. _____ (42:00)

Now on page 9. _____

Any questions?

Amber Figueroa: I think we are in a post food coma here. Ryan, you want to review the policy?

Ryan Pistoresi: We are now on the renal cancers Apple Health policy. So on the next slide are some of the abbreviations in this section.

The next slide are the list of drugs. Fortunately this is only one slide of drugs, not like some of the others that we've had today. And then as you've seen many times before today is the initial request for [inaudible]. So two pages. And then on the third slide is the re-authorization criteria. So nothing has changed.

On the next couple of slides… I had to put these out of order just because they didn't fit in alphabetical order. So that's why it's out of order relative to the other drug classes that we've reviewed, but no real reason for it being out of order besides some of the lists of indications were a little bit long and instead of putting it really narrow on certain slides I put them out of order.

For the next three slides… sorry, four total. So that is the policy as we are proposing it. So if there are any questions, any comments, we can make those now prior to going to stakeholders.

Amber Figueroa: There's no stakeholder input for this category. So we'll move to the motion. Any concerns or thoughts? Okay. I move that the Apple Health Medicaid Program implement the clinical criteria listed on slides 105 through 107 as recommended. Renal oncology drugs listed on slide 104 are considered safe and efficacious for their respective FDA indications. All drugs are preferred for their FDA labeled indications.

Susan Flatebo: I second.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: The motion carries. We'll move on to oral oncology drugs for lung cancer.

Rebecca Borgert: Okay. Looking through… obviously a big topic. Again, there are a lot of non-oral therapies that we won't discuss in depth. But… so lung cancer is the leading cause of cancer death in both men and women in the United States. You can see the numbers there in terms of projective diagnosis and in death. As a direct result of the decline in tobacco smoking rates, there was a 45% decline in lung cancer death rate for men between 1993 and 2015 and a 19% decline between 2002 and 2015 for women. Efforts at tobacco cessation efforts have paid dividends. However, between 10 and 25% of lung cancer cases are diagnosed in patients who have never smoked. So it's not strictly a

disease of patients who have been exposed to tobacco. Although some of those 10 to 25% might be second hand smoke, might be implicated, but there are certainly a population of patients for whom tobacco is unrelated to tobacco. So lung cancer is divided into two major subtypes – non-small cell lung cancer and small cell lung cancer. Non-small cell lung cancer accounts for 80% of all cases. So definitely the most common and within non-small cell lung cancer there is two histologic subtypes – squamous cell and non-squamous cell. And the reason that's important is it has some implications for treatment. So that's why I mention it. So treatment of lung cancer is multimodality. It may [inaudible] surgery, radiation, chemotherapy, targeted therapy, which we are going to focus on today, and most recently immunotherapy has become stand of care in the treatment of advanced lung cancer. Genomic profiling now allows further classification of non-small cell lung cancer based on the presence of specific oncogenes. So these oncogenes may occur much more frequently in adenocarcinoma, which is one of the histologic subtypes, but may be seen in squamous cell histology, particularly in patients who have never smoked. So EGFR sensitizing mutations occur in about 10% of Caucasians, but they may be as high as 50% for patients with East Asian descent. ALK or anaplastic lymphoma kinase translocations occur in about 2 to 7% of cases. ROS1 mutations 1 to 2%. EGFR, ALK and ROS1 all occur more commonly in non-smokers as opposed to smokers. The TKIs aimed at these specific oncogenes are now considered standard of care for these patients and for first line therapy. The problem is that development of resistance occurs with these agents. The intervals vary, but typically responses are in the neighborhood of about a year. So you can see that it is the minority of lung cancer diagnoses that are able to identify one of these sensitizing mutations, but when you can't identify the mutation the drugs work very, very well albeit for a limited period of time. I just want to say a word about [inaudible] mutations, which are found in about 1 to 2% of lung cancer carcinomas. Patients with [inaudible] mutations are typically current or former smokers. In contrast to EGFR, ALK and ROS1, which occur more commonly in non-smokers. So mutations in [inaudible] typically are not simultaneous with patients who have either EGFR or ALK. I'm not going to cover [inaudible] mutations in lung cancer in this TCR because the

[inaudible] patients are much more common in melanoma and those drugs are included in the skin cancer TCR.

