DECISION PAPER

DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS

May 2013

I. REVIEW OF RECENTLY APPROVED U.S. FOOD AND DRUG ADMINISTRATION (FDA) AGENTS

A. Non-Insulin Diabetes Drugs: Sodium Glucose Co-Transporter 2 (SGLT2)Inhibitors—Canagliflozin (Invokana)

Relative Clinical Effectiveness Conclusion—Canagliflozin (Invokana) is a new diabetes drug with a novel mechanism of action and the first FDA-approved SGLT2 inhibitor. SGLT2 inhibitors are a new subclass of the Non-Insulin Diabetes Drug Class. The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee concluded (15 for, 1 opposed, 0 abstained, 1 absent) that despite its unique mechanism of action to increase urinary glucose excretion, canagliflozin (Invokana) does not offer a clinically compelling advantage over the other non-insulin drugs included on the Uniform Formulary (UF). Canagliflozin has several safety concerns in the setting of modest decreases in hemoglobin A1c.

Relative Cost-Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) that canagliflozin (Invokana) is not cost-effective compared to other non-insulin diabetes drugs currently available on the UF. Cost minimization analysis (CMA) showed canagliflozin is more costly than metformin, glyburide, pioglitazone (Actos, generic), sitagliptin (Januvia), and exenatide (Byetta), in terms of cost per day of therapy.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (13 for, 1 opposed, 1 abstained, 2 absent) canagliflozin (Invokana) be designated nonformulary (NF) due to the lack of compelling clinical advantages, safety concerns, lack of long-term outcomes and adverse event data, and cost disadvantage compared to UF products.

2. ***COMMITTEE ACTION: MEDICAL NECESSITY (MN) CRITERIA***
The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 2 absent) the following MN criteria for canagliflozin (Invokana): use of formulary agents is contraindicated. (See Appendix B for full criteria.)

3. ***COMMITTEE ACTION: PRIOR AUTHORIZATION (PA) CRITERIA***
In the Non-Insulin Diabetes Drug Class, existing automated prior authorization (step therapy) requires a trial of metformin or a sulfonylurea, prior to the use of a dipeptidyl-dipeptidase-4 (DPP-4) inhibitor, a thiazolidinedione (TZD), or a glucagon-like peptide-1 receptor agonist (GLP1RA), based on positive efficacy and long-term outcomes data with metformin and the sulfonylureas.

The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 2 absent) a trial of metformin, a sulfonylurea, or a DPP-4 inhibitor in all new and current users of SGLT2 inhibitors, canagliflozin (Invokana), due to the modest hemoglobin A1c lowering and safety concerns. (See Appendix C for full criteria.)

4. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***
The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 2 absent) 1) an effective date of the first Wednesday after a 30-day implementation period in all POS, and 2) TMA send a letter to beneficiaries affected by the UF and PA decisions. Based on the P&T Committee's recommendation, the effective date is September 11, 2013.

Director, TMA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

II. UF DRUG CLASS REVIEWS

A. Anti-Gout Drugs

Relative Clinical Effectiveness Conclusion—The P&T Committee evaluated the Anti-Gout Drug Class. The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) the following clinical effectiveness conclusions:

- Colchicine is a very old drug that is available in one branded formulation, (Colcrys), which has a patent extending to 2029.
- For an acute gout attack, clinical practice guidelines support colchicine as first line treatment, along with non-steroidal anti-inflammatory drugs (NSAIDs) or prednisone. Treatment should be initiated within the first 24 hours of symptom onset.

- For chronic gout, urate lowering therapy (ULT) with allopurinol or febuxostat is recommended as first line. Based on head-to-head trials, febuxostat (Uloric) 40 mg and allopurinol 300 mg were equally efficacious in lowering serum uric acid (sUA) to less than 6mg/dL in one study (CONFIRMS). Febuxostat 80 mg was superior to allopurinol 300 mg in lowering sUA to less than 6mg/dL in two studies (FACT and APEX).
- Higher doses of allopurinol (doses > 300mg), although not well studied, may be required in some patients to decrease sUA.
- Systematic reviews from the Cochrane group, and evidence-based organizations from Canada, the United Kingdom, and Europe recommend febuxostat as an alternative ULT in patients who cannot tolerate allopurinol.
- In terms of clinical coverage, one anti-inflammatory agent (colchicine) and one xanthine oxidase inhibitor (allopurinol or febuxostat) is required on the UF to meet the needs of the majority of DoD beneficiaries.

Relative Cost-Effectiveness Conclusion—Pharmacoeconomic analyses were performed for the Anti-Gout Drug Class, including CMA and budget impact analysis (BIA). The class was subdivided into chronic drugs (allopurinol and febuxostat) and acute drugs (colchicine).

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) generic allopurinol (Zyloprim) was the most cost-effective of the chronic drugs, followed by branded febuxostat (Uloric), based on the weighted average cost per day of treatment across all three POS. Branded colchicine (Colcrys) was the only acute agent examined in the analysis; a cost analysis was conducted. Results from the CMA and BIA showed that among available formulary options examined, scenarios where allopurinol (Zyloprim) is the Basic Core Formulary (BCF) step-preferred agent, febuxostat (Uloric) is the NF non-preferred agent (with all current and new users required to try allopurinol first), and colchicine (Colcrys) is UF presented a maximum cost-avoidance projection.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (12 for, 4 opposed, 1 abstained, 0 absent) the following scenario for the UF, which is the most clinically and cost-effective option for the MHS:
    - allopurinol be designated UF and step-preferred (e.g., "in front of the step");
    - febuxostat (Uloric) be designated NF and non step-preferred (e.g., "behind the step"); and

- colchicine (Colcrys), probenecid, and the fixed dose combination of colchicine/probenecid be designated formulary on the UF and exempt from step therapy.
- This recommendation includes step therapy, which requires a trial of allopurinol prior to using febuxostat (Uloric) in all current and new users of febuxostat.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) maintaining allopurinol as BCF.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) MN criteria for febuxostat (Uloric). (See Appendix B for full criteria.)

4. ***COMMITTEE ACTION: PA CRITERIA***—After extensive discussion, the P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) PA criteria for all current and new users of febuxostat (Uloric), requiring a trial of allopurinol prior to use of febuxostat. (See Appendix C for full criteria.)

5. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in all POS; 2) TMA send a letter to beneficiaries affected by the UF and PA decisions. Additional recommendations made by the P&T Committee were to provide messaging to retail pharmacies to designate that PA and step therapy is required, with a trial of allopurinol prior to febuxostat (Uloric); and that the Anti-Gout Drug Class be added to the Rapid Response Program for the Retail Network and Mail Order Pharmacy. Based on the P&T Committee's recommendation, the effective date is November 6, 2013.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Pulmonary II Drugs

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) the following at the February 2013 meeting:

- Aclidinium inhaler (Tudorza) is the second long-acting muscarinic agent (LAMA) on the market. Three clinical trials reported statistically significant improvement in spirometric endpoints, and two of the trials reported significantly fewer chronic obstructive pulmonary disease (COPD) exacerbations, compared to placebo.
- For aclidinium, the adverse event profile appears minimal, with primarily anticholinergic events reported. Longer duration and larger comparative trials are needed to determine aclidinium's place in therapy.
- Several trials have shown the LAMA tiotropium (Spiriva) is associated with clinically significant improvements in spirometric endpoints and reductions in risk for COPD exacerbations. Tiotropium is also reported to reduce the proportion of patients hospitalized for COPD exacerbations.
- Reports of a possible link between tiotropium and adverse cardiovascular events including death, stroke, and myocardial infarction have not been confirmed in prospective trials.
- Roflumilast (Daliresp) is the first oral selective inhibitor of phosphodiesterase type 4 (PDE-4) marketed in the United States. In two clinical trials, roflumilast was associated with statistically significant reductions in the rate of COPD exacerbations.
- For roflumilast, safety issues identified by the FDA included psychiatric events (including suicide), weight loss, gastrointestinal upset and severe diarrhea, and nasal tumors. However, the FDA did not require additional prospective safety studies.
- Albuterol/ipratropium soft mist inhaler (Combivent Respimat) is the new propellant-free inhaler that is replacing the ozone-depleting chlorofluorocarbon (CFC)-containing Combivent metered dose inhaler (MDI). The clinical trial used to obtain FDA approval showed Combivent Respimat was non-inferior to Combivent CFC MDI in terms of improvements in spirometric endpoints.

Relative Cost-Effectiveness Conclusion—The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 2 absent) the following:

- CMA within the LAMA subclass showed that tiotropium (Spiriva) was more cost-effective than aclidinium (Tudorza). BIA results where Spiriva was designated BCF and Tudorza designated UF resulted in the greatest cost-avoidance to the MHS.

- CMA was conducted within the COPD subclass, which includes the short-acting muscarinic agents (SAMA), short-acting beta agonist (SABA)/SAMA combination drugs, and PDE-4 inhibitors. The results showed that ipratropium nebulized solution (Atrovent; generic) was the most cost-effective agent, followed by ipratropium/albuterol nebulized solution (DuoNeb; generic), ipratropium hydrofluoroalkane MDI (Atrovent HFA), ipratropium/albuterol soft mist inhaler (Combivent Respimat), and roflumilast (Daliresp). Ipratropium/albuterol (Combivent) was not included in the cost-effectiveness analysis due to market discontinuation by December 2013. BIA projections for all scenarios were very similar.

    1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (12 for, 1 opposed, 2 abstained, 2 absent) aclidinium inhaler (Tudorza), tiotropium inhaler (Spiriva), ipratropium nebulized solution (Atrovent; generic), ipratropium/albuterol nebulized solution (DuoNeb; generic), ipratropium HFA MDI (Atrovent HFA), ipratropium/albuterol soft mist inhaler (Combivent Respimat), and roflumilast (Daliresp) remain designated Uniform Formulary. Ipratropium/albuterol MDI (Combivent) will remain designated UF, pending discontinuation in December 2013.

    2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (13 for, 0 opposed, 2 abstained, 2 absent) maintaining ipratropium HFA MDI (Atrovent HFA) and ipratropium/albuterol nebulized solution (DuoNeb; generic), on the BCF, and recommended adding tiotropium (Spiriva) to the BCF, upon signing of the minutes.

Director, TMA, Decision: ☒Approved □ Disapproved

Approved, but modified as follows:

C. Self-Monitoring Blood Glucose System (SMBGS) Test Strips

Background and Relative Clinical Effectiveness—The P&T Committee reviewed the clinical effectiveness of the SMBGS test strips, including the attributes of the test strips and glucometers. Candidates for inclusion on the UF must meet all minimum required technical standards and United States Federal Government contracting requirements.

The P&T Committee reviewed the existing technical requirements approved in May 2007, and recommended updates to the criteria.

Relative Clinical Effectiveness Conclusion—The P&T Committee agreed (17 for, 0 opposed, 0 abstained, 0 absent) on the following for the minimum technical requirements and U.S. Federal Government contracting requirements for the SMBGS test strips. The full clinical effectiveness conclusion will be presented at the August 2013 meeting:

- *U.S Federal Government contracting requirements*: SMBGS test strips eligible for inclusion on the Uniform Formulary must be available at all 3 POS and must be compliant with the Trade Agreements Act. Corresponding SMBGS glucometers must also be compliant with the Trade Agreements Act. Manufacturers of SMBGS glucometers will be required to provide DoD beneficiaries with a no-cost glucometer.
- *Minimum technical requirements*: Candidate SMBGS test strips eligible for inclusion on the Uniform Formulary must meet minimum technical requirements in the areas of accuracy, sample size, alternate site testing, results time, memory capacity, ease of use, customer support, downloading capabilities, and data management capabilities. See pages 19-20 for detailed technical requirements.

Relative Cost-Effectiveness Conclusion—The P&T Committee reviewed proposed condition sets for contract solicitation. The cost-effectiveness analysis and UF and BCF recommendations will be presented at an upcoming meeting.

D. Corticosteroid Immune Modulators (Topical Steroids)

The P&T Committee evaluated the Corticosteroid Immune Modulators (Topical Steroids) Drug Class. The class is comprised of 22 individual chemical entities, available in over 100 different formulations and vehicles. The Stoughton-Cornell classification system, which divides the drugs into seven classes based on their vasoconstrictive properties, was used to further divide the drugs into high- (classes 1 and 2 steroids), medium- (classes 3, 4, and 5), and low-potency agents (classes 6 and 7). Over-the-counter (OTC) products are excluded from the class.

Relative Clinical Effectiveness Conclusion—The P&T Committee agreed (16 for, 0 opposed, 0 abstained, 1 absent) with the clinical effectiveness conclusion. The full clinical effectiveness evaluation will be reported in the August meeting minutes.

Relative Cost-Effectiveness Conclusion—The P&T Committee reviewed proposed condition sets for contract solicitation. The cost-effectiveness analysis and UF and BCF recommendations will be presented at an upcoming meeting.

III. BCF ISSUES

A. Emergency Contraceptives

The Emergency Contraceptives were last reviewed by the P&T Committee in August 2011. Levonorgestrel 0.75 mg (Next Choice, the generic for Plan B) was designated as BCF. Next Choice was discontinued by the manufacturer in early 2013. The currently available emergency contraceptives include levonorgestrel 0.75 mg available from a generic manufacturer; levonorgestrel 1.5 mg (Next Choice One Dose, Plan B One Step); and ulipristal (Ella). A prescription is required for all ages for Ella; and for patients under age 17 for generic levonorgestrel 0.75 mg, and levonorgestrel 1.5 mg (Next Choice One Dose). On April 15, 2013, the age restriction was lowered to under age 15 for Plan B One Step by the FDA. A cost analysis showed that Plan B One Step has the lowest cost of the currently available emergency contraceptives.

1. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee voted (15 for, 0 opposed, 2 abstained, 0 absent) upon signing of the minutes, to:
   a) remove levonorgestrel 0.75 mg (Next Choice) from the BCF; and
   b) add levonorgestrel 1.5 mg (Plan B One Step) to the BCF.
   c) No other changes to the Uniform Formulary are recommended; generic levonorgestrel 0.75 mg, levonorgestrel 1.5 mg (Next Choice One Dose, generic Plan B One Step), and ulipristal (Ella) remain UF.

2. ***COMMITTEE ACTION: QLs AND AGE LIMITS***—The P&T Committee voted (15 for, 0 opposed, 2 abstained, 0 absent) upon signing of the minutes, to:
   a) maintain the current QLs at all three POS of one fill per prescription, with no refills (new prescription required for every fill).
   b) For the current age limits, MTFs should follow their individual service policies, and for the Mail Order and Retail points of service, the FDA labeling should be followed.

Director, TMA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

As the FDA has now approved emergency contraceptive Plan B One-Step to be available over the counter without restrictions, and as regulations required by section 702 of the FY13 NDAA to include OTCs on the uniform formulary have not yet been

prescribed, no emergency contraceptive shall be included on the BCF. Nevertheless, MTFs shall ~~treat~~ carry Plan B One-Step as ~~any other OTC in deciding whether to~~ provide it, and at no cost.

B. Gastrointestinal-1 (GI-1) Drug Class—Mesalamine (Asacol)

The GI-1 Drug Class was previously reviewed by the P&T Committee in February 2011. Mesalamine delayed release tablets (Asacol) were designated as BCF. In March 2013, Asacol tablets were discontinued by the manufacturer, Warner Chilcott, and supplies have been depleted. Warner Chilcott subsequently received FDA approval for a new formulation, Delzicol capsules, which is substantially more costly than Asacol. Several other mesalamine delayed release tablets are on the UF, including Asacol HD, Apriso, Lialda, and Pentasa. These products use different proprietary methods to delay release of the drug into the large intestine and, therefore, are not interchangeable and have different FDA-approved indications and dosing.

1. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee voted (16 for, 0 opposed, 1 abstained, 0 absent) upon signing of the minutes, to:
   a) remove mesalamine delayed release tablets (Asacol) from the BCF.
   b) The GI-1 Drug Class will not have a designated BCF product until the class can be re-reviewed for UF status. MTFs are advised to order what they need to meet local needs.

Director, TMA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

IV. UTILIZATION MANAGEMENT

A. PA

1. **Injectable Gonadotropins**—The P&T Committee clarified the PA criteria to set a 60-day expiration date for the PA, to help ensure that an authorization memorandum is included with each assisted reproductive technology (ART) cycle. A 60-day expiration is sufficient for a patient to complete an ART cycle.

   a) ***COMMITTEE ACTION: INJECTABLE GONADOTROPINS***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 1 absent) clarifying the existing PA criteria for the injectable gonadotropins to have a 60-day expiration date for the PA.

2. **Proton Pump Inhibitors: Pantoprazole Change from Non-Preferred to Step-Preferred Status**—In November 2012, the P&T Committee recommended reclassification of pantoprazole as formulary on the UF, due to availability of cost-effective generic formulations; pantoprazole remained non-preferred. The cost of generic pantoprazole tablets has continued to decline since November 2012. The P&T Committee recommended revising the PA criteria to designate pantoprazole as step preferred (i.e., in front of the step).

    a) ***COMMITTEE ACTION: PANTOPRAZOLE PA CRITERIA/ STEP-PREFERRED STATUS***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) designating pantoprazole as step-preferred (i.e., in front of the step) on the UF.

3. **Antilipidemics-2: Icosapent ethyl (Vascepa)**—Icosapent ethyl (Vascepa) is the second prescription fish oil product marketed. The P&T Committee recommended manual PA criteria for all current and new users of Vascepa, limiting use to the FDA-approved indication; the manual PA criteria for Vascepa will be the same as criteria for Lovaza.

    a) ***COMMITTEE ACTION: ICOSAPENT ETHYL (VASCEPA) PA CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) manual PA criteria for all current and new users of Vascepa, limiting use to the FDA-approved indication. (See Appendix C for full criteria.)

4. **Abiraterone (Zytiga)**—PA criteria for abiraterone (Zytiga) were recommended at the November 2012 meeting, consistent with the FDA labeling. The FDA has subsequently updated the approved labeling for patients with metastatic castration-resistant prostate cancer with concomitant prednisone.

    a) ***COMMITTEE ACTION: ABIRATERONE (ZYTIGA) PA CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) revising the abiraterone (Zytiga) PA criteria for use in patients with a documented diagnosis of metastatic castration-resistant prostate cancer on concomitant prednisone. The previous criterion for prior chemotherapy containing docetaxel is no longer required.

B. Quantity Limits (QLs)

1. **Oral tretinoin 10 mg capsules (Vesanoid)**—Oral tretinoin 10 mg capsules are approved for inducing remission in acute promyelocytic leukemia. Quantity limits are in place for several oral chemotherapy agents. The P&T Committee recommended QLs for oral tretinoin 10 mg capsules due to the high cost and adverse event profile.

   a) ***COMMITTEE ACTION: ORAL TRETINOIN 10MG CAPSULES (VESANOID) QLs***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) QLs/days supply limits for oral tretinoin 10 mg capsules (Vesanoid), based on FDA-approved labeling, limiting use to a 30-day supply in the Retail Network, and a 45-day supply in the Mail Order.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

SUBMITTED BY:

John P. Kugler, M.D., MPH
DoD P&T Committee Chair

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.

Jonathan Woodson, M.D.
Director

8/6/2013
Date

DEPARTMENT OF DEFENSE

PHARMACY AND THERAPEUTICS COMMITTEE MINUTES AND RECOMMENDATIONS

May 2013

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on May 15, 2013, at the DoD Pharmacoeconomic Center (PEC), Fort Sam Houston, Texas.

II. ATTENDANCE

The attendance roster is found in Appendix A.

A. Review Minutes of Last Meetings

1. **Approval of February 2013 Minutes**—Jonathon Woodson, M.D., Director, approved the minutes for the February 2013 DoD P&T Committee meeting on May 13, 2013.

III. REQUIREMENTS

All clinical and cost evaluations for new drugs and full drug class reviews included, but were not limited to, the requirements stated in 32 Code of Federal Regulations 199.21(e)(1). All Uniform Formulary (UF) and Basic Core Formulary (BCF) recommendations considered the conclusions from the relative clinical effectiveness and relative cost-effectiveness determinations, and other relevant factors. Medical necessity (MN) criteria were based on the clinical and cost evaluations, and the conditions for establishing MN for a nonformulary (NF) medication.

IV. REVIEW OF RECENTLY APPROVED U.S. FOOD AND DRUG ADMINISTRATION (FDA) AGENTS

A. Non-Insulin Diabetes Drugs: Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors—Canagliflozin (Invokana)

Relative Clinical Effectiveness Conclusion—Canagliflozin (Invokana) is a new diabetes drug with a novel mechanism of action and the first FDA-approved SGLT2 inhibitor. SGLT2 inhibitors are a new subclass of the Non-Insulin Diabetes Drug Class, which was originally reviewed in November 2010. The Non-Insulin Diabetes Drug Class also includes the following subclasses: biguanides (metformin), sulfonylureas,

thiazolidinedione (TZD), dipeptidyl-dipeptidase-4 (DPP-4) inhibitors, glucagon-like peptide-1 receptor agonists (GLP1RAs), pramlintide, dopamine agonists, meglitinides, and alpha glucosidase inhibitors.

