Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board
Meeting Transcription
October 19, 2022

Jordan Storhaug: All right. Well, we will now convene the P&T Committee Meeting. I am Jordan Storhaug, the Chair of the P&T Committee. I will read off the names of the participating attendees. Please say "here" when I call your name. For the P&T Committee Members, Virginia Buccola.

Virginia Buccola: Here.

Jordan Storhaug: Kavita Chawla.

Kavita Chawla: Here.

Jordan Storhaug: Michael Corsilles.

Michael Corsilles: Here.

Jordan Storhaug: Susan Flatebo.

Susan Flatebo: Here.

Jordan Storhaug: Jon MacKay.

Jon MacKay: Here.

Jordan Storhaug: Leah Marcotte.

Leah Marcotte: Here.

Jordan Storhaug: Alex Park.

Alex Park: Good morning. Present.

Leta Evaskus: Jordan, you're muted.

Jordan Storhaug: Something up with my mute.

Leta Evaskus: Sorry.

Jordan Storhaug: All right. Next, Diane Schwilke.

Diane Schwilke: I'm here.

Jordan Storhaug: And then Laura Beste won't be able to attend today. From the Health Care Authority, Laura Crocker.

Laura Crocker: Here.

Jordan Storhaug: Luke Dearden.

Luke Dearden: Here.

Jordan Storhaug: Leta Evaskus.

Leta Evaskus: Here

Jordan Storhaug: Amy Irwin. Next is Liz Punsalan.

Liz Punsalan: Here.

Jordan Storhaug: Ryan Pistoresi.

Ryan Pistoresi: Good morning.

Jordan Storhaug: Donna Sullivan. Marissa Tabile.

Marissa Tabile: Here.

Jordan Storhaug: Ryan Taketomo.

Ryan Taketomo: Here.

Jordan Storhaug: Joey Zarate.

Joey Zarate: Good morning.

Jordan Storhaug: From Labor & Industries, Christy Pham. From the Drug Effectiveness Review Project presenters, Sara Kennedy.

Sara Kennedy: Here.

Jordan Storhaug: Shannon Robalino.

Shannon Robalino: Here.

Jordan Storhaug: And Beth Shaw.

Beth Shaw: Good morning.

Jordan Storhaug: And then our Magellan Medicaid Administration presenters, Umang Patel.

Umang Patel: Here.

Jordan Storhaug: And Kara Delaney.

Kara Delaney: I am here.

Jordan Storhaug: Thank you. And then just for your information, for our Managed Care Organizations, our representatives are Greg Simas of Moline Healthcare, Heidi Goodrich from Moline Healthcare, Petra Eichelsdoerfer from United Healthcare, Omar Daoud from Community Health Plan of Washington, and Jeffrey Natividad from Community Health Plan of Washington. Now, Leta will go over the meeting logistics.

Leta Evaskus: Thanks, Jordan. The committee and presenters can mute and unmute themselves. Please mute yourself when you're not speaking to limit the background noise. Presenters, please share your webcams while presenting, and the committee, please share your webcams during discussions and motion consideration. For stakeholder participation. The Chair will read the list of stakeholder names who pre-registered to speak. Please raise your hand so we can find you and unmute you. After the Chair will ask if there are any other stakeholders, you can raise your hand, and we will call on you and unmute you. You can also use the Q&A box. We will address your questions during the stakeholder time. We'll be turning off the chat after each drug class stakeholder testimony time period concludes for this committee to make a motion. And lastly, the meeting is being recorded, so please state your

name every time you speak. I have two announcements. First, a reminder that stakeholders should not contact the committee to ask questions about the P&T meetings. This can cause a conflict of interest and disqualify them from being on the P&T Committee. For all questions, you can email me at pdp@hca.wa.gov. Second, this is Leah Marcotte's last meeting with us. So Leah, I want to thank you for your time serving as a P&T Committee Member. We really appreciate your contribution with us, and we'll miss you.

Leah Marcotte: Thank you, all. I really enjoyed serving on this committee. Sorry to leave.

Leta Evaskus: Okay, and with that **[cross-talk]** --

Jordan Storhaug: Are we ready to start our first topic?

Leta Evaskus: Yeah.

Jordan Storhaug: Great. Perfect. So our first topic for discussion is the Calcitonin Gene-Related Peptide Inhibitors. And with that, we should have a presentation from Sara Kennedy.

Leta Evaskus: Okay, just a second. Let me share my screen here. Sorry. Just having some technical difficulties here. Okay. Can you guys see my screen?

Sara Kennedy: Yes, it just loaded.

Leta Evaskus: Okay, great. Okay, there's a little delay. All right.

Sara Kennedy: Would you just like to say "next slide" as we **[cross-talk]** --

Leta Evaskus: Yeah. And then just know there might be just a second delay there. Thanks.

Sara Kennedy: All right. Thank you. Hello, everyone. I'm Sara Kennedy. And this is the topic brief presentation on Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Migraine Prevention and Treatment and for Cluster Headache Prevention. Next slide, please. So, this just gives a quick overview of what I'll be covering today. So we'll do a brief summary of the methods. We'll go over the PICOS, then the key questions, the findings, and a quick summary at the end. Next slide, please. So we looked for published trials in PubMed, the Cochrane Library, and also via Google Scholar searches, and then we looked for ongoing studies by searching clinicaltrials.gov. And the searches for the topic

brief were limited to March 1, 2019 through February 28, 2022, to capture the relevant studies published since the 2020 systematic review on this topic. Next slide, please. So this slide summarizes the PICOS, and the populations included adults with episodic or chronic migraine, adults with acute migraine headache, and adults with chronic cluster headache. Next slide. So we included studies that were assessing CGRP inhibitors that are FDA approved and shown here. So in total, the topic brief included six CGRP inhibitors: eptinezumab, erenumab, fremanezumab, galcanezumab, rimegepant, ubrogepant. And I will note that none of these drugs were new to the scope for this topic brief. But that rimegepant had a new indication for preventive treatment of migraine since the last update for this topic. And I'll also add that in the full report, we will include atogepant, which was FDA approved in September of 2021, but it was not included in the scope of the topic brief. Next slide. So eligible comparators were placebos, other CGRP inhibitors, or other standard of care or pharmacological treatments. And then eligible outcomes of interest include migraine events, pain relief, quality of life, functional or disability outcomes, use of rescue therapies in the case of the preventive treatments, health care utilization outcomes, and harms, including adverse events, serious adverse events, and discontinuations due to adverse events. And then as far as study designs go, we included randomized controlled trials. Next slide. This slide summarizes the key questions, and the first is about the effectiveness and harms for preventing episodic or chronic migraine, an episodic or chronic cluster headache. The second key question is about effectiveness and harms for the acute treatment of migraine and cluster headaches. And then the third key question relates to the ongoing studies. Next slide, please. So now we will move into the findings. So the previous report, which was completed in April of 2020, included 27 RCTs. And then in this topic brief, we identified 11 new RCTs reported in 16 publications. So for chronic migraine prevention, there were five new RCTs reported in seven publications, then there were also three new publications associated with RCTs that were included in the previous report. For episodic migraine prevention, there were four new RCTs, and that was reported in six publications. And then there were also three new publications associated with RCTs that were in the previous report. For acute migraine treatment, there was one new RCT reported in two publications, and one new publication reporting additional outcomes from two RCTs that were included in the previous report. And then for chronic cluster headache, there was one new RCT. Next slide, please. So these next slides show detailed study information including Drug, Comparator, Phase, Sample Size, Duration, and Outcomes of the studies that were included in the topic brief, and they're

sorted by Indication and then by Drug. So I won't go over these in a huge amount of detail, but I will note which rows are brand new trials and which ones are companion publications that were related to trials included in the previous report. So this slide shows studies of chronic migraine prevention, and all four of these are brand new RCTs. Next slide. This slide also shows chronic migraine prevention studies. Lipton, 2020, is a new companion publication related to the previously included HALO CM RCT, and it reports additional quality of life outcomes. MaassenVanDenBrink, 2021 is a new companion publication, and that is related to the previously included FOCUS RCT, and it reports subgroup findings by age and sex. Ford, 2020 is a new companion publication related to the previously included REGAIN trial, and that one is reporting additional functioning and disability outcomes. And then Mulleners, 2020., in the bottom row, is a brand new RCT that was reported in two publications. Next slide. So this slide and the next slide summarize the episodic migraine prevention publications Kawata, 2022 is a new companion publication, and it was reporting additional functioning outcomes from two previously included RCTs from ARISE and STRIVE. And then, Lanteri-Minet is a new companion publication to the previously included LIBERTY trial reporting additional functional outcomes. And Croop, 2021 is a brand new RCT. Next slide. So this slide continues the episodic migraine prevention studies. And Sakai, 2021 is a new trial of fremanezumab. And then Sakai, 2020 is a new trial of galcanezumab. And that one has two companion publications. And then Smith, 2020 is a companion to the previously included PROMISE-1 RCT, and that one reported one year outcomes. And Wang, 2021 is a new trial. Next slide, please. The slide shows the acute migraine treatment studies. Winner, 2021 is a new trial that was reported in two publications. And then Dodick, 2020 is a new companion reporting outcomes from two previously included trials from ACHIEVE-I AND ACHIEVE-II, and it reported additional functioning and disability outcomes. Next slide. And this slide shows the one new trial for cluster headache prevention. And next slide. This gives a breakdown of the 20 ongoing studies of CGRP inhibitors. Among those there were three head-to-head comparisons that are detailed there. Next slide. Just move into the summary. So in total, we identified 11 new RCTs that were reported and 16 publications and 20 ongoing studies of CGRP inhibitors for chronic migraine prevention, episodic migraine prevention, and acute migraine treatment, or cluster headache prevention. So this brought the total to at least 30 RCTs, including everything that was in the 2020 report and then identified for this topic. So next slide. I should just say questions? Are there any questions?

Jordan Storhaug: Thank you so much, Sara, for that presentation. With that then I think the next part is we do have a couple of stakeholders on this topic. In order that we have first is Rochelle Yang of Teva, then Carrie Johnson of Amgen and then a third, Charlie Lovan from AbbVie. Do we have Rochelle available?

Rochelle Yang: Can you hear me?

Jordan Storhaug: We can hear you. Go ahead and present. You have three minutes.

Rochelle Yang: All right, thanks. My name is Rochelle Yang, part of the Medical Affairs Team at Teva and just here to provide you with some updates on Ajovy or fremanezumab. Just as a quick reminder, Ajovy is a self -injectable subcutaneous CGRP inhibitor that is indicated for the prevention of migraine in adults. And it is the only self-injectable CGRP inhibitor that is available in both monthly and quarterly dosing and was evaluated in the Phase III randomized controlled trials in the US, HALO, and FOCUS. I wanted to highlight two recently published real world evidence studies in the US. The first is the claims database study of just under 1000 patients with migraine who are prescribed Ajovy, which have a high rate of patient adherence with a mean proportion of days covered of over 86%, and persistence was found to be more than 75% after at least six months. And also in the subgroup of migraine patients with comorbid depression or anxiety at baseline, which are two common comorbidities associated with migraine, there were also reductions in prescribed antidepressant and anti-anxiety medication use, respectively. The second study I wanted to go over as a retrospective chart review study on just over 1000 patients with migraine, who had initiated Ajovy, which found improvements in clinical outcomes, such as the monthly migraine days, monthly headache days, the migraine disability assessment questionnaire, and the headache impact test scores after six months. And these positive outcomes were seen in patients regardless of whether they were on the monthly or the quarterly dosing of Ajovy and how many prior treatments they had tried and failed. So these studies add to the evidence of efficacy and safety that has seen with Ajovy across a broad population of patients with migraine. And we respectfully ask the committee to consider adding Ajovy on the Apple Health PDL. Thank you for your time.

Jordan Storhaug: Thank you. Next, we have Carrie Johnson from Amgen.

Carrie Johnson: Can you hear me okay?

Jordan Storhaug: We can. Go ahead. You have three minutes.

Carrie Johnson: Okay, thank you. Good morning. My name is Carrie Johnson and I'm a pharmacist with Amgen Medical Affairs. Thank you for the opportunity to provide the committee with updated information on Aimovig or erenumab. Aimovig was FDA-approved in 2018 and is indicated for the preventive treatment of migraine. Aimovig is the first and only CGRP monoclonal antibody that targets the CGRP receptor, and the only self-administered monoclonal antibody that comes in two dosing options, which allows for customized treatment for patients with episodic or chronic migraine. Aimovig has an established safety and tolerability profile. The most common adverse reactions in clinical studies were injection site reactions and constipation. Please see the full prescribing information at amgen.com, which provides further information. I'd like to provide the committee with two updates. Onne our head-to-head trial and, two, our long-term open-label extension data. The HER_MES trial was the first head-to-head trial comparing the tolerability and efficacy of Aimovig with topiramate. This was a 24-week study that enrolled 777 patients with an average of 10.4 monthly migraine days. The primary endpoint was tolerability determined by discontinuation of treatment due to adverse drug reactions during the 24-week treatment phase. Discontinuation was 10.6% with Aimovig and 38.9% with topiramate. The secondary endpoint of efficacy determined by 50% reduction or more from baseline in monthly migraine days. The final three months was achieved in 55.4% of patients on Aimovig versus 31.2% of patients on topiramate. Safety findings in the study were consistent with those seen in previous Aimovig clinical trials. Second, our long-term extension studies have evaluated long term safety and efficacy of Aimovig in chronic and episodic migraine, particularly in episodic migraine, we have our five-year open-label extension data. Aimovig is the only CGRP therapy with five-year clinical trials open-label extension data, and this is fully published. No new safety signals or increased incidence of rates of adverse events or serious adverse events over five years of exposure. In addition, 71% of the 212 trial participants that completed the study had a 50% or more reduction in their baseline monthly migraine days. The main reduction in monthly migraine days was 5.3 days in a population that averaged 8.7 migraine days per month at baseline. Clinically relevant improvement and patient reported outcomes were stained throughout the trial as well. In conclusion, migraine pathophysiology is multifactorial, complex, and heterogeneous, and no two patients' migraine experience or response to treatment are the same. Aimovig has unique mechanisms of action, published head-to-head data, and

five-year long-term data. Aimovig has also demonstrated a high level of satisfaction by patients and providers. Thank you for your time in providing these updates. And I'm happy to address any questions.

Jordan Storhaug: All right. Thank you very much. Next, we will have Charlie Lovan of AbbVie.

Charlie Lovan: Thank you. Good morning. My name is Charlie Lovan. I'm a Medical Outcomes Liaison with AbbVie. Thank you for the opportunity to speak today regarding the CGRP category and specifically AbbVie's approved therapy, atogepant, known as Qulipta. So as Carrie just mentioned, this is not included in the current report due to its approval and pivotal publication dates, so I'd like to give a brief overview. Qulipta is an oral CGRP receptor antagonist that is indicated for preventive treatment of migraine in adults . It's the only CGRP product with three doses providing dose flexibility. The approved doses are 10 mg, 30 mg, or 60 mg once daily. Qulipta was evaluated in a Phase III double-blind, placebo-controlled study called the ADVANCE trial. The primary endpoint of change from baseline and mean monthly migraine days across 12 weeks compared to placebo was met. In addition, all six key rank secondary endpoints compared to placebo were met including three patient reported outcomes, change from baseline in acute medication use, change in headache days, and 50% respond rates, and 55% to 60% of patients experience at least a 50% reduction in mean monthly migraine days across the 12-week treatment period, and during weeks 9 through 12, 61% to 71% of patients experience a 50% reduction in mean monthly migraine days, and 21% to 28% experienced a 100% reduction in migraine days. Qulipta significantly reduced mean monthly acute medication use days by roughly 50%. The goal of reducing acute medication use is of increasing interest as novel branded acute medications have been recently approved. In regard to safety, Qulipta has no contraindications, warnings, or precautions in the USPI. The most frequent reported adverse event in the Phase III trials were upper respiratory tract infection, nausea, and constipation. None of the adverse events were considered serious. All reported cases of nausea were mild or moderate in severity. The discontinuation rates due to adverse reactions for nausea, constipation, and fatigue were 0.5%. No Hy's law cases were identified indicating Qulipta has not been shown to have a risk of drug-induced liver injury. So in summary, Qulipta provides a daily oral option for preventative treatment of migraine with three approved doses that all have demonstrated significant improvements versus placebo in clinical and quality of life measures. Thanks again to the committee for the opportunity to share this information.

Jordan Storhaug: Thank you. I just want to give an additional opportunity if we have any other stakeholders.

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

Jordan Storhaug: Okay. At that point then I think we are ready to entertain the motion. And I believe for clarity for this one, we will not have to find the scan to the surveillance be adequate as it's a brief topic brief. But we will have to do that for the other two DERP presentations.

Leta Evaskus: That is correct.

Ryan Pistoresi: Hi. This is Ryan Pistoresi. So just to kind of orient you to where we are with the future for this, we did request that DERP do a full updated class review based off of your recommendation or your motion at the December 15, 2021 meeting, and so that will be ready next year. So we will have a full update that will go into more detail around that. But we wanted to present this to you just to show you kind of where we were and what to expect for that future P&T topic.

Jordan Storhaug: So at this point, I think we're open for discussion, or if anybody would like to make a motion.

Christy Pham: Hi, this is Christy Pham from L&I. I just wanted to see if this would be a point where we wanted to clarify concurrent use. We have seen requests from several providers in our system that are requesting both CGRP inhibitors for preventive and acute treatment of migraine. And I have not found in any evidence or studies that had patients on both the monoclonal as well as the small-molecule Gepants, and I was wondering if we wanted to comment on concurrent use here?

Donna Sullivan: So this is Donna. I'm sorry. Was that a question? I might have missed it.

Christy Pham: I just wanted to bring up that point because I was just reading the motion, and it doesn't say anything about whether it can be used concurrently if a provider is prescribing both for prevention and acute or abortive treatment of migraine.

Donna Sullivan: Normally, we don't make recommendations on what we consider utilization management tools. So we wouldn't put that into the motion about what's first-line, second line, what can or cannot be used together in these motions, but we established that in our clinical policies.

Christy Pham: Okay.

Donna Sullivan: **[Cross-talk]** So sorry for the awkward silence there.

Kavita Chawla: Kavita Chawla **[cross-talk]** -- oh, sorry. If I understand Christy's question correctly, are you saying, Christy, that like in the motion, it says, safety and efficacy for the treatment of acute migraine, while some of these medications' providers use for both acute migraine as well as migraine prevention? And we're not calling that out in the motion?

Christy Pham: It's just, yeah. It's just not mentioned.

Multiple speakers: **[Cross-talk]** --

Kavita Chawla: For migraine prevention.

Donna Sullivan: Yeah. Okay. Now I'm tracking better now. Sorry about that. In the past, what we have done, I think when we originally reviewed this there was not the acute treatment indications. So we normally then when there are multiple indications, if they have been studied, we would say for their FDA-approved indication. But this was just a surveillance. Was this a surveillance, or was this a full report?

Multiple speakers: **[Cross-talk]** --

Donna Sullivan: Okay, so there has not been a completed report on the use for acute treatment of migraines, and so we wouldn't really be able to say anything specific to that particular indication. They can still be used for that indication if they are approved, or preferred, because we'll have them on prior authorization, I believe. And we would add that indication in our policy and approve for the FDA label.

Kavita Chawla Kavita here. I think, Donna, what you're saying is, like, later in the motion it says, "efficacious for the treatment of their approved indications." And so if

FDA indication says that is approved for migraine prevention, then that would automatically include that. Am I understanding that right?

Donna Sullivan: I'm thinking at this point in time it should not say for their FDA-approved indications because the one indication has not been studied in depth. We haven't done a full report and a full evaluation of the evidence.

Alex Park: Donna, **[cross-talk]** it's Alex Park here. I just wanted to clarify then, are you recommending that we take out that statement in the motion about the approved indications until -- I think it's eptinezumab that hasn't been looked at for acute treatment.

Donna Sullivan: Where are you seeing FDA-approved indication? I'm trying to read and I'm --

Alex Park: Yeah, I know. It's small on the screen, but when we look at the 2020 motion from August 19th **[cross-talk]** --

Donna Sullivan: Oh, yeah, yeah. Okay. I was looking at the one motion where it had the actual -- this is a different one now. So, yeah. I would not put "for their approved indications" because the one indication has not been fully evaluated. So, yes, Dr. Park, I am recommending removing that and say for the treatment of prophylaxis of migraine, or for the treatment of migraine prophylaxis.

Alex Park: I think I see where you're coming from. I just want to think aloud for a minute. So this is a topic brief. So there has been no evaluation of studies in this, but Ryan says there is going to be a full updated class review, which will include the review of those studies that will be brought to this committee at a later date.

Donna Sullivan: So what we've done in the past if we know there's a full review coming -- Ryan, is it coming soon? Or is it next year? Do you know? It'll be some time next year. We'll probably need to look at what other report surveillance documents and topic briefs for April onward. So at the earliest, I'm thinking April. Otherwise, it would probably be June.

Donna Sullivan: Okay. So, Dr. Park, sometimes what we have done, or what the committee has done when we know that there is a full update coming, we have either just not made -- we just kind of pass on making a motion on this. Or you just reiterate the same motion because we know we're going to get the updated report next time. So reiterating the same motion from last time or just

passing results in the same outcome, that there would be no change until we get the full report.

Alex Park: I would be in favor of that. It sounds like we need to approve the brief. And then we could leave the prior motion because my understanding is that eptinezumab is not -- I'm trying to figure out the slide. Slide 4, it has an indication of acute treatment for migraine, but then the next column over says it's not yet approved. So if it's not yet approved, then maybe we can leave that prior motion as is because it's not yet an approved indication. So in that case, I will move that we reiterate the prior motion and accept the topic brief as adequate.

Jon MacKay: I'm Jon MacKay. I'll second that motion.

Jordan Storhaug: Okay. All in favor of accepting the brief as adequate, please say, "aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Any opposed?

Unknown speaker: Aye.

Jordan Storhaug: Okay. And since we did that part, and then I'll just divide up two parts. Alex, do you want to make your second part of the motion, which is to reiterate the second -- the prior motion?

Alex Park: Oh, sure. This is Alex Park. I move that we reiterate the prior motion of August 19, 2020.

Jordan Storhaug: And can I get a second?

Leah Marcotte: This is Leah Marcotte. I second.

Jordan Storhaug: Perfect. And all in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Thank you. Moving on to our next topic then is Second-Generation Antidepressants. This will be a surveillance and presentation by Shannon Robalino.

Shannon Robalino: Thank you. Start it here in just a second. So far, I'm not seeing anything.

Leta Evaskus: Yeah, sorry. The **[cross-talk]** --

Shannon Robalino: Okay. That's okay.

Leta Evaskus: **[Cross-talk]** take a minute to open. Okay.

Shannon Robalino: It's been wanting to update this morning.

Leta Evaskus: Okay. There we go.