I'm going to go to the page that says Guidelines. So just a word about ASCO guidelines for lung cancer. So ASCO has a clinical practice guideline that recommend molecular testing in order to facilitate appropriate selection of lung cancer patients who may be treated with TKIs. Their recommendation is that biomarker testing should be performed in all tumors with an adenocarcinoma component, non-squamous, non-small cell histology or any non-small cell histology when clinical figures indicate a high probability of an oncogenic driver. So patients who are young, and are very light or absent tobacco exposure. After that it is probably a very expensive guideline for the systemic treatment of stage 4 non-small cell lung cancer, but it is currently undergoing review for update. It is a couple years out of date so it really wasn't worth reviewing here, but they should be releasing their updated guidelines soon.

Let's move on to the NCCN guidelines for non-small cell lung cancer. I want to start on page 36. _____ (53:30)

We will now go to page 37. _____

Now I'm going to go on to page 38. _____

Let's go back to page 37. _____

That takes us to page 39. _____

Now I want to go back to page…

Rafael Santana-Davila: This is my real area of expertise. I can bore you to death until 9 a.m. tomorrow morning about this. So I don't know how somebody would give erlotinib, erdafitinib or lorlatinib in a [inaudible] setting because… before I said there is really no Phase 3 data. This is the exception to the rule. This is where there is Phase 3 data and it is better tolerated, has less symptoms… less adverse events and has evidence of better

progression [inaudible] and overall survival. So to me it's a no-brainer unless there is a contraindication to that drug.

Rebecca Borgert: Yeah, yeah, exactly. Yep. Thank you. Okay. So now I'm going to go back to page 36. _____ (59:00)

If you click on that link it takes you to page 40. _____

Let's go back to page 36. _____

Rafael Santana-Davila: [inaudible] is more common than ROS1. Why was that reviewed?

Rebecca Borgert: Yeah. Because the way we structure things drugs can only fall into one TCR and since those drugs were originally approved for melanoma before they were used in lung cancer they fall under the skin cancer or melanoma TCR. Yeah. We can't have… the way the market [inaudible] are set up they can't… a drug cannot app… even though a drug obviously can have multiple different indications across potentially different tumor types as in this situation, it can only be in one. So since they were first used in melanoma it's in the skin cancer TPR.

Rafael Santana-Davila: Got it.

Amber Figueroa: Are there any questions for Rebecca or Dr. Santana?

Ryan Pistoresi: We are now for the Apple Health policy for the lung cancer subclass.

Amber Figueroa: Hold on one minute.

Rafael Santana-Davila: You also mentioned topotecan here, which is not a target agent. It's a chemotherapy drug that is used for small cell lung cancer. Do you want to discuss that as well, or not?

Ryan Pistoresi: In the policy or in the Magellan slide?

Rafael Santana-Davila: In the policy.

Rebecca Borgert: The topotecan is an oral… well, actually, it's an…

Ryan Pistoresi: Sorry, could you repeat the question?

Rafael Santana-Davila: It's in the policy, as well as topotecan, which we then hear about.

Rebecca Borgert: Yeah, Ryan, I can speak to that. So topotecan oral drug also is available as an IV drug. It is as, doctor, I'm sorry, I didn't catch your name. It is used in small cell lung cancer as opposed to non-small cell lung cancer. I think it has a fairly limited niche role and for the sake of time I did not cover it, but it is included in the market basket.

Amber Figueroa: Okay, Ryan, your turn.

Ryan Pistoresi: Okay. So this is for the lung cancer policy. Just wanted to note that when we go to the list of drugs that's on slide 122 we are missing the new drug that Rebecca mentioned, the lorlatinib. So when we do make the motion we'll have to go back to the Magellan slides rather than these slides since that was included. If you do want to know the indication that it is approved for is treatment of ALK positive metastatic non-small cell lung cancer after disease progression on crizotinib and at least one other ALK inhibitor for metastatic disease or alectinib as the first ALK inhibitor for metastatic disease or ceritinib as the first ALK inhibitor for metastatic disease. So that is on slide 115.

And so the rest you kind of know the drill already. So the criteria and then the indications. And then the motion when… well, actually stakeholder first and then the motion when you're ready.