The P&T Committee concluded (15 for, 1 opposed, 0 abstained, 1 absent):

- Efficacy of canagliflozin is limited to eight clinical trials, showing moderate decreases in hemoglobin A1c from baseline ranging from 0.63% (with insulin) to 1.11% (monotherapy in treatment-naïve patients).
- Canagliflozin has safety concerns of hypotension, impaired renal function, hyperkalemia, hypermagnesemia, hyperphosphatemia, increases in low-density lipoprotein (LDL) cholesterol and hemoglobin, hypoglycemia, urinary tract infections in both men and women, and genital mycotic infections.
- There is limited safety information available and no long-term outcomes trials have been completed to date with canagliflozin.
- Despite its unique mechanism of action to increase urinary glucose excretion, canagliflozin (Invokana) does not offer a clinically compelling advantage over the other non-insulin drugs included on the UF.

Relative Cost-Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) that canagliflozin (Invokana) is not cost-effective compared to other non-insulin diabetes drugs currently available on the UF. Cost minimization analysis (CMA) showed canagliflozin is more costly than metformin, glyburide, pioglitazone (Actos, generic), sitagliptin (Januvia), and exenatide (Byetta), in terms of cost per day of therapy.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (13 for, 1 opposed, 1 abstained, 2 absent) canagliflozin (Invokana) be designated NF due to the lack of compelling clinical advantages, safety concerns, lack of long-term outcomes and adverse event data, and cost disadvantage compared to UF products.

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 2 absent) the following MN criteria for canagliflozin (Invokana): use of formulary agents is contraindicated. (See Appendix B for full criteria.)

3. ***COMMITTEE ACTION: PRIOR AUTHORIZATION (PA) CRITERIA***—In the Non-Insulin Diabetes Drug Class, existing automated prior authorization (step therapy) requires a trial of metformin or a

sulfonylurea, prior to the use of a DPP-4 inhibitor, a TZD, or a GLP1RA, based on positive efficacy and long-term outcomes data with metformin and the sulfonylureas.

The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 2 absent) a trial of metformin, a sulfonylurea, or a DPP-4 inhibitor in all new and current users of SGLT2 inhibitors, canagliflozin (Invokana), due to the modest hemoglobin A1c lowering and safety concerns. (See Appendix C for full criteria.)

4. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***
The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 2 absent) 1) an effective date of the first Wednesday after a 30-day implementation period in all POS, and 2) TMA send a letter to beneficiaries affected by the UF and PA decisions. Based on the P&T Committee's recommendation, the effective date is September 11, 2013.

V. UF DRUG CLASS REVIEWS

A. Anti-Gout Drugs

Background and Relative Clinical Effectiveness—The P&T Committee evaluated the Anti-Gout Drug Class. This class has not been previously reviewed for UF placement. Drugs in the class include allopurinol (Zyloprim, generic), probenecid, colchicine (Colcrys), colchicine/probenecid, and febuxostat (Uloric). Allopurinol is currently designated as a BCF product (pre-UF Rule decision).

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) the following clinical effectiveness conclusions:

- Colchicine is a very old drug that is available in one branded formulation, (Colcrys), which has a patent extending to 2029.
- For an acute gout attack, clinical practice guidelines support colchicine as first line treatment, along with non-steroidal anti-inflammatory agents (NSAIDs) or prednisone. Treatment should be initiated within the first 24 hours of symptom onset.
- For chronic gout, urate-lowering therapy (ULT) with allopurinol or febuxostat is recommended as first line. Based on head-to-head trials, febuxostat (Uloric) 40 mg and allopurinol 300 mg were equally efficacious in lowering serum uric acid (sUA) to less than 6mg/dL in one study

(CONFIRMS). Febuxostat 80 mg was superior to allopurinol 300 mg in lowering sUA to less than 6mg/dL in two studies (FACT and APEX).

- Higher doses of allopurinol (doses > 300mg), although not well studied, may be required in some patients to decrease sUA.
- Systematic reviews from the Cochrane group, and evidence-based organizations from Canada, the UK, and Europe recommend febuxostat as an alternative ULT in patients who cannot tolerate allopurinol.
- Use of colchicine for prophylaxis helps prevent gout flares during initiation of ULT. However, in published trials, gout flares increased when prophylaxis was discontinued. Guidelines recommend administering colchicine or NSAID prophylaxis for up to 6 months.
- Head-to-head studies show similar rates of adverse events with febuxostat and allopurinol.
- Febuxostat warnings from the FDA include liver enzyme elevations. Liver function tests should be tested at initiation of therapy and monitored throughout treatment.
- Febuxostat warnings from the European Medicines Association (EMA) include the potential for increased cardiovascular (CV) events. According to the EMA, febuxostat should not be used in patients with ischemic heart disease or congestive heart failure, due to increased risk of CV events.
- In terms of clinical coverage, one anti-inflammatory agent (colchicine) and one xanthine oxidase inhibitor (allopurinol or febuxostat) are required on the UF to meet the needs of the majority of DoD beneficiaries.

Relative Cost-Effectiveness Analysis and Conclusion—Pharmacoeconomic analyses were performed for the Anti-Gout Drug Class, including CMA and budget impact analyses (BIAs). The class was subdivided into chronic drugs (allopurinol and febuxostat) and acute drugs (colchicine). For the BIAs, several of the model's key assumptions were varied, with corresponding sensitivity analyses conducted.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) generic allopurinol (Zyloprim) was the most cost-effective of the chronic drugs, followed by branded febuxostat (Uloric), based on the weighted average cost per day of treatment across all three POS. Branded colchicine (Colcrys) was the only acute agent examined in the analysis; a cost analysis was conducted. CMA and BIA results showed that among available formulary options examined, scenarios where allopurinol (Zyloprim) is the BCF step-preferred agent, febuxostat (Uloric) is the NF non-preferred agent (with all current and new users required to try allopurinol first), and colchicine (Colcrys) is UF presented a maximum cost-avoidance projection.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (12 for, 4 opposed, 1 abstained, 0 absent) the following scenario for the UF, which is the most clinically and cost-effective option for the MHS:
    - allopurinol be designated UF and step-preferred (e.g., "in front of the step") ;
    - febuxostat (Uloric) be designated NF and non step-preferred (e.g., "behind the step"); and
    - colchicine (Colcrys), probenecid, and the fixed dose combination of colchicine/probenecid be designated formulary on the UF and exempt from step therapy.
    - This recommendation includes step therapy, which requires a trial of allopurinol prior to using febuxostat (Uloric) in all current and new users of febuxostat.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) maintaining allopurinol as BCF.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) MN criteria for febuxostat (Uloric). (See Appendix B for full criteria.)

