DEPARTMENT OF DEFENSE

PHARMACY AND THERAPEUTICS COMMITTEE
MINUTES AND RECOMMENDATIONS

November 2014

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on November 19 and 20, 2014, at the Defense Health Agency (DHA) Formulary Management Branch, Fort Sam Houston, Texas.

II. ATTENDANCE

The attendance roster is listed in Appendix A.

A. Review Minutes of Last Meetings

1. **Approval of August Minutes**—Lt. Gen. Douglas J. Robb, DO, MPH, Director, DHA, approved the minutes from the August 2014 DoD P&T Committee meeting on November 13, 2014.

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. Insulin Drugs: Miscellaneous Insulin Delivery Devices—Valeritas V-Go (V-Go)

Background—V-Go is a disposable insulin delivery device approved for patients with diabetes mellitus. Unlike an insulin pump, V-Go does not require any tubing or catheters. The device is filled daily with rapid-acting insulin, allowing for continuous administration of basal insulin and optional bolus dosing. After 24 hours, the device is discarded and replaced with a new unit.

The advantages of using V-Go include convenience for the patient who desires increased control over their blood glucose levels and elimination of the need for multiple daily insulin injections. Compared to multiple insulin injections, V-Go may reduce prandial glycemic excursions.

There are no randomized controlled trials using the V-Go insulin delivery device compared to usual care with basal or basal/bolus insulin dosing using pens or vials. Limitations of the V-Go studies include small sample sizes (<140 patients enrolled), varied efficacy endpoints, short trial duration, and lack of published studies. Another limitation is that reports of patients requiring overall reduced total daily insulin doses was based on subjective patient-reported data and not on objective endpoints. Additionally, the discontinuation rates in the V-Go studies were high. Although the V-Go studies reported improvements in hemoglobin A1c- lowering, it is difficult to attribute those improvements to the V-Go device due to the lack of control groups and limitations in study design. Long-term data on whether the V-Go device improves patient adherence is lacking.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) that the V-Go delivery device offers patient convenience because multiple daily insulin injections are not needed; however, it offers no clinically compelling advantages over existing UF insulin agents administered with pens or vials.

Relative Cost-Effectiveness Analysis and Conclusion—Cost-minimization analysis (CMA) was performed. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) that the CMA showed V-Go was more costly than other combinations of basal/bolus insulin (e.g., Lantus/Novolog) currently on the UF.

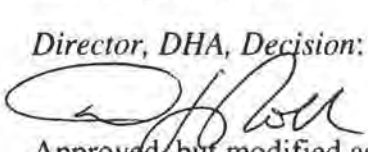
1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) V-Go be designated NF due to the lack of compelling clinical advantages and the cost disadvantage compared to the other UF products.

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) MN criteria for V-Go. See Appendix B for the full criteria.

3. ***COMMITTEE ACTION: PRIOR AUTHORIZATION (PA) CRITERIA***
Manual PA criteria were recommended at the August 2014 DoD P&T Committee meeting and implemented on November 14, 2014. The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) clarifying the PA criteria for V-Go. See Appendix C for the full criteria.

4. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) an effective date of the first Wednesday after a 60-day implementation period in all points of service (POS). Based on the P&T Committee's recommendation, the effective date is April 8, 2015.

Director, DHA, Decision: ☒ Approved ☐ Disapproved



Approved, but modified as follows:

B. Chronic Obstructive Pulmonary Disease (COPD) Drugs—Umeclidinium/Vilanterol (Anoro Ellipta)

Background—Umeclidinium/vilanterol is the first fixed dose combination of a long-acting muscarinic agent (LAMA) with a long-acting beta agonist (LABA) to reach the market. Anoro Ellipta is indicated for maintenance treatment of COPD; in contrast, other products have the additional indication for reducing COPD exacerbations (Spiriva, Advair, and Breo Ellipta).

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the main clinical benefits of umeclidinium/vilanterol are its superior improvements in forced expiration volume in 1 second (FEV_1) compared to single ingredient inhalers, the convenience to patients of combining two long-acting bronchodilators into one inhaler, and once daily dosing. The COPD agents will be re-reviewed at an upcoming meeting for UF and BCF placement. Additionally, the P&T Committee recommended adding the LAMA/LABA combinations to the Pulmonary II Drug Class, which includes other chemical entities used for treating COPD.

Relative Cost-Effectiveness Analysis and Conclusion—CMA was performed to evaluate umeclidinium/vilanterol (Anoro Ellipta) with other LAMA and LABA therapies in the treatment of COPD. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA showed that the Anoro Ellipta fixed dose combination bronchodilator offers a cost-effective alternative to combining available LAMA and LABA inhalers.

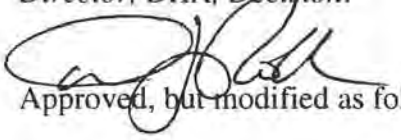
1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) umeclidinium/vilanterol (Anoro Ellipta) be designated formulary on the UF, based on clinical and cost effectiveness.

2. ***COMMITTEE ACTION: QLs***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) the following QLs for umeclidinium/vilanterol (Anoro Ellipta), consistent with the FDA-approved package labeling:

    - Retail Network: 1 inhaler per 30 days
    - Mail Order Pharmacy: 3 inhalers per 90 days

3. ***COMMITTEE ACTION: TRICARE FOR LIFE PHARMACY DRUG LIST***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) adding Anoro Ellipta to the TRICARE for Life Pharmacy Drug List due to the potential for additional cost avoidance, and for consistency with other inhaled bronchodilators on the UF that are already included on the Pharmacy Drug List.

Director, DHA, Decision: ☑ Approved ☐ Disapprov



Approved, but modified as follows:

C. Glaucoma Drugs: Brinzolamide 1%/Brimonidine 0.2% Ophthalmic Suspension (Simbrinza)

Background—Brinzolamide/brimonidine ophthalmic suspension (Simbrinza) is the first fixed dose combination product for glaucoma that has components other than a beta blocker. It contains a carbonic anhydrase inhibitor (brinzolamide, Azopt) and an alpha 2 adrenergic receptor agonist (brimonidine, Alphagan).

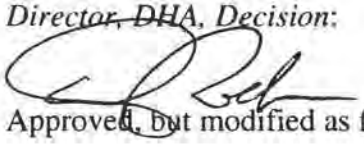
Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) Simbrinza's fixed combination offers a convenience to the patient versus using two drugs concomitantly, even though it requires dosing three times a day. Simbriniza also decreases intraocular pressure to a greater extent than the individual components administered alone.

Relative Cost-Effectiveness Analysis and Conclusion—CMA was performed to evaluate brinzolamide/brimonidine (Simbrinza) with other drugs used in the treatment of glaucoma. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA showed that brinzolamide/brimonidine (Simbrinza) was comparable to the UF carbonic anhydrase inhibitors and alpha 2 adrenergic receptor agonists when taken in combination.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) brinzolamide 1%/brimonidine 0.2% ophthalmic suspension (Simbrinza) be designated with formulary status on the UF, based on clinical and cost effectiveness.