Amber Figueroa: There are no stakeholders for this category so we'll go ahead and move to the motion.

Woman: One clarification. So are the Magellan slides 115 and 116 or just 115? It seems like there are two different things that are being presented on both slides, but I think it is 115 only.

Woman: I'll go ahead and make the motion. I move that the Apple Health Medicaid Program implement the clinical criteria listed on slides 123 to 125 as recommended. The lung oncology drugs listed on Magellan slide

115 are considered safe and efficacious for their respective FDA indications. All drugs are preferred for their FDA labeled indications.

Catherine Brown: I second.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: And the motion carries. Okay. Let's move on to skin cancer drugs.

Rebecca Borgert: So in terms of the drugs that we're going to talk about for this class we can largely divide into two groups either melanoma or non-melanoma skin cancer. Non-melanoma skin cancer is predominantly basal cell carcinoma or squamous cell carcinoma. There are certainly other cancers that do involve the skin—cutaneous lymphomas, some sarcomas, Merkel cell carcinoma, but we're not going to talk about those today.

So in terms of non-melanoma skin cancer it is the most common type of cancer that is diagnosed in the U.S., non-melanoma skin cancer with more than 5 million cases per year and accounts for 97% of all skin cancers and basal cell carcinoma is twice as common as squamous cell carcinoma of the skin. Basal cell carcinoma the risk is increased by both exposure to both UV-A and UV-B radiation. It rarely metastasizes but can cause extensive local tissue destruction and potentially bone degradation. Surgery is the primary modality of treatment, preferably Moh's micrographic surgery and other local therapy options include radiation, cryosurgery, photodynamic therapy, topical 5-FU or Imiquimod. And then with melanoma you see the numbers there for the projections. The prognosis for cutaneous melanoma depends on the stage at diagnosis. For localized disease five year survival is over 90%, but for distant metastatic disease it's less than 10%. Immunotherapy has made long-term remission actually a reality for some patients, which is nothing short of amazing. BRAF mutations occur in about 50% of metastatic cutaneous melanoma. For BRAF+ patients, monotherapy with BRAF inhibitors improves response rate, progression free survival and overall survival when compared to single-

agent chemotherapy. Again, this is one of these diseases that never responded very well to chemotherapy. And then the combination of BRAF and MEK inhibitors improves response rate, duration of response, progression free survival and overall survival compared to BRAF therapy by itself; so BRAF monotherapy. And also results in a lower incidence of development of secondary skin cancer as compared to monotherapy with BRAF inhibitors.

Let's move on to the cutaneous melanoma guidelines. Actually, before I jump into the guidelines SCCN guidelines. I just want to say that the only ASCO guideline around melanoma is related to fentanyl lymph node biopsy. So not super applicable to our discussion. The American Academy of Dermatology did publish melanoma guidelines in January last month, but basically they correspond to the NCCN guidelines and I have the link there if you want to look at the American Academy of Dermatology guidelines. Now we can move on to the NCCN guidelines.

Let's start on page 45. _____ (1:12)

Now let's go to page 7. _____ (1:15)

Amber Figueroa: Any questions on that? Ryan?

Ryan Pistoresi: So now moving on to the Apple Health policy for skin cancers. I will have you note that the list of drugs is incomplete in this section as well. So we can look at the drugs on page 133 and 134 for the purposes of the motion in this class. As you can see there's a total of eight drugs listed in this review and we only have these five. So apologies about needing to kind of go between the other slides, but if you go to 133 and 134 it has all of the indications that we should have included in the Apple Health policy slides, but weren't able to.

Amber Figueroa: For this class we do not have any stakeholder input.

Susan Flatebo: I move that the Apple Health Medicaid Program implement the clinical criteria listed on slides 342 to 344 as recommended. The scan oncology drugs listed on Magellan slides 133 to 134 are considered safe and

efficacious for their respective FDA indications. All drugs are preferred for their FDA labeled indications.

Virginia Buccola: I second.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: Okay. The motion carries. I think at the end of this I'm going to go home and request a full body CT scan just to…

Rafael Santana-Davila: No, don't do that.

Amber Figueroa: All right. Let's move on to the last oncology category, other.