Shannon Robalino: Great. Thank you. Yeah, so let's go ahead and get started on this surveillance report. Move to the next slide, please. So, as the previous topic brief, this will follow kind of the same pattern of some history, PICOS, the key questions, methods, findings, and a summary of a surveillance report. Next slide, please. So, In terms of this topic's history, you can see that 18 years ago, there was the original report in November of 2004. And two years ago, we did a rapid review on the use of three newer second-generation antidepressants, and last year we did a surveillance. So this is another surveillance brief here. If we can move on to the next slide, please. So, I'll go through this pretty quick, just a little bit of background on the conditions here. So major depressive disorder, is on the rise. And in 2020, you may recall that there was the beginning of a global pandemic, and the number of adults with depressive disorder increased at that point. It is holding steady with around 6.5% to 7% of US adults experiencing a depressive episode. So if we move on to the next slide, please. This is generalized anxiety disorder. Currently, none of these treatments are approved for generalized anxiety disorder. But this is, again, a condition that is pretty common these days. Unfortunately, most of the studies that publish any prevalence are actually looking at a two-week period instead of the six-month period that the DSM requires to be diagnosed with generalized anxiety disorder. And the data on that prevalence is actually about 20 years out of date. So a little bit of background there. If we move to the next slide, please, we'll look at the PICOS. So we're interested in only adults with major depressive disorder or generalized anxiety disorder. We're looking only at these three treatments: vortioxetine, vilazodone, and levomilnacipran. And next slide, please. We are comparing those three newer second-generation antidepressants with some more common ones that have been on the market for a while. I won't read through these, but you can see there are quite a few of them. Next slide, please. And on this side, there are even more of them. So we can move on to Slide 8, please. So in terms of

outcomes of interest, they are pretty common things that you expect a response, remission, or effectiveness for the condition, prevention of relapse and recurrence, quality of life outcomes, adverse events, including serious adverse events, and any discontinuation related to adverse events. In terms of what kind of studies we are looking for, we are only looking at RCTs with a minimum of six weeks' treatment. We will take some non-randomized trials with larger study populations of 100 participants or more but only for harms-related outcomes. Slide 9, please. So, three key questions here. What is the effectiveness or harms of these treatments? And is there any difference in the effectiveness or harms in subgroups? Next slide, please. So, as before, we search for trials in some trial registries and a number of trial registries as well as the FDA, looking for any ongoing trials or ones that we may have missed and what to search for in full publication. We then search in Ovid MEDLINE and Google Scholar using any trial identifiers. And then we also look for any actions from the FDA on the FDA website and IPD Analytics. The searches for this particular surveillance document covered about a one-year period from June 2021 to June 2022. Slide 11, please, and we can move on to Slide 12 for the findings. So we did find two new RCTs or two recently published RCTs for vilazodone. Both of these take place in India and are comparing vilazodone for six to eight weeks in adults. You can see that they go up to the age of 60 or 65. Again, this is a **[audio cuts out] [39:28]** document, so we didn't dig into anything other than kind of an overview of each of these trials. Next slide, please. In terms of vortioxetine, again, we found two new RCTs comparing this drug to again in Korea or China and looking at these drugs for six weeks in the first trial or up to 24 weeks in the Chinese trial. Next slide, please. So we also identified two non-randomized studies. Again, these will be for harms only. Both of these are for vortioxetine and are from Italy. The first at the top, Di Nicola is in an Italian registry looking for harms up to one year, and the other is a prospective cohort, again, looking for harms. Slide 15, please. So just to summarize what we have in terms of the ongoing head-to-head RCTs. So these were the trials that have not been published. You'll see that finally we have a trial looking at levomilnacipran. This is actually a trial looking at the older adults, so over the age of 60. This trial was originally supposed to complete earlier this year, but it has been delayed to December of this year. Next, we have two in vortioxetine in that 18 to 65 population. These ends of trials have passed, and as of the June search date, we did not identify any publications related to them. And finally, there is an another vortioxetine ongoing trial that is looking at this drug in older adults. And that is also passed by a few years now, and as of June 2022, we did not find any publications related to that

trial. Next slide, please. So now look at the FDA actions if we move on to the next slide. So just a reminder that this was done earlier this year. So this slide is now a little bit out of date. Vilazodone here were generic formulations that were submitted some time ago because the license of exclusivity was expiring in June 2022 at the time. When we presented this back in August, those hadn't been released, and they are now available. And there are four investigational drugs. Actually, there are now only three of these, as the one AXS was actually approved in August. So that is now available. The pipeline drug there at the top, cariprazine, this was originally approved by the FDA in 2015 for symptoms associated with bipolar 1 disorder and is looking at potential adjunctive treatment in patients with depressive disorder who are having an adequate response to their current antidepressant medications. Slide 18, please. So in terms of any new indications, harms, or warnings, there were no new indications identified. But all three did have a new warning for symptoms of sexual dysfunction that came out in July 2021 for vilazodone and then September of 2021 for the other two treatments. Next slide, please. So in terms of the overall summary, if we go on to the next slide. So this is accumulative look at any research we have identified since the rapid review in 2020. So we still have no publications for levomilnacipran. We have three RCTs for vilazodone, four RCTs for vortioxetine, and then two non-randomized trials for vortioxetine, and those would be looking at harms only. Four ongoing studies including one for levomilnacipran. And a note that none of these studies include generalized anxiety disorder. The next slide, please. In terms of any FDA actions, again since the 2020 rapid review, so far, no new indications are worthies for now three pipeline therapies. There were two Blackbox Warnings for levomilnacipran and vortioxetine for suicidal thoughts or behavior in young adults. There were a number of new harms or warnings, five for levomilnacipran, which included serotonin syndrome, increased risk of bleeding, angle closure glaucoma, hyponatremia, and sexual dysfunction. And sexual dysfunction also vilazodone and vortioxetine, which vortioxetine also had a couple of other warnings about increased bleeding and discontinuation syndrome. We already touched on that there were generic formulations that received pre-approval, and those are now available. Next slide, please. So with that, I would take any questions if you have any. Thank you.

Jordan Storhaug: Thank you so much for that presentation. I don't see that we have any scheduled stakeholders, but we are open to the floor if someone would like to speak.

Leta Evaskus: Jordan, this is Leta. I do not see any hands raised.

Jordan Storhaug: All right. With that then, we can move to accepting the surveillance report.

Virginia Buccola: This is this is Virginia Buccola. And I would propose to accept the surveillance as adequate. Do we have a second?

Diane Schwilke: Diane Schwilke, I second.

Jordan Storhaug: Perfect. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay, perfect. And then let's take a look at the motion.

Virginia Buccola: This is Virginia Buccola, again, and I'm happy to reiterate the prior motion. And why have I forgotten how to do this? Do I need to reread the prior motion, or can I -- we just **[cross-talk]** --

Jordan Storhaug: I think if we do a reiteration you don't have to read it.

Virginia Buccola: Okay, thank you.

Jordan Storhaug: So that's a nice part there. Do we have a second though?

Kavita Chawla: Kavita Chawla. I second.

Jordan Storhaug: Okay. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Thank you, guys. So our next topic then is multiple sclerosis, a surveillance report, and that is going to be led by Beth Shaw.

Beth Shaw: Thank you.

Leta Evaskus: Just give me a second, Beth.

Beth Shaw: Sorry?

Leta Evaskus: Just give me a second to pull this up.

Beth Shaw: Of course. Yeah. No problem.

Leta Evaskus: Okay.

Beth Shaw: Thank you. So I'll be presenting to you the Surveillance Report on Disease-Modifying Drugs for Multiple Sclerosis.

On the next slide, you can see the format of this presentation, which you have seen in the previous two presentations. So on Slide 2, you can see the topic history for this report. So as with the one that you've just heard about, this was originally presented back in July of 2007, so around 15 years ago. Since then, there has been a series of updates. You can see through from 2010 up until the most recent update that was presented in May 2020. Since the publication of that full systematic review, we've also conducted one prior surveillance report that was presented to our DERP participants in June of 2021. So this is the second surveillance report on this topic since that systematic review that was published in May of 2020. So moving on to the next slide, I'll just give you a bit of background about multiple sclerosis. So MS is the most common immune-mediated inflammatory demyelinating disease of the central nervous system. And in a study conducted by the National MS Society, in the US, around nearly 1 million adults are estimated to be living with MS in the US. And evidence suggests that the prevalence of MS has been increasing over the past five decades, and the occurrence of this disease tends to be higher in women than in men. MS occurs when the body's immune system attacks the fatty tissue myelin, which surrounds and insulates neurons and allows for efficient transmission of nerve impulses. And in MS, this abnormal immune response causes the degradation of myelin, which leads to neurologic dysfunction. So symptoms of MS include sensory issues such as numbness, muscle weakness or spasms, problems with vision, dizziness, and trouble walking or speaking. It typically presents in early adulthood, with patients experiencing one or more clinically distinct episodes neurological dysfunction that partially resolve. So on the next slide, you can see kind of graphic depictions of how MS kind of looks over time. So approximately 85% to 90% of people with MS have the relapsing-remitting type, so RRMS at onset, and that is the pattern that you can see in that top left hand corner. So people relapse, and then they return to that previous level of disability or function. The majority of those cases eventually move into secondary progressive MS, and that can often occur over the course of

decades, and the pattern for moving into that secondary progressive MS you can see in the top right hand corner. There is a specific group of people, so around 10% of people, have what's called steadily progressing MS called primary progressive multiple sclerosis, and that is where the disability progresses steadily over time independent of those relapses, and that is the pattern that you can see in the bottom left hand corner. So moving on to the next slide. The disease-modifying drugs for multiple sclerosis largely consists of treatments targeted to people with those relapsing forms of the disease. And the goal of the disease-modifying therapies is to reduce the number of relapses, delay that progression to disability, and to limit new MS disease-related activity as seen as on MRI imaging. These disease-modifying therapies can also be used for clinically isolated syndrome, so that is where people have the first attack that is suggestive of MS. And it can be used for people after that first clinically isolated syndrome, and the aim of treatment in that situation is to delay that second attack and again, progression, to MS. So moving now into our PICOS. For this report and subsequent surveillance, we were looking for studies that included adult outpatients with multiple sclerosis, and we included all those different types of MS, so the relapsing-remitting type, secondary progressive, primary progressive, and the older term for progressive-relapsing MS. We also included people with that first attack that was suggestive MS. So that was adult outpatients with clinically isolated syndrome. Moving on now to the Interventions, there is a long list of interventions that are approved for multiple sclerosis. You can see here the generic name on the left-hand side, the brand name as well as the FDA-approval date. So this list is ordered for the most recent FDA approval date at the top. So the most recent one that we looked at in the surveillance report was Ozanimod that was approved in March of 2020, but it goes all the way back to the 1990s with drugs like the Interferon Betas and glatiramer acetate. In terms of Comparators, on the next slide you can see here that we were looking at those head-to-head comparisons. We were also looking for placebo-controlled trials for those interventions where we didn't find those head-to-head comparisons and for the drugs that were at the time of the report were considered as pipeline therapies. In terms of Outcomes, we were looking for health-related outcomes such as measures of disability, measures of clinical exacerbation or relapse. We were interested in quality of life as well as functional outcomes such as wheelchair use, or time lost from work. We were also interested in discontinuation rates with these drugs. And specifically for CIS, we were looking at measures of progression to a diagnosis with multiple sclerosis. And, of course, we were looking for adverse events as well as withdrawals due to adverse events. In terms of Study

Design, on Slide 9, you can see that we are looking for randomized-controlled trials and placebo-controlled trials that lasted for 12 weeks or longer. And we were also looking for retrospective and prospective cohort studies that were directly comparing interventions of interest specifically for harms. Again, those studies had to have last 12 weeks or longer, and we were really looking for large studies there, so studies with a minimum total sample size of 1000 participants. In terms of the Key Questions, we were looking for effectiveness, both with people with MS and for people with that first event suggestive of MS. We were looking for harms in both of those groups. We were looking for variation by subgroup, so that could be by patient characteristics such as use of prior disease-modifying therapies, the subtype of MS, or the presence of other comorbidities. And we were looking for ongoing studies that would be relevant. In terms of our Methods on the next slide, Shannon, just walked you very nicely through the process that we take for the surveillance. This is exactly the same method. And so, I'll just point out here that the searches for this specific surveillance report was from March 13, 2021, which was the date of the search in the previous surveillance report through to May 2nd of this year. So moving now into our Findings. In terms of newly published studies, we didn't identify any newly published randomized control trials in the second surveillance report. However, we did identify three newly published cohort studies. So we have the PASSAGE study. This was actually terminated in July of 2020 because of slow enrollment rate and a higher than expected discontinuation rate. However, although it was terminated, the results were published by Novartis on their clinical trials results website. So it's not published formally, but the results are available on that website. We also identified two other studies, the PVSEPK study and the DRUMS study. So on the next slide, we talk you through a bit more detail of each of those studies. So again, you can see on the left-hand side the details of that study. We've got information on the population sample size as well as the intervention comparator and outcomes. So that terminated study, the PASSAGE study, looked at just over 3000 people with relapsing MS, and they were really looking at the safety of fingolimod compared with other disease--modifying therapies. We also have the PVSEPK study, which looked at over 200,000 cases, where they were looking at a basket of MS drugs. And you can see them listed on the slide here. And they were really looking at the association of the use of these disease-modifying therapies with cancer. So that was a specific adverse event that they were looking for in the PVSEPK trial. In the DRUM study, again, a large sample size, nearly 36,000 adults with MS Again, looking at the range of disease-modifying therapies. And here they reported on outcomes around

hospitalization and health service use. The actual study protocol for this cohort study did list other outcomes such as mortality, disability, and adverse events. However, at the time of writing this surveillance report, we were not able to identify any formal publications that had reported on outcomes beyond hospitalization and health service use. So moving on now to the Ongoing Studies. We identified six ongoing studies that would be eligible for this topic if they were published. So there were four randomized control trials. Three trials of peginterferon beta versus the other interferon betas. And then I believe this is a type, and we have got one trial of cladribine with placebo. And cladribine is one of those pipeline therapies, hence the placebo comparison. And those sample sizes range from 80 to 399. We have also identified two ongoing cohort studies, again, focusing on the safety of these disease-modifying therapies. One is looking at the impact of these therapies, the association of the use of those with pregnancy outcomes, and there's one cohort study that is looking at the risk of contracting COVID-19 and COVID-19 related outcomes for people on these disease-modifying therapies. And, again, large sample sizes by design with just over 1000, and the other study is looking at just over 14,000 people. So moving now into the New FDA Actions. So on the next slide, you can see that no new drugs or formulations were identified since the searches in that first surveillance report. Moving on to Indications, Harms, and Warnings. No new indications were identified since the searches in the most recent surveillance report. However, in 2022, the FDA did add a new warning of adult onset Still's disease to the prescribing label for alemtuzumab. So in summary, you can see that since the completion of the most recent systematic review, we identified three new randomized-controlled trials. These are all identified in the previous surveillance document. One of those RCTs compared fingolimod and glatiramer acetate in adults with relapsing-remitting MS. One compared morning and evening administration of interferon beta-1a in adults with relapsing MS, and one compared fingolimod and interferon beta-1b in adults with acute optic neuritis. And as you have just heard in this surveillance report, we identified three new cohort studies, one assessing the safety fingolimod versus other disease-modifying therapies, one assessing the association between a range of disease-modifying therapies and cancer, and one assessing the association between these therapies and healthcare utilization. And on the next slide, you can see that since the completion of the most recent systematic review, we've identified those six ongoing studies, the three head-to-head randomized-controlled trials comparing peginterferon beta-1a with the interferon betas, that single placebo-controlled study of cladribine, and the two cohort studies comparing the

harms of disease-modifying therapies, specifically in pregnancy and for COVID-19. And on the next slide, you can see that since the completion again of the most recent systematic review, we identified a series of new warnings and serious harms, one of which was identified in this surveillance document. So there has been a series of warnings added to alemtuzumab, including that adult Still's disease that was added in 2022. There's been some alignment of the warnings for the dimethyl fumarate and diroximel fumarate. There was the addition of hepatic injury for glatiramer acetate. Again, a series of warnings or ocrelizumab and for ozanimod. There are some warnings added around anaphylaxis and injection site reactions for the peginterferon beta-1a, as well as cutaneous malignancies for siponimod. And, again, a series of warnings added for teriflunomide, including a box warning on hepatic injury. And on the next slide, again, you can see that since the completion of the most recent DERP systematic review, we identified three new drugs and one new formulation, all of which were identified in that previous surveillance document. So ozanimod was approved in March of 2020. We have ofatumumab in August of 2020, and ponesimod that was approved in March of 2021. And there was a new formulation of peginterferon beta-1a with an intramuscular formulation that was approved. Thank you. I believe that is it, so happy to take any questions.

Jordan Storhaug: Thank you, Beth. I very much appreciate it. We do have one stakeholder pre-signed up for this. That would be Rosalynde Finch from Biogen.

Rosalynde Finch: Can you hear me?

Jordan Storhaug: Yes, Lynda. We can hear you. You've got three minutes. Go ahead.

Rosalynde Finch: Great. Thank you very much. So good morning. Linda Finch. I'm a Medical Account Director with Biogen. And today, I'm going to speak to you about Vumerity or diroximel fumarate, which was approved in October 2019 for the treatment of relapsing forms of MS to include clinically-isolated syndrome, relapsing-remitting MS, and active secondary progressive MS in adults. Vumerity has a distinct chemical structure from Tecfidera dimethyl fumarate, but it is converted to the same active metabolite, monomethyl fumarate. And because of this bioequivalence, we can expect to see the same efficacy and safety profile as Tecfidera, which has now been prescribed for over 425,000 patients, representing over 810,000 patient years. And I want to share with you the studies for improved patient-reported gastrointestinal tolerability versus Tecfidera. So this study is called EVOLVE-MS-2, and this

was a Phase III randomized active-controlled five week head-to-head study. It evaluated patient-reported GI tolerability for Vumerity versus Tecfidera in relapsing-remitting MS patients. Patients who were treated with Vumerity experienced a statistically significant improvement in a patient-reported outcome measuring GI adverse events symptom intensity. And adverse events leading to study discontinuation reported in 1.6% of Vumerity patients versus 6% of Tecfidera patients, and the GI discontinuation rates were point 8% for Vumerity, versus 4.8% for Tecfidera. Recently published real-world data has reinforced that patients are highly adherent to Vumerity, consistent with the expectations based on our clinical trial data. And then recently, the National Institute for Health and Care Excellence (NICE) published guidance in June 2022 recommending diroximel fumarate or Vumerity as a first-line DMD option for treatment of active relapsing-remitting MS. In this progressive illness, it's important to have access to the appropriate medication as early in the disease as possible in order to prevent relapse and disability progression. The oral disease-modifying therapies that are available are very different medications with different mechanisms of actions, tolerability profiles, monitoring requirements, drug interactions, and contraindications, and all of these factors are important inappropriate drug selection. So in conclusion, I respectfully ask that you consider including Vumerity in your PDL as a first-line option for patients with relapsing forms of MS. I thank you for your time. And I'm happy to answer any questions that you have on Vumerity.

Jordan Storhaug: Thank you very much. I should open up to see if we have any other stakeholders who happen to previously be signed up.

Leta Evaskus: This is Leta. I do not see any other hands raised. Thank you, Leta. With that then, I'll take the committee to look at our motions. And first we'll need to determine whether or not the surveillance was adequate.

Leah Marcotte: This is Leah Marcotte, and I am motion to approve the adequacy of the surveillance.

Jordan Storhaug: Perfect. Do we have a second?

Diane Schwilke: Diane Schwilke, I second.

Jordan Storhaug: Perfect. All approve, say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Anybody not approving? Okay. All right. And then any discussion about a motion?

Susan Flatebo: This is Susan Flatebo. I'd like to reiterate the prior motion.

Jordan Storhaug: Perfect. Do we have a second?

Michael Corsilles: This is Michael Corsilles. I second.

Jordan Storhaug: All right. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Well, I think now it brings us through the first part of the morning. We're set up for a 10-minute break. It looks like we're running about 10 minutes early. I think we can take that break but be back at 10:20. Does that sound appropriate, Leta?

Leta Evaskus: That sounds great.

Jordan Storhaug: All right. Perfect. See you guys in just about 10 minutes.

Leta Evaskus: Thank you.

Jordan Storhaug: **[Audio cuts out] [68:30]** So we will now reconvene. We'll reconvene as the Drug Utilization Review Board, and we will be able to start our topics with antihyperlipidemics. And now starts the part with Umang's busy day, helping us out with all the topics.

Marissa Tabile: Hi, this is Marissa. I'm just trying to get the presentation up, so apologies.

Jordan Storhaug: All right.

Marissa Tabile: Okay.

Jordan Storhaug: Umang, are you ready for 2%.

Umang Patel: Sorry. Yes, I am. Right ready to go.

Jordan Storhaug: Thank you.

Umang Patel: So the first topic you have your trip, fix others. And just to remind the committee on this the first category here. Sometimes Magellan health has the classes kind of under a different name than Apple Health. And so the top larger name is the one that we usually go by, and the committee can find those TCRs on the SharePoint and then the names below it in all caps or the names found in the Apple Health PDL. And then on the next slide here, just to give a little bit of background and update. So for Lipotropics, the National Health and Nutrition Examination Survey reported that between 2015 to 2018 approximately 11% of adults had high cholesterol and 18% had low HDL, a higher prevalence in women compared to men. And many clinical trials have demonstrated that a serum concentration of LDL and low levels of HDL are a major risk factor for coronary heart disease. On the next slide here, we have a guideline update from the American Association of Clinical Endocrinologists and American College of Endocrinology in 2020. Although CV outcomes trials with colesevelam and bempedoic acid are not published. Outcome trials with statins and ezetimibe or PCSK-9 inhibitors suggest further reduction LDL, though any combination of drugs would provide ASCVD benefit. The algorithm advocates for progression of therapy intensity in order to reach targets. The 2019 approval of icosapent ethyl marked the first FDA approval of a medication that lowers triglycerides and reduces ASCVD as the REDUCE-IT trial used for approval for a triglyceride decrease of only 18%. The algorithm states that the CV outcome benefit does not appear to be related to the reduction in triglycerides. And for patients with hypertriglyceridemia who do not have established ASCVD or diabetes with two or more risk factors and are not at the triglyceride goal of less than 150 with statin therapy, then a fibrate omega-3 fatty acid or niacin can be considered. In order to decrease the potential for acute pancreatitis, all patients with severe hypertriglyceridemia should receive a fibrate prescription-grade omega-3 fatty acid and/or niacin. Continuing with the guidelines on the next slide. In 2020, The Endocrine Society published a clinical practice guideline focusing on lipid management in patients with endocrine disorders, with the objective of preventing CV events and triglyceride-induced pancreatitis. And it also addresses whether treatment of the endocrine disorder improves lipid abnormalities as well as CV outcomes. The guidance recommends drug therapy as an adjunct to diet and exercise to prevent pancreatitis in adults with fasting triglyceride levels of 500 or greater. Statin therapy is recommended in addition to lifestyle changes to

decrease the CV risk in adults with type 2 diabetes and other risk factors. And additional details on these recommendations and for type 1 diabetes, obesity, thyroid disease, excess glucocorticoids, growth hormone secretion disorder, polycystic ovarian syndrome, and menopause or hormone replacement are also provided. In 2021, the American College of Cardiology published a consensus decision pathway on the management of ASCVD risk reduction in patients with persistent hypertriglyceridemia, which is defined as triglyceride levels greater than 175. After a minimum of 4 to 12 weeks of lifestyle intervention, a stable dose of maximally-tolerated statin when indicated in management of secondary causes. They emphasize the necessary lifestyle interventions for hypertriglyceridemia and recommend a low-fat diet and consideration of fibrates and prescription-grade omega-3 fatty acids. They also note that fibrates provide benefit as monotherapy but not when combined with statin. Additional guidelines in 2021 on the next slide. The American Heart Association published the scientific pathway on physical activity as a crucial component in the first-line treatment for increased blood pressure or cholesterol. They detailed mild-to-moderate risk patient groups, appropriate for lifestyle only treatment of increased cholesterol as well as description of the recommendations, usual effects, and consideration for lifestyle management with physical activity. Guidance and resources are also provided for evaluating, prescribing, counseling, and referring to assist in increased physical activity. And lastly, last year, the American College of Cardiology published a consensus decision pathway for the management of risk reduction in patients with persistent hypertriglyceridemia. You know what? I apologize. This was a copy from the previous slide, so please go ahead and disregard that. Moving along. On the next slide here, we have drug specific updates. So Repatha, and, again, reminding the committee when there are updates, specific updates, such as indication or formulation, I try to bold the specific updates here so it's easier for you to read. When there are new drug updates, everything is bolded. So last year in October 2021, the FDA approved an expanded indication for Repatha to reduce LDL as an adjunct to diet and other LDL-lowering therapies in pediatric patients 10 years of age or older, with heterozygous familial hyperlipidemia, and in adults and pediatric patients 10 years of age or older with homozygous familial hyperlipidemia. And previously, this is only approved in pediatric patients 13 years of age or older with homozygous familial hyperlipidemia. So as you can see, there are a few other indications that this medication run with. And in terms of dosage, in adults and pediatric patients 10 years of age or older with homozygous familial hyperlipidemia, initial dose is 420 mcg once monthly subcutaneously, and it can be increased to 420 mcg every two

weeks of a clinical meaningful response is not achieved in 12 weeks. On the next and final slide for this class, we have Leqvio. And in December 2021, the FDA approved this medication, which is a small interfering RNA directed to the PCSK-9 mRNA, which is indicated as an adjunct to diet and maximally-tolerated statin therapy for the treatment of adults with heterozygous familial hyperlipidemia or clinical ASCVD who require additional lowering of LDL. The effect of this medication on CV morbidity and mortality has not been established. In terms of precautions, it is recommended to discontinue when a patient with pregnancy is recognized. If a patient has renal impairment, no dose adjustment is necessary for patients with mild, moderate, or severe renal impairment. And if a patient has hepatic impairment, no dose adjustment is necessary in patients with mild-to-moderate hepatic impairment, and it has not been studied in patients with severe hepatic impairment. In terms of dosage, the recommended dose in combination with a maximally-tolerated statin is 284 mg as a single subcutaneous injection initially, again at three months, and then every six months after that, and it should be administered by a healthcare professional. And it is available in the formulation of injections, which are 284 mcg/1.5 mL in a single-dose prefilled syringe. I'll go ahead and pause here for the committee.

Jordan Storhaug: Thank you. Opportunity for anybody with questions. But I'll put a note our next presenter will be Carrie Johnson from Amgen as our next stakeholder. Marissa, do you want to update us?

Marissa Tabile: Hi, this is Marissa. So I just wanted to bring up the AHPDL to the DUR Board. So these are the two classes that Umang had just given his review on. So as you can see for the MTP inhibitors. We currently have Juxtapid as preferred. And then for our PCSK-9s, we currently have Praluent preferred on our AHPDL. And then I think we can go ahead and kick it off to stakeholder input if we're ready.