Director, DHA, Decision: ☑ Approved ☐ Disapproved



Approved, but modified as follows:

D. Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)—Bromfenac 0.07% Ophthalmic Solution (Prolensa)

Background—Bromfenac 0.07% (Prolensa) is FDA-indicated for the treatment of postoperative inflammation and pain in patients following cataract surgery. It is the third bromfenac formulation to obtain FDA approval. The branded formulations of bromfenac 0.09% (Xibrom)

dosed twice daily and bromfenac 0.09% (Bromday) dosed once daily (QD) have been discontinued by the manufacturer.

There are no head-to-head clinical trials comparing Prolensa with another ophthalmic NSAID. There is no data to show that Prolensa is better tolerated when compared to generic bromfenac 0.09% (Bromday) QD. While Prolensa offers the convenience of once daily dosing, generic Bromday is also dosed once daily.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) that Prolensa does not offer clinically relevant advantages over the other UF ocular NSAIDs that are FDA-approved for use following cataract surgery.

Relative Cost-Effectiveness Analysis and Conclusion—CMA was performed to evaluate bromfenac 0.07% ophthalmic solution (Prolensa) with other ophthalmic NSAIDs on the UF. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) that Prolensa was the most costly ocular NSAID.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) bromfenac 0.07% ophthalmic solution (Prolensa) be designated NF due to the lack of compelling clinical advantages and the cost disadvantage compared to the other UF products.

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) MN criteria for bromfenac 0.07% ophthalmic solution (Prolensa). See Appendix B for the full criteria.

3. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) an effective date of the first Wednesday after a 90-day implementation period in all POS. Based on the P&T Committee's recommendation, the effective date is May 6, 2015.

Director, DHA Decision ☑ Approved ☐ Disapproved

Approved, but modified as follows:

V. UF DRUG CLASS REVIEWS

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

Background—The P&T Committee reviewed the clinical effectiveness of the SMBGS test strips. See Appendix D for a full list of the SMBGS test strips in the class. 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.

U.S. Federal Government contracting requirements stated the following:

> The Company shall ensure test strips are made available to all three Points of Service (Military Treatment Facilities, TRICARE Mail Order Pharmacy, and Retail Network). In accordance with industry practice, the Company shall make meters available to DoD beneficiaries at no additional charge or cost to the DoD beneficiary.

The FDA classifies SMBGS test strips and glucometers as medical devices rather than drugs. The clinical effectiveness review focused on differences in the technical aspects/attributes among the test strips and glucometers. The P&T Committee recommended that the potential test strips considered for inclusion on the UF should meet standards relating to such factors as FDA requirements for accuracy based on the International Organization for Standardization (ISO) 15197 guidelines from 2003, sample size, alternate site testing, result time, memory capacity, ease of calibration, customer support, downloading capabilities, and data management capabilities.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following for the SMBGS test strips:

- Potential SMBGS test strips considered for inclusion on the UF must meet all U.S. Federal Government contracting requirements and the technical factors listed above.
- Potential SMBGS test strips considered for inclusion on the UF included FreeStyle Lite; FreeStyle InsuLinx; Precision Xtra; ACCU-CHEK Aviva Plus; OneTouch Ultra Blue; OneTouch Verio; CONTOUR NEXT; TRUEtest; Nova Max; GLUCOCARD 01-SENSOR; GLUCOCARD Vital; and Prodigy No Coding.
- *Overall relative clinical effectiveness conclusion:* The P&T Committee concluded there were no clinically relevant differences between the 12 SMBGS test strips that were reviewed and met the contracting requirements and technical factors, and that any of the 12 test strips were acceptable for inclusion on the UF.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and budget impact analysis (BIA) were performed to evaluate the SMBGS test strips that were considered for inclusion on the UF. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

- Results from a comprehensive cost analysis, which included a CMA and considered the cost of patient switching and related DoD administrative costs in addition to SMBGS test strip per unit costs, showed FreeStyle Lite and Precision Xtra test strips were the most cost-effective SMBGS test strips, followed by ACCU-CHEK Aviva Plus, GLUCOCARD Vital and GLUCOCARD 01-SENSOR, TRUEtest, Prodigy No Coding, CONTOUR NEXT, Nova Max, and all other SMBGS test strips. OneTouch Ultra Blue test strips were the least cost-effective.

- BIA was performed to evaluate the potential impact of scenarios, with selected test strips designated step-preferred and UF or non-preferred and NF on the UF. BIA results showed the scenario with FreeStyle Lite and Precision Xtra designated as step-preferred on the UF and all remaining test strips designated NF and non-step preferred, where all current and new users are required to try FreeStyle Lite or Precision Xtra first, was the most cost-effective option for the Military Health System (MHS).

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) the following:

    - UF and step-preferred:
        - FreeStyle Lite
        - Precision Xtra

    - NF and non-step preferred:
        - ACCU-CHEK Aviva Plus
        - GLUCOCARD 01-SENSOR
        - GLUCOCARD Vital
        - CONTOUR NEXT
        - FreeStyle InsuLinx
        - Nova Max
        - TRUEtest
        - Prodigy No Coding
        - OneTouch Verio
        - OneTouch Ultra Blue
        - All other test strips listed in Appendix D with the exception of FreeStyle Lite and Precision Xtra

    - This recommendation includes step therapy, which requires a trial of FreeStyle Lite or Precision Xtra prior to use of a NF test strip. The recommendation requires all current and new users of a non-preferred test strip try FreeStyle Lite or Precision Xtra, or meet the PA criteria for the non-preferred strips.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) maintaining Precision Xtra test strips on the BCF and adding FreeStyle Lite test strips to the BCF.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) MN criteria for the SMBGS test strips. See Appendix B for full criteria.

4. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) manual PA criteria for all new and current users of NF test strips. The manual PA criteria requires a trial of FreeStyle Lite or Precision Xtra prior to the use of a NF test strip. See Appendix C for the full criteria.

5. ***COMMITTEE ACTION: QLs***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) QLs for the SMBGS test strips, limiting use to 100 strips per 30-day supply in the Retail Network and 300 strips per 90-day supply in the Mail Order and MTF points of service. See Appendix F for the full criteria.

   Quantity Limits for the SMBGS test strips may be exceeded in the following situations: patient is receiving insulin; using an insulin pump; has gestational diabetes; requires more frequent testing due to endocrine disorders (e.g., insulinoma, endogenous hyperinsulinism, non-islet cell tumor); or, has a history of poorly controlled blood glucose levels with adverse outcomes (e.g., ketoacidosis or hypoglycemic episode), requiring medical intervention.

6. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday after a 120-day implementation period in all POS; and, 2) DHA send a letter to beneficiaries affected by the UF and PA decisions. Based on the P&T Committee's recommendation, the effective date is June 3, 2015.

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows: implement in 180 days.

B. Multiple Sclerosis (MS)

Relative Clinical Effectiveness—The P&T Committee evaluated the relative clinical effectiveness of the MS Drug Class, which is comprised of the following injectable and oral disease-modifying drugs:

- **Injectable:** Interferon beta-1b (Betaseron and Extavia subcutaneous (SC) injections), interferon beta-1a (Avonex intramuscular (IM) injection; Rebif SC injection), and, glatiramer (Copaxone 20 mg SC daily injection and 40 mg three times a week (TIW) SC injection)

- **Oral**: dimethyl fumarate (Tecfidera), fingolimod (Gilenya), and teriflunomide (Aubagio)

Relative Clinical Effectiveness Conclusion—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) the following conclusions for the MS drugs:

1. For the injectables, no one interferon product is preferred over the other in terms of efficacy and safety. Interferon beta-1a IM (Avonex) is possibly less effective than the other interferons, based on the Oregon Drug Effectiveness Review Project (DERP, 2010).
2. In a Cochrane review (2014), similar outcomes (including clinical and magnetic resonance imaging activity measures) were reported when the interferons were compared to glatiramer (Copaxone) for treating patients with relapsing-remitting forms of MS. These findings differ from the DERP 2010 report, where Avonex was presented as less effective.
3. The Copaxone 40 mg TIW formulation has the convenience of less frequent administration than the 20 mg daily Copaxone formulation. However, the 40 mg TIW product has not been directly compared to the 20 mg daily formulation for efficacy or safety; trials are ongoing.
4. There are no head-to-head trials of one oral drug with another oral drug; placebo controlled studies were used to obtain FDA approval. Limited data from head-to-head trials of the injectables versus oral medications report the following:
    - Fingolimod produces a greater reduction in the annualized relapse rate (ARR) compared to interferon beta-1a IM (Avonex).
    - Teriflunomide (Aubagio) 14 mg and interferon beta-1a SC (Rebif) produced similar reductions in the ARR, while teriflunomide 7 mg was less effective than the 14 mg dose and Rebif.
    - There were no clinically relevant differences in the ARR when glatiramer (Copaxone) was compared to dimethyl fumarate (Tecfidera).
5. The Canadian Agency for Drugs in Technology and Health (CADTH, October 2013) reported the relative ARRs of the various MS treatments compared to placebo. Fingolimod (Gilenya) and dimethyl fumarate (Tecfidera) had the lowest ARRs; teriflunomide, interferon beta-1b SC (Betaseron), interferon beta-1a SC (Rebif), and glatiramer (Copaxone) all had similar ARRs; and, interferon beta-1a (Avonex) had the highest ARR.
6. The MS drugs have distinctly different adverse event profiles. Copaxone has the advantage of a pregnancy category B rating.
7. Dalfampridine (Ampyra) is an orally administered drug that is not disease-modifying; it is solely approved for symptom management to improve walking distance.

8. Due to their differing safety profiles and low degree of therapeutic interchangeability, several MS products are required on the UF to meet the needs of the MHS population.

Relative Cost-Effectiveness Analysis and Conclusion—A cost-effectiveness analysis (CEA) and BIA were performed to evaluate the MS Drug Class. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

- CEA results showed that, when considering the incremental cost-effectiveness ratios per relapse avoided, all scenarios were within a range considered to be cost-effective to the MHS. Ampyra was not included in the CEA as it is not a disease-modifying drug.
- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that all modeled scenarios demonstrated a similar level of cost avoidance for the MHS, with only slight differences between evaluated scenarios.

1. ***COMMITTEE ACTION: UF RECOMMENDATIONS***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) the following:
    - UF:
        - Interferon beta-1a SQ (Rebif and Rebif Rebidose)
        - Interferon beta-1a IM (Avonex IM)
        - Interferon beta-1b SC (Betaseron)
        - Interferon beta-1b SC (Extavia)
        - Dalfampridine (Ampyra)
        - Dimethyl fumarate (Tecfidera)
        - Fingolimod (Gilenya)
        - Glatiramer (Copaxone)
        - Teriflunomide (Aubagio)
    - NF: None
2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The MS Drugs Class is now a BCF class; it was previously an Extended Core Formulary (ECF) drug class. The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) interferon beta-1b SC (Betaseron) be designated with BCF status since it is the most cost-effective MS drug. As a result of this action, interferon beta-1a IM (Avonex) is no longer ECF; it remains on the UF.
3. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—Manual PA criteria recommended in November 2010 and November 2013 currently apply to fingolimod (Gilenya) and dimethyl fumarate (Tecfidera), respectively. The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) maintaining the current PA criteria for Tecfidera and

revising the PA criteria for Gilenya due to recent updates in the package insert for cardiovascular toxicity. See Appendix C for full criteria.

4. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date no later than 30 days after signing of the minutes in all POS.

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

VI. UTILIZATION MANAGEMENT

A. Prior Authorizations and Medical Necessity

1. **Hepatitis C Virus (HCV) Agents, Direct Acting Antivirals (DAAs): Ledipasvir/Sofosbuvir (Harvoni) Manual PA Criteria and QLs**—Ledipasvir 90 mg/sofosbuvir 400 mg (Harvoni) is a once daily fixed dose combination tablet that was approved by the FDA in October 2014 for the treatment of HCV genotype 1. It is the first FDA-approved interferon-free regimen indicated to treat HCV genotype 1. Harvoni will be reviewed as a new drug at an upcoming meeting.

   a) ***COMMITTEE ACTION: HARVONI MANUAL PA CRITERIA***—PA criteria currently apply to the DAAs. The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for new users of ledipasvir/sofosbuvir (Harvoni), consistent with FDA-approved labeling. Prior authorization will expire after 8–24 weeks based on the treatment regimen. See Appendix E for the full criteria.

2. **Hepatitis C Virus Agents, Direct Acting Antivirals (DAAs): Simeprevir (Olysio) Manual PA Criteria**—PA criteria were recommended for Simeprevir (Olysio) at the May 2014 DoD P&T Committee meeting. Simeprevir received a new FDA indication in November 2014 as a component of an interferon-free combination treatment for chronic HCV genotype 1.

   a) ***COMMITTEE ACTION: SIMEPREVIR (OLYSIO) PA CRITERIA***
   The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) revising the existing PA criteria for Olysio to include the expanded FDA-approved indication. See Appendix E for the full criteria.