4. ***COMMITTEE ACTION: PA CRITERIA***—After extensive discussion, the P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) PA criteria for all current and new users of febuxostat (Uloric), requiring a trial of allopurinol prior to use of febuxostat. (See Appendix C for full criteria.)

5. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in all POS; 2) TMA send a letter to beneficiaries affected by the UF and PA decisions. Additional recommendations made by the P&T Committee were to provide messaging to retail pharmacies to designate that PA and step therapy is required, with a trial of allopurinol prior to febuxostat (Uloric) and that the Anti-Gout Drug Class be added to the Rapid Response Program for the Retail Network and Mail Order Pharmacy. Based on the P&T Committee's recommendation, the effective date is November 6, 2013.

B. Pulmonary II Drugs

Background and Relative Clinical Effectiveness—The Pulmonary II Drug Class is comprised of two subclasses, the long-acting muscarinic agents (LAMAs), aclidinium inhaler (Tudorza) and tiotropium inhaler (Spiriva), and the chronic obstructive pulmonary disease (COPD) drugs [comprised of the short-acting muscarinic agents (SAMAs), short-acting beta agonist (SAMA/SABA) combinations and the phosphodiesterase type 4 (PDE-4) inhibitors].

Combivent metered dose inhaler (MDI) is one of the last available chlorofluorocarbon (CFC) MDIs on the market and will have supplies exhausted by December 2013. Its replacement is Combivent Respimat, a new CFC- and propellant-free formulation.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) the following at the February 2013 meeting:

- Aclidinium inhaler (Tudorza) is the second LAMA on the market. The three clinical trials used to obtain FDA approval reported statistically significant improvement in spirometric endpoints, and two of the trials reported significantly fewer COPD exacerbations with aclidinium, compared to placebo.
- For aclidinium, the adverse event profile appears minimal, with primarily anticholinergic events reported. However, there is limited safety data with the 400 mcg approved dose. The FDA requires a prospective clinical trial to assess CV safety. Longer duration and larger comparative trials are needed to determine aclidinium's place in therapy.
- Several trials have shown the LAMA tiotropium (Spiriva) is associated with clinically significant improvements in spirometric endpoints and reductions in risk for COPD exacerbations. Tiotropium is also reported to reduce the proportion of patients hospitalized for COPD exacerbations.
- Reports of a possible link between tiotropium and adverse CV events including death, stroke, and myocardial infarction have not been confirmed in prospective trials.
- Roflumilast (Daliresp) is the first oral selective inhibitor of PDE-4 marketed in the United States. Its FDA indication is limited to reducing the incidence of COPD exacerbations in patients with severe COPD. In two clinical trials, roflumilast was associated with statistically significant reductions in the rate of COPD exacerbations.
- For roflumilast, safety issues identified by the FDA included psychiatric events (including suicide), weight loss, gastrointestinal upset and severe diarrhea, and

nasal tumors. However, the FDA did not require additional prospective safety studies. A risk evaluation and mitigation strategy program was not required.

- Albuterol/ipratropium inhaler (Combivent Respimat) is the new propellant-free inhaler that is replacing the ozone-depleting CFC-containing Combivent MDI. The clinical trial used to obtain FDA approval showed Combivent Respimat was non-inferior to Combivent CFC MDI in terms of improvements in spirometric endpoints.

Relative Cost-Effectiveness Analysis and Conclusion—The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 2 absent) the following:

- CMA within the LAMA subclass showed that tiotropium (Spiriva) was more cost-effective than aclidinium (Tudorza). BIA results where Spiriva was designated BCF and Tudorza designated UF resulted in the greatest cost-avoidance to the MHS.
- CMA was conducted within the COPD subclass, which includes the SAMAs, SABA/SAMA combination drugs, and PDE-4 inhibitors. The results showed ipratropium nebulized solution (Atrovent; generic) was the most cost-effective agent, followed by ipratropium/albuterol nebulized solution (DuoNeb; generic), ipratropium hydrofluoroalkane (HFA) MDI (Atrovent HFA), ipratropium/albuterol soft mist inhaler (Combivent Respimat), and roflumilast (Daliresp). Ipratropium/albuterol (Combivent) was not included in the cost-effectiveness analysis due to market discontinuation by December 2013. BIA projections for all scenarios were very similar.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (12 for, 1 opposed, 2 abstained, 2 absent) aclidinium inhaler (Tudorza), tiotropium inhaler (Spiriva), ipratropium nebulized solution (Atrovent; generic), ipratropium/albuterol nebulized solution (DuoNeb; generic), ipratropium HFA MDI (Atrovent HFA), ipratropium/albuterol soft mist inhaler (Combivent Respimat), and roflumilast (Daliresp) remain designated UF. Ipratropium/albuterol MDI (Combivent) will remain designated UF, pending discontinuation in December 2013.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (13 for, 0 opposed, 2 abstained, 2 absent) maintaining ipratropium HFA MDI (Atrovent HFA) and ipratropium/albuterol nebulized solution (DuoNeb; generic) on the BCF, and recommended adding tiotropium (Spiriva) the BCF, upon signing of the minutes.

C. Self-Monitoring Blood Glucose System (SMBGS) Test Strips

Background and Relative Clinical Effectiveness—The P&T Committee reviewed the clinical effectiveness of the SMBGS test strips, including the attributes of the test strips and glucometers. The SMBGS test strips were previously reviewed for UF placement in August 2008. The primary goal for this review is to ensure uniform availability of quality SMBGS test strips across the MHS (MTF, Retail, and Mail Order points of service). SMBGS glucometers are not included as part of the TRICARE outpatient pharmacy benefit (they are included under the medical benefit) and are not the focus of the review; however, provisions have been made to provide SMBGS glucometers at no cost to MHS beneficiaries.

The FDA classifies SMBGS test strips and glucometers as medical devices, rather than drugs, thus the focus of the clinical effectiveness review centers on differences in the technical aspects/attributes among the products. Candidates for inclusion on the UF must meet all minimum required technical standards and United States Federal Government contracting requirements. The P&T Committee reviewed the existing technical requirements approved in May 2007, and recommended updates to the criteria.

Relative Clinical Effectiveness Conclusion—The P&T Committee agreed (17 for, 0 opposed, 0 abstained, 0 absent) on the following for the minimum technical requirements and U.S. Federal Government contracting requirements for the SMBGS test strips. The full clinical effectiveness conclusion will be presented at the August 2013 meeting:

- *U.S Federal Government contracting requirements*: SMBGS test strips eligible for inclusion on the Uniform Formulary must be available at all 3 POS and must be compliant with the Trade Agreements Act. Corresponding SMBGS glucometers must also be compliant with the Trade Agreements Act. Manufacturers of SMBGS glucometers will be required to provide DoD beneficiaries with a no-cost glucometer.
- *Minimum technical requirements*: Candidate SMBGS test strips eligible for inclusion on the Uniform Formulary must meet the following minimum technical requirements:
    - Accuracy: Must meet FDA standards for accuracy based on the International Organization for Standardization (ISO) 15197 guidelines.
    - Sample size of $\leq$ 1 microliter
    - Alternate site testing: more than one alternate site approved.
    - Result time: $\leq$ 10 seconds
    - Memory capacity: $\geq$ 250 readings

- Ease of use: glucometer must be easy to code/calibrate, have a large visual display, and be easy to handle for patients with dexterity issues.
- Customer support: 24-hour helpline available, for beneficiaries residing outside the continental United States.
- Downloading capabilities: results must be downloadable
- Data management capabilities: data management capabilities required (e.g., software, cloud computing).