Rebecca Borgert: Yes, other. Okay. So agents in this class are indicated for a wide variety of solid tumors some of which are CNS malignancies such as glioblastoma, anaplastic astrocytoma, colorectal cancer, gastrointestinal stromal tumor or GIST, hepatocellular carcinoma, medullary thyroid carcinoma and ovarian cancer. Agents that are in this review include those traditional cytotoxic as well as targeted therapies. In many of these disease states these agents have a limited role and some highlights of this that I wanted to talk to you about today is the three PARP inhibitors and their role in the treatment of ovarian cancer. Ovarian cancer is the fifth most common cause of cancer-related deaths in U.S. women. More than 70% of ovarian cancer patients present with advanced staged disease and less than 40% are cured. There is a genetic association between BRCA1 and BRCA2 genotypes and the risk of developing ovarian cancer but these genetic predispositions only account for 15% of all ovarian cancers. Primary treatment of advanced ovarian cancer usually begins with cytoreductive surgery and adjuvant therapy is usually recommended. The PARP inhibitors in particular they prevent normal base excision repairs in single-stranded DNA breaks and appear to have increased cytotoxicity in BRCA-mutated cells, which is how they were originally studied. So the original PARP inhibitor approvals in ovarian cancer were in BRCA-mutated patients whether that was a germline or somatic

mutation. But now all three are approved for maintenance therapy regardless of BRCA status in patients who have had a complete response or a partial response platinum-based therapy.

Everything went so well right up here until the very end. With ovarian cancer I'm sorry to say that they published a version which is dated March 9th—dated in the future. That's the most common one. So all of my page numbers are screwed up. This is going to be a little bit difficult to walk through because the page numbers I have listed have changed because they published an updated version in between when I put this presentation together and now. So it was all going so well up until right at the very end. I just discovered that two minutes ago.

Basically, I think I'll just… rather than try to hunt and peck for these guidelines I'll try and summarize the role of PARP inhibitors in ovarian cancer. So olaparib, which was the original drug in this class has received FDA approval for maintenance treatment for deleterious or suspected deleterious germline or somatic BRCA-mutated advanced ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum-based therapy.

Niraparib or olaparib or rucaparib, so all three, are category 2A recommendations for patients who have relapse disease that their relapse occurred six months or more after they completed their chemotherapy. Olaparib also has an indication in patients who have received three or more lines of therapy. And rucaparib in two or more lines of therapy. So, you know, ovarian cancer is very much a disease where, particularly advanced ovarian cancer, you know, they do the debulking surgery and then they… platinum-based therapy is the standard of care and then… but inevitably, unfortunately, in most patients disease progression occurs at some time and that's where the PARP inhibitors have come in. So they were sequentially approved, you know, second line, third line, blah, blah, blah, blah, blah, but now I think the important take home point is that they are all approved as maintenance therapy in the first line setting to patients who responded to platinum-based therapy. So they basically are now the standard of care in patients who have received first line recommended platinum-based therapy. And I apologize about the page that I… it was going to

be more trouble than it was worth to try to go through the slides that correspond to page numbers. But if anybody has any questions I'll try and answer and I apologize for that.

Amber Figueroa: Any questions for Becky? All right.

Ryan Pistoresi: We are now onto the Apple Health policy for the other cancers. So as you may notice on slide 159 with the list of drugs it is actually larger than what was included in the Magellan slides and that's because we have listed a few of the drugs that were reviewed in other sections here again just because they are… they were reviewed for their indications in those other disease classes, but since they have some FDA approved indications for other disease… for other types of cancers they are included here as well. So that's why we do have a few new drugs that we talked about previously like dabrafenib was in the skin cancer one and also in the lung cancer one and it's back again for the other cancers. So just letting you know that there are a few more drugs in this list than there were on the Magellan slide.

And so we did list the different indications. Although we didn't really spell out which ones were for this other cancers, versus the others. So if you do go to the dabrafenib you will see the metastatic melanoma still included in there. We're just trying to be comprehensive when we have these drugs in the multiple drug classes. And also it looks like… yep, yep… so, yeah, it looks like we have all of them listed here up till 168 and then the motion is on slide 169.

Amber Figueroa: Is there a reason that we… that you reported on a drug that's been discontinued?