3. **Targeted Immunomodulatory Biologics (TIBs): Adalimumab (Humira), Apremilast (Otezla), and Etanercept (Enbrel)**—The TIBs were reviewed by the P&T Committee in August 2014 and automated PA (step therapy) and manual PA criteria

were recommended for the class. Recently, adalimumab (Humira) received FDA approval for pediatric Crohn's disease in patients as young as six years and juvenile idiopathic arthritis (JIA) in patients as young as four years; apremilast (Otezla) received FDA approval for plaque psoriasis. PA criteria were updated for Humira and Otezla to reflect their new respective FDA indications. See Appendix C for the full criteria.

Accordingly, step therapy criteria and MN criteria for etanercept (Enbrel) were also revised since Enbrel and Humira are now indicated for the same age range in patients with JIA.

a) ***COMMITTEE ACTION: ADALIMUMAB (HUMIRA) AND APREMILAST (OTEZLA) PA CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) revised manual and step therapy PA criteria for Humira and Otezla, consistent with the new FDA-approved product labeling. See Appendix C for the full criteria.

b) ***COMMITTEE ACTION: ETANERCEPT (ENBREL) MN AND PA CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) an update to the MN and PA criteria for Enbrel since Humira is now indicated for JIA. See Appendices B and C for the full criteria.

4. **Prostate Cancer: Enzalutamide (Xtandi)**—Xtandi is an androgen receptor inhibitor that prolongs survival of metastatic castration-resistant prostate cancer. Manual PA criteria were recommended at the November 2012 P&T Committee meeting. The package insert for Xtandi was updated to state that prior treatment with docetaxel is no longer required.

a) ***COMMITTEE ACTION: ENZALUTAMIDE (XTANDI) PA CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) an update to the manual PA criteria for Xtandi, consistent with the product's labeling for treatment of metastatic castration-resistant prostate cancer. See Appendix C for the full criteria.

5. **Non-Insulin Diabetes Mellitus Drugs: Glucagon-Like Peptide-1 Receptor Agonist (GLP1RAs); Exenatide Once Weekly Pen (Bydureon Pen)**—Exenatide (Bydureon) is now available in a pre-filled pen, in addition to the original vial formulation. The manufacturer states that they do not intend to discontinue the original vial formulation. Both products are dosed once weekly. However, the cost of the Bydureon pen formulation is significantly higher than the Bydureon vials despite having the same dosing and FDA-approved indications. Exenatide (Byetta) is also available in a pen formulation that is dosed twice daily. Manual PA criteria were recommended for the Bydureon pen due to the cost and because other exenatide products (Bydureon vials and Byetta) are available on the UF. The GLP1RA Drug Subclass, including the Bydureon

pen formulation, is scheduled for review at an upcoming meeting.

a) ***COMMITTEE ACTION: EXENATIDE PEN (BYDUREON PEN) PA CRITERIA***—The P&T Committee recommended (16 for, 1 opposed, 0 abstained, 1 absent) manual PA criteria for the Bydureon pen, requiring use of Bydureon vials first. Additionally, a trial of metformin or a sulfonylurea is also required, consistent with the PA criteria for other GLP1RAs. See Appendix C for the full criteria.

B. QLs—QLs for several drugs were reviewed, including the HCV direct acting antiviral ledipasvir/sofosbuvir (Harvoni); the pulmonary fibrosis drugs nintedanib (Ofev) and pirfenidone (Esbriet); and, the LABA olodaterol (Striverdi Respimat). QLs apply to the other products in these drug classes.

1. ***COMMITTEE ACTIONS: QLs***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) QLs for ledipasvir/sofosbuvir (Harvoni), nintedanib (Ofev), pirfenidone (Esbriet), and olodaterol (Striverdi Respimat), consistent with the product labeling. See Appendix F for QLs.

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

VII. SECTION 716 OF THE NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FISCAL YEAR 2013 PILOT PROGRAM FOR REFILLS OF MAINTENANCE MEDICATIONS FOR TRICARE FOR LIFE BENFICIARIES THROUGH THE TRICARE MAIL ORDER PROGRAM

A. Medication Drug List for the Pilot Program: Updates—The Medication Drug list for the Pilot Program for TRICARE for Life beneficiaries was recommended at the November 2013 P&T Committee meeting. An update to the drug list is required due to products discontinuations from the market, availability issues, and to ensure consistency within the drug classes. See the TRICARE Formulary Search Tool at *http://pec.ha.osd.mil/TFL_maintenance_drug_list.php* for the full medication drug list.

1. ***COMMITTEE ACTION: MAINTENANCE MEDICATION PROGRAM DRUG LIST UPDATE***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) changes to the list of covered maintenance medications for the Section 716 pilot program. Implementation will occur upon signing of the minutes. See Appendix H for the full list of changes.

☒ Approved ☐ Disapproved

Director, DHA, Decision:

Approved, but modified as follows:

VIII. LINE EXTENSIONS

A. Formulary Status Clarification—The P&T Committee clarified the formulary status for one product line extension ("follow-on product") by the original manufacturer. Line extensions have the same FDA indications and pricing as the "parent" drug.

1. ***COMMITTEE ACTION: LINE EXTENSIONS FORMULARY STATUS CLARIFICATION***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) clarifying the formulary status of insulin detemir (Levemir Flextouch). The Levemir Flextouch formulation is replacing the Levemir Flexpen formulation, which was discontinued from the market in the summer of 2014. Implementation will occur upon signing of the minutes.

    - Insulin detemir (Levemir Flextouch): NF, similar to Levemir Flexpen

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

IX. COMPOUND PRESCRIPTIONS

A. PA Criteria—The P&T Committee was presented with an update on the status of compounded medications. MHS expenditures for compounded medications are significant and increasing, and compounded medications have a high potential for inappropriate use. From June 2013 through May 2014, 140,000 beneficiaries filled 360,000 compounded prescriptions that totaled over $410 million in expenditures at the Retail Network and Mail Order POS. In an effort to decrease inappropriate use and ensure safety for beneficiaries, PA criteria were proposed.

1. ***COMMITTEE ACTION: COMPOUND PRESCRIPTIONS MANUAL PA CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) manual PA criteria for all new and current users of compounds. Coverage will be approved if the prescriber provides the following information listed below and implementation of the PA will occur when a final recommendation is made.

    a) What is the diagnosis?

b) Has the patient tried commercially available products for the diagnosis provided? Please state all products tried.

c) Is there a current national drug shortage of an otherwise commercially available product?

d) What is the proposed duration of therapy?

AND

The patient meets the following criteria:

(1) Each active ingredient(s) is/are a chemical entity of an FDA-approved drug for marketing in the United States AND the drugs have not been withdrawn for safety reasons from the U.S. market. (If True, proceed to (2); if False, claim rejects.)

(2) Each active ingredient(s) used in this compound is indicated by the FDA to treat the diagnosis provided. (If True, proceed to (3); if False, claim rejects.)