Relative Cost-Effectiveness Conclusion—The P&T Committee reviewed proposed condition sets for contract solicitation. The cost-effectiveness analysis and UF and BCF recommendations will be presented at an upcoming meeting.

D. Corticosteroid Immune Modulators (Topical Steroids)

The P&T Committee evaluated the Corticosteroid Immune Modulators (Topical Steroids) Drug Class. The class is comprised of 22 individual chemical entities, available in over 100 different formulations and vehicles. The Stoughton-Cornell classification system, which divides the drugs into seven classes based on their vasoconstrictive properties, was used to further divide the drugs into high- (classes 1 and 2 steroids), medium- (classes 3, 4, and 5), and low-potency agents (classes 6 and 7). Over-the-counter (OTC) products are excluded from the class.

Relative Clinical Effectiveness Conclusion—The P&T Committee agreed (16 for, 0 opposed, 0 abstained, 1 absent) with the clinical effectiveness conclusion. The full clinical effectiveness evaluation will be reported in the August meeting minutes.

Relative Cost-Effectiveness Conclusion—The P&T Committee reviewed proposed condition sets for contract solicitation. The cost-effectiveness analysis and UF and BCF recommendations will be presented at an upcoming meeting.

VI. BCF ISSUES

A. Emergency Contraceptives

The Emergency Contraceptives were last reviewed by the P&T Committee in August 2011. Levonorgestrel 0.75 mg (Next Choice, the generic for Plan B) was designated as BCF. Next Choice was discontinued by the manufacturer in early 2013. The currently available emergency contraceptives include levonorgestrel 0.75 mg available from a

generic manufacturer; levonorgestrel 1.5 mg (Next Choice One Dose, Plan B One Step); and ulipristal (Ella). A prescription is required for all ages for Ella; and for patients under age 17 for generic levonorgestrel 0.75 mg, and levonorgestrel 1.5 mg (Next Choice One Dose). On April 15, 2013, the age restriction was lowered to under age 15 for Plan B One Step by the FDA. A cost analysis showed that Plan B One Step has the lowest cost of the currently available emergency contraceptives.

1. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee voted (15 for, 0 opposed, 2 abstained, 0 absent) upon signing of the minutes, to:
   a) remove levonorgestrel 0.75 mg (Next Choice) from the BCF; and
   b) add levonorgestrel 1.5 mg (Plan B One Step) to the BCF.
   c) No other changes to the Uniform Formulary are recommended; generic levonorgestrel 0.75 mg, levonorgestrel 1.5 mg (Next Choice One Dose, generic Plan B One Step), and ulipristal (Ella) remain UF.

2. ***COMMITTEE ACTION: QLs AND AGE LIMITS***—The P&T Committee voted (15 for, 0 opposed, 2 abstained, 0 absent) upon signing of the minutes, to:
   a) maintain the current QLs at all three POS of one fill per prescription, with no refills (new prescription required for every fill).
   b) For the current age limits, MTFs should follow their individual service policies, and for the Mail Order and Retail points of service, the FDA labeling should be followed.

Note from Decision Paper on p 8: As the FDA has now approved emergency contraceptive Plan B One-Step to be available over the counter without restrictions, and as regulations required by section 702 of the FY13 NDAA to include OTCs on the uniform formulary have not yet been prescribed, no emergency contraceptive shall be included on the BCF. MTFs shall ~~treat~~ Plan B One-Step ~~as any other OTC in deciding~~ and ~~whether to~~ provide it at no cost. carry JPK nevertheless,

B. Gastrointestinal-1 (GI-1) Drug Class—Mesalamine (Asacol)

The GI-1 Drug Class was previously reviewed by the P&T Committee in February 2011. Mesalamine delayed release tablets (Asacol) were designated as BCF. In March 2013, Asacol tablets were discontinued by the manufacturer, Warner Chilcott, and supplies have been depleted. Warner Chilcott subsequently received FDA approval for a new formulation, Delzicol capsules, which is substantially more costly than Asacol.

Several other mesalamine delayed release tablets are on the UF, including Asacol HD, Apriso, Lialda, and Pentasa. These products use different proprietary methods to delay release of the drug into the large intestine and, therefore, are not interchangeable and have different FDA-approved indications and dosing.

1. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee voted (16 for, 0 opposed, 1 abstained, 0 absent) upon signing of the minutes, to:
   a) remove mesalamine delayed release tablets (Asacol) from the BCF.
   b) The GI-1 Drug Class will not have a designated BCF product until the class can be re-reviewed for UF status. MTFs are advised to order what they need to meet local needs.

VII. UTILIZATION MANAGEMENT

A. PA

1. **Injectable Gonadotropins**—In November 2012, PA criteria for the injectable gonadotropins was revised to allow for use in conjunction with a noncoital reproductive technology, as outlined in the ASD(HA) April 2012 "Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members." A Signed Authorization Memorandum from TMA must be included with the prescription, and a new prescription is required for each assisted reproductive technology (ART) cycle. The P&T Committee clarified the PA criteria to set a 60-day expiration date for the PA, to help ensure that an authorization memorandum is included with each ART cycle. A 60-day expiration is sufficient for a patient to complete an ART cycle.

   a) ***COMMITTEE ACTION: INJECTABLE GONADOTROPINS***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 1 absent) clarifying the existing PA criteria for the injectable gonadotropins to have a 60-day expiration date for the PA.

2. **Proton Pump Inhibitors (PPIs): Pantoprazole Change from Non-Preferred to Step-Preferred Status**—The PPIs currently have PA criteria (step therapy) requiring a trial of omeprazole or esomeprazole (Nexium) prior to use of the other PPIs. Omeprazole and esomeprazole are BCF and step-preferred. In November 2012, the P&T Committee

recommended reclassification of pantoprazole as formulary on the UF, due to availability of cost-effective generic formulations; pantoprazole remained non-preferred. The other PPIs, lansoprazole (Prevacid), rabeprazole (Aciphex), and omeprazole/sodium bicarbonate (Zegerid), are NF and non-preferred. The cost of generic pantoprazole tablets has continued to decline since November 2012. The P&T Committee recommended revising the PA criteria to designate pantoprazole as step-preferred (i.e., in front of the step).

a) ***COMMITTEE ACTION: PANTOPRAZOLE PA CRITERIA/ STEP-PREFERRED STATUS***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) designating pantoprazole as step-preferred (i.e., in front of the step) on the UF.