Jordan Storhaug: Perfect. Carrie, are you ready to present?

Carrie Johnson: Yes. Can you hear me okay?

Jordan Storhaug: Yes. We can hear you. You have three minutes.

Carrie Johnson: Great. Thank you so much. Good morning. Again, my name is Carrie Johnson, pharmacist with Amgen Medical Affairs. Thank you for the opportunity to

provide the committee with updated information on Repatha. As a reminder, Repatha is a fully human monoclonal antibody to PCSK-9. It was initially approved in 2015, and over 1 million patients globally have received it in cumulative post-marketing patient exposure. Indicates reduced MI, stroke, and coronary revascularization in adult patients with established cardiovascular disease, as well as indicator for LDL reduction in patients with primary hyperlipidemia or familial hypercholesterolemia. As mentioned in the review, in September 2021, the Repatha label was updated with the pediatric indications. Please refer to the prescribing information for full product details, which is available at amgen.com. I want to provide the community with two updates. 1.) Long-term data from the FOURIER trial, which represents the longest study exposure to a PCSK-9 inhibitor so far has now been fully published. This open-label extension study enrolled 600 patients from FOURIER, the median follow-up and extension study was five years, and the maximum exposure to Repatha was 8.4 years. Primary endpoint was subject incident of treatment emergent adverse events. Secondary endpoints were percent change LDL-C and MACE were pre-specified exploratory endpoints**.** In terms of safety, the annualized incident rate of all adverse events of interest were similar in the FOURIER parent study and the FOURIER open-label population. Open-label extension populations achieved LDL-C in the patients in the open-label extension was very similar to that of the Repatha treated arm of the parent study. Over 80% of patients achieved an LDL-C less than 55 mg/dL. Patients initially randomized to Repatha in the parent study continued to accrue cardiovascular benefit for several years during the extension period. Patients on continuous Repatha were less likely to have MACE events when compared with the open-label extension patients originally randomized to placebo. There was a continued divergence in the risk of MACE between both groups in the first several years of the open-label extension. These data support the notion that earlier initiation of treatment strategies to lower LDL-C is more effective at preventing cardiovascular events. As mentioned, in review, the American College of Cardiology has published the 2022 experts' decision pathway. PCSK-9s now are preferred as the initial. The monoclonal antibodies are preferred as initial PCSK-9 of choice due to demonstrated safety, efficacy, and cardiovascular outcomes data. Repatha recommends a lower LDL-C threshold, and PCSK-9 monoclonal antibodies may be preferred as initial non-statin agents in adult patients with ASCVD at a higher risk when more than 20% additional lowering is needed. In summary, Repatha significantly lowers LDL-C in several groups and is the only PCSK-9 approved in the US to lower LDL-C in pediatric patients greater than or equal to 10

years of age. Recently published pathway recommends them and data from the recent four-year, open-label extension represents the longest study exposure to PCSK-9 inhibitors so far and supports long-term safety and efficacy Repatha. We respectfully request consideration of Repatha to an addition to the PDL.

Jordan Storhaug: Thank you so very much.

Carrie Johnson: Thank you.

Jordan Storhaug: Appreciate the presentation. Just if anybody else would like to speak, please raise your hand.

Leta Evaskus: This is Leta. I see Karen Johnsen has her hand up.

Jordan Storhaug: Okay.

Karen Johnsen: Thank you. Can you hear me? Apologies for my voice.

Jordan Storhaug: No problem. Yeah, we can hear you well. You have three minutes. Go ahead.

Karen Johnsen: All right. Thank you. Good morning, Washington P&T Committee Members. My name is Karen Johnsen, and I'm a Population Health MSL with Novartis. I want to first thank you for your time this opportunity to share information on Leqvio (inclisiran), a new drug approved by the FDA in December 2021 as an adjunct to diet and maximally-tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease [ASCVD) require additional lowering of LDL cholesterol or LDL-C. Cardiovascular disease remains the leading cause of death in the US, with ASCVD being the main contributor. Despite the availability of numerous lipid-lowering therapies, effective and sustained LDL cholesterol reduction remains a challenge, with approximately 80% of patients with ASCVD unable to achieve guideline recommended LDL cholesterol goals on statins alone. Leqvio is a first in class small interfering RNA (siRNA) LDL-lowering agent, which uses the body's natural process of RNA interference to prevent the production of the PCSK-9 protein, thereby resulting in an increased clearance of LDL. The recommended dose of Leqvio in combination with maximally-tolerated statin therapy is 284 mg administered by a healthcare professional as a single subcutaneous injection initially, again at three months, and then every six months. In Phase III

clinical trials, Leqvio resulted in an effective and sustained reduction in LDL of up to 52% compared to placebo at month 17 in patients with heterozygous FH or clinical ASCVD and elevated LDL levels despite receiving maximally-tolerated statin therapy. And Leqvio was reported to be well tolerated with the safety profile comparable to placebo and with no dose adjustment necessary in patients with impaired renal or hepatic function. Adverse events that occurred in clinical trials and at least 3% of patients were injection site reactions, arthralgia, urinary tract infection, diarrhea, bronchitis, pain in extremity and dyspnea. Leqvio has no known drug interactions, no contraindications, precautions, or warnings in the FDA-approved label, In summary, Leqvio delivers effective and sustained LDL reduction of up to 52%. And with twice-yearly HCP-administered dosing uniquely positioned Leqvio to circumvent the adherence challenges commonly seen with other lipid-lowering therapies. In closing. Novartis respectfully requests that a new drug class be added under the antihyperlipidemics titled "siRNA" and to include Leqvio as the preferred in the Washington PDL. This recognizes Leqvio as first-in-class status as an siRNA for LDL lowering. Thank you for your time and consideration. And I'd be happy to answer any questions you have for me.

Jordan Storhaug: Thank you. Leta, I think if I'm right, we have Scott Andersen on next to speak.

Leta Evaskus: Yes.

Scott Andersen: Hi, everyone. Can you hear me?

Jordan Storhaug: Yes, we can hear you. If you have three minutes. Go ahead and let us know who you represent.

Scott Andersen: Good morning. I'm Scott Andersen. I'm a Director of Medical Affairs at Regeneron Pharmaceuticals. Thanks for this opportunity. Real brief comment here. In reviewing the PCSK-9 monograph, I'd like to highlight that Praluent is now indicated as an adjunct to other lipid-lowering therapies in adults with homozygous familial hypercholesterolemia. It's an indication that was received last year. And what we would ask is that it just be added to the medical necessity portion of the document to reflect current labeling. That is all I have. Thanks very much for your time.

Jordan Storhaug: Thank you. I think that is it for presenters. But I'll have Leta confirm for me.

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

Jordan Storhaug: Okay. With that then, we can take a look at the motion.

Diane Schwilke: Okay. This is Diane Schwilke. I move that all products in the drug classes listed on Slide 2 are considered safe and efficacious for their medically-accepted indications that are eligible for preferred status and grandfathering. at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Jordan Storhaug: Thank you, Diane. Do we have a second?

Kavita Chawla: Kavita Chawla. I second.

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. Thank you, everybody. Back to Umang, Antivirals looks like our next topic.

Umang Patel: Perfect. All righty. The next topic here we have are Antivirals: Orals, specifically Influenza Agents. Going to the next slide, a little bit of background. So the flu is a common illness affecting most people at least once in their lifetime. Uncomplicated illnesses typically resolved after three to seven days and are often self-limiting. Persons at higher risk for influenza complications. There is a huge list here. I will read off a few. Those less than two years of age or 65 years of age or older, immunocompromised, pregnant, or postpartum, etc. And then the influenza vaccination is the primary method for preventing influenza. The second half here is primarily for the Committee's leisure. It goes into the granular detail on the various components that helped create the influenza vaccine and are updated annually by the CDC, as well. I will say for the 2021-2022, the third bullet here, the inactivated influenza vaccines, recombinant influenza vaccines, and the live attenuated influenza vaccines are available.

Going to the next slide here. According to the CDC, there are three FDA

approved neuraminidase inhibitor antiviral drugs that are recommended for the 2020-2021 season. These are Tamiflu, Relenza, and Rapivab. The fourth recommended FDA-approved product is a cap-dependent endonuclease inhibitor, which is Xofluza. Adamantanes are not recommended for the use in the US due to resistance to these drugs by many influenza A and B viruses. Empiric antiviral treatments without waiting for lab confirmation is recommended as early as possible for any patient with confirmed or suspected influenza, who has severe, complicated, or progressive illness, is hospitalized, or is at high risk for influenza complications. In addition, empiric antiviral treatment of non-high-risk outpatients with suspected influenza can be started based on clinical judgment without an office visit. According to the CDC, Tamiflu is the recommended antiviral for patients with severe, complicated, or progressive illness, or those who are hospitalized. There is insufficient data for Relenza, Rapivab, and Xofluza in patients with severe influenza and co-infection with influenza A or B viruses and SARS-CoV-2 can occur and should be considered particularly in hospitalized patients with severe respiratory disease.

On the next slide here going into drug-specific updates for Xofluza. There were two updates. First, in October 2021, the product labeling was updated to include a new 80 mg tablet strength, and the 40 mg tablet packaged as a one-tablet single dose. This was previously a two-tablet presentation. And the 20 mg tablet strength was removed. In August 2022, FDA expanded the indication to include those 5 to 11 years of age for treatment of acute uncomplicated influenza in patients who have been symptomatic for no more than 48 hours and are otherwise healthy and for patients 5 to 11 years of age for post exposure prophylaxis of influenza. Previously this was only approved in patients 12 years of age or older with those respective indications. There are no changes to Warnings and Precautions. The dosing, as you can imagine, is stratified by age and weight. And as I mentioned, the changes in availability were made in October 2021. This one is a relatively short class, so I'll pause right there for the committee.

Jordan Storhaug: Thank you so much, Umang. Marissa, you want to give us the current status?

Marissa Tabile: Hi, this is Marissa. So I have displayed here Antivirals: Influenza Agents. So right now we have the generic Tamiflu (oseltamivir) preferred, as well as the rimantadine. Everything else, so Relenza and the Xofluza are non-preferred on our AHPDL. And I can take any questions, or we can move to stakeholder whenever you're ready.

Jordan Storhaug: For stakeholders, we don't have any previously identified stakeholders, but anybody can raise their hand if they would like to present.

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

Jordan Storhaug: All right. With that, then we can take a look at the motion and start any discussion we'd like to have.

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

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

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. It looks like our next topic is Cardiovascular Agents. And back to Umang.

Umang Patel: All righty. This one is going to be really quick, so you may not need to unmute, Jordan. But just reminding the committee when we look at significant clinical updates, we look at around the last 12 to 13 months. And if there are no significant clinical updates, we don't do the background or guideline updates because there are no updates, as is with the sinus note inhibitors. So I'm going to pause right there for the committee, as well.

Jordan Storhaug: All right. Thanks, Umang. Marissa, did you want to give us an update for this one?

Marissa Tabile: Hi, this is Marissa. Yes. So currently in our AHPDL, we have Corlanor in The Sinus Node Inhibitor Class. And it looks like we actually have just the tablet formulation as our preferred agent in that class.

Jordan Storhaug: All right. Thank you. I don't have any previously identified stakeholders. I'll see if anybody would like to raise their hand.

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

Jordan Storhaug: All right. Then we'll take a look at the motion.

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

Diane Schwilke: Diane Schwilke. I second.

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Our next topic is Gastrointestinal Agents. Back to Umang.

Umang Patel: Perfect. Thank you. So the next class is going to be actually Pituitary Suppressive Agents.

Jordan Storhaug: Sorry about that. Go ahead and thank you.

Umang Patel: No problem. So this will be looking at specifically endocrine and metabolic agents, pituitary suppressants, and oncology agents, LHRH analogs and injectables here. So, moving to the background here for prostate cancer -- and just to let the committee know, there are oncology subclasses later as well, so some of this may be repetitive. So for prostate cancer from 2014 to 2018, the median age at diagnosis was 67 years of age in the US. The estimated number of new cases is about 250,000 with estimated deaths around 34,000. The treatment options depend on several factors such as patients assigned risk group at time of initial diagnosis, the projected

survival, based on age and comorbidities, and the benefits and potential side effects of treatment. Treatment options consist of active surveillance, radiation therapy, hormonal therapy, chemotherapy, surgery, or a combination of two or more of these. And active surveillance, also referred to as watchful waiting is a monitoring of cancer progression before initiating treatment. Radiation Therapy uses high-powered energy to kill the cells. Hormonal therapy, also called Androgen Deprivation Therapy, is the mainstay of treatment for metastatic prostate cancer. An ADT lowers androgen, which is testosterone and dihydrotestosterone levels, which cause the prostate tumor to shrink or grow more slowly. Luteinizing hormone releasing hormone or LHRH agonist, prevent signaling of the testicles to make testosterone, therefore decreasing circulating testosterone levels. This class of drugs includes the GnRH agonists, such as Camcevi, Eligard, Lupron Depot, Zoladex, Trelstar, Vantas, as well as the GnRH antagonists such as Firmagon, Orgovyx, and anti-androgens, such as Casodex and Nilandron which are given it in conjunction with LHRH agonists. And these drugs prevent testosterone from reaching the cancer cells. Chemotherapy treatment is used to kill rapidly growing cancer cells, and surgery involves the removal of the prostate gland, which is deemed as radical prostatectomy, some surrounding tissue, and a few lymph nodes. On the next slide here, just a drug-specific update in May of 2021, the FDA-approved Camcevi, which is a GnRH agonist for the treatment of adult patients with advanced prostate cancer. In terms of Warnings and Precautions, there are tumor flares, transient worsening of bone pain, either obstruction, spinal cord compression, or the occurrence of additional signs and symptoms of prostate cancer may develop during the first few weeks of treatment. It is recommended to monitor patients closely and manage symptoms. Additionally hyperglycemia and diabetes and this can increase the risk of developing diabetes in men receiving GnRH agonists. Cardiovascular diseases were reporting an increased risk of MI, sudden cardiac death, and stroke. And lastly, embryo-fetal toxicity, which it can -- it may cause fetal harm. The dosing is 42 mg subcutaneously every month, and it is available in an injectable emulsion of 42 mg. I will go ahead and pause right here for the committee.

Jordan Storhaug: Thank you. Marissa, did you want to give us an update?

Marissa Tabile: Hi, this is Marissa. So just to give the committee a head's up, we do have -- even though some of these drugs have like the same generic name, the way that we have it separated on our AHPDL is like Umang stated, we have the

endocrine and metabolic agents and oncology agents. Some of them are in those specific PDL classes. So for the first part, the Endocrine and Metabolic Agents Pituitary Suppressants, that is where you will see Lupron, Orilissa, Supprelin, Synarel, and Triptodur live in that class. And it looks like everything else is preferred in that class except for Triptodur that is non-preferred. And apologies for the zooming or the scrolling. Let me go down. So for our oncology agents, LHRH analogs injectable that is where the Camcevi, Fensolvi, generic leuprolide, some Lupron, Trelstar, and Zoladex live in that particular class. And as you can see, all of the products in that class are preferred. And I can take any questions or move to stakeholder input when we're ready.

Jordan Storhaug: If you have any questions, please feel free to ask them. We don't have any stakeholders previously signed up, but they can, of course, raise your hands.

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

Jordan Storhaug: Okay. We can take a look at our motion.

Marissa Tabile: This is Marissa. So just to inform the committee, you guys will be making two separate motions because they are two different drug classes. So, for the first motion, we'll be doing the Endocrine and Metabolic Agents : Pituitary Suppressants. And then the next one after that will be the LHRH analogs injectable.

Virginia Buccola: This is Virginia Buccola, and I'm happy to make the motion that all products in the Endocrine and Metabolic Agents : Pituitary Suppressants drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

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

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Aye. Any opposed? Okay. Then we can take a look at the second motion then.

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

Alex Park: This is Alex Park. I second the motion.

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. So now we're on to those Gastrointestinal Agents. I was excited for starting with Inflammatory Bowel Agents. It looks like for the next few topics, we won't have a lot to update, so we want everybody to stay available. Umang.

Umang Patel: Perfect. Thank you, Jordan. I was going to say please don't get too excited. There are not a lot of updates for some of these. And, Marissa, if you would like me to do it a different way, just let me know -- but as you can see, the next few slides, there are a few topics that aren't significant clinical updates over the last 13-14 months. So I can just go one-by-one, and then as the committee votes, and then introduce the next one. So the first class that we have here are ulcerative colitis agents, specifically inflammatory bowel agents with no updates. And back to the committee.

Jordan Storhaug: All right. We do not have any previously identified stakeholders, but if somebody would like to present, please raise your hand. Marissa, I think probably you're going to give us an update on what currently is covered or preferred.

Marissa Tabile: Hi, this is Marissa. Yes. So let me just go ahead and show. Okay, so here are our Gastrointestinal Agents : Inflammatory Bowel Agents drug class. So

looking at it, we currently have Apriso, balsalazide, Canasa, Delzicol, Lialda, mesalamine, and then Pentasa and sulfasalazine as our preferred agents in this class. I can take any questions.

Jordan Storhaug: We'll just see if Leta sees any stakeholders I don't.

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

Jordan Storhaug: Okay. Let's take a look at the motion.

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

Diane Schwilke: Diane Schwilke. I second.

Jordan Storhaug: Thank you to both of you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. With that, we'll get our quick update from Umang regarding gastrointestinal agents, irritable bowel syndrome agents, and GI motility.

Umang Patel: Perfect. Next subclass for the chronic GI class will be IBS/GI motility. As I mentioned earlier, this class does not have any significant clinical updates, and we'll volley it right back to the committee.

Jordan Storhaug: Marissa, it looks like you're ready.

Marissa Tabile: Yep. Hi, this is Marissa. So this is our Irritable Bowel Syndrome (IBS) Agents : GI Motility class. So it's a little big. We'll try to go down a little bit slower. So currently, in this class, we have Amitiza, dicyclomine hydrochloride, glycopyrrolate, hyoscyamine, different formulations of hyoscyamine. It looks like we have Linzess, lubiprostone, Movantik, NuLev, Oscimin. I apologize if I

pronounced that incorrectly. And those are our preferred products in this class. And I'm happy to take any questions.

Kavita Chawla: Hey, Marissa, it's Kavita here. One, this really is helpful, this new thing that we're doing to review the formulary as we go. So thank you for doing this. For some of these, is it possible to see the generic or the chemical names rather than the brand names? It seems like it's a mix of generic and brand names. Yeah. Does that makes sense?

Marissa Tabile: Yeah. I apologize. I believe we have it. So the way that our file is, I believe we have like a label name and a generic name, and these are going off of the label name, which in our system shows both the brand and the generic. But maybe moving forward because I can't do it right now, unless I do that lunch. I can take that and make sure that we show the brands and their associated generics, so it's a little easier for you to read. I apologize.

Kavita Chawla: Yeah. I appreciate that. Thank you. I don't recognize the brand names as often. So thank you.

Marissa Tabile: Yeah. No problem. Thanks for the feedback.

Jordan Storhaug; Absolutely. We do not have any previously identified stakeholders. I don't see any hands raised.

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

Jordan Storhaug: All right. We can take a look at the motion.

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

Jon MacKay: This is Jon MacKay. I second the motion.

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Back to Umang. I won't steal any of his thunder though.

Umang Patel: All righty. Next slide is Phosphate Binders, still in the GI class. Again, no significant recent clinical updates and right back to Jordan and the committee.

Jordan Storhaug: Thank you. So, Marissa, go ahead.

Marissa Tabile: Hi, this is Marissa. Apologies for the scrolling. So here in our Phosphate Binder Agents class, we have calcium acetate, and Phoslyra, as well as sevelamer carbonate as our preferred products in this class.

Jordan Storhaug: Perfect. We don't have any previously identify stakeholders. We'll take a look and see. If we have anybody who wants to raise their hand, or opportunity for any questions.

Marissa Tabile: Again, this is Marissa. I just wanted to make a note. I'm just looking at our publication right now, and I don't know if this is going to be helpful for the committee or not. I believe if you see like in this example of the Auryxia and then the calcium acetate. I believe that is the brand, and then underneath will be the generic. So if you see on our PDL that there's not anything underneath it with a generic name, then most likely, it's just a brand product. And then also, I did want to point out as well in this column D, you'll see that there are B's and G's, and I forgot that this was in here. But if you see G, then that means that is a generic product, and if you see a B, that means that it's a brand product, if that is helpful.

Jordan Storhaug: All right. Well, I think we can take a look at the motion.

Jon MacKay: This is John McKay. I move to approve all products in the Gastrointestinal Agents : Phosphate Binder Agents drug class are considered safe and efficacious for their medically accepted indication and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with

the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Susan Flatebo: This is Susan Flatebo. I second.

Jordan Storhaug: Thank you to both of you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? With that, then we'll be back to Umang for the next topic.

Umang Patel: Okay, next we have Bladder Relaxant Preparations in the Apple Health PDL referred to as Overactive Bladder Agents. Again, no significant clinical updates. So right back to you, Jordan.

Jordan Storhaug: Thank you. And with that, I'll say ahead we don't have any stakeholders previously identified. Go ahead and raise your hands while we hear from Marissa.

Marissa Tabile: This is Marissa. So this is our Overactive bladder Agents class. In this class we currently have generic bethanechol, fesoterodine, oxybutynin, solifenacin, and Toviaz as our preferred products in this class.

Jordan Storhaug: Excellent. Just looking to see if we had any hands raised. I don't see any so far, so we can go ahead and get our motion ready to review.

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

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

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. Back to Umang for our next topic.

Umang Patel: All righty. Next one is for Hematological Agents : Hereditary Angioedema Treatments, and no clinical updates regarding this subclass. And right back to you.

Jordan Storhaug: Thank you. So there aren't any stakeholders previously identified for this one. Go and raise your hand while we hear from Marissa.

Marissa Tabile: Hi, this is Marissa. So this is our Hereditary Angioedema Agents drug class. And right now we have icatibant acetate, Kalbitor, and Sajazir as our preferred products in this class. And I'm happy to take any questions about the AHPDL.

Jordan Storhaug: I was just looking through the list. I don't see any raised hands for stakeholder presentation, so we can go ahead and take a look at the motion.

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

Michael Corsilles: This is Michael Corsilles. I second.

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Back to Umang for our next topic.

Umang Patel: Okay. The next and final of the string of no clinical updates are going to be Potassium Binders. And so, again, no clinical updates here. And back to the committee.

Jordan Storhaug: Thank you. We do not have any stakeholders for this topic. But if you're interested, go ahead, and raise your hand, but I'll turn it over to Marissa.

Marissa Tabile: This is where it's done. So this right here that I've highlighted is our miscellaneous therapeutic class potassium removing agents. So in this class we currently have Lokelma, sodium polystyrene sulfonate, and it looks like brand name SBS are our preferred products in this class. And I'm happy to take any questions.

Jordan Storhaug: All right. I did a look through. I did not see any hands raised. So we can go on and take a look at our motion.

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

Diane Schwilke: Diane Schwilke. I second.

Jordan Storhaug: Thank you to both of you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Thank you, group. Now back to Umang. This time he's got some updates for us. So thank you, Umang. Take it away.

Umang Patel: Perfect. Absolutely. All righty. So for the next topic, we have Multiple Sclerosis Agents.

Go in right to the next slide, a little bit of background. So MS is a complex human autoimmune-type inflammatory disease of the central nervous system. More than 2.3 million people worldwide have MS. One million people in the US. It occurs most commonly in Caucasians with rare cases in African Americans and Asian Americans. Although the etiology is predominantly unknown, it is characterized pathologically by demyelination and subsequent axonal degeneration. The nerve degeneration associated with MS can result

in a wide variety of symptoms, including sensory disturbances in the limbs, optic nerve dysfunction, ataxia, fatigue, bladder, bowel, and sexual dysfunction. Severe cases may result in partial or complex, excuse me, complete paralysis. And while cognitive impairment occurs in approximately half of people with MS, only 10% experienced serious intellectual deterioration. MS can be categorized as either relapsing-remitting, which is observed in the majority of about 85% to 90% of patients, or a primary progressive, which is observed in 10%. Relapses or attacks typically present sub-acutely with symptoms developing over hours to several days, persisting for several days or weeks, and then gradually dissipating.

On the next slide here, the clinical course of MS falls into one of the following categories, with the potential to progress from less severe to more severe types. The first is clinically isolated syndrome (CIS). The first episode of neurologic symptoms due to inflammation or demyelination lasting at least 24 hours. Patients with MRI-detected brain lesions consistent with MS are at high risk of developing MS. The next is relapsing-remitting MS, and this is clearly defined self-limited attacks of neurologic dysfunction, followed by periods of remission without disease progression. Most patients experience a recovery of function that is often but not always complete. The third being primary progressive, and this is a nearly continuous worsening disease not interrupted by distinct relapses. And some of these individuals have occasional plateaus and temporary minor improvements. And lastly, secondary progressive, and this is where relapsing-remitting disease course at onset followed by progression with or without occasional relapses, minor remissions and plateaus, and most patients eventually convert to progressive MS.