(3) An FDA-approved commercially available product is not appropriate because the patient requires a unique dosage form or concentration (e.g., inability to take a solid dosage form, dose based on age or weight) and/or an FDA-approved product cannot be taken due to allergies or contraindication. (If True, Approved; if False, claim rejects.

Director, DHA, Decision: □ Approved ☒ Disapproved

Approved, but modified as follows: pending consideration of BAP recommendations.

X. SPECIALTY MEDICATIONS

A. Clinical Services Drug List and DoD Specialty Agent Reporting List—The P&T Committee was briefed on two separate drug lists for specialty medications, the Clinical Services Drug List and the DoD Specialty Agent Reporting List.

Drugs are assigned to the DoD Specialty Agent Reporting List when they generally meet at least two of these four criteria: cost $500 or more per dose or $6,000 or more per year, have a difficult or unusual process of delivery, require patient management beyond traditional dispensing practices, or as defined by DoD. The DoD Specialty Agent Reporting List is used internally for reporting purposes to monitor drug spend and trends in utilization of specialty medications.

The Clinical Services Drug List is a subset of the DoD Specialty Agent Reporting List and identifies drugs for which contractor-provided pharmacy services at the Retail Network and Mail Order Pharmacy will be provided in conjunction with the new TRICARE Pharmacy contract effective in May 2015.

The P&T Committee reviewed the list of drugs recommended for the Clinical Services Drugs List and voted to remove drugs that are no longer marketed, remove drugs that do not require enhanced clinical services, remove certain drugs classes to allow consideration at future P&T Committee meetings, and add drugs to the list that meet the definition above and require enhanced clinical services.

The Clinical Services Drug List comprises 79 products from a variety of drug classes, including bleeding disorders (hemophilia), MS, HCV, rheumatoid arthritis and other inflammatory conditions, oncology, osteoporosis, neutropenia, acromegaly, iron overload, and hormonal therapies.

The P&T Committee also recommended that additions or deletions to the Clinical Services Drug List be made administratively when new products are approved or when market discontinuations occur to maintain the currency of the list and to ensure timely patient access to specialty medications. The P&T Committee will then review any administrative actions at the next scheduled P&T Committee meeting.

1. ***COMMITTEE ACTION: CLINICAL SERVICES DRUG LIST AND DOD SPECIALTY AGENT REPORTING LIST***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) the changes to the Clinical Services Drug List outlined above, and recommended the List be maintained administratively, with any additions or deletions reported at the next scheduled DoD P&T Committee meeting.

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

XI. ITEMS FOR INFORMATION

A. Naloxone—The P&T Committee was briefed on an executive action by President Obama to expand the availability of opioid overdose reversal kits for first responders on military bases and other areas under DoD control to improve patient safety and prevent suicides. In April 2014, the FDA approved the first naloxone auto-injectable (Evzio) formulation intended for caregiver administration in emergency situations. The potential implications of wider access of Evzio to patients/family members using opioids who are at increased risk for opioid overdose were discussed. Updates to the P&T Committee will be provided as new information becomes available.

B. UF Proposed Rule—A Proposed Pharmacy TRICARE Rule published in the CFR on September 19, 2014 (http://www.gpo.gov/fdsys/pkg/FR-2014-09-19/pdf/2014-22276.pdf) proposes administrative changes to align the Pharmacy Benefit Program regulation with the statute (10 U.S.C. 1074g), clarifies some uniform formulary procedures, and designates the over-the-counter demonstration program as permanent. The main points of the Proposed Rule are to limit NF drugs to one point of service, place new drugs approved by the FDA in a provisional status for 120 days, and allow generic drugs to be placed in the third tier co-pay. The review period is scheduled to end on January 19, 2015.

XII. ADJOURNMENT

The meeting adjourned at 1130 hours on November 20, 2014. The next meeting will be in February 2015.

Appendix A—Attendance: November 2014 P&T Committee Meeting

Appendix B—Table of Medical Necessity Criteria

Appendix C—Table of Prior Authorization Criteria

Appendix D—Table of Self-Monitoring Blood Glucose System Test Strips

Appendix E—Table of Prior Authorization Criteria for Hepatitis C Drugs

Appendix F—Table of Quantity Limits

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

Appendix H—Section 716 Maintenance Medication Program Drug List

Appendix I—Table of Abbreviations

SUBMITTED BY:

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

DECISION ON RECOMMENDATIONS

Director, DHA, decisions are as annotated above.

Douglas J. Robb, DO, MPH
Lieutenant General, USAF, MC, CFS
Director

3 Feb 2015
Date

Appendix A—Attendance: November 2014 P&T Committee Meeting

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
George Jones, PharmD, M.S.	Chief, DHA Pharmacy Operations Division
LTC Robert Conrad, MS	DHA Pharmacy Operations Division (Recorder)
COL John Spain, MS	Army, Pharmacy Officer
Col Scott Sprenger, BSC	Air Force, Pharmacy Officer
CDR Aaron Middlekauf, USCG	Coast Guard, Pharmacy Officer Alternate
CAPT Thinh Ha, MSC	Navy, Pharmacy Officer
COL Ted Cieslak, MC	Army, Physician at Large
Col Michael Wynn, MC	Army, Family Practice Physician
LCDR Carey Welsh, MC	Navy, Pediatrics Physician
Col James Jablonski, MC	Air Force, Physician at Large
CDR Brian King, MC	Navy, Internal Medicine Physician
COL Jack Lewi, MC	Army, Internal Medicine Physician
CDR Shaun Carstairs, MC	Navy, Physician at Large
Lt Col William Hannah, MC	Air Force, Internal Medicine Physician
Maj Larissa Weir, MC	Air Force, OB/GYN Physician
Dr. Miguel Montalvo	TRICARE Regional Office-South, Chief of Clinical Operations Division and Medical Director
Voting Members Absent	
Col Michael Spilker, BSC	DHA Deputy Chief, Pharmacy Operations Division
Mr. Joe Canzolino	U.S. Department of Veterans Affairs
Nonvoting Members Present	
Mr. Paul Hutter	Principal Deputy General Counsel, DHA
Mr. Bryan Wheeler via DCO	Deputy General Counsel, DHA
Guests	
Mr. Bill Davies via DCO	DHA Pharmacy Operations Division
MAJ Kevin Ridderhoff	DHA, Pharmacy Operations Division
CDR Ryan Schupbach	Indian Health Service
LT Kendra Jenkins via DCO	DHA, Pharmacy Operations Division

Appendix A—Attendance (continued)