Ryan Pistoresi: So that's a good question. This drug was originally in this drug class. When we were doing the review I did notice that it was discontinued, but it still may be available on the market. And so we just wanted to be, you know, comprehensive and to include it. So this drug may come back at a future time to which if we have a motion in place then we have coverage criteria for it. If it is gone for good then, you know, we're just trying to be safe and cover our bases in case this drug comes

back and it's the same form or in a different form or potentially a generic.

Rebecca Borgert: Was that question in any relation to Lynparza in the tablets versus the capsules? Is that what that question was about?

Ryan Pistoresi: No. So when I was doing my research on this it looked like altretamine or Hexalen. I saw a notice that it was being discontinued at the end of September of last year, but there still may be drug in warehouses and it may still be used.

Rebecca Borgert: Exactly. That's what I was going to say. That's kind of Magellan's policy is because there could still be drug on pharmacy shelves for up to… we typically say about three years after a manufacture discontinuation before we delete the drugs out of the CTR. Yep.

Ryan Pistoresi: Thanks for that clarification. Does that answer your question? All right. Thanks.

Amber Figueroa: There are no stakeholders for this category.

Alex Park: I have a question about the drugs that have indications across different malignancies. This is obviously one of those categories. So for instance, sorafenib is listed here, but we also listed it in the renal cell section. I'm looking back. There was this trametinib drug which we listed in the skin cancer section, but there are indications for it in lung cancer and thyroid cancer as well. It's not included in this other cancer section. Could the clinician use it for something other than skin cancer?

Rafael Santana-Davila: When we were reviewing it, it was listed in the melanoma section and lung cancer.

Alex Park: Yes, it was in the melanoma section, but it has indications…

Rafael Santana-Davila: There was a mention that it can also be used for lung cancer.

Donna Sullivan: I mean one of the reasons why we set up the criteria for the prior authorization the way we did is because they are… some of them are

indicated across different types of cancer. And so if it's listed in one of the classes then that policy will look at whatever FDA indications that it is approved for. So if it's being used for one of these conditions where it's not listed there we will still follow the FDA labeling on those products. And that's one of the reasons why we didn't try to pigeon-hole these into which diseases that they treat because that would have been a little bit more complicated.

Amber Figueroa: Any other questions? Anybody?

Nancy Lee: I move that the Apple Health Medicaid Program implement the clinical criteria listed on slides 160 through 162 as recommended. The other oncology drugs listed on slide 159 are considered safe and efficacious for their respective FDA indications. All drugs are preferred for their FDA-labeled indications.

Alex Park: I second.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: And the motion carries. I want to thank Becky. Your presentation was amazing. I don't think that you stumbled over any of those hmm, hmm, hmm, hmm nib names at all. So thank you so much for that. We really appreciate a nice comprehensive review.

Rafael Santana-Davila: That's part of being an oncologist. You just have to pronounce the names of these.

Amber Figueroa: Thank you. Also want to thank you Dr. Santana for being here and answering our questions. All right. Shall we go ahead and go to the next category?

Leta Evaskus: Unless you guys need a break.

Amber Figueroa: We can keep going. So we'll move on to migraine products.

Emily Peltier: I'll be presenting the calcitonin gene-related peptide receptor inhibitors or CGRPs. Next slide.

So just some background. These are the newer migraine medications and the DERP CGRP review was presented at the December meeting. So that is after these slides in your packets if you want to review that, but I'll just be presenting the Apple Health policy. I want to focus on the significant quality of life disruptions that migraines can cause. Then we'll be talking about the calcitonin gene-related peptide inhibitors and how we will treat those on the Apple Health PDL. Next slide.

Starting with… this is just a scoring took that is used in migraine got the HIT-6. So it's a scale used to measure the quality of life impact on patients with migraines. It's on a score of 76… 78. A clinical meaningful change… so from baseline after they have been taking the medication is defined as about a 5-point decrease and this is from clinical trials in patients with migraines and a whole slew of treatments for those migraines. Specifically for the CGRP inhibitors and Botox in studies with chronic migraine patients were found to have about a 6 to 7 point reduction in this HIT-6 score. This information will be useful when we get to the clinical criteria. Next slide.

This is just a list of the medications. So we have Aimovig or erenumab, Ajovy or fremanezumab, Emgality or galcanezumab and the dosing is there as well. These are sub-q injections. Most of them are dosed monthly. Next slide.