3. **Antilipidemics-2: Icosapent ethyl (Vascepa)**—Icosapent ethyl (Vascepa) is the second prescription fish oil product marketed. Icosapent ethyl has the same FDA-approved labeling and dosing as omega-3-acid ethyl esters (Lovaza). Vascepa is not as effective as Lovaza at lowering triglycerides, but does not adversely affect LDL levels. PA criteria apply to Lovaza, limiting use to the FDA-approved indications, due to the large number of off-label, non-supportable uses. The P&T Committee recommended manual PA criteria for all current and new users of Vascepa, limiting use to the FDA-approved indication; the manual PA criteria for Vascepa will be the same as criteria for Lovaza.

   a) ***COMMITTEE ACTION: ICOSAPENT ETHYL (VASCEPA) PA CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) manual PA criteria for all current and new users of Vascepa, limiting use to the FDA-approved indication. (See Appendix C for full criteria.)

4. **Abiraterone (Zytiga)**— Zytiga is an inhibitor of CYP 17 (an enzyme expressed in testicular, adrenal, and prostatic tumor tissues that is required for androgen biosynthesis). PA criteria for abiraterone (Zytiga) were recommended at the November 2012 meeting, consistent with the FDA labeling. At that time, Zytiga was FDA-approved for treatment of patients with metastatic castration-resistant prostate cancer who had previously received docetaxel. The FDA has subsequently updated the approved labeling for patients with metastatic castration-resistant prostate cancer with concomitant prednisone.

a) ***COMMITTEE ACTION: ABIRATERONE (ZYTIGA) PA CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) revising the abiraterone (Zytiga) PA criteria for use in patients with a documented diagnosis of metastatic castration-resistant prostate cancer on concomitant prednisone. The previous criterion for prior chemotherapy containing docetaxel is no longer required.

B. Quantity Limits (QLs)

1. **Oral tretinoin 10 mg capsules (Vesanoid)**—Oral tretinoin 10 mg capsules are approved for inducing remission in acute promyelocytic leukemia. The product was previously available under the trade name Vesanoid, but now only generic formulations are available. Quantity limits are in place for several oral chemotherapy agents. The P&T Committee recommended QLs for oral tretinoin 10 mg capsules due to the high cost and adverse event profile.

a) ***COMMITTEE ACTION: ORAL TRETINOIN 10MG CAPSULES (VESANOID) QLs***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) QLs/days supply limits for oral tretinoin 10 mg capsules (Vesanoid), based on FDA-approved labeling, limiting use to a 30-day supply in the Retail Network, and a 45-day supply in the Mail Order.

VIII. ADJOURNMENT

The meeting adjourned at 1630 hours on May 15, 2013. The next meeting will be in August 2013.

Appendix A—Attendance: May 2013 P&T Committee Meeting

Appendix B—Table of Medical Necessity Criteria

Appendix C—Table of Prior Authorization Criteria

Appendix D—Table of Implementation Status of UF Recommendations/Decisions Summary

Appendix E—Table of Abbreviations

Appendix A—Attendance: May 2013 P&T Committee Meeting

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
CDR Joe Lawrence, MSC	Director, DoD Pharmacoeconomic Center (Recorder)
Col George Jones, BSC	Deputy Chief, Pharmaceutical Operations Directorate
COL Peter Bulatao, MS for COL John Spain, MS	Army, Pharmacy Officer
Col Mike Spilker, BSC	Air Force, Pharmacy Officer
CDR Aaron Middlekauf for CAPT Deborah Thompson, USCG	Coast Guard, Pharmacy Officer
CAPT Edward Norton, MSC	Navy, Pharmacy Officer (Pharmacy Consultant BUMED)
COL Ted Cieslak, MC	Army, Physician at Large
Col Lowell Sensintaffer, MC	Air Force, Physician at Large
CAPT Walter Downs, MC	Navy, Internal Medicine Physician
COL Jack Lewi, MC	Army, Internal Medicine Physician
CDR Shaun Carstairs, MC	Navy, Physician at Large
COL Bruce Lovins, MC	Army, Family Practice Physician
Lt Col William Hannah, MC	Air Force, Internal Medicine Physician
Maj Jeremy King, MC	Air Force, OB/GYN Physician
LCDR Christine Olsen, MC	Navy, Pediatrics
Mr. Joe Canzolino	U.S. Department of Veterans Affairs
Nonvoting Members Present	
Mr. David Hurt	Associate General Counsel, TMA
COL Todd Williams, MS	Defense Medical Materiel Program Office
Maj Dan Castiglia via DCO	Defense Logistics Agency Troop Support
Guests	
Mr. Bill Davies via DCO	TRICARE Management Activity, Pharmaceutical Operations Directorate
CAPT Joel A. Roos	Navy Medicine Training Support Center
LCDR David Sohl	University of Texas Masters Student
Maj Ellen Roska	University of Texas PhD Student

Appendix A—Attendance (continued)

Others Present	
LCDR Marisol Martinez, USPHS	DoD Pharmacoeconomic Center
LCDR Joshua Devine, USPHS	DoD Pharmacoeconomic Center
LCDR Bob Selvester, MC	DoD Pharmacoeconomic Center
LCDR Ola Ojo, MSC	DoD Pharmacoeconomic Center
LCDR Linh Quach, MSC	DoD Pharmacoeconomic Center
Maj David Folmar, BSC	DoD Pharmacoeconomic Center
MAJ Misty Cowan, MC	DoD Pharmacoeconomic Center
Dr. David Meade	DoD Pharmacoeconomic Center
Dr. Angela Allerman	DoD Pharmacoeconomic Center
Dr. Shana Trice	DoD Pharmacoeconomic Center
Dr. Amy Lugo	DoD Pharmacoeconomic Center
Dr. Teresa Anekwe via DCO	DoD Pharmacoeconomic Center
Dr. Eugene Moore	DoD Pharmacoeconomic Center
Dr. Jeremy Briggs	DoD Pharmacoeconomic Center
Dr. Brian Beck	DoD Pharmacoeconomic Center
LT Kendra Jenkins, USPHS	Pharmacy Resident
Ms. Deborah Garcia	DoD Pharmacy Outcomes Research Team contractor
Dr. Esmond Nwokeji	DoD Pharmacy Outcomes Research Team contractor
Mr. Kirk Stocker	DoD Pharmacy Outcomes Research Team contractor

Appendix B—Table of Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
• Canagliflozin (Invokana) **Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors**	• Use of the formulary agent is contraindicated
• Febuxostat (Uloric) **Anti-gout Drugs**	• Use of allopurinol is contraindicated. • The patient has experienced significant adverse effects from allopurinol that are not expected to occur with the non-formulary medication. • Use of allopurinol has resulted in therapeutic failure. • The patient previously responded to non-formulary agent and changing to allopurinol would incur unacceptable risk.