Others Present	
CAPT Walter Downs, MC	DHA Pharmacy Operations Division
CDR Joshua Devine, USPHS	DHA Pharmacy Operations Division
CDR Edward Vonberg, BSC	DHA Pharmacy Operations Division
LTC Misty Cowan, MC	DHA Pharmacy Operations Division
LCDR Marisol Martinez, USPHS	DHA Pharmacy Operations Division
Maj David Folmar, BSC	DHA Pharmacy Operations Division
Maj Ronald Khoury, MC	DHA Pharmacy Operations Division
Angela Allerman, PharmD, BCPS	DHA Pharmacy Operations Division
Shana Trice, PharmD, BCPS	DHA Pharmacy Operations Division
Amy Lugo, PharmD, BCPS via DCO	DHA Pharmacy Operations Division
Eugene Moore, PharmD, BCPS	DHA Pharmacy Operations Division
Brian Beck, PharmD, BCPS	DHA Pharmacy Operations Division
David Meade, PharmD, BCPS	DHA Pharmacy Operations Division
Ms. Deborah Garcia	DHA Pharmacy Operations Division contractor
Mr. Kirk Stocker	DHA Pharmacy Operations Division contractor
Esmond Nwokeji, PhD	DHA Pharmacy Operations Division contractor

Appendix B—Table of Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
• Valeritas Insulin Delivery Device (V-Go) **Insulin–Miscellaneous Insulin Delivery Devices**	• Formulary agents result or are likely to result in therapeutic failure **Formulary alternative:** Uniform Formulary insulin products (insulin glargine, insulin lispro, insulin aspart) pens and vials
• Bromfenac 0.07% ophthalmic solution (Prolensa) **Ophthalmic NSAIDS**	• Patient has experienced or is likely to experience significant adverse effects from formulary agents **Formulary alternatives:** bromfenac, diclofenac, flurbiprofen, ketorolac, nepafenac ophthalmic NSAIDs
• ACCU-CHEK Aviva Plus • GLUCOCARD 01-SENSOR • GLUCOCARD Vital • CONTOUR NEXT • FreeStyle InsuLinx • Nova Max • TRUEtest • Prodigy No Coding • One Touch Verio • One Touch Ultra Blue • Plus all other SMBGS test strips listed in Appendix D, except for FreeStyle Lite and Precision Xtra **Self-Monitoring Blood Glucose System (SMBGS) test strips**	• No alternative formulary – applies in the following situations: • Patient is blind/severely visually impaired and requires a test strip used in a talking meter – Prodigy Voice, Prodigy AutoCode, Advocate Redicode • Patient uses an insulin pump and requires a specific test strip that communicates wirelessly with a specific meter o Contour NEXT strip with CONTOUR NEXT Link meter for Medtronic pump o Nova Max strip with Nova Max Link meter for Medtronic pump o For Retail Network Only: One Touch Ultra test strips with One Touch Ultra Link meter for Medtronic Mini Med Paradigm insulin pump o For Retail Network Only: One Touch Ultra test strips with One Touch Ping meter and using the One Touch Ping insulin pump • The patient has a documented physical or mental health disability requiring a special strip or meter. For example, the patient requires ACCU-CHEK Aviva Plus strip due to manual dexterity issues (Arthritis Association Seal of Approval) **Formulary alternatives:** Freestyle Lite and Precision Xtra
• Etanercept (Enbrel) **Targeted Immunomodulatory Biologics (TIBs)**	• Use of adalimumab (Humira) is contraindicated • The patient has experienced or is likely to experience significant adverse effects from adalimumab (Humira) • Adalimumab (Humira) resulted or is likely to result in therapeutic failure. • The patient previously responded to the nonformulary agent and changing to adalimumab (Humira) would incur unacceptable risk • No alternative formulary agent applies only to: 1. Abatacept (Orencia): The patient is transitioning from IV abatacept or has symptomatic congestive heart failure (CHF). 2. Anakinra (Kineret): The patient has neonatal onset multisystem inflammatory disease (NOMID), a subtype of cryopyrin associated periodic syndrome (CAPS). 3. Etanercept (Enbrel): The patient has hepatitis C infection. 4. Tocilizumab (Actemra): The patient is transitioning from IV abatacept or has symptomatic CHF. **Formulary alternative: adalimumab (Humira)**

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• Valeritas Insulin Delivery Device (V-Go) **Insulin–Miscellaneous Insulin Delivery Devices**	PA criteria apply to all new users of the V-Go device. Manual PA criteria: (1) Patient has Type 2 diabetes mellitus (2) Patient does not need more than 40 units of basal insulin daily AND the patient does not need more than 36 units of bolus insulin daily (3) Patient does not need less than 2 unit increments of bolus dosing (4) Patient has been maintained on stable basal insulin for at least 3 months (at dosages ranging from 20U to 40U) (5) Patient has been using prandial insulin for at least 3 months
• Fingolimod (Gilenya) **Multiple Sclerosis Drugs (MS)**	Manual PA criteria: • A documented diagnosis of relapsing forms of MS • No current use of a disease-modifying therapy (e.g., interferon 1a or 1b or Copaxone) • Avoid use in patients with significant cardiac history, including: o Patients with a recent history (within the past 6 months) of class III/IV heart failure, myocardial infarction, unstable angina, stroke, transient ischemic attack, or decompensated heart failure requiring hospitalization o Those with a history or presence of Mobitz type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker o Patients with a baseline QTc interval ≥500 ms o Those receiving treatment with class Ia or class III antiarrhythmic drugs
• ACCU-CHEK Aviva Plus • GLUCOCARD 01-SENSOR • GLUCOCARD Vital • CONTOUR NEXT • FreeStyle InsuLinx • Nova Max • TRUEtest • Prodigy No Coding • One Touch Verio • One Touch Ultra Blue • Plus all other SMBGS test strips listed in Appendix D **Self-Monitoring Blood Glucose System (SMBGS) test strips**	New and current users of the nonformulary test strips are required to try FreeStyle Lite or Precision Xtra Manual PA Criteria—Non-preferred test strip allowed if: • Patient is blind/severely visually impaired and requires a test strip used in a talking meter – Prodigy Voice, Prodigy AutoCode, Advocate Redicode • Patient uses an insulin pump and requires a specific test strip that communicates wirelessly with a specific meter o Contour NEXT strip with CONTOUR NEXT Link meter for Medtronic pump o Nova Max strip with Nova Max Link meter for Medtronic pump o For Retail Network Only: One Touch Ultra test strips with One Touch Ultra Link meter for Medtronic Mini Med Paradigm insulin pump o For Retail Network Only: One Touch Ultra test strips with One Touch Ping meter and using the One Touch Ping insulin pump • The patient has a documented physical or mental health disability requiring a special strip or meter. For example, the patient requires ACCU-CHEK Aviva Plus strip due to manual dexterity issues (Arthritis Association Seal of Approval)
• Adalimumab (Humira) **Targeted Immunomodulatory Biologics (TIBs)**	Coverage approved for patients ≥ 18 years with: (Changes highlighted in bold) • Moderate to severe active rheumatoid arthritis, active psoriatic arthritis, or active ankylosing spondylitis • Moderate to severe chronic plaque psoriasis who are candidates for systemic or phototherapy, and when other systemic therapies are medically