This is just a broad overview of the seven clinical criteria that I will get into the next couple of slides. Really looking at diagnosis, number of migraines per month, who is prescribing the medication, the preferred therapies that the patient has been on before, the baseline migraine measurement, so that quality of life score that we talked about and then we also have a quantity limit and any prior treatment with Botox. Next slide.

The initial request criteria so just starting with that diagnosis, making sure that they have a diagnosis of migraine headaches, and that the patient is experiencing four or more migraines per month. And then

making sure that it is prescribed by a specialist in either neurology, internal medicine, or other migraine pain specialty. So it is prescribed by or the prescriber has consulted with one of those specialists. Next slide.

So this is the trial and failure of the preferred therapies. So making sure that the patient has failed a three-month trial of at least one agent from each of the following classes of these preventative medications. We defined this as an inability to reduce migraine headaches by two or more days per month and then the documentation of their adherence is required for these therapies unless the drug class is contraindicated or they had intolerance to the treatment. Those are the classes and they are on the next slide.

These are the four drug classes. The preferred preventative medications and then the drugs that have compendia support are listed there. So again we would require one from each of those classes except we combined the beta blocker and the calcium channel blockers. So one anticonvulsant topiramate or divalproex, the antidepressants venlafaxine, amitriptyline or nortriptyline, and then a beta-blocker or a calcium channel blocker so propranolol, metoprolol or atenolol and calcium channel blockers verapamil. So those are the preferred therapies that we would require the patients to use before they try the CGRPs. Next slide.

This is the final slide of the initial request criteria. So we would require a baseline measurement from a standard migraine instrument. So that HIT-6 that we talked about before and then we would also require these quantity limits. So basically just the recommended dose for all of these medications and then finally we would require the patient to not receive Botox in the previous 12 weeks. If all of those criteria are met then the medication will be approved for three months. Next slide.

As far as the reauthorization criteria the migraine days need to be reduced by at least 40% from baseline or documentation of significant improvement in the quality of life measure. So that HIT-6 number we would require a six-point reduction. So that's kind of how we defined the positive effect of the medication and then again we would require

the quantity limit with the only difference being that 675 quarterly dose for the Ajovy. If these criteria are met then the medication will be approved for 12 months. Next slide.

And that wraps up the policy. So I'll open it up to stakeholder comments.

Amber Figueroa: I have a question. Is this something that is prescribed and then the patient is taught how to inject it or they get it and bring it into the clinic and we give it or how does this work?

Emily Peltier: Um, so kind of a combination of them. Most of them are approved for self-administration. All of them are approved for self-administration and then I think some of them also are indicated for health care administration, as well. So a combination of the two.

Jordan Storhaug: I'm a little confused about the Botox part of it because it looks like in the criteria summary it talks about previous Botox, but then in the specifics it doesn't mention Botox again except that they shouldn't have received it within the past 12 weeks. Can you speak to that a little bit more?

Donna Sullivan: Are you asking how we cover Botox?

Jordan Storhaug: My question is, is Botox required before… in order for a person to get approved for this?

Donna Sullivan: No, it's not.

Emily Peltier: No, it's not, just the preferred therapies of those four drug classes, but we want to make sure they haven't had a recent Botox dose.

Constance Huynh: I have a question. This is Constance. There is the third one, the Emgality that can actually be done quarterly. Is that right? There's an option of it being monthly or quarterly.

Donna Sullivan: Ajovy.

Constance Huynh: Oh, Ajovy is the option that you can do quarterly. So is there a different recommendation if they do it by the quarterly that you would give them three-quarters worth? Because your criteria medication will be approved for three months, but I'm assuming that's for the monthly ones?

Emily Peltier: So the initial criteria we have a different quantity limit. So that doesn't include the quarterly dose until they meet criteria for the reauthorization. Does that answer your question?

Constance Huynh: So then a follow-up question would be, is the initial approval going to be just for monthly?

Emily Peltier: Yes.

Constance Huynh: Okay. Thank you.