On the next slide, we'll look at drug-specific updates, first being Tascenso ODT. In December 2021, the FDA approved a new formulation of fingolimod, which is Tascenso ODT, and this is a sphingosine 1-phosphate receptor modulator, which is indicated for the treatment of relapsing form of MS to include clinically isolated syndrome, relapsing-remitting, and active secondary progressive disease in pediatric patients 10 years of age or older, weighing 40 kilograms or less. Since this is a formulation of an existing medication, I categorized this as a new indication. And so, there are no changes to the existing limitations, dosage, or availability. For the dosage, I should clarify for the specific pediatric niche population here. The dosing is 0.25 mg once daily with or without food.

On the next slide here, there was an FDA communication specific to glatiramer acetate, and this is in respect to Copaxone and Glatopa, the brand names of said generic. The FDA is warning that auto-injector devices that are optional for use with glatiramer acetate injections may not be compatible for use across FDA-approved glatiramer acetate injection drug products and has resulted in missed and partial doses. There are currently three FDA-approved glatiramer acetate injection drug products. Copaxone Glatopa, and generic, and they are all on the market, all available in a single-prefilled syringe with an attached needle for subcutaneous administration. Patients may administer the dose using only the syringe or by inserting the syringe into an autoinjector, and these are reusable and are available by prescription separately. And the FDA has requested that the drug product manufacturers update their labeling to instruct users to confirm the autoinjector is compatible before using it to inject the medication. Pause right there for the committee.

Jordan Storhaug: Thank you. We don't have any scheduled stakeholder. So if you're interested in presenting, please raise your hand. But let's pass it off to Marissa first for an update.

Marissa Tabile: Hi, this is Marissa. So this is our Multiple Sclerosis Agents drug class. It's a little big, so I'm going to try to go through it a little slower. So currently in this class, we have Avonex, Avonex Pen, Betaseron, Copaxone, generic dimethyl fumarate. It looks like there's different formulations that we have preferred. We have Kesimpta, and it looks like those are the only preferred products in this class. So I'm happy to take any questions that the Board might have.

Jordan Storhaug: I do see that we do have some stakeholder hands raised. First, I'll call on Lynda Finch to present and then second, Shirley Quach. Lynda, are you ready?

Lynda Finch: I am. Thank you. So **[cross-talk]** --

Jordan Storhaug: Go ahead and present.

Lynda Finch: Hello again. Lynda Finch, Medical Account Director at Biogen. And I'd like to share some new data on Tysabri from a study called STRIVE, which was just published in September of this year. It was a prospective four-year multicenter, observational, open-label, single arm study of Tysabri treatment

in anti-JC virus negative patients who have early relapsing-remitting MS. So the study objectives examined the effects of Tysabri on cognitive processing speed, confirmed disability improvement, and patient reported outcomes. The clinical and secondary endpoints were assessed annually over four years in STRIVE. And at all for annual assessments, the proportion of patients in the intent to treat population of 222, who exhibited clinically meaningful improvements in their cognitive processing speed score, from baseline range from 41.9% to 54%. The cumulative probability of confirmed disability improvement at four years in patients in the ITT population with a baseline expanded disability score of two or more was 43.9%. So that is improvement that I'm speaking of statistically significant reductions in the mean change from screening in the physical and psychological scores on the MSIS-29, indicating improved quality of life were observed overall four years, and a statistically significant decrease from screening and the impact of MS on regular activity signifying an improvement in work productivity was also observed over all four years of the study. Over four years of treatment with Tysabri and STRIVE patients with early relapsing-remitting MS experienced improvement in cognitive processing speed disability in patient reported outcomes. I want to share that your current criteria require that MS patients try and fail two therapies prior to using Tysabri, and these criteria do not take into account the heterogeneity of MS, and some patients have aggressive disease early on, and cognitive impairment begins early in the disease course. The CMSC guidelines cite evidence to support the use of Tysabri as an option for early aggressive disease, and that is characterized by frequent relapses with incomplete recovery and the accumulation of MRI lesions. The AAN guidelines also recommend Tysabri or another high-efficacy DMT for people with highly-active MS. So I respectfully request that Washington Medicaid follow these nationally-recommended guidelines for the treatment of MS and allow the use of Tysabri as a first-line option for patients with early aggressive disease and earlier access for patients who are JCV negative and have a low risk of PML, which is currently estimated at one in 10,000. Thank you for your time and attention. And I'm happy to take any questions.

Jordan Storhaug: Thank you. With that, we'll get Shirley Quach up here. And please let us know who you represent.

Shirley Quach: Hi, can you hear me?

Jordan Storhaug: We can hear you Go ahead.

Shirley Quach: Good. Perfect. Well, good morning. Washington P&T Committee Members. My name is Shirley Quach. I am a Population Health MSL at Novartis. I just want to first thank you for your thorough and thoughtful review of the MS class and this opportunity to provide some new information on Kesimpta. The four-year long term efficacy and safety data of Kesimpta treatment in patients with RMS in the Phase III ASCLEPIOS I and II trials, and ALITHIOS extension study was presented and shared at the American Academy of Neurology in April of this year. Kesimpta maintained a similar safety profile as seen in the pivotal Phase III trials, up to four years of treatment with no new safety risk identified over the treatment period. And data showed that continuous treatment with Kesimpta for up to four years was associated with fewer relapses as well as reduced risk of three-month and six-month confirmed disability worsening and less lesion activity versus those who switch. In addition to demonstrating efficacy up to four years, a continuous treatment of Kesimpta participants who did switch from teriflunomide to Kesimpta in the extension phase demonstrated pronounced reductions in relapses and MRI lesions. And the overall rates of adverse events, serious adverse events, and overall rate of serious infections were consistent with those observed in the Phase III ASCLEPIOS I and II trials. Thank you for your time and consideration. And I'd be happy to answer any questions you have for me. Thank you.

Jordan Storhaug: Thank you. Now looks like we do have another stakeholder, Sophia Yun.

Sophia Yun: Hello. Can everyone hear me?

Jordan Storhaug: Yes, we can. Please let us know who you represent.

Sophia Yun: Perfect. Thank you so much. Good morning. My name is Sophia Yun, and I'm a pharmacist with Janssen Scientific Affairs. Thank you again for the thoughtful review of the multiple sclerosis class as well as this opportunity to provide testimony on Ponvory (ponesimod), which was approved in March of 2021 for the treatment of adults with relapsing forms of MS clinically-isolated syndrome and active secondary progressive disease. Ponvory received the FDA approval based off of results from the OPTIMUM study, which was the first head-to-head study comparing two oral DMTs. OPTIMUM is a Phase III randomized-control trial comparing teriflunomide with Ponvory. Ponvory showed an annualized relapse rate reduction of 30.5%, which translates to roughly one relapse every five years for patients receiving Ponvory versus one relapse every 3.5 years for those taking Aubagio. Ponvory demonstrated

fewer brain lesions as well as a lower degree of brain volume loss in Aubagio. Brain volume loss has also been shown to be greater in patients who suffer from multiple sclerosis in those who do not have the disease. The safety profile of Ponvory was similar to Aubagio and consistent with other medications in this class. And in a long-term follow-up analysis, approximately 60% of patients were still taking Ponvory after eight years. The PK data that is available for Ponvory demonstrates a 33-hour half-life with lymphocyte counts that were shown to return to baseline in 90% of patients by seven days after the last dose. Patients may also attempt Aubagio after those seven days after the last dose of Ponvory, which is the shortest interval in its class. Ponvory has also the fewest barriers to initiation among the S1P, as it requires no genetic testing, has a low potential for DDIs, no known food-drug interaction, and fewer than 10% of patients requiring that first dose cardiac monitoring. So we respectfully request that Washington patients step through only one preferred agent before starting Ponvory due to the superiority of Ponvory over Aubagio per the OPTIMUM trial as well as having the least amount of restrictions to start up compared to the other S1Ps, and the short half-life that allows for that quick recovery of lymphocytes in the event of infection as well as for pregnancy in a population that is largely comprised of women of childbearing age. Thank you so much, and happy to take any questions.

Jordan Storhaug: Thank you. And thank you to all of our stakeholders and participators. I think we're ready now to take a look at the motion. Leta could double check I'm not missing anybody, but we can get that ready.

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

Susan Flatebo: **[Cross-talk]** Hi this is Susan.

Virginia Buccola: **[Cross-talk]** This is Virginia Buccola.

Susan Flatebo: Go ahead.

Virginia Buccola: Okay. I'll go ahead. Thanks. This is Virginia. I move that all products in the Multiple Sclerosis Agents drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same

indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Susan Flatebo: **[Cross-talk]** This is Susan Flatebo. I second. **[cross-talk]** --

Jordan Storhaug: All right. Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay, well with then, I'll turn to Leta maybe for some advice about what we want to do here. Our next agenda item is lunch, but we're running about 40 minutes ahead. I don't know if you want to try to do some of the afternoon or try to stay close to our time for our stakeholders.

Leta Evaskus: I'm thinking we should take lunch now just in case people are calling in a little later for the next topics. It will get closer. They should call in earlier. So if you guys don't mind taking an earlier lunch, we can reconvene at noon?

Jordan Storhaug: Sounds good. And we'll see everybody at noon.

Leta Evaskus: All right. Thank you.

Jordan Storhaug: All right. Looks like we are ready to get started again. Our first pick after lunch here will be Substance Use Disorder, and we'll hand it off to Umang.

Umang Patel: All right. Perfect. So the next class that we'll review are the Opioid Dependency Treatments. The four subclasses that fall under here are the agents for opioid withdrawal, opioid antagonists, subcutaneous partial agonist and transmucosal partial agonist. So on the next slide here, first a little bit of background, the prescription and illicit opioid abuse and misuse has reached national interest and was declared a National Public Health Emergency by the DHHS Acting Secretary in 2017. The 2020 National Survey on Drug Use and Health reported there was an estimated 37.3 million Americans aged 12 years of age or older who were current or in the past month illicit drug users. Of this, approximately 9.4 million aged 12 and older misused opioids in the past year, 40.3 million people aged 12 years of age or older were considered to have a substance use disorder in the past year, including 28 million with alcohol use disorder, 18.4 million with an illicit drug use disorder, and 2.7 million with an opioid use disorder. In 2020, the US Preventive Services Task Force issued a final recommendation statement

on screening for unhealthy drug use. For adults, they recommend screening implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. For adolescents, the current evidence is insufficient to determine the benefit and harms of screening for unhealthy drug use. On the next slide here, according to the American Society of Addiction Medicine, in 2020, they state that the choice of medication which can be buprenorphine, methadone, naltrexone should be a shared decision between clinician and patient and should consider patient preferences, treatment history, concomitant medical conditions, and treatment settings. Additionally, all FDA-approved medications should be available options to all patients with individual needs, taken into consideration for deciding between buprenorphine, methadone, naltrexone in conjunction with psychosocial treatment services, although they do provide some additional context for treatment selection. There is a lot of information here, so to the committee, I did my best to kind of underline the main takeaway topics. Some of them don't have underlying info because all of the entire context is important. There is no recommended time limit for the pharmacological treatment of opioid use disorder. Methadone is recommended for patients who may benefit from an additional supervision in an OTP Opioid Treatment Program, and buprenorphine may be dispensed in OTP or an office-based opioid treatment, while naltrexone may be prescribed in any setting. Oral naltrexone requires special attention to medication adherence and may require observed administration for some patients. The combined use of benzos and sedative hypnotics increases the risk of serious adverse effects when administered with methadone and buprenorphine. However, the harm of untreated opioid use disorder may outweigh the risk. Buprenorphine and methadone are the standard treatment options for managing the acute withdrawals from opioid. And when buprenorphine is selected for managing opioid withdrawal, buprenorphine should not be initiated until there are objective signs of opioid withdrawal and add a dose to suppress the withdrawal symptoms. ASAM also notes that the methadone and buprenorphine are more effective in decreasing symptoms and aiding in the completion of withdrawal. Additionally, the group states that alpha-2 adrenergic agonists such as clonidine, and lofexidine are safe and effective in managing opioid withdrawals. And the focused update also includes recommendations for special populations because this may impact drug selection, psychosocial services, and overall care planning. ASAM also recommends that naltrexone, for the reversal for opioid overdose, and training for patients and significant other should be provided to patients when being treated for or with a history of opioid use disorder. On the next

slide here we see the World Health Organization in partnership with the United Nations Office on Drugs and Crime in 2020. They updated their international standards for the treatment of drug use disorders. They recommend tapering doses of opioid agonist for opiate withdrawals, although alpha-2 adrenergic agonists may be used. Naloxone should be on hand for people with opioid dependence and their families for use in the event of opioid overdose, and they should be trained to manage opioid overdoses. Detoxification followed by relapse prevention treatment using the opioid antagonist Naltrexone is useful for patients motivated to abstain from opioid use. And some groups of individuals of OUD may require specialized tailored care such as women, pregnant women, children, and adolescents, the elderly, indigenous populations, and there is a litany of other subclasses here. On the next slide, according to DHHS last year, they recommend to further expand access to buprenorphine for the treatment of OUD. They released new guidelines, which were the practice guidelines of the administration of buprenorphine for treating OUD, allowing eligible physicians, PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives to prescribe buprenorphine to up to 30 patients outside of completing all of the previous waiver requirements. And the guidance emphasizes, however, that those who forego the training will be limited to treating a maximum of 30 patients, and prescribers must still submit a Notice of Intent before prescribing buprenorphine. Moving along to drug specific updates. In October 2021, the FDA approved a new formulation of naloxone hydrochloride named Zimhi, which is an opioid antagonist indicated in pediatric and adult patients for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or CNS depression. It is intended for immediate administration as emergency therapy in settings where opioids may be present and is not a substitute for emergency medical care. In terms of limitation, there is a risk of recurrent respiratory and CNS depression. It is recommended to keep patients under continued surveillance and administer repeat doses of naloxone using a new nasal spray with each dose as necessary while awaiting emergency medical assistance. In terms of dosage, it is an intramuscular subcutaneous use only. They recommend seeking emergency medical care immediately after, intended to be administered by individuals 12 years of age or older, and to administer to adult or pediatric patients in the anterolateral aspect of the thigh, through clothing if necessary. And the availability is 5 mg/0.5 mL Naloxone hydrochloride solution in a single-dose prefilled syringe for said injection. On the next and final slide, here we have two smaller updates. First the FDA communication in January of this year, they issued a drug safety

communication warning that dental problems including tooth decay, cavities, oral infections, and loss of teeth have been reported with medications containing buprenorphine that are dissolved in the mouth. And dental problems including serious cases have been reported even in patients with no history of dental issues. Despite this, the FDA states benefits of these medications outweigh the risk for OUD, and healthcare practitioners should inquire about dental concerns and advise patients of the importance of taking extra steps after the medicine has completely dissolved, including to gently rinse their teeth and gums with water and then swallow and wait at least one hour before brushing their teeth. In terms of the new formulations, Naloxone injection in February of this year, the FDA approved a Naloxone injection 10 mg for use by military personnel and chemical incident responders for it, and there are two specific indications. One, the emergency treatment of patients 12 years of age or older, where use of high potency opioids such as fentanyl analogues as a chemical weapon is suspected, and 2.) temporary prophylaxis of respiratory and/or CNS depression in military personnel and chemical incident responders entering an area contaminated with high potency opioids such as fentanyl analogs. I'll go ahead and pause there for the committee.

Jordan Storhaug: Thank you. We do not have any scheduled stakeholders for this topic, but feel free to raise your hand. Marissa, go and give us an update.

Marissa Tabile: Hi, this is Marissa. So these are four substance use disorder classes that Umang had mentioned. So I'll go through them one by one. So this first one is agents for opioid withdrawal, which it looks like there's only one product in this class, which is Lucemyra. And right now that is non-preferred. For opioid antagonists, for this class we have Kloxxado, naloxone injections and naltrexone with brand name Narcan, brand name Vivitrol, and brand name Zimhi as our preferred products. In our opioid partial antagonist subcutaneous class, we have Sublocade, which is preferred. And then in the opioid partial antagonist transmucosal, we have buprenorphine-naloxone, which is the generic Suboxone, and we also have the sublingual films, and the sublingual tablets are preferred, and then we have brand name Suboxone film preferred in that class. So I can take any questions that the Board has regarding these classes.

Jordan Storhaug: I am not seeing any stakeholders, so I think we can take a look at the motion.

Virginia Buccola: This is Virginia Buccola. And I move that all products in the drug classes listed on slide 27 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of the HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Alex Park: This is Alex Park seconding the motion.

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. Back to Umang for our next topic.

Umang Patel: Perfect. Next one will be Stimulants and Related Agents. In the subclasses that make up this umbrella class we'll have Dopamine and Norepinephrine Reuptake Inhibitors, Histamine Receptor Antagonists and Inverse Agonist, Non-stimulants, along with Long-Acting, Short-Acting, and Miscellaneous stimulants, as well. On the next slide here, so ADHD or attention deficit hyperactivity disorder, is the most common use for stimulants and for the treatment of ADHD, in which they are considered first-line therapy. It has been diagnosed in approximately 15% of children aged 4 to 17 and about 4% of adults. And it is a chronic condition with core symptoms of inattention, hyperactivity, and difficulty controlling behavior. It may also be accompanied by internalized disorders such as sadness and anxiety as well as aggressive and oppositional disorder. And the three main types are primary hyperactive, primary inattentive, and mixed. In 2020, the medical letter suggests that school-aged children, adolescents, and adults began with an oral stimulant, noting that none of the agents have shown to be more effective than the other. However, some patients may respond better to amphetamines than to methylphenidate and vice versa. They advise that the use of long-acting formulations, which generally contain both immediate and extended-release components, has become standard clinical practice, and the addition of short-acting stimulants may improve symptom control early in the morning or to prolong the duration of action in the afternoon, while the alpha-agonist clonidine and guanfacine and the selective norepinephrine reuptake inhibitor, atomoxetine, can reduce ADHD symptoms, these agents

are considered less effective than stimulants and the use of pitolisant and solriamfetol were not addressed drugs for ADHD. On the next slide here, we have Evekeo ODT. This medication had two updates in the same month in April 2021. The FDA approved this medication for the treatment of ADHD in pediatric patients three to 17 years of age. Previously, it was only approved in children six years of age or older. And they also approved a 2.5 mg strength, and it was already approved as 5 mg, 10 mg, 15 mg, and 20 mg. No changes to warning such as Blackbox Warnings that all CNS stimulants carry for high potential for abuse and dependence, blood pressure and heart rate increase, psychiatric adverse effects, or in pregnancy. In terms of dosing, since this is the new extended age range, they recommend for patients three to five years of age, starting dose of 2.5 mg daily and, if necessary, administrating an additional dose after four to six hours, and to titrate the dose in increments of 2.5 mg at weekly intervals. And the availability, as I mentioned, is an ODT, an orally disintegrating tablet in the strengths I mentioned earlier. On the next slide, here we have Qelbree. And so, in April 2022, the FDA approved expanded indications for Qelbree for use in adults with ADHD. Previously, this was only approved for pediatric patients six to 18 years of age. And so, inverse of most medications, we see now the adults are the added age group in this medication. No changes to any of the warnings that already existed. The respective dosing for adults due to the expanded indications, is 200 mg once daily. Titration may occur in 200 mg weekly increments, and the maximum dose is 600 mg daily. On the next slide, we have Dyanavel. And in November 2021, the FDA approved a new extended-release tablet formulation for the treatment of ADHD in patients six years of age or older. Again, this is just a formulation expansion. So no indication warning or dosage changes. Just there used to be an extended-release oral suspension, and now there are extended-release tablets, 5 mg, 10 mg, 15 mg, and 20. On the next slide, we have Xelstrym. So on March 2022, the FDA approved a new transdermal system formulation for Xelstrym, which is dextroamphetamine, and this was for the treatment of ADHD in adults and pediatric patients six years of age or older. The warnings, as you can imagine, are very similar to the previous stimulants I've mentioned. Blackbox warning for high potential of abuse and dependence, blood pressure and heart rate increase, as it is a stimulant, psychiatric adverse reactions, pregnancy, which may cause fetal harm. And specifically, here with Xelstrym, we see a dose adjustment is recommended for patients who have severe renal impairment and have ESRD, end-stage renal disease. In terms of dosing for pediatric patients, they recommend starting dose of 4.5 mg per 9 hours and to titrate dosage in weekly increments of 4.5 mg up to a maximum

of 18 mg per 9 hours. In adults, it is 9 mg per 9 hours, maximum dose of 18 mg per 9 hours, and it's recommended to apply one transdermal system two hours before an effect is needed and removed within 9 hours. The availability, again, for transdermal patch, so 4.5 mg per 9 hours, so the dosing is 4.5 mg/9 hours, 13.5 mg/9 hours, and 18 mg/9 hours. On the next slide here, we have Relexxii. And so, in June of this year, the FDA approved Relexxii for the treatment of ADHD in pediatric patients 6 years of age or older and adults 65 years of age or younger with ADHD, Attention Deficit Hyperactivity Disorder. Very similar warnings again. You can see a theme here. A Blackbox warning for abuse, dependence, blood pressure, heart rate increase. A unique one here is long-term suppression of growth, so it's recommended to monitor height and weight at appropriate intervals in pediatric patients. And GI obstruction, so healthcare practitioners need to avoid use with pre-existing GI narrowing. In terms of dosage, patients 6 to 17 years of age, the starting dose is 18 mg once daily. It may be increased by 18 mg once per day at weekly intervals, and the maximum dose for pediatric patients 6 to 12 years of age is 54 mg daily, and 13 to 17 years of age is 72 mg once daily. For adults up to 65 years of age, the starting dose is 18 mg or 36 mg once daily. May be increased by 18 mg once daily at weekly intervals and a maximum of 72 mg daily. The availability is in extended-release tablets, and those are in 18 mg, 27 mg, 36 mg, 45 mg, 54 mg, 63 mg, and 72 mg. All righty, on the next and final slice for this class, just a few updates. First with methylphenidate as of March 2022, this was the first FDA-approved generic for Noven's Daytrana from Mylan. And in terms of recall, so what guanfacine extended-release of April last year, Apotex issued a voluntary recall of three lots of guanfacine extended-release tablets 2 mg to the consumer level due to trace amounts of quetiapine found in one lot. Out of caution, two other lots were also recalled. No adverse effects related to this recall have been reported, but exposure in trace amounts could result in a hypersensitivity reaction. In addition, exposure to quetiapine could result in additive effects of lowering blood pressure, sleepiness, sedation, and dizziness. Go ahead pause right there for the committee.

Jordan Storhaug: Thank you, Umang. We do have two stakeholders that previously have signed up. First up is Patrick Harvey, and then second was a Maitrey Patel. So if you guys want to get ready, and anybody else who is interested speaking, go ahead, and raise your hand as well. But first, let's hear from Marissa.

Marissa Tabile: This is Marissa. So here are our ADHD / Anti-narcolepsy subclasses that we have that Umang just mentioned. So the first one that we have is dopamine

and norepinephrine reuptake inhibitors or DNRIs. So currently, we only have one product in that class, which is Sunosi, and that is non-preferred. The next class is the histamine H3 receptor antagonist/inverse agonist class. We only have one product in that class, which is Wakix, and that is preferred. The next class is the nonstimulants. And this one, our preferred products are atomoxetine generic, clonidine generic, and that is the ER and the regular. Guanfacine ER and regular, and everything else is non-preferred, and it looks like those are all brand products that are all preferred in that class. Moving on to our Stimulants : Long-acting class. Currently, the preferred products in this class are brand name Adderall XR, the generic amphetamine dextroamphetamine. We have brand name Concerta preferred, generic dexmethylphenidate, and that comes in various formulations that we have. We have both ER and regular. And then we have methylphenidate hydrochloride that is preferred that is generic, and then another methylphenidate ER capsule, and then brand name Vyvanse. Both the capsules and the chewables are preferred in that class. Moving on to the Stimulants : Miscellaneous. In this class, we have our Modafinil, which is generic that is preferred, and generic Modafinil are the preferred products in that class. And then moving on to our last class, which is the short-acting stimulants. In this class, we have the amphetamine dextroamphetamine generic, so generic Adderall, which is just regular, not ER. We have dexmethylphenidate that is short-acting, as well. And then we have brand new Focalin and methylene and methylphenidate generic. It looks like we just have the solutions and the tablets as the preferred products in this class. And I can take any questions that the Board might have regarding the PDL.

Jordan Storhaug: All right. I think we're ready to move on to our stakeholders. So first up, we'll have Patrick Harvey of Supernus Pharmaceuticals.