Drug / Drug Class	Prior Authorization Criteria
• Adalimumab (Humira) **Targeted Immunomodulatory Biologics (TIBs)**	less appropriate • Moderate to severely active Crohn's disease following an inadequate response to conventional therapy, loss of response to Remicade, or an inability to tolerate Remicade • Moderate to severely active ulcerative colitis following inadequate response to immunosuppressants **Pediatric patients with** • **Moderate to severe active polyarticular juvenile idiopathic arthritis (pediatric patients: 2–17 years)** • **Moderate to severely active Crohn's disease (≥ 6 years)** who have had an inadequate response to corticosteroids, azathioprine, 6-mercaptopurine, or methotrexate Coverage is NOT provided for concomitant use with other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Apremilast (Otezla) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Otezla if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF • Adverse reactions to Humira not expected with requested non-step preferred TIB AND Coverage approved for patients ≥ 18 years with: • Active psoriatic arthritis • **Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy** Coverage is NOT provided for concomitant use with other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Etanercept (Enbrel) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Enbrel if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF)

Drug / Drug Class	Prior Authorization Criteria
• Etanercept (Enbrel) **Targeted Immunomodulatory Biologics (TIBs)**	• Adverse reactions to Humira not expected with requested non-step preferred TIB • There is no formulary alternative (Enbrel is prescribed for a patient with hepatitis C virus) AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis, active psoriatic arthritis, or active ankylosing spondylitis • Moderate to severe chronic plaque psoriasis who are candidates for systemic or phototherapy Coverage approved for pediatric patients (age 2–17) with: • Moderate to severe active polyarticular Juvenile Idiopathic Arthritis Coverage is NOT provided for concomitant use with other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Enzalutamide (Xtandi) **Prostate Cancer Drugs**	Coverage is approved if: • Documented diagnosis of metastatic castration-resistant prostate cancer No expiration date for the PA
• Exenatide once weekly pen (Bydureon pen) **Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs)**	New GLP1RA users are required to try metformin or a sulfonylurea (SU) before receiving Byetta, Bydureon, or Victoza. Automated PA criteria: The patient has received a prescription for metformin or SU at any Military Health System pharmacy point of 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: Byetta, Bydureon, or Victoza is approved (e.g., trial of metformin or SU is NOT required) if: 1) The patient has a confirmed diagnosis of Type 2 Diabetes Mellitus 2) The patient has experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or history of lactic acidosis. 3) The patient has experienced the following adverse event while receiving a SU: hypoglycemia requiring medical treatment. 4) The patient has a contraindication to both metformin and a SU. 5) The patient has had an inadequate response to metformin and a SU. 6) **Also for exenatide once weekly (Bydureon pen)** ▪ **Coverage approved if patient has first tried Bydureon 2mg vial/cartridge first AND** ▪ **Patient has dexterity issues and cannot assemble the Bydureon vial/cartridge**

Appendix D—Table of Self-Monitoring Blood Glucose System Test Strips in the Class

FreeStyle Lite	Easy Touch	Reveal test strip
Precision Xtra	Easy Touch glucose	Relion Confirm Micro
ACCU-CHEK Aviva Plus	Easy Gluco	Relion Prime
GLUCOCARD 01-SENSOR	Easy Gluco G2 test strip	Rightest GS100 test strips
GLUCOCARD Vital	Element test strips	Rightest GS 300 test strips
CONTOUR NEXT	Element Plus	Rightest GS 550 test strips
FreeStyle Insulinx	Embrace	SmartDiabetes Xpres
Nova Max	Evencare test strip	Smartest test
TRUEtest	Evencare G2	Surechek test strips
Prodigy No Coding	EZ Smart	Surestep
OneTouch Verio	EZ Smart Plus Fast Take	Surestep Pro
OneTouch Ultra Blue	Fifty50 test strip	Sure test
ACCU-CHEK	Fora G20	Solus v2
ACCU-CHEK Active	Fora test strip	Telcare test strips
ACCU-CHEK Advantage	Fora v10	Tracer BG
ACCU-CHEK Aviva	Fora V12	TRUEtrack
ACCU-CHEK Comfort Curve	Fora V30a	TRUEtrack Smart System
ACCU-CHEK Instant	G-4 test strip	Ultima
ACCU-CHEK Smartview	GE blood glucose test	Ultratrak
AccuTrend glucose	GE100 blood glucose test strip	Ultratrak Pro
Acura test strips	GLUCOCARD Expression	Ultratrak Ultimate test strip
Advance test strips	GLUCOCARD X sensor	Victory
Advocate test strip	Glucolab	Wavesense AMP
Advocate Redi-Code	Glucose test strip	Wavesense Jazz
Advocate Redi-Code+	Glucometer Encore	Wavesense Presto
Ascensia Elite	Glucostix	
Assure 3	Infinity	
Assure 4	Keynote	
Assure Platinum	Liberty test strips	
Assure Pro	Micro	
BD test strips	Microdot	
BG-star	Neutek 2Tek test strips	
Blood glucose test strips	On Call Vivid test strip	
Blood glucose test strips – Leader	Optium	
Chemstrip BG	Optium EZ	
ChoiceDM G20	Pocketchem EZ	
ChoiceDM GD20	Precision PCX	
Clever Check	Precision PCX Plus	
Clever Choice test strips	Precision Point Of Care	
Clever Choice Pro	Precision QID	
Contour	Premium blood glucose	
Control	Prestige test	
Dextrostix reagent	Prestige smart system	
Easymax	Prodigy	
EasyPlus glucose test strips	Quintet	
EasyPlus mini strip	Quintet AC	
Easy Pro Plus	RefuAH Plus test strip	

Appendix E—Table of Prior Authorization (PA) Criteria for Hepatitis C Drugs

Prior Authorization Criteria

Ledipasvir/sofosbuvir (Harvoni)
Direct Acting Antiviral Subclass

- New users of ledipasvir/sofosbuvir (Harvoni) are required to undergo the PA process.
- Current users are not affected by PA; they can continue therapy uninterrupted.
- Patients are encouraged to use the Mail Order Pharmacy or MTFs to fill their Harvoni prescriptions.
- Consult the AASLD/IDSA HCV guidelines (www.hcvguidelines.org) for the most up-to-date and comprehensive treatment for HCV. Unique patient populations are also addressed, and treatment recommendations may differ from those for the general population.

Manual PA Criteria:

- Age ≥ 18
- Has laboratory evidence of chronic HCV genotype 1 infection
    1. State the HCV genotype and HCV RNA viral load on the PA form
- Ledipasvir/sofosbuvir (Harvoni) is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
- The patient is not co-infected with Hepatitis B virus (HBV).