Amber Figueroa: On slide 6 prescribed by or in consultation with a specialist in neurology, internal medicine or other migraine pain specialty. I'm just thinking about… I mean family medicine sees tons of migraines. So I guess… and I get frustrated when I have patients that have no insurance where they can get a lot of these newer drugs for free or nearly free with rebates from the companies or whatever, but they have to spend $600 to see the neurologist to get is prescribed. I'm okay with it because it says in consultation with. So I think that's okay. I don't know that internal medicine specializes in migraines any more than family, but…

Jordan Storhaug: I agree with that. In Spokane we currently do not have any neurologists who are accepting headache patients and Spokane is not a tiny area, but a huge area shortage. If there is a reason, you know, especially in some ways this is a pretty liberal policy in that they only have to try one preventative medicine in order to qualify for this one. But I feel like that is going to be a huge restriction in time and, you know, in our location right now possibility to be able to see a consultant.

Ryan Pistoresi: Do you think we should remove that "prescribed by or in consultation with" in light of the situation going on in eastern Washington?

Jordan Storhaug: That would be my suggestion. I don't think it is going to add very much and will be a burden on patients.

Ryan Pistoresi: Okay.

Leta Evaskus: What do you want it to say?

Ryan Pistoresi: We can just delete it.

Woman: You can just take the whole bullet out.

Leta Evaskus: Okay. Thank you.

Amber Figueroa: Any other questions or comments at this point? We have three stakeholders, Dr. Sylvia Churchill, Anthony Wheeler and Donald Moran.

[inaudible]

Amber Figueroa: Okay. Anthony Wheeler?

Anthony Wheeler: Yep. All right. Thanks. I'm Anthony Wheeler. I'm an employee of Eli Lilly & Company. We manufacture galcanezumab, which is being marketed as Emgality. This is part of the CGRP class that you were discussing, which includes Aimovig and Ajovy. Emgality is indicated for the prevention of migraine in adults. It's administered once a month. There's a single 240 mg loading dose at the beginning of treatment and then it's 120 mg once a month thereafter. It's delivered via a single-use auto injector device. It's very easy to use. There's no reconstituting or mixing necessary or it can be delivered using a pre-filled syringe if patients or providers prefer that. It is self-administered so to answer I think one of the panel's questions this isn't necessarily a physician-administered drug. This was studied in three randomized controlled Phase 3 clinical trials. Two of these studies looked at patients who had episodic migraines so between 4 and 14 migraine headache days per

month and then one trial looked at patients with chronic migraine—patients who had more than 14 migraine headache days per month.

Emgality significantly reduced the average number of monthly migraine headache days in all three of these trials compared to placebo. Consider that the episodic migraine trials went on for six months and then the chronic migraine trial went on for three months, but there was a nine-month extension to that. So there was a total of 12 months of data from that study. And then significantly more patients on Emgality had at least a 50 or 75 or 100% reduction in their migraines in any given month compared to placebo and also less than 2% of patients across the Phase 3 clinical trials discontinued Emgality due to an adverse event, but you can certainly see the package insert for all the safety details. Thanks for letting me provide a few comments. I'm happy to answer any questions you might have.

Amber Figueroa: Can you speak to the most common side effects?

Anthony Wheeler: Sure. Injection site reaction or injection site irritation is far and away the most common. There were a few other side effects that I'm blanking on that were like way less than 1% occurrence, but injection site reactions is really the big one.

Amber Figueroa: Any other questions? Okay. Donald Moran?

[inaudible]

Amber Figueroa: Okay. Very good. So that's it for stakeholders.

Donna Sullivan: Since we reviewed the CGRP class last… at the last meeting we don't need the efficacious and the safety comments or the preferred status. We'll use the recommendation that you made as the P&T Committee for the December meeting to pick preferred drugs. So this is just really approving the clinical criteria that we just reviewed.

Virginia Buccola: I move that the Apple Health Medicaid Program implement the clinical criteria listed on slides 7 through 10 as recommended.

Alex Park: I second.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: The motion carries.