Patrick Harvey: Thank you, and good afternoon. As he said, this is Patrick Harvey of Supernus Pharmaceutical Field Medical Affairs, I'd like to thank you for the opportunity to make a few comments regarding Qelbree. I will refer you to the complete prescribing information for full product details. We are respectfully requesting and ask that you consider Qelbree be recommended as a preferred on the PDL, allowing for a step-through either atomoxetine or any two preferred agents versus requiring all patients to fail atomoxetine. Qelbree, as you know, the new chemical entity and a once-daily nonstimulant now approved in adults and children six years of age and up, and it is the only non-stimulant that can be opened and sprinkled for those kids who have trouble swallowing. Studies show stimulants are not an option for 10% to

30% of ADHD patients, and we believe that would be clinically inappropriate to require patients to step-through atomoxetine which represents only 3% or 4% of the ADHD population. Placing an undue barrier to access on patients in need of an unscheduled treatment options leading to higher prior authorization rejection rates and perhaps driving more patients will be treated with controlled substances. In a recent survey, 52% of use have admitted to diverting their prescription stimulants, and in 2015, it was estimated that 5 million adults living in the United States misused prescription stimulants in the previous year. While we have no head-to-head studies comparing Qelbree and Strattera, I would like to highlight some key differences between Qelbree and Strattera based on labeling for your consideration. In our Phase III clinical trials in both children and adults, there was statistically significant reduction in ADHD rating scale as well as clinical global impression improvement scores as early as the first week in children and second week in adults. And they showed the same symptom improvement over the course of a one-year open-label extension study. Atomoxetine, on the other hand, may take a median time improvement of four weeks, and at least 12 weeks to full response and over 14 weeks to remission. High blood pressure is the most common chronic condition in adult patients, and any medications that further exacerbates high blood pressure may not be an appropriate option. Currently, atomoxetine the only other nonstimulant option approved for the treatment of adult ADHD carries warnings of serious cardiovascular events and severe liver injury as well as higher rates of sexual dysfunction. Qelbree's impact on cardiovascular parameters was mild, and no patients in the adult trials discontinued due to cardiovascular adverse events. Even at supratherapeutic doses, it had no impact on QTC prolongations, and there were no ECG changes observed. And there have been no reported drug-induced liver injuries associated with Qelbree. Late last year, FDA requested labeling changes for Strattera but not Qelbree to include risk of aggression and manic symptoms, which may have prompted the Oregon Medicaid to move Qelbree to their PDL a couple of weeks ago. So for these reasons, we ask now that patients receive Qelbree after failure of either atomoxetine or any two preferred PDL agents. And I'll be happy to answer any questions.

Jordan Storhaug: Thank you very much. Thank you very much. Next person we have is Maitrey Patel from Corium.

Maitrey Patel: Am I audible?

Jordan Storhaug: Yes, we can hear you. Go ahead.

Maitrey Patel: Thank you. Hello, everyone. My name is Maitrey Patel. I am a Senior Medical Science Liaison with Corium, and I'll be presenting on Azstarys. Azstarys is a CNS stimulant approved for the treatment of ADHD in patients six years of age and older, including adults. I will focus on three key areas. First, the unique characteristics of Azstarys, second, the duration of action and efficacy of Azstarys, and third, important safety information. I'll start with the unique characteristics. Azstarys contains two active ingredients in the following ratio: 30% dexmethylphenidate plus 70% serdexmethylphenidate, which is the first and only methylphenidate program. Serdexmethylphenidate is a new molecular entity and classified as a schedule IV controlled substance. However, Azstarys, itself is classified as a schedule II controlled substance as it contains 30% dexmethylphenidate, which is schedule II. Serdexmethylphenidate produces lower drug-liking effects compared to other scheduled II and schedule IV controlled substances in human abuse studies. Azstarys is available in three dosage strengths, equivalent to 20 mg, 30 mg, and 40 mg total dexmethylphenidate. Azstarys comes in a capsule form, and it is administered orally once daily in the morning with or without food and can be taken home or consumed by sprinkling contents into 50 mL water or two tablespoons of applesauce. Next, I would like to share information regarding duration of action and efficacy of Azstarys. With many ADHD treatments there remains vulnerable periods of time with inadequate drug coverage either in the morning or early evening hours of the day. And so Azstarys' unique co-formulation is designed to provide both early onset within 30 minutes and extended duration up to 13 hours. Azstarys has demonstrated a significant improvement in attention in behavior of children ages 6 to 12 years old, as measured by SKAMP scores in the classroom setting for a 13-hour period. Finally, I would like to share important safety information. Azstarys has demonstrated a safety profile consistent with that observed for other methylphenidate products. And Azstarys had no notable safety signals identified. In the long-term, 12-month, open-label, safety study, Azstarys did not have a clinically-significant impact on height and weight and did not worsen sleep. For full prescribing important safety information, please refer to the Azstarys package insert. I would like to thank the committee for the time. And I would be happy to answer any questions. Please consider access to Azstarys for patients aged 6 and older diagnosed with ADHD. Thank you.

Jordan Storhaug: Thank you. Our next speaker then will be Zach Echlin. And, Zach, if you could let us know who you are representing.

Leta Evaskus: This is Leta. Zach, you need to unmute yourself, as well.

Zach Echlin: Hi. Can you hear me now?

Leta Evaskus: Yes.

Zach Echlin: Hi. Yes. My name is Zach Echlin. I don't represent anyone. I'm a Molina patient. I've had sleep apnea since 2013. Basically, what I'd like to quickly discuss is -- Do you want patients with sleep apnea? Do you want them self-medicating with caffeine, nicotine, cocaine, other stimulants, or do you want them taking medications like Modafinil? The reason I asked that question is in trying to get the medication Modafinil, which has really been honestly, life-changing for me, there's a policy that has been put in place by the Washington Health Authority. If anyone is interested, it is at 61.40.00.AA.1. And it puts in place requirements in order for me to get Modafinil. And one of the requirements is that either I'm using a CPAP, BiPAP, or mandibular advancement device. With the CPAP or BiPAP, it requires that I'm using it 70% of nights for a minimum of four hours per night. That can be very difficult meeting those requirements. The doctors are constantly playing around with my pressures, playing around with different masks, different devices. I've had both CPAP and BiPAP, and it can be difficult to maintain the compliance. It's sort of funny. Last time I went to pull a report, or the doctor has pulled report for the last six months, it said that I was 69% compliant for four hours per night. So that would mean I wouldn't get the medication under this medical policy. So my question is, is do you want people with sleep apnea? Do you want them taking Modafinil? Or do you want them self-medicating with, like I said, caffeine, nicotine, cocaine, other stimulants. I would think you would want them taking Modafinil. If you research it, people with sleep apnea, they often do self-medicate with different stimulants. It's a known issue. So that is all I had to say. I'd love to take any questions.

Jordan Storhaug: Thank you, Zach. I do not see any other people with their hands raised, stakeholders, so I think we're ready for the motion.

Susan Flatebo: This is Susan Flatebo. I move that all products in the drug classes listed on Slide 30 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the

discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized, unless contraindicated, not clinically appropriate, or only one product is preferred.

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

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. With that, then I'll turn it back to Umang for our next topic.

Umang Patel: Perfect. The next class we have will be the anti-allergens. These are in the Apple Health PDL, the Allergenic Extracts and Biologicals. On the next slide here, allergic rhinitis or hay fever can be presented with or without allergic conjunctivitis. It affects approximately 8% of adults and 9% of children in the United States. Allergen avoidance and medication therapy can provide significant symptom relief, but for many, symptoms remain present. For some of these patients, allergen immunotherapy is a reasonable alternative. Subcutaneous immunotherapy (SKIT) has proven to be effective in the management of allergic rhinitis and asthma since the early 20th century. However, it requires regular injections, typically over a period of three to five years, and carries the potential of serious systemic allergic reactions in response to the treatment itself. On the next slide, just a drug specific update, the only one for this class. So the FDA approved an expanded indication for Ragwitek to include pediatric patients as young as five years old for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen. Previously, it was only approved in patients 18 to 65 years of age. This does not affect any of the other Warnings and Precautions, specifically the Blackbox warning. No changes to dosage, nor is availability, as well. We'll pause right there for the committee.

Jordan Storhaug: Thank you. We do not currently have any stakeholders listed. If you would like to speak, please raise your hand. But first to Marissa for an update.

Marissa Tabile: This is Marissa. So this is the Allergenic Extracts/Biological Oral class that Umang just went over. And as you can see in this class, we pretty much have everything preferred. There are no non-preferred products in this class. So I can answer any questions.

Jordan Storhaug: I'm not seeing any hands raised. So I don't think we have any stockholders. So we can move on to the motion.

Michael Corsilles: This is Michael Corsilles. I move that all products in the Allergenic Extracts/Biologicals oral drug class are considered safe and efficacious for their medically accepting indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Jon MacKay: This is Jon MacKay. I second.

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. Next, I think we're back to Umang again for the next topic.

Umang Patel: Yes. The next class we have are Antipsychotics and this includes Antipsychotic Combinations, 2nd Generation, and Parkinson Psychotic Disorder, as well. Moving on to a little bit of background. So schizophrenia is the most common psychotic illness, which affects about 1% of the population. Between 25% and 50% of schizophrenic patients attempt suicide, and 10% of patients succeed in their attempt. Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, negative symptoms, and at least one of these should be delusions, hallucinations, or disorganized speech. According to the American Academy of Child and Adolescent Psychiatry, I just wanted to point this out because this is from almost about nine years ago, because this practice parameter is more than five years old, it is considered a historical practice parameter. However, they have not released newer guidelines as of yet. In terms of guidelines on the next slide, the American Psychiatric Association in 2020

stated since schizophrenia is a chronic illness that afflicts all aspects of life, the goal of treatment is to stabilize the patient, particularly to reduce acute symptoms, to return to baseline functioning, to prevent recurrence of symptoms, and maximize functioning and quality of life. Goals may also be based on individual patient preferences impacting school, employment, and other quality-of-life impacting components. Guidelines recommend that patients with schizophrenia be treated with an antipsychotic including monitoring for both safety and efficacy. An antipsychotic should be continued in patients whose symptoms improve, with the APA suggesting that the same antipsychotic be used. They recommend clozapine, specifically, be used in patients with treatment-resistant schizophrenia and in patients with a significant risk of suicide. They also suggest clozapine for patients with aggressive behavior despite other treatments. And a long-acting injectable is suggested for patients who prefer this therapy or for patients with a history of uncertain of the poor adherence. Notably, these guidelines state that an evidence-based base ranking or algorithm approach or antipsychotic selection is not practical due to the clinical trial heterogeneity and limited comparative trials. In addition, there is no preference for 1st generation antipsychotics or 2nd generation antipsychotics. So clinically meaningful distinctions such as tolerability do occur. With the exception of clozapine, no antipsychotic has demonstrated superior efficacy when compared to other agents within the class. They also state that there is no reliable strategy to predict response. Thus, initial treatment choice is often individualized and includes several patient-specific factors. And the guideline also details management of adverse effects, such as acute dystonia, Parkinsonism, akathisia, and tardive dyskinesia, some of which may warrant a switch to an alternative antipsychotic treatment. Next slide, we have Bipolar Disorder, and so I stratify these by the subtopics, first being schizophrenia, now with bipolar disorder. The lifelong prevalence estimates bipolar disorder ranges from 0.9% to 2.1% of the population, characterized by episodes of mania, depression, or mixed state. Criterion used to diagnose bipolar I disorder is the presence of a manic episode, which is defined as persistent elevated, expansive, or irritable mood for at least one week with increased energy and activity or mixed features, such as rapidly alternating polarity of mood, sadness, irritability, and mania for at least one week. And three or more other characteristic symptoms, such as inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual, etc. As you can see, there is a litany here. I listed here the American Psychiatric Association guidelines from 2002. Again, being 20 years old, it is well over one year, so I won't be going over that, but it's just here for the committee's leisure. On the next

slide here, we have drug-specific updates, first being Invega Hafyera. So in September 2021, the FDA approved a once every six months' injection in the treatment of schizophrenia in adults after they have been adequately treated with Invega Sustenna, which is a once-monthly or Invega Trinza every three months. It is approved as an injectable suspension in single-dose prefilled syringes. The warnings, as you can imagine, similar to its counterparts, Blackbox warning elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death and not approved for the treatment of patients with dementia related psychosis. There are things such as cerebrovascular adverse reactions in elderly patients with dementia-related psychosis. In terms of pregnancy, it may cause extrapyramidal and/or withdrawal symptoms in neonates with third trimester exposure. And it is not recommended in renal impairment. The dosing is stratified by indication in previous medication. And as I mentioned earlier, the availability are extended-release injectables suspension. Continuing onward. Next, we have Caplyta. So in December 2021, the FDA approved a new indication for the treatment of depressive episodes associated with bipolar I or bipolar II in adults as monotherapy and as an adjunctive therapy with lithium or valproate. It is already approved for schizophrenia in adults here. As you can see, just an expansion in indication here. And then in May of 2022, they approved two new strengths, 10.5 mg and 21 mg capsules. It was already available in 42 mg capsules. So again, just the expanded indication and additional capsule strength availability here. And lastly, next we have Rexulti. In December 2021, the FDA expanded the indication to include treatment of schizophrenia in pediatric patients 13 to 17 years of age. Previously, it was only indicated in adults. Again, no changes to warnings in terms of dosing for this new indication. Starting dose is 0.5 mg per day. Recommended dose is 2 mg to 4 mg per day, with a max dose of being 4 mg. No changes to warnings or availability. Now we'll pause right here for the committee.

Jordan Storhaug: Thank you, Umang. We do have a number of stakeholders for this topic. I'll let the first two -- I'll put you on notice. So first will be Madeline Shurtleff, and then number two will be Micah Lands. But first we'll hear from Marissa.

Marissa Tabile: Hi, this is Marissa. So what I have displayed up first is our 2nd Generation Antipsychotics class. And I will mention the preferred products, which we currently have as Abilify Maintena. We have aripiprazole generic tablets, Aristada brand name, clozapine generic, Geodon brand name. Invega Hafyera, Sustenna, and Trinza injections are all preferred. Latuda tablets generic, olanzapine solution and tablets as well as the ODT. We have quetiapine

fumarate tablets, both IR and ER. Risperdal Consta, risperidone solution and tablets and ODT. We have Vraylar capsule, ziprasidone generic. It looks like we have the capsules and the solutions. And those are our preferred products for the 2nd Generations. Moving on to our antipsychotic combinations. In this class, we don't have any preferred products, but right now, other products that are in that class are the olanzapine/fluoxetine combination, and the Symbyax, which I believe this one is the generic of that. Next is the Parkinson psychotic disorder. And in this class, we only have Nuplazid, and that is preferred both the capsules and the tablets in that class. And I'll be happy to take any questions from the Board.

Jordan Storhaug: Thank you, Marissa. Our first stakeholder then will be Madeline Shurtleff from Otsuka. After that will be Micah Lands. Madeline, whenever you're ready.

Madeline Shurtleff: Okay. Are you guys able to hear me okay?

Jordan Storhaug: Yes. We can hear you very well.

Madeline Shurtleff: Okay, great. Thank you. So my name is Madeline Shurtleff, and I am the Managed Market Liaison with Otsuka. Thank you for this opportunity to provide information on Rexulti. Rexulti is an atypical antipsychotic indicated for use as adjunctive therapy to antidepressants for the treatment of major depressive disorder in adults, and the treatment of schizophrenia in adults and, as you heard, a new indication for treatment of schizophrenia in pediatric patients ages 13 years and older. In fair balance. I call your attention to the box warning for Rexulti of increased mortality in elderly patients with dementia-related psychosis as well as due to suicidal thoughts and behaviors in children, adolescents, and young adults. For the complete safety information, please refer to the full prescribing information for Rexulti. Schizophrenia is a heterogeneous disorder with a wide range of factors that impact its clinical course. There is a substantial interpatient variability in response to different antipsychotic medications. It is important to match antipsychotic agents to individual patient needs. Drug utilization management policies that hinder access to medications and continuity of care may interfere with treatment. Monotherapy antidepressants are widely recommended as the first-line treatment for major depressive disorder. Additionally, adjunctive treatment with atypical antipsychotic agents may help achieve symptom improvement. Although multiple monotherapy anti-depressive treatments are available in various therapeutic classes,

approximately 50% of patients with MDD do not achieve response to initial monotherapy, and as many as 1/3 do not achieve remission after multiple treatment trials. This presents a need for additional tolerable and efficacious treatment options. Improving patient life engagement and functioning are important goals in treating MDD. A post hoc analysis of brexpiprazole trial data examined changes in life engagement following initiation of adjunctive brexpiprazole in patients with MDD using real-world data. A retrospective real-world study evaluated 624 patients diagnosed with MDD aged 18 years or greater and prescribed brexpiprazole for at least 30 days. Statistically significant changes in life engagement scores were observed from as early as one month after the index state. More than 50% of patients on brexpiprazole demonstrated an improvement in life engagement within six months, with significant improvement being observed from as early as one month from initiation. Improvement was seen across the four domains of life engagement with emotional and social domains showing the greatest level of improvement. In closing, Otsuka respectfully requests that Rexulti be included on the Washington State Preferred Drug List. Upon request, I'm happy to provide the committee with any specific medical information you may need. Thank you.

Jordan Storhaug: Thank you. Next up will be Micah Lands from Intra-Cellular Therapies. And after that will be Nikki Behner.

Micah Lands: Great. Can everyone hear me okay?

Jordan Storhaug: Yes. We can hear you well.

Micah Lands: Great. So good afternoon. My name is Micah Lands, and I'm the MSL representing Intra-Cellular Therapies. Thank you for the opportunity to speak with you today about lumateperone, brand name Caplyta. Caplyta is an atypical antipsychotic indicated for the treatment of adults with schizophrenia and depressive episodes, associated with bipolar I or bipolar II disorder as both monotherapy and adjunctive therapy with lithium or valproate. Caplyta's approval for the treatment of bipolar depression in adults was based on two positive pivotal clinical trials. In both six-week monotherapy and adjunctive therapy studies, Caplyta 42 mg statistically significantly separated from placebo on the primary efficacy outcome the MADRS total score, in addition to the key secondary outcome, based on a clinician-rated scale CGI-BP-S. The most common adverse reactions with Caplyta 42 mg in both short-term studies were solemn with sedation,

dizziness, nausea, and dry mouth. Main changes from baseline in metabolic parameters including fasting glucose, insulin, total cholesterol triglycerides, and bodyweight were all similar to placebo. Prolactin level changes and motoric adverse effects during these studies were also similar to placebo. No single TEAE led to discontinuation in 2% or greater of patients. In a six-month open-label trial with Caplyta in patients with bipolar depression, there were no new safety signals observed with long-term treatment, and efficacy was maintained at six months. Similar to other drugs in the antipsychotic class, Caplyta has box warnings not to be used to treat elderly patients with dementia-related psychosis and to closely monitor for worsening or emergence of suicidal thoughts and behaviors. The safety and effectiveness of Caplyta have not been established in pediatric patients. Additional Warnings and Precautions are described in the full prescribing information. In April 2022. The FDA approved two new dosage strengths of Caplyta at 21 mg and 10.5 mg for use in patients with moderate or severe hepatic impairment and patients taking strong or moderate CYP3A4 inhibitors. Thank you for considering Caplyta in your formulary discussion. And I welcome any questions you may have.

Jordan Storhaug: Thank you. Next up we will have a Nikki Behner, a psychiatric nurse from Mount Vernon. And after that will be Charlie Lovan.

Laura Crocker: Jordan, this is Laura. I don't see Nikki in our attendees list.

Jordan Storhaug: I was having the same trouble. So, Nikki, if you're there, go ahead and raise your hand. But in the meanwhile, let's go ahead and go to Charlie Lovan of AbbVie.

Charlie Lovan: Hey there. Hi again. So I'm Charlie Lovan. I'm a Medical Outcomes Science Liaison with AbbVie. Bear with me. I do know that Vraylar is on the PDL, but I do have an ask at the end of my testimony. So Vraylar is the once-daily oral, second-generation, atypical antipsychotic approved in adults for the treatment of schizophrenia, the acute treatment of manic or mixed episodes of bipolar I disorder, and the treatment of depressive episodes associated with bipolar I disorder. Vraylar does have an established safety and efficacy profile in more than nine clinical trials across its three distinct indications. And Vraylar has Box Warnings regarding suicidal thoughts, behaviors, and increased mortality in elderly patients with dementia-related psychosis. It also has some of the same Warnings and Precautions other atypical antipsychotics, and I encourage you to review all of those in the full

prescribing information. Vraylar does have several characteristics which distinguish it from other drugs in this class. I'm going to highlight four of those. So first, I'd like to bring to your attention that Vraylar's unique pharmacological profile. The precise mechanism of action is not fully characterized, but it is known that Vraylar is a D3 and D2 partial ,agonist and it's the only D3 preferred atypical antipsychotic. Second, Vraylar and its two pharmacologically equal potent major active metabolites have a long half-life, and a long half-life relative to available atypical antipsychotics. Third, Vraylar has a neutral metabolic profile with a low risk of weight gain and sedation. This is particularly important in these patients with bipolar I disorder and schizophrenia because they are at an increased risk for early mortality caused by cardiovascular disease. And then lastly, Vraylar is one of only two monotherapies that are FDA-approved for treating a full spectrum of bipolar I disorder episodes, including manic, mixed, and depressive episodes. And it's the only treatment approved for the full spectrum of bipolar I disorder that is considered metabolically neutral with low risk of weight gain and minimal sedation. So I do want to ask and request of the committee that you consider the nuance of the PDL and the policy criteria relative to agents that are non-preferred on the PDL. So Vraylar is currently on the PDL as preferred with a prior authorization. However, the non-preferred branded agents in this class actually have an easier route to access. So by failing two preferred agents, you can have access to a non-preferred agent by failing two preferred agents. However, the Vraylar policy in bipolar depression requires failure of three agents including Latuda as a requirement as one of those three. So in essence, the non-preferred agents are failed two while the preferred agent of Vraylar is fail three. So I am requesting Vraylar be a parity in this respect as a preferred agent. Thank you.

Jordan Storhaug: Thank you. Just a last call for any stakeholders. So I'll see if we have any hands raised. There, I do see a hand raised. The name is Paul Thompson. If you would like to speak, go ahead now, and just let us know who you represent, if anybody.

Paul Thompson: Hi. Thank you. Can you hear me?

Jordan Storhaug: Yes, we can hear you.

Paul Thompson: Oh, great. Great. Thank you. My name is Paul Thompson. I'm a Health Outcomes MSL at Alkermes. And I'd like to thank the committee for the opportunity to provide testimony on Lybalvi. Schizophrenia and bipolar I

disorder are serious mental illnesses requiring long-term treatment and are associated comorbidities and decreased life expectancy. Although efficacious for the treatment of schizophrenia and bipolar I disorder, olanzapine has been associated with the risk of significant weight gain. Lybalvi is a combination of olanzapine and samidorphan and opioid receptor antagonist. It is indicated for the treatment of schizophrenia and bipolar I disorder in adults. For bipolar I disorder that is both for acute treatment of manic or mixed episodes as monotherapy or adjunct to lithium or valproate, and maintenance monotherapy treatment. Lybalvi safety and efficacy in adults with bipolar I disorder is based on adequate and well-controlled studies of orally-administered olanzapine. The approval of Lybalvi in schizophrenia is partly based on adequate and well-controlled studies of orally-administered olanzapine and on two Phase III randomized controlled trials of Lybalvi. In Study 1, Lybalvi demonstrated statistically significant improvement in PANSS total score compared to placebo at four weeks. The inclusion of samidorphan and Lybalvi did not appear to negatively impact the antipsychotic efficacy of Lybalvi. In study two, Lybalvi met its co-primary endpoints demonstrating significantly less weight gain from baseline at week 24 and significantly lower proportion of patients who gained greater than 10% body weight compared to olanzapine at week 24. Lybalvi patients were half as likely to gain 10% of baseline weight over 24 weeks compared to patients treated with olanzapine. Patients with diabetes mellitus were excluded from this trial, and there was a 30% early discontinuation rate over the 24-week trial. Safety and tolerability were also evaluated in an open-label, 52-week extension studies. The most common adverse events for Lybalvi in schizophrenia are increased weight, somnolence, dry mouth, and headache. Lybalvi does have a Box Warning for increased mortality in elderly patients with dementia-related psychosis. Samidorphan is an opioid-antagonist and can precipitate opioid withdrawal. Lybalvi is contraindicated in patients using opioids or undergoing acute opioid withdrawal. An opioid-free interval is required prior to initiation of Lybalvi. Please refer to the prescribing information for contraindications of lithium or valproate if administered with Lybalvi. In closing, Lybalvi illustrated statistically significant less weight gain than olanzapine while providing antipsychotic efficacy in adults with schizophrenia. We respectfully ask that Lybalvi be made accessible to subscribers of the Apple Health PDL without coverage restrictions. I am also the MSL for other products in this class, Aristada and Aristada Initio. And I would like to ask the committee -- I know we're running out of time, if you have any questions on either Lybalvi, Aristada, or Aristada Initio. Thank you.