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• Canagliflozin (Invokana) **Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors**	All new and current users of an SLGPT2 inhibitor are required to try metformin, a sulfonylurea (SU), or a DPP-4 inhibitor before receiving canagliflozin (Invokana). Automated PA criteria—The patient has filled a prescription for metformin, a SU, or a DPP-4 inhibitor at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA criteria—If automated criteria are not met, canagliflozin (SGLT2 inhibitor) is approved (e.g., trial of metformin or SU or DPP-4 inhibitor is NOT required) if: • The patient has experienced any of the following issues on metformin: o impaired renal function precluding treatment with metformin o history of lactic acidosis • The patient has experienced any of the following issues on a sulfonylurea: o hypoglycemia requiring medical treatment • The patient has had inadequate response to metformin or a SU or a DPP-4 inhibitor • The patient has a contraindication to metformin or a SU or DPP-4 inhibitor
• Febuxostat (Uloric) **Anti-gout Drugs**	New and current users of febuxostat (Uloric) are required to try allopurinol. Automated PA Criteria—The patient has received a prescription for allopurinol at any Military Health System pharmacy point service (Military Treatment Facilities, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA Criteria—If automated criteria are not met, febuxostat (Uloric) is approved (e.g., a trial of allopurinol is not required) if: • The patient has experienced any of the following issues with at least one of the following with allopurinol, which is not expected to occur with febuxostat (Uloric): o The patient has had an inadequate response to allopurinol (failure to achieve serum uric acid levels < 6 mg/day) after an adequate trial (at least 300 mg per day of allopurinol) o The patient has had intolerable adverse effects (e.g., hypersensitivity) to allopurinol o The patient has a contraindication to allopurinol (e.g., renal impairment)

• icosapent ethyl (Vascepa) **Antilipidemic-2s**	New and current users of Vascepa are required to undergo the PA process. <u>Manual PA Criteria</u>—Vascepa is approved if: • Patients Receiving Statins: o Patients with triglyceride (TG) Levels > 500 mg/dL AND o Inadequate TG-lowering response to a therapeutic trial of niacin (1-g/day), unable to tolerate niacin/fibrate or who are not a candidate for niacin/fibrate therapy * ** • Patients NOT Receiving Statins: o Patients with TG Levels > 500 mg/dL AND o Inadequate response to a therapeutic trial of monotherapy with both a fibrate and niacin (1-2 g/day), unable to tolerate a fibrate and niacin or who are not candidates for fibrates** and niacin therapy • Patients with TG <500 mg/dL or <500 mg/dL with an inadequate TG-lowering response to niacin or fibrates or who are unable to tolerate/are not candidates for niacin or fibrates • Coverage is not approved for the use of Vascepa for the treatment of other conditions, including: ADHD, Alzheimer's disease, bipolar disorder, Crohn's disease, cystic fibrosis, dementia, depression, inflammatory bowel disease, intermittent claudication, metabolic syndrome, osteoporosis, PTSD, renal disease (IgA nephropathy), rheumatoid arthritis, schizophrenia, Type 2 diabetes mellitus, and ulcerative colitis *Not candidates for niacin: patients with a history of confirmed PUD (perforation, ulceration, or upper GIB), gouty attacks (presence of intra-articular uric acid crystals in the affected joint), and/or poorly controlled diabetes **Not candidates for fibrates: patients with hepatic or severe renal dysfunction, including primary biliary cirrhosis and preexisting gallbladder disease
• abiraterone (Zytiga) **Oral Chemotherapy Drugs for Prostate Cancer**	<u>Manual PA Criteria</u>—Coverage approved for treatment of patients: • With a documented diagnosis of metastatic castration-resistant prostate cancer AND • Patient is receiving concomitant prednisone

Appendix D—Table of Implementation Status of UF Recommendations/Decisions Summary

Date	DoD PEC Drug Class	Type of Action*	BCF/ECF Medications MTFs must have BCF meds on formulary	UF Medications MTFs may have on formulary	Nonformulary Medications MTFs may not have on formulary	Decision Date / Implement Date	PA and QL Issues	Comments
May 2013	**Pulmonary II Drugs**	UF Class Review	▪ Ipratropium HFA MDI (Atrovent HFA) ▪ Ipratropium/ albuterol nebulized solution (DuoNeb) ▪ Tiotropium inhaler (Spiriva)	▪ Aclidinium inhaler (Tudorza) ▪ Ipratropium nebulized solution (Atrovent) ▪ Ipratropium / albuterol soft mist inhaler (Combivent Respimat) ▪ Roflumilast (Daliresp)	▪ None	Pending signing of the minutes	None	▪ Combivent Respimat added to the BCF
May 2013	**Anti-Gout Drugs**	UF class review	▪ Allopurinol	▪ colchicine (Colcrys) ▪ probenecid ▪ colchicine/probenecid	▪ Febuxostat (Uloric)	Pending signing of the minutes / 90 days	Step therapy (automated PA); requires a trial of allopurinol prior to use of Uloric in all new and current users of Uloric.	▪ Step therapy does not apply to colchicine, probenecid, or colchicine/ probenecid
May 2013	**Non-Insulin Diabetes Drugs: Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors**	New Drug review	▪ None	▪ None	▪ **Canagliflozin (Invokana) recommended for NF May 2013**	Pending signing of the minutes / 30 days	Step therapy (automated PA); requires a trial of metformin, an SU, or a DPP-4 inhibitor in all new and current users of a SGLT2 inhibitor	BCF, UF, and NF drugs are designated for the non-insulin diabetes drugs for metformin, sulfonylureas, DPP-4 inhibitors, GLP1RA agonists, TZDs, meglitinides, and alpha glucosidase inhibitors (see Minutes November 2010, August 2012, and November 2012).

TRICARE Formulary Search tool: http://www.pec.ha.osd.mil/formulary_search.php

Appendix E—Table of Abbreviations

ASD(HA)	Assistant Secretary of Defense for Health Affairs
ART	assisted reproductive technology
BCF	Basic Core Formulary
BIA	budget impact analysis
CFC	chlorofluorocarbon
CMA	cost minimization analysis
COPD	chronic obstructive pulmonary disease
CV	cardiovascular
DCO	Defense Connect Online
DoD	Department of Defense
DPP-4	dipeptidyl-dipeptidase-4
EMA	European Medicines Association
FDA	U.S. Food and Drug Administration
GI-1	Gastrointestinal-1 Drug Class
GLP1RA	glucagon-like peptide-1 receptor agonist
HFA	hydrofluoroalkane
LAMA	long-acting muscarinic agent
LDL	low-density lipoprotein cholesterol
MDI	metered dose inhaler
MHS	Military Health System
MN	medical necessity
MTF	Military Treatment Facility
NF	nonformulary
NSAIDs	nonsteroidal anti-inflammatory drugs
OTC	over-the-counter
P&T	Pharmacy and Therapeutics
PA	prior authorization
PDE-4	phosphodiesterase-4
PEC	Pharmacoeconomic Center
POS	points of service
PPIs	proton pump inhibitors
QLs	quantity limits
SABA	short-acting beta agonist
SAMA	short-acting muscarinic agent
SGLT2	sodium glucose co-transporter 2
SMBGS	self-monitoring blood glucose system
SU	sulfonylurea
sUA	serum uric acid
TG	triglyceride
TZD	thiazolidinedione
ULT	urate-lowering therapy
UF	Uniform Formulary