Donna Sullivan: And so the last presentation… I really don't want to take the time to go through these drug classes, but if you want to just take a few minutes and peruse them. If you have any questions then we can discuss the drug classes, but these are the drug classes that will be going into effect in April. They are a lot of the antibiotics, antifungals, I think some of the topical steroids, dermatologic drugs, a lot of them are just older drugs that have been used pretty often. So if you have any questions you can just peruse the drug classes and ask about them. There's a few drug classes that you will notice where there's only one drug in the class and it's not preferred. We struggle with do we call it preferred and it's still on PA? Or do we call it non-preferred if we're… if the PA criteria makes it use another drug first? So if you're asking why that's kind of why we fell on the… we'll call them non-preferred if we're requiring step therapy or use of another drug prior to that drug being used. So you might notice that on a few of the drug classes.

Dave Johnson: I just wanted to comment as well that it looks like these slides were prepared before we realized that we're missing some. So the groups that we didn't reject messaging on are missing from here. So there's five more classes that are going live. The amino penicillins, the natural penicillins, the penicillin combination sulfonamides, and vaginal antibiotics are all going live and there's no slides in here. There's also… the changes that we made that were reflected in the most recent file are not reflected in the slides. There's two or three that I can list if you guys want me to.

Donna Sullivan: If you want to, you can.

Dave Johnson: So in the diclofenac 3% gel is listed as preferred. It is on PA because it's so much more expensive. And oral ketoconazole was moved from being preferred to being non-preferred.

Donna Sullivan: Thank you, David.

Amber Figueroa: I have a question on slide 16 for genital warts. Does… what are we…

Donna Sullivan: So the way that we have classified these drugs is the Medi-Span designation. So erenumab is not designated specifically for genital warts and so it is covered in another class, but it is not grouped in this particular drug class. That happens to a lot of the drugs where they have multiple indications.

Amber Figueroa: Just wouldn't feel right if somebody came in with a genital wart and I would tell them, "Well, there's nothing we can do for you. Have a nice life."

So on page 30 the bisphosphonates the orals are preferred and the injectables are not?

Donna Sullivan: Yes, that is correct.

Susan Flatebo: You have the zoledronic acid listed though. That's injectable.

Donna Sullivan: Oh, so the zoledronic acid is an injectable, but all of the others are orals.

Dave Johnson: Donna, has there been a change in ibandronate? You have it listed as preferred and…

Donna Sullivan: Yes. So that is a change. I think ibandronate we… I thought we had announced it but maybe we didn't. I did look up the price and it was considerably… it was similar to the alendronate so I had made the decision to make it preferred, but I don't know if it's… we'll double check to make sure it's gotten programmed. But, yes.

Nancy Lee: I had a question about the thyroid agents in terms of the preferred including like armor and NP. Did we at one time talk about…?

Donna Sullivan: What slide are you on?

Nancy Lee: 46. In terms of like levothyroxine as being the preferred. No, did we not talk about that?

Donna Sullivan: I remember Petra made a comment about it. I don't remember what the comment was, but I remember you said something about it. And we were talking about armor thyroid because it was one of those weird situations where there's no… it's not FDA approved, but there is a federal Medicaid federal rebate. So it's kind of one of those strange, I think, situations. But there were a considerable amount of people on it and you had mentioned that you wanted to keep it preferred. I remember that. And then the generic levothyroxines and the liothyronine for others. Did you have a question specifically?

Nancy Lee: I just forgot. I know we talked about it and couldn't remember what the conclusion of what we discussed, but thank you for reminding me.

Donna Sullivan: Okay. Thank you.

Amber Figueroa: All right. Has everybody had a chance to sufficiently review those? Any other comments or questions? Leta, way to go navigating that.

Donna Sullivan: Can we just have a motion to formally accept the…

Leta Evaskus: Excuse me, she was giving me a compliment.

Donna Sullivan: I didn't want you to adjourn too quickly.

Amber Figueroa: I move that we accept the miscellaneous therapeutic drug classes listed on all of those slides.

Donna Sullivan: These are the April 2019 drug classes.

Amber Figueroa: To roll it out April 1st.

Donna Sullivan: Thank you.

Amber Figueroa: To be included on the Apple Health PDL. There, that sounds more official. Are you supposed to type something or I just say it?

Donna Sullivan: No, it's recording.

Connie: This is Connie and I second it.

Amber Figueroa: All in favor?

Group: Aye.

Amber Figueroa: All right. The motion carries. Now, Leta, way to go. Good job working through all of those charts. Awesome. Any other comments? Okay. The meeting is adjourned.