Jordan Storhaug: Thank you. I think that was our last. Any other stakeholders want to raise their hands quickly, we'll be able to do that. Otherwise, I think we're ready to go on to the motion.

Virginia Buccola: This is this is Virginia **[cross-talk]** Buccola. Before we go to the motion, I wanted to actually thank the observation of one of the stakeholders around parity in terms of number of drugs that need to be tried -- preferred drugs that need to be tried before access to a non-preferred product between schizophrenia and bipolar. I saw Leta's hand go up. I didn't know if that was in response to what I started to say.

Leta Evaskus: This is Leta. No, Sorry. That was an accident.

Virginia Buccola: Oh, okay. I don't know if somebody would be able to comment to us today on how we might help to remedy that lack of parity.

Marissa Tabile: Hey, Ginni. This is Marissa. So you were just wondering why some of our non-preferred have a try and fail two and some don't is what you're **[cross-talk]** seeing?

Virginia Buccola: **[Cross-talk]** It was specific to -- again, I'm sorry, I don't know which stakeholder it was. I think it was the second to the last noticed that for one of the newer and second-generation antipsychotics, when used for the indication of schizophrenia, two non-preferred products were required in order to reach the brand name agent. When used for the indication of bipolar disorder there, it was noticed that they had to try three preferred products in order to reach the non-preferred.

Charlie Lovan: Sorry. This is Charlie. I was the one that spoke. It is actually the opposite. Where the preferred drug of Vraylar, in bipolar, you must fail three, but in non-preferred drugs, you must fail two. You actually have to fail more therapies in the preferred drug than a non-preferred drug.

Virginia Buccola: Oh, okay. I'm sorry. I misunderstood. So I think what you were stating is a little different than what I thought I heard. Thank you, Charlie, for clarifying that.

Jordan Storhaug: So for my understanding -- and, Marissa, I think, will be the expert on this is that our current prior authorization for Vraylar requires three drugs before

it's able to be used. Marissa, are you able to speak if that is accurate? And any comments regarding that?

Marissa Tabile: Hi, yeah. This is Marissa. So that is an accurate statement. So the reason why it stepped through three is because we actually have a drug-specific policy for Vraylar. The other non-preferred products that we have in that class don't have any real drug-specific policy that we've created, and those would just be step thru two. For this particular product, we took into consideration the evidence, different budget impact models that we looked at, and we decided that three would be the best for this specific product. Of course, we would love to create policies for all of them, but we, unfortunately, didn't have the time to create all of them for all of the different anti-psychotics. But that is the reasoning I guess, the rationale for this particular product, which is taking into consideration different aspects of evidence utilization, any financial impacts that it had, and that was the reason why this one is three.

Virginia Buccola: Okay. Thank you for clarifying that. That is helpful.

Marissa Tabile: Mm-hmm. You're welcome.

Jordan Storhaug: Marissa, would you be able to pull up the motion for us?

Marissa Tabile: This is Marissa. Yes, I can. I'm sorry. There you go. You should be able to see it now.

Diane Schwilke: So this is Diane Schwilke, and I move that all products in the drug class listed on slide 35 are considered safe and efficacious for the medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Susan Flatebo: This is Susan Flatebo. I second.

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. Thank you, Marissa, there for helping us out both with your advice and, again, the screen is all set up. It does look like we're getting through our time, and so we're ready for another break. Looks like we're kind of scheduled for about 10 minutes for that. Should we go ahead and just say 1:20? Does that work out?

Leta Evaskus: This is Leta. I think that works.

Jordan Storhaug: Okay. Perfect. All right. See everybody at 1:20.

Leta Evaskus: Thank you.

[break]

Jordan Storhaug: All right. Welcome back, everybody. It looks like the next topic we have is Movement Disorder Agents, so I will pass it back to Umang.

Umang Patel: Perfect. All righty. The next topic, Movement Disorders, does not have any significant clinical updates. So I'll go ahead and pause there and hand it right back to Jordan.

Jordan Storhaug: Okay. Thank you, Umang. We will have two stakeholders that are previously signed up for this. First is Rochelle Yang, and second is John Deason. Marissa, do you want to give us an update first?

Marissa Tabile: Hi, this is Marissa. So this is our Movement Disorders Agent drug class, and currently **[audio cuts out] [13:48]** we have tetrabenazine and Austedo as our preferred products.

Jordan Storhaug: All right, with that update, I think we are ready for Rochelle.

Rochelle Yang: All right, thanks so much. My name is Rochelle Yang, and I'm with the Teva Medical Affairs Team. I wanted to provide you with some quick clinical trial updates around Austedo or deutetrabenazine. And firstly, I would like to thank the committee for allowing continued access to Austedo for Washington Medicaid patients. Just as a quick reminder, Austedo is a VMAT2 inhibitor that was approved in 2017. And so far, it is the only drug approved for both Korea and Huntington's disease as well as part of dyskinesia, which are both movement disorders. I wanted to share some recently published results of the open-label trials in both Huntington's disease and tardive

dyskinesia, just keeping in mind that these are both open-label studies, so there is no direct comparator. So firstly, the RIM-TD trial was the three year-long, open-label extension of Austedo in tardive dyskinesia, comprised of patients who had completed the two randomized control trials, and there were 343 patients enrolled. Overall, patients experience continued improvements in the primary endpoint, which is the change in AIMS score from baseline that were sustained over a three-year period, with a mean reduction of 6.6 points in AIMS score from a baseline of 10.7. And then secondly, we have the ARC-HD trial, which actually just published last month. This is a three-year long, open-label extension for Austedo in Chorea and Huntington's disease, and this study included 119 patients, including both patients who had completed and rolled over from the first HD randomized-control trial as well as the group of patients who had switched overnight from tetrabenazine to Austedo. And patients saw an improvement in total maximal Chorea score from baseline to week eight, which was then sustained to week 145. In terms of safety in both of these trials, Austedo is generally well-tolerated over the three-year period with a safety profile that was consistent with that seen in their respective pivotal trials. And no new safety signals detected including safety signals for depression and suicidality were the exposure-adjusted incidence rates were similar to or lower than placebo in the clinical trials or in the randomized trials. So, in short, both of these trials add to the body of evidence supporting Austedo's efficacy and safety. And with that, I will turn it back to you.

Jordan Storhaug: Thank you very much. Our next presenter we have signed up is John Deason of Neurocrine Biosciences.

Leta Evaskus: This is Leta. John, you need to unmute yourself, as well.

John Deason: It just popped up there. Perfect. Thank you, Leta. So, good afternoon. My name is John Deason from Neurocrine Biosciences Medical Affairs Department. And I appreciate the opportunity to speak to you today about Ingrezza or generic valbenazine capsules. It is indicated for the treatment of adults with tardive dyskinesia (TD). TD is an often persistent and disruptive condition associated with prolonged exposure to dopamine receptor blocking agents, including antipsychotic and antiemetic drugs. Symptoms include involuntary movements of the face, trunk, and/or extremities. TD is often persistent and often irreversible and requires unique management. It's important to keep in mind when discussing the treatment of TD that the predominant underlying condition that patients with TD are receiving their

antipsychotic treatment for is typically a serious mental illness, such as schizophrenia, schizoaffective disorder, or a mood disorder. And these patients with both the serious mental illness and TD, they must not only deal with the stigma associated with having a severe mental illness, but also the additional stigma associated with their involuntary movements. Making open access to FDA-approved VMAT2 inhibitors for the treatment of TD, including Ingrezza important. Recommendations from a recent systematic review article include VMAT2 inhibitors as first-line treatment for TD. And in addition, the 2020 APA Schizophrenia guidelines also recommended VMAT2 inhibitors for the treatment of TD. Now the efficacy and safety of Ingrezza were established in multiple clinical trials, and adults with TD and stable schizophrenia, schizoaffective disorder, or a mood disorder, and out of respect for the Board's time, I'll refer you to the Ingrezza PI for the comprehensive overview of the efficacy and safety data including Warnings and Precautions. In summary, Ingrezza has shown to be an effective once daily treatment for adults with TD, a this is regardless of patient age, concomitant medications, and primary diagnosis with long-term safety and efficacy data up to 48 weeks. Ingrezza is also the only FDA-approved treatment for adults with TD that can be taken once daily with or without food. I appreciate the Board's time today and would respectfully request that the Board provide equal access to Ingrezza by making it available as a preferred agent on the state PDL for the treatment of TD in adults.

Jordan Storhaug: Thank you. I don't see any other stakeholders interested in speaking, so we are ready for the motion.

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

Virginia Buccola: This is Virginia Buccola, and I'll second that.

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. We'll bring it back to Umang for our next topic.

Umang Patel: All righty. Perfect. So the next class will be the Ophthalmic Agents, Glaucoma class. And this will encompass a few subclasses, all within the glaucoma agents. We have adrenergic agents, combinations, beta blockers and their combinations, carbonic anhydrase inhibitors, kinase inhibitors, miotics, and prostaglandins. And so for this class, little bit of background. Approximately 2.7 million people in the United States suffer from glaucoma. It is the second most common cause of permanent blindness in the US and the most common cause of blindness among African American and Hispanics. Risk factors include elevated interocular pressure, advancing age defined as over 40 years of age, family history of glaucoma, and African American or Hispanic descent. Increased IOP is common in glaucoma and is believed to contribute to the damage to the optic nerve which can lead to loss of visual sensitivity and field. However, some patients with glaucoma have normal IOP and many patients with elevated IOP do not have glaucoma. IOP alone is no longer considered a diagnostic criterion for glaucoma. And two major types of glaucoma have been identified, open-angle and closed-angle. In open-angle, there is reduced flow through the trabecular meshwork. Open-angle glaucoma accounts for the majority of cases. And in closed-angle glaucoma, the iris is pushed forward against the trabecular meshwork blocking fluid from escaping. Production of IOP may be achieved either by decreasing the rate of production of the aqueous humor or increasing the rate of outflow of aqueous humor from the anterior chamber of the eye. Ocular hypertensive agents can delay or prevent the development of primary open-angle glaucoma in some patients, as well. And in this class, the only significant clinical update recently is a discontinuation of Trusopt. In April 2022, at Merck reported to the FDA its intent to discontinue Trusopt 2% ophthalmic solution on Tax Day, April 15th of this year, and the generics will remain available. I'll go ahead and pause there for the committee.

Jordan Storhaug: Thank you. Charlie from AbbVie is going to be back as a stakeholder for this topic. But first, we'll get an update from Marissa.

Marissa Tabile: This is Marissa. So these are our Glaucoma Agents subclasses. So the first one is the Adrenergic Agents. And as you can see in this class, right now we currently have Alphagan P and brimonidine generic as our preferred products. In the Adrenergic Agents Combinations class, we have brimonidine/dorzolamide generic, and Simbrinza. Those are both preferred

in that class. Moving on to the Beta Blockers Glaucoma Agents. In this class, we currently have a timolol maleate and Ocudose and timolol ophthalmic gel preferred as well as Timoptic brand name Ocudose as our preferred products. Moving on to Beta Blocker Combinations, we currently have brimonidine tartrate and timolol combo, Combigan, dorzolamide/timolol. And then there's another one here, timolol/brimonidine/dorzolamide combination, and timolol/dorzolamide/latanoprost and timolol/latanoprost combinations as preferred. In the Carbonic Anhydrase Inhibitors class, we have brinzolamide and dorzolamide preferred. And in our kinase inhibitors class, we have Rhopressa and Rocklatan, and those are both preferred in that class. In the Miotics class, we currently have phospholine iodide preferred in that class. And the last one is the Prostaglandins. In this one, we have latanoprost as the preferred product. And I can answer any questions about the AHPDL.

Jordan Storhaug: All right, so with that, I think we're ready to hear from our stakeholders. First off is Charlie Lovan with AbbVie.

Charlie Lovan: Hi, there, It's Charlie Lovan, again. I'm with Medical Affairs at AbbVie, This is the last time you'll hear from me, at least for today. So thank you for another opportunity to talk with you. This time it's about Lumigan, the brand name bimatoprost 0.01% ophthalmic solution. So open-angle glaucoma is a chronic progressive disease, and it's the leading cause of irreversible total visual field blindness. And so far, the only approach proven effective in preserving visual field function is lowering the ocular pressure. So every mmHg elevation translates to up to 19% increased risk of progression, and no single interocular pressure level is ideal for every patient, and guidelines recommend each patient's treatment plan be individualized. Lumigan is a prostaglandin analog indicated for the reduction of elevated interocular pressure in patients with open-angle glaucoma or ocular hypertension. I'd like to highlight three important points about Lumigan for you. First, Lumigan has two modes of action unlike other prostaglandin analogs, such as latanoprost. You can look at the package inserts. So while the precise mechanism of action is not fully characterized, it is believed to lower interocular pressure by increasing outflow of aqueous humor through both trabecular meshwork and uveoscleral routes, but acting in this way, Lumigan selectively mimics the effects of naturally-occurring prostamides. Second, I would like to bring to your attention that comparison of Lumigan 0.01% solution with bimatoprost 0.03% drops in a study by Katz and Associates. The Lumigan with its lower concentration produced equitable interocular

pressure-lowering efficacy across 12 months of the study while cutting treatment-related adverse events by one-third. And the discontinuation time due to ocular adverse events was also significantly lower in the Lumigan arm. And lastly, Lumigan may work in patients who do not respond to other prostaglandin analogs. I would like to share information from a study by Meyers and Associates. And that for patients previously treated with latanoprost and switched to Lumigan, a lowering of an additional 4 mmHg was observed, and switches within this class may be valuable for patients who are not reaching their treatment goal with their initial therapy. This allows the patient to stay on a single medication used once daily at bedtime and continuing a simplified eyedrop regimen, thereby not requiring wait time between different eyedrops. The most common adverse events with Lumigan was conjunctival hyperemia, and in the pivotal study, approximately 1.6% of patients discontinued therapy for this reason. So for a comprehensive safety and efficacy picture, again, refer to the prescribing information at rxabbvie.com. And I will close by respectfully asking that Lumigan be considered as the preferred option for Washington Medicaid patients. Thank you.

Jordan Storhaug: Thank you very much. I do not see any other stakeholders at this time, so we can go ahead and take a look at the motion.

Alex Park: This is Alex Park. I move that all products of the drug classes listed on Slide 40 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

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

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. With that, we'll be back to Umang for our next topic.

Umang Patel: All righty. Perfect. The next class we'll have continuing in Ophthalmic Agents will be specifically Immunomodulators. So, a little background here. Keratoconjunctivitis sicca (KCS) is defined as dry disease, related to either decreased tear volume, aqueous deficient dry eye, or rapid evaporative loss, evaporative dry eyes due to poor tear quality. Both of these conditions may be present in dry eye syndrome. In terms of the term dry syndrome, dry eye disease keratoconjunctivitis sicca and keratitis sicca are often used interchangeably with the term keratoconjunctivitis sicca being an older term. There is considerable overlap with other ophthalmic conditions such as meibomian gland dysfunction. DES or KCS affects approximately 10% to 30% of the US population and occurs more commonly in patients over 50 years of age, with approximately twice as many women as men affected. However, due to increased use of soft contact lenses and frequent smartphone and computer usage, the prevalence of the DES is increasing among young adults aged 18 to 34 years of age. Patients with KCS or DES may have the following complaints: sensation of ocular dryness, grittiness, foreign body or irritation, hyperemia, mucoid discharge, excessive tearing, photophobia, and blurry vision. On the next slide here, the only clinical update for this class. There is a new generic in February of this year. Cyclosporine ophthalmic emulsion was approved by the FDA, which is the first generic for Restasis. Cyclosporine ophthalmic 0.05% to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca, and the launch occurred in February of this year, as well. I will pause right there for the committee.

Jordan Storhaug: Thank you. We do not have any stakeholders previously signed up, so if you are interested in speaking, please raise your hand. But first to Marissa for our update.

Marissa Tabile: Hi, this is Marissa. So this is our Ophthalmic Agents, Immunomodulators drug class, and currently in this class we have the generic cyclosporine preferred and brand name Restasis preferred in this class. And I can answer any questions anyone has.

Jordan Storhaug: I am not seeing any stakeholders so I think we can go ahead and take a look at our motion.

Jon MacKay: This is Jon MacKay. I move that all products and the Ophthalmic Agents : Immunomodulators drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and

grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Diane Schwilke: Diane Schwilke. I second.

Jordan Storhaug: Thank you. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. We'll be back to Umang again for our next topic.

Umang Patel: Perfect. Okay, the next few classes will be similar to earlier, this one being Idiopathic Pulmonary Fibrosis. Again, no significant clinical updates here. So I will pause here for Jordan and the committee.

Jordan Storhaug: All right, perfect. Thank you, Umang. We will have one stakeholder for this topic already signed up. It is Michael Horton. But first let's get our drugs from Marissa. So this is the Respiratory Agents Pulmonary Fibrosing Agents drug class. And currently in this class we have Esbriet, Ofev, and pirfenidone. Pirfenidone is the generic. And we currently have all of those products preferred in this class. And I can take any questions anyone has regarding the AHPDL.

Jordan Storhaug: All right. It looks like we're ready for our stakeholder, Michael Horton.

Leta Evaskus: This is Leta. I do not see Michael Horton in the meeting.

Jordan Storhaug: Okay. Anybody want to raise their hand to speak? Otherwise, it looks like we're ready for a motion.

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

Jordan Storhaug: All right, I will invite the committee to turn on their cameras, and we'll consider the motion.

Kavita Chawla: **[Cross-talk]** This is Kavita Chawla. **[cross-talk]**

Susan Flatebo: **[Cross-talk]** This is Susan Flatebo. I move that all products in the Respiratory Agents : Pulmonary Fibrosing Agents drug class are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Jon MacKay: This is Jon MacKay. I second the motion.

Jordan Storhaug: All right. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. We'll be back to Umang again for our next topic.

Umang Patel: Okay. The next one is also going to be a quick turnaround, Smoking Cessation Agents : Smoking Deterrence - Miscellaneous. Again, no significant updates in this class, and it's back to the committee.

Jordan Storhaug: Thank you. We do not have any scheduled stakeholders for this, so if somebody would like to speak, please raise your hand. But Marissa, tell us about these agents.

Marissa Tabile; Hi, this is Marissa. So this is our Smoking Deterrence: Miscellaneous and Other drug class. And currently in this class, the products that are in it are apo-varenicline, which is I believe like Chantix. And then we have bupropion hydrochloride ER, and then the generic Chantix, which is varenicline. Those products are all preferred in this class. And I'm happy to take any questions anyone might have.

Jordan Storhaug: I am not seeing any stakeholders, so I think we're ready to take a look at the motion.

Kavita Chawla: Can I ask a procedural question? This has come up a few times today, but I just want to clarify. And it's a question from Marissa. When there is an agent that is preferred, yet it requires a prior authorization, what exactly -- how does that go? That process, what does that look like?

Marissa Tabile: This is Marissa. So when you're wondering about PA, you're wondering, like, is there criteria for it? Is there -- I guess, could you clarify, I guess, what you mean by that? I guess I don't understand the question.

Kavita Chawla: Yeah. Good point. Yeah. Kavita again. I guess in my mind -- if it was a preferred agent, then it is automatically approved, and it should not require a prior authorization. So maybe I'm missing something pretty basic here in the definition of a preferred agent.

Donna Sullivan: Hi, Marissa. This is Donna. I can jump in and answer this one. Sometimes there are preferred drugs that require clinical -- all of the drugs in the class require prior authorization regardless of whether it's preferred or not preferred. And we have a clinical policy for it. In general, a preferred drug -- most preferred drugs are not on prior authorization unless there is a clinical policy. Or if we want to determine medical necessity where newer drugs where we haven't, we have yet to create an actual policy. We want to review them for medical necessity.

Kavita Chawla: Okay, got it. Thank you, Donna

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

Kavita Chawla: This is Kavita. I second the motion.

Jordan Storhaug: All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? Okay. We'll turn it back one more time to Umang for our last topic.

Umang Patel: All righty. Your next and probably one of the most dense topics here will be Oncology. And, Marissa, I may need to ask you in terms of presenting, I have

these kinds of stratified by different sub oncology groups. Would you like me to go through all of them? For example, the first one is Prostate. Or should I break them up the way they are?

Marissa Tabile: Hi, this is Marissa. Yeah, Umang, you can just present it the way that you have it.

Umang Patel: Okay.

Marissa Tabile: So just we have one motion, and this is for the DUR Board, as well, we have one motion that will encompass all of our oncology agents. So we'll do one motion for all of them at the very, very end. So like Umang was kind of alluding to -- the way that Magellan has them categorized on their end is by disease state. Whereas, here at the Health Care Authority, we characterize our oncology agents by the mechanism of action. Umang did a great job listing where those drugs live on our PDL in his slide, so you'll see what classes they are in, in reference to our AHPDL. So that is why you may see it labeled a little funny. But Umang, if you need a break, by all means because I know this section is very long, just let me know if you need to drink some water or take a break, and then we can do that. This is a very long section, so I completely understand. But I'll go ahead and let you kick it off if you're ready.

Umang Patel: Yep. Sounds good. Thank you. Perfect. So the first subclass we'll look at is the Prostate Oncology section. This encompasses the androgen biosynthesis inhibitors and the antiandrogen oral medications here. On the next slide, just a little bit of background. In the United States, prostate cancer is most commonly diagnosed in men excluding nonmelanoma skin cancer, with an estimated about 250,000 cases projected in 2021. While prostate cancer accounts for the largest percentage of diagnosed cases in US males, it only accounts for about 11% of all cancer deaths in this population, far behind lung cancer, the leading cause of cancer deaths, which accounts for 22% of US male cancer deaths. Prostate cancer is rare in men under the age of 40, but the risk increases with each subsequent decade of life. Overall, one in eight men will develop prostate cancer during their lifetime. Aside from age, the risk factors most strongly associated with development of prostate cancer include race, ethnicity, and family history. Prostate cancer mortality in non-Hispanic African Americans is more than twice that seen in the US Caucasian population, and it may represent an indolent disease in some patients and a highly aggressive disease and others. Androgens, specifically testosterone, on

the next slide, are a known growth signal for prostate cancer, and the majority of prostate cancers are hormonally dependent. Due to the hormone responsiveness of the tumor, Androgen Deprivation Therapy is a cornerstone of prostate cancer treatment. It's utilized as the backbone of therapy and advanced for metastatic disease as well as in combination with radiation therapy for clinically localized disease. ADT can be accomplished by utilizing either a surgical approach or a medical approach with administration of luteinizing hormone-releasing hormone or a LHRH antagonist to suppress your testosterone concentrations to castrate levels. IV chemotherapy options such as docetaxel or cabazitaxel as well as immunotherapy options for certain patients, including Provenge or Keytruda, and a radiopharmaceutical option, such as Xofigo may be utilized in the treatment of metastatic prostate cancer. On the next slide here, in July of this year, the FDA approved in the expanded indications for Nubeqa for the treatment of adults with metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel. Previously, this was approved for non-metastatic castration-resistant prostate cancer (nmCRPC). No changes to any of the Warnings/Precautions. Dosing is still 600 mg administered orally twice daily, and no changes in the availability for this medication here. And an additional update in this class is a new generic. In July of 2022, FDA approved the first generic of abiraterone acetate for Sun's Yonsa tablets, which is by Teva. I'm going to go ahead and pause there. That is the end of the Prostate subsection. Any questions from the committee? Or just move it right along to Hematologic?

Jordan Storhaug: I think you can keep on going, Umang, as long as you don't need a break yet.

Umang Patel: Okay. Sounds good. All right. The next one we have will be the Hematologic Oncology section. On this slide, you can see that I've done my best to break down the sections. As you know, the Apple Health PDL does a great job of breaking subclasses down, primarily by mechanism of action. And so, in this class we have medication classes, such as Multikinase Inhibitors, the PI3K Inhibitors, Proteasome Inhibitors, Retinoids, Thalidomide, and Tyrosine Kinase Inhibitors. As you can see, there are some bolded medications here, and those are to indicate these are the drug-specific ones with some form of update, those being Ukoniq, Zydelig, Ninlaro, Lenalidomide, Calquence, Imbruvica, Scemblix, and Tasigna. So going right along, again, a little bit of background disease. I also want to let the committee know, as you can imagine, hematologic oncology encompasses a lot of substance-disease states in it, whether it's multiple myeloma, graft versus host disease, just a huge litany of them. In the background and guidelines, I will only be reviewing the

ones that correlate with drug-specific updates. And so, if you don't see a lot of other hematologic diseases in here, they just did not correlate with specific updates in this in the last 12 to 13 months. So for the first one, here we have Graft versus Host Disease. Now this is an immune-mediated disease that can result following hematopoietic stem cell transplant. When transplanted cells (graft) recognize the recipient's body as foreign. Organ systems most commonly impacted by acute graft versus host disease include the skin, GI tract, and liver. Chronic graft versus host disease is generally an extension of acute graft versus host disease that often develops more than 100 days after transplant, but it can also occur in those without acute graft versus host disease. Symptoms include ocular manifestations, such as burning, irritation, photophobia, pain, oral or GI manifestations, respiratory manifestations, and neuromuscular manifestations. In terms of treatment, the American Society of Blood and Marrow Transplantation has guidelines from 2019 that were reaffirmed from 2012, this, the NCCN Guidelines, and the NIH guidelines are all over a year old, so I'm not going to go into too much in detail, but these are here for the Committee's reference if you wanted to refer back to them. On the next slide, we have Waldenström's macroglobulinemia or lymphoplasmacytic lymphoma is a B-cell disorder presenting as bone marrow infiltration with lymphoplasmacytic cells that are CD19+, CD20+, and CD22+. According to the NCCN Guidelines in terms of recommendations for treatment, they recommend treating only those patients who are symptomatic. Symptoms may include hyperviscosity, neuropathy symptomatic adenopathy, organomegaly, amyloidosis, cryoglobulinemia, and cytopenia. Both zanubrutinib and ibrutinib with or without rituximab are listed as options for primary treatment, again, both category 1 preferred with ixazomib combined with rituximab and dexamethasone as category 2A, and other recommended regimens for primary therapy. For patients who have received previous therapies for Waldenström's macroglobulinemia, zanubrutinib and ibrutinib with or without rituximab are category 1 preferred agents. Acalabrutinib is category 2A, other recommended treatment options as well. Up to 40% of Waldenström's macroglobulinemia patients may have recurrent mutations in the CXCR4 gene, and certain CXCR4 mutations may confer resistance to ibrutinib. Therefore, the NCCN Guidelines recommend consideration of gene mutation testing for patients being initiated on improvement therapy as category 2A, useful in certain circumstances as well. No current US guidelines exist for the treatment of erythema nodosum leprosum, hypereosinophilic syndrome or chronic eosinophilic leukemia. And on the next slide, we have Philadelphia chromosome positive (Ph+) ALL. This is rare in pediatric cases of ALL

occurring in approximately 2% of cases. In contrast, approximately 25% of adult cases of ALL are Philadelphia chromosome positive. The NCCN Guidelines recommend incorporating a TKI in the frontline regimen for Philadelphia chromosome positive ALL as an established standard of care for adolescents and young adults and adult patients. The TKI may be combined with either chemotherapy or corticosteroids depending on the patient's age and comorbidities. TKI options for induction therapy of Philadelphia chromosome positive ALL in adult adolescents, young adults, and adult patients include Gleevec, Sprycel to Tasigna, Bosulif, and Iclusig. The guidelines state that dasatinib and imatinib are the preferred TKIs for induction therapy, while ponatinib is the preferred as part of the hyper-CVAD chemotherapy regimen. In addition, and NCCN ALL guidelines also note Bosulif is an option but state there's limited data for that particular TKI and Philadelphia chromosome positive ALL. Mutation testing for ABL gene should be considered as this mutation can confer greater resistance or susceptibility to particular TKI. And the choice of specific TKI should also be based on disease-related features. Pediatric patients with Philadelphia chromosome positive ALL are also candidates for TKI therapy. Guidelines for pediatric ALL specifically lists combined treatment regimens containing imatinib or dasatinib. In a study by Children's Oncology Group utilizing imatinib for children with Philadelphia positive ALL demonstrated a five-year event-free survival of 70%, which is superior to historic controls prior to the introduction of imatinib. Next, we have mantle cell lymphoma (MCL). While technically classified as an aggressive lymphoma, it possesses characteristics of both indolent and aggressive and NHLs. The median overall survival is approximately four to five years, but there is no evidence of survival plateau, which is similar to indolent lymphomas. The chromosomal translocation t(11;14) is usually present in MCL, and it is highly resistant to conventional chemotherapy and displays an aggressive disease course. In terms of treatment, the NCCN Guidelines indicate that lenalidomide plus rituximab is one of several regimens that may be utilized for induction therapy when a less aggressive regimen is indicated. In the second-line setting, all BTK inhibitors -- and BTK being Bruton tyrosine kinase inhibitors including Calquence, Imbruvica, with or without rituximab. And Brukinsa as well as lenalidomide plus rituximab are listed as preferred options. **[Cross-talk]** The NCCN Guidelines note that acalabrutinib and zanubrutinib have not been shown to be effective for ibrutinib refractory MCL with BTK C4815 mutations. However, patients with intolerance to ibrutinib have been successfully treated with acalabrutinib or zanubrutinib without recurrence of symptoms. Venetoclax with or without rituximab is a category 2A and is

useful in certain circumstances or recommendations. Okay, so moving right to the next slide with drug-specific updates. First, we have Brukinsa. September of last year, FDA approved a new indication for the treatment of adult patients with Waldenström's macroglobulinemia. But, as you can see, this medication does have additional indications. There is a note for this that the indication is approved under accelerated approval based on the response rate, and continued approval for this indication may be contingent upon verification. No updates or changes to Warnings and Precautions, dosing, or availability here. Moving along to Tasigna. So in October of 2021, FDA approved label revision for Tasigna for the treatment of pediatric patients one year of age with chronic phase and accelerated phase Philadelphia chromosome positive CML with resistance or intolerance to prior TKI therapy. And, previously, it was approved in this population for chronic phase only. Again, no changes to Warnings and Precautions. The dosing, as you can see, for this expanded indication here for pediatric dosing will be 230 mg/m2 orally twice daily, rounded to the nearest 50 mg dose, with a maximum single dose of 400 mg. Okay, on the next slide here, we have Scemblix. In November of 2021, FDA approved Scemblix for the treatment of adult patients with Philadelphia chromosome-positive CML in chronic phase and previously treated with two or more TKIs, and Philadelphia chromosome-positive CML in chronic phase with the T315I mutation. In terms of Warnings and Precautions, there is cardiovascular toxicity. It is recommended that healthcare practitioners monitor patients with history of cardiovascular risk factors for signs and symptoms. In addition, for embryo-fetal toxicity, it may cause fetal harm, and it's recommended to advise females of reproductive potential of the potential risk to the fetus and to use effective contraception. Dosing here, as you can see, and availabilities in 20 mg and 40 mg film-coated tablets. Next, we have Ninlaro. In May of 2022, the indication revised with limitation of use, stating it is not recommended in the maintenance setting or newly diagnosed multiple myeloma in combination with lenalidomide and dexamethasone outside of controlled clinical trials. Again, no changes to warnings, precautions, dosage, or availability here. Okay, continuing on. In August of this year, the FDA approved a new formulation of Calquence in the form of tablets for the treatment of adults with chronic lymphocytic leukemia and small lymphocytic lymphoma. The treatment of adult patients with mantle cell lymphoma who have received one or greater prior therapy was also granted under accelerated approval contingent on confirmatory trials. So as you can see here, no changes to Warnings and Precautions or dosing. And in terms of availability, the expanded availability with tablets here. Okay. Moving forward with

Imbruvica. In May of 2022, the FDA expanded the indication of chronic Graft versus Host Disease after failure of one or greater lines of systemic therapy to include pediatric patients one year of age or older. And previously, this is only indicated in adults. And so no changes in Warning and Precautions. The dosing, as you can imagine, is stratified by indication. But just to give the committee some information about the chronic graft versus host disease. Patients 12 years of age or older are recommended take 420 mg daily, and patients one to less than 12 years of age are recommended 240 mg/m2 taken orally once daily up to a dose of 420. Okay. And on the next slide, we have some FDA communications. First is for Ukoniq. And so, there were three updates here, first in February 2022, where the FDA was investigating possible increased risk of death with lymphoma medicine, Ukoniq, based on interim data from the UNITY trial in patients with chronic lymphocytic leukemia, which was an unapproved clinical use. The interim study data revealed a possible increased risk of death in patients treated with a combination of Ukoniq and an anti-CD20 monoclonal antibody drug compared to those treated with standard treatment. Ukoniq is FDA-approved to treat relapsed or refractory marginal zone lymphoma and follicular lymphoma. The FDA is advising healthcare practitioners to review patient progress and discuss risk and benefits of Ukoniq with patients. And then in February of 2022, the manufacturer voluntarily withdrew Ukoniq from sale for the indications of adult and marginal zone lymphoma. We have received one or more prior anti-CD20 based regimen and for the treatment of adults with follicular lymphoma who have received three or greater prior systemic therapies. And these accelerated approvals were granted in February 2021. And then lastly for Ukoniq, in June of 2022, the FDA published a drug safety communication stating that Ukoniq approval has been withdrawn for marginal zone lymphoma and follicular lymphoma due to safety concerns. FDA advised healthcare practitioners to switch patients to alternative treatments. And for limited cases, Ukoniq will be available via expanded access from TG Therapeutics. A new generic that did come out in October of last year, FDA approved the lenalidomide, the first generic to Celgene's Revlimid in the strengths of 2.5 mg and 20 mg by Dr. Reddy's. Okay. And on the final slide for Hematologics, there was an FDA communication for Zydelig in February of this year. Gilead announced the voluntary withdrawal of indications for the treatment of relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, which were approved under an accelerated approval based on objective response rates of 54% and 58%, respectively. The decision to withdraw these indications is based on an ongoing challenge of enrolling patients in the confirmatory trials. Okay. In the

next subclass, we do have Breast Oncology - Breast Cancer Medications. The four subclasses being antineoplastics, cyclin-dependent kinases, poly ADP-ribose polymerases or PARP inhibitors, and additional TKIs as well. Okay, so, just to give a little bit of background for Breast Cancer. It is the most common site of cancer for women in the United States accounting for 30% of all cancer diagnoses and a second only to lung cancer as a cause of cancer death in American women. It is estimated that there will be 287,000 new cases of breast cancer diagnosed this year, and there will be an estimated 43,000 deaths. The incidence of breast cancer in US women continues to increase by about 0.05% per year. Known risk factors that may be contributing include a decline in fertility rates and an increase in body weight. Despite this increasing incidence, death rates from breast cancer have declined by 42% since 1989, largely due to improvements in both early detection and treatment. The overall five-year survival for women diagnosed with breast cancer is 99%. Patients who present with localized disease have a 98.9% five-year survival rate. However, prognosis for patients presenting with distant metastatic cancer is much poorer, with a five-year survival rate of only 29%. And breast cancer is most frequently diagnosed in women between the ages of 55 to 64 with a median age of 62 years. Rarely is breast cancer diagnosed in men. Other risk factors include endocrine, genetic, environmental, and lifestyle factors. And some of these risk factors are modifiable, some are not, and the impact of these factors are variable. On the next slide here, in terms of neoadjuvant treatment of breast cancer, historically, the role of neoadjuvant chemotherapy was limited to breast cancer patients with inoperable, locally-advanced disease, but contemporary breast cancer treatment protocols now often include neoadjuvant therapy. There are several reasons for this expanded role of neoadjuvant therapy. First, neoadjuvant therapy can increase the likelihood of patients being able to undergo breast-conserving surgery. Second, studies have shown that patients with triple-negative breast cancer and those with HER2-positive disease who achieve a pathologic complete response defined as the absence of invasive disease in the breast and lymph nodes following neoadjuvant therapy have an improved prognosis. Recently published research has focused on response to neoadjuvant treatment as a predictive marker and a guide for selecting subsequent adjuvant therapy. According to the ASCO last year regarding neoadjuvant chemotherapy, endocrine therapy, and targeted therapy recommends neoadjuvant therapy with any of these modalities if the patient has inflammatory breast cancer or if the patient has unresectable or locally-advanced disease at presentation, such that the disease may be rendered resectable with neoadjuvant treatment. Furthermore, the ASCO

guidelines states neoadjuvant systemic therapy should be offered to patients with high-risk TNBC in whom the finding of residual disease at time of surgery would guide recommendations related to adjuvant therapy. Regarding neoadjuvant endocrine therapy, the ASCO guidelines states that postmenopausal patients with HR-positive/HER2-negative disease may receive a neoadjuvant aromatase inhibitor therapy to increase local regional treatment options. Or if there's no intent for surgery, endocrine therapy may be used for disease control. However, for pre-menopausal patients with HR-positive/HER2-negative early stage diseases, neoadjuvant endocrine therapy should not be routinely offered outside of a clinical trial. On the next slide here, we have a little bit of an overview of the subclasses that are that comprise the breast cancer class. We have the antineoplastics, the CDK inhibitors, the PARP inhibitors, and the TKIs. Of these, the bolded will have some clinical updates. We have Kisqali, Verzenio, Lynparza, Rubraca, Talzenna. On the next slide here, for Talzenna. In October 2021, FDA approved two new strengths, 0.5 mg and 0.75 mg capsules, 0.25 mg and 1 mg are already approved. No updates to the Indications, Warnings, or Dosage. It has just an expanded formulation here. Okay. Next slide, we have Verzenio. So there were two updates, both occurring in October of last year. First, the FDA approved the new indication for Verzenio in combination with endocrine therapy, which is tamoxifen or an aromatase inhibitor for adjuvant treatment of adult patients with HR-positive, HER2-negative, node-positive, early breast cancer at high risk of recurrence and a Ki-67 score of 20% or greater, as determined by an FDA-approved test. The FDA also approved the Agilent Ki-67 IHC MIB-1 PharmDx assay as a companion diagnostic for the indication. In addition to that indication, in combination with an aromatase inhibitor was expanded to include both postmenopausal women and men, and the indication in combination with fulvestrant was expanded to include adult patients. Previously, this was only women. So an expanded indication for both is highlighted here. And as you can see, it does have two other indications as well. No updates to any of the warnings, the dosing, or the availability here as well. Next slide, we have updates for Kisqali. Kisqali/Femara, essentially for the medication ribociclib and ribociclib/letrozole combo. So in December of 2021, FDA approved and expanded indication to include men for treatment with hormone receptor-positive, human epidermal growth factor receptor 2 (HER2) -negative advanced or metastatic cancer in combination with fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy. Previously, this is only for postmenopausal women for this indication. No updates to Warnings, Dosing or Availability here. Okay. And on

the next slide, here we have Lynparza. And so two updates for this medication. First in March of this year, the FDA approved the new indication for the adjuvant treatment of adult patients with deleterious or suspected deleterious germline BRCA mutated HER2-negative high-risk early breast cancer who have previously been treated with neoadjuvant or adjuvant chemotherapy. And then in September of this year, AstraZeneca has voluntarily withdrawn the indication for the treatment of adult patients with deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer who have been treated with three or more prior lines of chemo. Lynparza maintains the indications for select patients with ovarian, breast, pancreatic, and prostate cancer. No updates here for Warnings, Precautions, Dosing or Availability. All right. The next class here we have will be Oncology - Others. Now, just to let the committee know when Oncology - Others is almost like a catch-all. In this class review, there are so many numerous disease states that fall under other due to the large quantity of subclasses, the background, and various guidelines won't be reviewed, but they can be found in the TCR for the committee's review. And there are numerous sub-oncology classes ranging from bladder cancer, central nervous, cholangiocarcinoma, neurofibromatosis, thyroid, and soft tissue. So as you can tell, there is a huge subclass here, but I will only be going over the disease states in whom the respective treatments or clinical updates were relevant within the last year. On this slide here, you see the overview of the classes. So we have the Antineoplastics, FGFR Kinase Inhibitors, MEK Inhibitors, Multikinase Inhibitors, the PARP Inhibitors, the Tropomyosin Receptor Kinase Inhibitors, and TKIs, as well. And the medications that will be updated here are Truseltiq and Rubraca, as well. For Truseltiq here on the next slide, you can see in June of 2021, the FDA granted accelerated approval to Truseltiq for adults with previously-treated, unresectable, locally-advanced, or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test. We have no other updates to Warnings, Dosing, or Availability here. And then on the next and final slide for this, we have an FDA communication for Rubraca. In June of this year, Clovis Oncology voluntarily withdrew the indication for monotherapy in patients with deleterious BRCA mutation associated with epithelial ovarian, fallopian tube, or primary peritoneal cancer after two or more chemotherapies. This indication was approved under accelerated approval in December 2016. Okay, next we will have lung cancer, where the subclasses will be Topoisomerase Inhibitors. We have Tropomyosin Receptor Kinase Inhibitors, and TKI, as well. So lung cancer is the leading cause of cancer death in both men and women in the

United States. In 2022, an estimated 236,000 new cases of lung cancer will be diagnosed, and 130,000 deaths are estimated to occur. Currently, the five-year survival is estimated to be about 23% and increased from 18%, which is reported in 2019. Declines in lung cancer mortality in the US have been accelerating in recent years. From 2005 to 2014, lung cancer mortality declined about 5%. But from 2014 to 2019, this decline more than doubled, resulting in a 4.9% decline in lung cancer mortality over that period. Additionally, there has been a steady decline in the incidence of lung cancer diagnoses in the US. The number of diagnoses declined 2.3% in the most recent measurements. And despite these encouraging trends, there are still more US lung cancer deaths annually than deaths from breast, prostate, and colorectal cancer combined. The primary risk factor for the development of lung cancer is smoking tobacco, accounting for approximately 85% to 90% of all lung cancer cases. The carcinogenic chemicals in cigarette smoke are responsible for most lung cancer related deaths, while exposure to secondhand smoke also results in an increased relative risk of developing lung cancer. While chemo prevention agents are not yet established, lung cancer screening using low-dose computerized tomography is recommended by the US Preventive Services Task Force who expanded their lung cancer screening guidelines in 2021. The guidelines now recommend annual screening with LDCT for patients 50 to 80 years of age, who are current smokers with at least a 20-pack-year smoking history and former smokers who have quit within the past 15 years. On the next slide here, we have some updates for guidelines. First for EGFR sensitizing mutations. Now these are all targeted therapy. For NCCN Guidelines, they have been updated to incorporate the use of Tagrisso and adjuvant setting an earlier stage NSCLC. The guidelines recommend the use of osimertinib for patients with stage 2B to 3A disease who have undergone complete resection or for patients with high risk stage 1B to 2A, EGFR mutation-positive disease, who received previous adjuvant chemotherapy or ineligible to receive platinum-based chemotherapy. Additionally, the ASCO Ontario Health or Cancer Care Ontario guidelines from last year regarding stage 4 non-squamous cell lung carcinoma with driver mutations indicate that osimertinib should be offered in the first-line setting for patients with T790M, L858R, or exon 19 deletion EGFR mutations. If osimertinib is not available in the first-line setting, gefitinib with chemotherapy or dacomitinib may be offered. Other option listed by the guidelines include afatinib, or erlotinib with bevacizumab; erlotinib with ramucirumab; or gefitinib, erlotinib, or icotinib (not available in the US) as single agents. In terms of the BRAF V60E mutations, the patients with advanced or metastatic lung cancer who were found to have a BRAF

V600E mutation, a combination of dabrafenib or Tafinlar plus Mekinist is recommended as preferred first-line therapy by the NCCN, while single agent Zelboraf may be an option in combination of dabrafenib plus trametinib is not tolerated. According to the ASCO guidelines, patients with stage 4 non-squamous cell lung carcinoma and BRAF V600E mutation should be offered dabrafenib and trametinib in the first-line setting. For patients who received targeted therapy in the first-line setting second line therapy should consist of standard of non-driver mutation guideline recommendations. Continuing to the next slide here. For the MET exon 14 skipping mutations, both Tabrecta and Tepmetko are listed as category 2A, preferred options, while Xalkori is classified as category 2A, useful in certain circumstances recommendation. The guidelines recommend offering capmatinib or tepotinib in the first-line setting. And if the patient does not receive one of these therapies in the first-line, it may be offered as second-line. In terms of ALK rearrangements, the ASCO 2021 updated guidelines regarding patients with stage 4 non-squamous cell lung carcinoma who harbor an ALK rearrangement recommend that alectinib or brigatinib be offered as first-line. The guidelines recommend that if alectinib or brigatinib are not available, patient should be offered ceritinib or crizotinib. Guidelines also outline drug choice for second-line therapy, as well. Lorlatinib in the second-line setting is recommended if the patient received alectinib or brigatinib in the first-line setting. If the patient received crizotinib in the first-line setting, then alectinib, brigatinib, or ceritinib should be offered. And in the third-line setting, lorlatinib may be offered. For ROS1 rearrangement -- again, these are all targeted therapy recommendations. The guidelines recommend crizotinib or entrectinib in the first-line setting. Other options include ceritinib or lorlatinib. And if targeted therapy was given in the first-line setting, then guidelines recommend that the standard treatment based on nondriver mutation guidelines slide be followed. On the next and final slide for guideline updates, we have RET rearrangements. Both Gavreto and Retevmo are listed as category 2A preferred first-line agent. They state that Retevmo or standard therapy based on nondriver mutation guidelines may be offered in the first-line setting. At the time of publication, Gavreto recommendations in the first-line setting was provisional pending confirmatory data. Recommendations for second-line setting for RET rearrangements are dependent on the therapy received in the first-line. If targeted therapy with Gavreto or Retevmo are not given in the first-line setting, they may be offered as second-line. And for NTRK fusions, both Rozlytrek and Vitrakvi are category 2A preferred options for first-line. Guidelines recommend Rozlytrek and Vitrakvi in this setting, and these drugs may be offered in the second-line setting with patients with

NTRK gene fusions who did not receive them in the first-line setting. On the next line here, you can see the subclasses that form up this class in the Apple Health PDL. So we have Multikinase Inhibitors, Topoisomerase Inhibitors, Tropomyosin Receptor Kinase Inhibitors, and lastly, TKIs. The two drug-specific updates here we have are Exkivity and Xalkori. So for Exkivity in September of last year, the FDA granted accelerated approval for this kinase inhibitor for the treatment of adult patients with locally-advanced or metastatic non-small cell lung cancer with epidermal growth factor receptor exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based therapy. In terms of Warnings and Precautions, we do have a Blackbox Warning. It can cause life-threatening heart rate-corrected QTc prolongation, including Torsades de Pointes, which can be fatal and requires monitoring of QTc and electrolytes at baseline and periodically during treatment. Additionally, other warnings can be cardiac toxicity and embryo-fetal toxicity, as well. For dosing ,the recommended dosage is 160 mg once daily, and the availability are 40 mg capsules. Next here, we have Xalkori. In July of this year, FDA approved this medication for the treatment of adult and pediatric patients one year of age or older, with unresectable, recurrent, or refractory inflammatory myofibroblastic tumor that is anaplastic lymphoma kinase-positive. As you can see, it does have other indications. No changes to Warnings and Precautions. In terms of Dosage for patients, for adults, the recommended dose is 250 mg twice daily, and for pediatrics it is 280 mg/m2 orally twice daily based on body surface area. I will go ahead and pause really quickly right there before we jump into renal cell carcinoma. Okay, thank you. So the next subclass we have is renal cell carcinoma, and these will encompass the mTOR Kinase Inhibitors, again, Multikinase Inhibitors, and TKIs, as well. A little bit of background. Cancers of the kidney and the renal pelvis account for approximately 4% of all newly-diagnosed cancers in the United States, with a 5% incidence in men and 3% in women. The median age at diagnosis is 65 years, and over 75% of cases are diagnosed and patients 55 years of age or older. The overall five-year survival was 76.5% from 2012 to 2018. If the disease is localized at the time of diagnosis, outcomes are excellent with a five-year survival of approximately 93%. However, patients diagnosed with advanced metastatic disease accounting for approximately 16% of diagnoses have much poorer outcomes with approximately 15.3% survival rate at five years. Approximately 85% of kidney tumors are renal cell carcinoma, and approximately 70% of all renal cell carcinoma have a clear cell histology. Other less common histologies are usually grouped together as non-clear cell tumors. The incidence of RCC and men is more than twice that of women. The

most common presenting triad of symptoms includes hematuria, flank mass, and flank pain. However, as the use of routine imaging has become more widespread, the frequency of incidental detection of RCC has increased, and only about 30% of patients are now diagnosed on the basis of symptoms. On the next slide here, we have the NCCN Guidelines in 2022. For first-line systemic therapy of favorable risk, clear cell histology, relapsed or stage 4 renal cell carcinoma recommend a TKI plus an immune checkpoint inhibitor as category 1 preferred options. Specifically, in Inlyta plus Keytruda or Cabometyx plus Opdivo or Lenvima plus pembrolizumab are the three TKI/CPI regimens included. Other recommended regimens for the same group of patients include monotherapy with Sutent, Votrient, or the combination of Inlyta plus avelumab. Axitinib monotherapy, is a category 2B recommendations listed as useful in certain circumstances. For this same group of patients with poor or intermediate risk, rather than favorable risk the same three TKI/CPI regimens are listed as category 1 preferred along with single agent about cabozantinib being a category 2A preferred option. Other options with these patients with poor intermediate risk largely mirror the favorable risk options defined above. And for subsequent therapy of RCC with clear-cell histology, category 1 preferred options include cabozantinib and lenvatinib plus everolimus. Additional options include axitinib as either a single agent or in combination with pembrolizumab, cabozantinib plus nivolumab, lenvatinib plus pembrolizumab, or single agent pazopanib, sunitinib, or tivozanib. Everolimus as a single agent is included as a category 2A, useful in certain circumstances. For patients with non-clear cell histology single agent, cabozantinib, sunitinib, axitinib, pazopanib, and everolimus are all category 2A recommendations, though cabozantinib and sunitinib are the preferred regimen. Importantly, sorafenib is now only included in the NCCN Guidelines as a category 3 recommendation for subsequent therapy that may be useful in certain circumstances. Okay. On the next slide here, we have kind of an overview. Again, as I mentioned a few slides ago, we have mTOR kinase, multikinase inhibitors, and TKI. The only drug-specific update here we have is for a TKI named Lenvima, which on the next slide you'll see in July 2021, Lenvima received a new indication in combination with avelumab and pembrolizumab. For the first-line treatment of patients with advanced renal cell carcinoma. Previously approved as a single agent for the treatment of advanced renal cell carcinoma after failure of one prior systemic therapy. No changes or updates to Warnings and Precautions. For this new indication, the Dosage is 20 mg once daily with pembrolizumab 200 mg administered IV infusion over 30 minutes every three weeks. And the dosing for other for the other indications can be found in the PI/TCR. And the availability here are 4

mg and 10 mg capsules. Okay, pause right there. Moving over to skin cancer. a little bit of background here. So melanoma skin cancer, the incidence in the US is increasing, but death rate due to melanoma is declining. In 2002 to 2006, the incidence of melanoma increased at a rate of 33% for men and 23% for women. Melanoma is increasing more rapidly than any other malignancy except lung cancer in women. Conversely, there have been recent declines in mortality for melanoma. From 2009 to 2013, the death rate for melanoma was stable, but from 2014 to 2018, the mortality due to melanoma declined 5.7% annually. In the US, it is estimated that there will be 106,000 new cases of melanoma and 2021 there will be an estimated 7000 deaths. The median age at diagnosis is about 65 years. Risk factors include both genetic factors such as skin type, inherited germline mutations, and environmental factors such as excessive sun exposure and UV-based artificial tanning. Despite the relationship to UV exposure. Melanoma can also occur in areas of the body without substantial sun exposure and can occur in any ethnic group. There are also noncutaneous forms of melanoma arising from melanocytes present in the mucosal membranes for the uveal tract of the eye. The treatment of noncutaneous melanoma may differ from that of cutaneous melanoma, and the treatment should be individualized for these patients. On the next slide, we have an overview of the classes. So we have the BRAF Kinase Inhibitors, the Hedgehog Pathway Inhibitors, and the MEK Inhibitors. And here we'll have updates for Tafinlar and Mekinist. First, we have Tafinlar. June of this year, the FDA approved this medication in combination with Mekinist for the treatment of adult and pediatric patients six years of age or older with unresectable or metastatic solid tumors with BRAF V600E mutations who have progressed following prior treatment and have no satisfactory alternative treatment options. And this accelerated approval requires verification of benefit in confirmatory trials. As you can see, this medication has other indications for different oncology for different cancer types such as thyroid cancer, non-small cell lung cancer, and metastatic melanoma. The dosing here would be for adult patients 2 mg once daily, and for pediatric it is based on bodyweight. The availability for this is 50 mg and 75 mg capsules. On the next slide here, we have Mekinist, where in June of this year, the FDA approved this medication again in combination with Tafinlar, from the previous slide, for the treatment of adult and pediatric patients six years of age or older with unresectable or metastatic solid tumor with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options. And this was the accelerated approval required verification of benefit in confirmatory trials. The dosing here again is 150 mg twice daily for adults and based on body

weight for pediatric patients. And the availability are 0.5 mg and 2 mg tablets. Okay, on the next slide and the final slide here, we have Retinoids. So, in this class, the main medication that falls under Oncology Agents : Retinoids, there is tretinoin. And there is no significant clinical update within the last 12 to 13 months. I'm going to pause right there for the committee, or whoever is still awake, and thank you for listening to me tongue tie myself through that. And happy to answer any questions.

Susan Flatebo: This is Susan Flatebo. I just wanted to say good job, Umang. This is my area of practice and, personally, I found your talk pretty fascinating. Although, I do have to say many of these oral oncolytics are unfamiliar to me, as well, because these specific gene mutations or deletions are quite rare. But anyway, good job.

Umang Patel: Thank you very much.

Jordan Storhaug: Yes, again. Thanks, Umang. Yeah, really good work and endurance through all of that. We do have multiple stakeholders. Three from Pfizer all signed up. First will be Lindsay Stansfield. So you can get ready. But, Marissa, did you want to go over these agents for us?

Marissa Tabile: Hi, this is Marissa Yeah. So I can go over the oncology agents. And great job, Umang. You pronounced the drugs, I think, pretty well -- a lot better than I ever could. Okay, so just to kind of give the committee an overview, for our general rule of thumb for our oral oncology agents is, for the most part, a lot of these products are preferred on our PDL. The only time that you may not see something preferred that is an oncolytic agent is something that has a generic already to the market. So one example right here that you can see is like the bicalutamide, that is preferred. But then the brand name Casodex is non-preferred, in that example. But for the most part, a lot of these oral oncolytics tend to be right now threatening medications with kind of very few generics. So in the androgen biosynthesis -- I'll try to go through this pretty quickly -- we have the abiraterone generic preferred, and then moving into the antiandrogens, you can see sometimes it's easier to just go through what's not preferred. So Casodex and Nilandron brand are non-preferred. And then moving on to pretty much our other classes that we've mentioned and are on the Agenda. You can see everything is pretty much preferred on our PDL. Not very many generic products in these classes. In the mTOR kinase inhibitors - oral, you'll see that Afinitor brand is non-preferred. And then everything else moving forward it looks like is preferred, with the

exception of Gleevec. Gleevec is non-preferred, and the Imbruvica suspension is non-preferred, but we have the capsules in the tablets preferred. And that is it for the oncology agents. Oh, and then it looks like Tarceva tablets are non-preferred at this time. So I can answer any questions that the Board might have regarding our AHPDL in these classes.

Jordan Storhaug: So I think we are ready to invite our stakeholders to speak. First up is Lindsay Stansfield. For these topics, it looks like they do have multiple drug classes that they're talking about. So for this one, I see that Lindsay we can give six minutes because she will cover two drug classes.

Lindsay Stansfield: Okay, thank you. Can you hear me okay?

Jordan Storhaug: We can hear you. Thank you.

Lindsay Stansfield: Okay. Good afternoon. My name is Lindsay. I'm a licensed pharmacist with Pfizer Oncology Medical Affairs. I'm here to provide the committee with efficacy and safety information for palbociclib known by its brand name Ibrance, the first CDK4/6 inhibitor approved by the FDA in February 2015. As was stated previously, breast cancer is the most common cancer among women in the United States and the second leading cause of cancer death in women. An estimated 168,000 women in the US are living with metastatic breast cancer of which 61% are hormone receptor-positive, HER2-negative Palbociclib 125 mg capsules and tablets are indicated for the treatment of adult patients with hormone receptor-positive, HER2-negative, advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine-based therapy in postmenopausal women or in men, or in combination with fulvestrant in patients with disease progression following endocrine therapy. In PALOMA-2, a Phase III trial of postmenopausal women with estrogen receptor-positive, HER2-negative metastatic breast cancer treated in the first-line setting. Palbociclib plus letrozole demonstrated a median progression free survival of 24.8 months versus 14.5 months with placebo plus letrozole resulting in a hazard ratio of 0.58 and a 95% confidence interval of 0.46 to 0.72. An updated analysis with extended follow up supported these original findings. In PALOMA-3, a Phase III trial of women with hormone receptor-positive, HER2-negative metastatic breast cancer whose disease progressed following endocrine therapy. Palbociclib plus fulvestrant demonstrated a median PFS of 9.5 months versus 4.6 months with palbociclib plus fulvestrant, resulting in a hazard ratio of 0.46 and a 95% confidence interval of 0.36 to 0.59. Neutropenia is the most frequently

reported all-grade adverse reaction in both PALOMA-2 AND PALOMA-3 trials at 80% and 83% respectively. Febrile neutropenia has been reported in 1.8% of patients exposed to palbociclib across the PALOMA trials. There was one death due to neutropenic sepsis in the PALOMA-3 trial. It's important that clinicians monitor the CBC prior to the start of palbociclib and at the beginning of each cycle, as well as on day 15 of the first two cycles and as clinically indicated thereafter. Severe, life-threatening, or fatal interstitial lung disease and/or pneumonitis can occur in patients treated with CDK4/6 inhibitors including palbociclib, but across clinical trials, only 1% of palbociclib treated patients had ILD. Palbociclib can cause fetal harm, so it's important to advise patients of the potential risk to the fetus and to use effective contraception. And the most common adverse reactions occurring in more than 10% of patients of any grade reported in PALOMA-2 and PALOMA-3 in combination with palbociclib plus letrozole included neutropenia, infections, leukopenia, fatigue, nausea, alopecia, stomatitis, diarrhea, anemia, rash, asthenia, thrombocytopenia, vomiting, decreased appetite, dry skin, and pyrexia. In closing, maintaining palbociclib on your formulary will continue to offer an additional treatment option for patients with hormone receptor-positive, HER2-negative advanced or metastatic breast cancer in the Washington Medicaid population. And based on the efficacy and safety of palbociclib. I respectfully request that the committee continues to make palbociclib available to your patients. Okay. The next drug I will be talking about is talazoparib. The prevalence of germline BRCA1 and BRCA2 mutations have been reported at 2.7% to 4.3% in the metastatic breast cancer population. BRCA mutations have been shown to increase the risk of developing breast cancer. While the lifetime risk of breast cancer in the general population is 13%, for BRCA1 and BRCA2 carriers, this risk is approximately 70%. Talazoparib is indicated for the treatment of adult patients with germline BRCA-mutated, HER2-negative, locally-advanced, or metastatic breast cancer. And appropriate patients to be selected based on the FDA-approved companion diagnostic for Talazoparib. Talazoparib an inhibitor of PARP, and PARP enzymes play an important role in DNA repair. The recommended starting dose is 1 mg capsule taken orally once daily. In the Phase III randomized registrational trial, in BRCA, patients on talazoparib have achieved a statistically significant improvement in PFS compared with physicians' choice of chemotherapy, resulting in 8.6 months PFS versus 5.6 months, which resulted in a hazard ratio of 0.54 and a 95% confidence interval of 0.41 to 0.71. MDS and AML had been reported in three out of 787 solid tumor patients treated with talazoparib in clinical studies. So it's important to monitor patients for hematologic toxicity at baseline and

monthly thereafter. Myelosuppression consisting of anemia, leukopenia, neutropenia, and thrombocytopenia have been reported in patients with talazoparib. And the grade three rates for these AEs are reported in the range of 15% to 39%. Talazoparib can cause fetal harm, so it's important to advise patients of the potential risk to a fetus and to use effective contraception. And the most common adverse reactions in at least 20% of patients include fatigue, anemia, nausea, neutropenia, headache, thrombocytopenia, vomiting, alopecia, diarrhea, and decreased appetite. In conclusion, maintaining talazoparib, an oral inhibitor of PARP on your formulary provides an additional treatment option for patients with germline BRCA-mutated, HER2-negative, locally-advanced, and metastatic breast cancer. Based on the efficacy and safety of talazoparib, I respectfully request that the committee continue to make talazoparib available to your patients. Thank you for your time and attention.

Jordan Storhaug: Thank you. Next up will be Jin Yun, from Pfizer, as well. Again this will be two drug classes and a total of six minutes.

Jin Yun: Hi. Can everybody hear me?

Jordan Storhaug: Yes, we can.

Jin Yun: All right. Great, thank you. Good afternoon. My name is Jin Yun, and I'm a licensed pharmacist with Pfizer Oncology Medical Affairs. Thank you for the opportunity to entrust the committee regarding Inlyta (axitinib) an oral tyrosine kinase inhibitor, indicated in combination with avelumab for first-line treatment of patients with advanced renal cell carcinoma (RCC) in combination with pembrolizumab for the first-line treatment of patients with advanced RCC as a single agent for the treatment of advanced RCC after failure of one prior systemic therapy. For dosing, Inlyta 5 mg is administered orally twice daily with avelumab 800 mg every two weeks. Inlyta 5 mg orally twice daily with pembrolizumab 200 mg every three weeks or 400 mg every six weeks. Inlyta as a single agent, the starting dose is 5 mg orally twice daily. Dose adjustments can be made based on individual safety and tolerability. The safety profile includes hypertension, hypertensive crisis, arterial and venous thromboembolic events, hemorrhage, cardiac failure, GI perforation and fistula formation, hypothyroidism, risk of impaired wound healing, reversible posterior leukoencephalopathy syndrome, **[indistinct] [04:55:10]**, hepatotoxicity, as well as major adverse cardiovascular events. The most common adverse reactions greater than 20% include diarrhea,

fatigue, hypertension, pain, nausea, mucositis, palmar-plantar erythrodysesthesia, dysphonia, decreased appetite, hypothyroidism, rash, hepatic toxicity, cough, dyspnea, abdominal pain, and headache. For first-line advanced RCC, the efficacy and safety of Inlyta in combination with avelumab was demonstrated in the JAVELIN Renal 101 trial. The major efficacy outcome measure were progression free survival and overall survival in patients with PD-L1 positive tumors. Progression-free survival was statistically significant in patients with PD-L1 positive tumors with a hazard ratio of 0.61. It was then tested in the **[indistinct] [04:56:01]** patient population, and a statistically significant improvement in progression-free survival was also demonstrated. In the first interim analysis, overall survival data **[indistinct] [04:56:13].** Inlyta in combination with pembrolizumab, the efficacy of Inlyta was investigated in the KEYNOTE-426 trial. The main efficacy outcome measures for overall survival and progression-free survival, is the statistically significant improvement, and overall survival was demonstrated at the pre-specified interim analysis in patients randomized with Inlyta in combination with pembrolizumab compared with sunitinib. The trial also demonstrated statistically significant improvements in progression-free survival and objective response rate. For second-line advanced RCC, the safety and efficacy of Inlyta monotherapy were evaluated in a randomized, open-label, multicenter, Phase III study versus **[audio cuts out] [indistinct] [04:56:52].** There was a statistically significant advantage for Inlyta over **[indistinct],** with median progression-free survival being 6.7 months in the Inlyta arm and 4.7 months in the **[indistinct] [04:57:03]** comparator arm, with a hazard ratio of 0.67. There was no statistically significant difference between the arms and overall survival. Moving on to the enzalutamide. Xtandi (enzalutamide) is an androgen receptor inhibitor indicated for the treatment of patients with castrations and prostate cancer as well as metastatic castration-sensitive prostate cancer. Enzalutamide is an androgen receptor inhibitor that **[indistinct] [04:57:32]** different steps in the anti-androgen signaling pathway. Enzalutamide dose is 160 mg once daily with or without food, swallowed whole, and taken at the same time each day. For patients with non-metastatic CRPC, the safety and efficacy of enzalutamide was evaluated in the Phase III PROSPER trial, with the median or the metastatic-free survival in the enzalutamide-treated patients was 36.6 months versus 14.7 months in the patients treated with placebo, a 71% risk reduction, a hazard ratio of 0.29. In patients with metastatic CRPC, the safety and efficacy of enzalutamide was evaluated in chemotherapy-naive metastatic CRPC patients in the PREVAIL trial. Enzalutamide significantly extended overall survival with metastatic CRPC, where the median overall

survival was 35.3 months versus 31.3 months in the placebo group, with a risk reduction of 23%. In the Phase III study, AFFIRM, the safety and efficacy of enzalutamide was evaluated in post-chemotherapy treated metastatic CRPC. Enzalutamide extended median overall survival post docetaxel in patients with metastatic CRPC, where the median overall survival was 18.4 months versus 13.6 months for those receiving placebo, a risk reduction 37%. For patients with metastatic CRPC, the safety and efficacy of enzalutamide has been evaluated in pivotal trials **[indistinct] [04:58:56]** ENZAMET trial the **[indistinct]** was radiographic progression-free survival as well as a 61% percent reduction in the risks of radiographic disease progression. In terms of new Warnings and Precautions, these include seizure, posterior reversible encephalopathy syndrome, hypersensitivity reactions, ischemic heart disease, falls and fractures, as well as embryo-fetal toxicity. In the data from four randomized placebo-controlled trials, the most common adverse reactions occurring greater than 10% occurred more frequently versus placebo and extended-treated patients were ischemia, fatigue, back pain, hot flash, constipation, arthralgia, decreased appetite, diarrhea, and hypertension. In conclusion, I respectfully request the committee to provide availability of Inlyta be extended for your patients. Thank you for your time and attention. Complete prescribing information can be found at the Pfizer.com website as well as the Astellas.com website.

Jordan Storhaug: Thank you. Our last scheduled speaker will be Bethany Boyd of Pfizer. Bethany has three drug classes, so it will be a total of nine minutes.

Bethany Boyd: Can you hear me okay?

Jordan Storhaug: Yes, we can. Go ahead.

Bethany Boyd: Okay. Good afternoon. My name is Bethany Boyd, and I'm a licensed pharmacist with Pfizer Oncology Medical Affairs. I'm here to provide the committee with efficacy and safety information for Braftovi (encorafenib). Braftovi is indicated in combination with cetuximab for the treatment of adult patients with metastatic colorectal cancer with a BRAF V600E mutation as detected by an FDA-approved test after prior therapy. Braftovi is not indicated for treatment of patients with wild-type BRAF CRC. Braftovi is a kinase inhibitor that targets BRAF V600E as well as wild-type and CRAF. Cetuximab is a monoclonal anybody antagonist that binds to EGFR. In the BEACON trial, which was a randomized Phase III, active-controlled, open-label, multicenter trial. Previously treated patients with BRAF V600E

metastatic colorectal cancer with disease progression after one or two prior therapies treated with Braftovi plus cetuximab demonstrated a statistically significant improvement in overall survival compared to the controlled arm of Folfiri plus cetuximab or Irinotecan plus cetuximab. Median overall survival was 8.4 months for the Braftovi/cetuximab arm compared to 5.4 months for the control arm. Warnings and Precautions for Braftovi with cetuximab are the following: New primary malignancies, tumor promotion in BRAF wild-type tumors, hemorrhage, uveitis, QT interval prolongation, embryo-fetal toxicity, and risks associated with combination treatment. In the BEACON trial, the most common adverse reactions for Braftovi/cetuximab compared to controlled arms for fatigue, nausea, diarrhea, dermatitis acneiform, abdominal pain, decreased appetite, arthralgia, and rash. Please refer to the package inserts for additional important safety information. In conclusion, Braftovi will offer treatment options in combination with cetuximab for previously treated adult patients with metastatic colorectal cancer with BRAF V600E mutations in the Washington State Medicaid population. And based on the efficacy and safety of this regimen, I respectfully request that the committee maintain the products' PDL status and allow for open access. Moving on to the Hedgehog pathway inhibitor. I'm not going to reintroduce myself. You already know who I am. I am here to talk about Glasdegib, which is brand name Daurismo. Glasdegib is a hedgehog pathway inhibitor indicated in combination with low-dose cytarabine for the treatment of newly diagnosed acute myeloid leukemia in adult patients who are 75 years or older or who had comorbidities that preclude use of intensive induction chemotherapy. Based on the mechanism of action, glasdegib does carry a Box Warning for embryo-fetal toxicity. Acute myeloid leukemia is a heterogeneous hematologic malignancy in the myeloid stem cells with varying clinical presentation. Although relatively rare, acute myeloid leukemia is the most common form of acute leukemia among adults worldwide and accounts for the largest number of annual deaths from leukemia in the US. The majority of new cases of AML are diagnosed in older adults. The median age of diagnosis is 68 years, with a 34% of patients diagnosed at age 75 years or older. Some other safety information that patients should know about are QT interval prolongation as well as anemia, hemorrhage, fatigue, febrile, neutropenia, thrombocytopenia, edema, musculoskeletal pain, nausea, dyspnea, decreased appetite, mucositis, constipation, and rash. In the BRIGHT study, 115 AML patients were randomized 2:1 to receive glasdegib with low-dose cytarabine compared to low-dose cytarabine alone. And these patients would take this regimen in 28 day cycles until disease progression or unacceptable toxicity occurred. Based

on the primary efficacy endpoint of overall survival, glasdegib plus low-dose cytarabine was statistically superior to low-dose cytarabine alone, with a median overall survival of 8.3 versus 4.3 months. Based on the safety and efficacy of this regimen, I respectfully request that the committee maintain Daurismo's PDL status and allow for open access. And on to MEK inhibitors. So this is the combination of Braftovi, which you heard about earlier, for colorectal cancer along with cetuximab. This is Braftovi with Mektovi. So BRAF inhibitor and a MEK inhibitor for BRAF mutant metastatic melanoma. Encorafenib plus binimetinib, (Braftovi plus Mektovi), are indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or B 600k mutation as detected by an FDA-approved test. Braftovi is not indicated for the treatment of patients with wild-type BRAF melanoma. Braftovi is a kinase inhibitor that targets a certain type of BRAF based on preclinical assays. And Mektovi is a reversible inhibitor of mitogen-activated, extracellular signal-regulated kinase 1 (MEK1) and MEK2 activity. In a Phase III randomized registrational trial, patients on Braftovi/Mektovi observed a statistically significant improvement in progression-free survival compared to vemurafenib monotherapy that control arm. Median progression-free survival was 14.9 months for the Braftovi/Mektovi arm compared to 7.3 months for the vemurafenib arm. Overall response rate was 63.5% for the patients with Braftovi/Mektovi compared to 40.8% for patients on vemurafenib, and the median overall survival was 33.6 months for patients receiving Braftovi/Mektovi compared to 16.9 months for patients taking vemurafenib. The most common adverse reactions for Braftovi/Mektovi compared to vemurafenib was fatigue, nausea, diarrhea, vomiting, abdominal pain, and arthralgia. The most common laboratory abnormalities were anemia, increased creatinine, increased GGT, increased ALT, hyperglycemia, and increased AST. In conclusion, Braftovi and Mektovi offer an additional treatment option for patients with unresectable or metastatic melanoma with the BRAF V600E or V600K mutation in the Washington Medicaid population. Based on the efficacy and safety of Braftovi and Mektovi, I respectfully request that the committee maintain these products' PDL status and allow for open access. Any questions? Thank you for your time.

Jordan Storhaug: Thank you. I am not seeing any other stakeholders, so I think we can take a look at our motion.

Kavita Chawla: This is Kavita Chawla. I move that all products in the drug classes listed on slides 49 and 50 are considered safe and efficacious for their medically accepted indications and are eligible for preferred status and grandfathering

at the discretion of HCA. Products in this class may require prior authorization to determine medical necessity. All non-preferred products require a trial of at least two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

Susan Flatebo: **[Cross-talk]** This is Susan Flatebo. I second.

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

Jordan Storhaug: Okay. I think Michael Corsilles has got that one as the second. And, therefore, we're ready for a final vote. All in favor, please say, "Aye."

Multiple speakers: Aye. Aye. Aye. Aye. Aye. Aye.

Jordan Storhaug: Any opposed? All right. With that, then, I think we are done with our business today. I'll see if any committee members or administration have anything for us before we finish then.

Leta Evaskus: This is Leta. Thank you, guys, for a great meeting. And I'll see you in December. Leah, thank you, again. I know this is your last meeting. So good luck to you in your new endeavors.

Donna Sullivan: Yeah, I just want to -- I'm sorry, I had a hard time getting off mute. I heard an "Aye" after "those opposed." I was wondering, was that just a delayed "Aye" for in favor of, or was that really an "Aye" for an opposed of the motion? Did anybody oppose? Okay. Can we just make sure that we capture that? I just wanted to make sure.

Jordan Storhaug: Thank you, Donna -- yeah -- for making it clear.

Donna Sullivan: You're welcome. And Leah, yeah, thank you so much for all of your service. We're really going to miss you. And next meeting will be saying goodbye to some more of you. So thank you all for your service on the P&T and DUR Board. I really appreciate it.

Leah Marcotte: Thank you all. I will miss all of you, and I'm so sorry. I didn't meet everyone in person. It's kind of a little bananas that we've been doing this for two years and still haven't met in person.

Leta Evaskus: It's been three years, Leah.

Leah Marcotte: Three. Oh, my goodness.

Leta Evaskus: You just finished your first term.

Jordan Storhaug: Yeah. All right. Well, thank you all. I'll see you in December.

Leta Evaskus: All right. Thanks, guys.

Donna Sullivan: All right. Thank you. Bye-bye.

Leah Marcotte: Thank you. Bye.

Kavita Chawla: Thank you.

[end of audio]