Treatment Regimens and Duration of Therapy

- Treatment and duration of therapy are approved for one of the following regimens outlined below, based on HCV genotype, prior treatment, and presence of cirrhosis.
- Prior authorization will expire after 8 weeks or 12 weeks or 24 weeks, based on the treatment regimen selected.

Genotype 1 Patient Populations	***Treatment Duration***
Treatment naïve with or without cirrhosis	8* - 12 weeks
Treatment experienced** without cirrhosis	12 weeks
Treatment experienced** with cirrhosis	24 weeks
*Consider treatment duration of 8 weeks in treatment-naïve patients without cirrhosis who have a pretreatment HCV RNA less than 6 million IU/mL. **Treatment-experienced patients who have failed treatment with either (a) peginterferon alfa plus ribavirin or (b) HCV protease inhibitor plus peginterferon alfa plus ribavirin	

Prior Authorization Criteria

Simeprevir (Olysio)
Direct Acting Antiviral Subclass

- New users of simeprevir (Olysio) are required to undergo the PA process.
- Current users are not affected by PA; they can continue therapy uninterrupted.
- The FDA-approved indication of simeprevir + PEG-interferon + ribavirin for 24 to 48 weeks is not recommended for HCV treatment by the AASLD/IDSA. See www.hcvguidelines.org.
- Patients are encouraged to use the Mail Order Pharmacy or MTFs to fill their simeprevir prescriptions.
- Consult the AASLD/IDSA HCV guidelines (www.hcvguidelines.org) for the most up-to-date and comprehensive treatment for HCV. Unique patient populations are also addressed, and treatment recommendations may differ from those for the general population.

Manual PA Criteria:

- Age ≥ 18
- Has laboratory evidence of chronic HCV genotype 1 infection
- State the HCV genotype and HCV RNA viral load on the PA form
- If HCV genotype 1a, the patient is negative for NS3 Q80K polymorphism at baseline
- Simeprevir (Olysio) is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
- The patient is not co-infected with HIV or Hepatitis B virus (HBV).
- Not recommended for monotherapy
- The patient has not previously used a HCV protease inhibitor (boceprevir, telaprevir, or simeprevir)

Treatment Regimens and Duration of Therapy

- Treatment and duration of therapy are approved for one of the following regimens outlined below, based on HCV genotype, prior treatment, and presence of cirrhosis.
- Prior authorization will expire after 12 weeks or 24 weeks, based on the treatment regimen selected.

Genotype 1 Patient Populations	Treatments	Treatment Duration
Treatment naïve or experienced* without cirrhosis	simeprevir 150 mg once daily sofosbuvir 400 mg once daily	12 weeks
Treatment naïve or experienced* with cirrhosis	simeprevir 150 mg once daily sofosbuvir 400 mg once daily	24 weeks
*Treatment-experienced patients who have failed treatment with peginterferon alfa plus ribavirin but not a HCV protease inhibitor Prior Authorization expires at the end of treatment duration (12–24 weeks)		

Appendix F—Table of Quantity Limits

Drug / Drug Class	Quantity Limits
Self-Monitoring Blood Glucose Test Strips (all products)	▪ Retail Network: 100 strips/30-day supply ▪ Mail Order and MTF: 300 strips/90-day supply Override criteria include the following situations: ▪ receiving insulin ▪ using an insulin pump ▪ gestational diabetes ▪ requires more frequent testing due to endocrine disorders (e.g., insulinoma, endogenous hyperinsulinism, non-islet cell tumor) ▪ history of poorly-controlled blood glucose levels with history of adverse outcomes (e.g., ketoacidosis or hypoglycemic episode) requiring medical intervention
• Umeclidinium/vilanterol (Anoro Ellipta) **Pulmonary II Drugs for COPD**	▪ Retail Network: 1 inhaler per 30 days ▪ Mail Order and MTF: 3 inhalers per 90 days
• Ledipasvir/sofosbuvir (Harvoni **Hepatitis C Drugs–Direct Acting Agents**	▪ Retail Network, Mail Order and MTF: 28 tablets per 28 days
• Nintedanib (Ofev) **Pulmonary Fibrosis**	▪ Retail Network, Mail Order, and MTF: 50/100 mg capsules, 60 tabs (30-day supply)
• Pirfenidone (Esbriet) **Pulmonary Fibrosis**	▪ Retail Network, Mail Order, and MTF: 267 mg caps, 270 capsules (30-day supply)
• Olodaterol (Striverdi Respimat) **Pulmonary Fibrosis Long-Acting Beta Agonist (LABA)**	▪ Retail Network: 1 inhaler (60 actuations) per 30 days ▪ Mail Order and MTF: 3 inhalers (180 actuations) per 90 days

Appendix G—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
Nov 2014	**Multiple Sclerosis Drugs**	UF class review Previously reviewed	▪ Interferon beta-1b SC (Betaseron)	▪ Interferon beta-1a SC (Rebif and Rebif Rebidose) ▪ Interferon beta-1a IM (Avonex) ▪ Interferon beta 1b SC (Extavia) ▪ Dalfampridine (Ampyra) ▪ Teriflunomide (Aubagio) ▪ Glatiramer (Copaxone) ▪ Fingolimod (Gilenya) ▪ Dimethyl fumarate (Tecfidera)	▪ None	Pending singing of the minutes / 30 days	▪PA required for Gilenya and Tecfidera (See Appendix C)	▪ MS drugs s are no longer an ECF class; Betaseron is now BCF and Avonex is removed from the ECF.
Nov 2014	**Pulmonary II: Chronic Obstructive Pulmonary Disease**	New Drug Review	▪ Ipratropium bromide (Atrovent HFA) ▪ Ipratropium bromide/albuterol nebulized solution (Duoneb) ▪ Salmeterol (Serevent) ▪ Tiotropium (Spiriva)	**May 2013** ▪ Aclidinium (Tudorza) ▪ Arformoterol (Brovana) ▪ Formoterol (Foradil) ▪ Ipratropium bromide/albuterol (Combivent Respimat) ▪ Roflumilast (Daliresp) **Nov 2014** ▪ **Umeclidinium/ vilanterol (Anoro Ellipta) Nov 2014**	▪ Formoterol (Perforomist) ▪ Indacaterol (Arcapta)	Pending signing of the minutes	▪QL apply	▪ BCF, UF, and NF choices are designated for COPD drugs for LABAs, LAMAs, SABA/SAMA, SAMAs, and oral PDE-4 inhibitors. See DoD P&T Minutes for Feb 2009, May 2013, and May 2014.
Nov 2014	**Ophthalmic NSAIDs**	New Drug Review	▪ None	**Aug 2010** ▪ Bromfenac 0.9%, generic ▪ Diclofenac (Voltaren) ▪ Flurbiprofen (Ocufen) ▪ Ketorolac 0.4% (Acular LS) ▪ Ketorolac 0.45% (Acuvail) ▪ Ketorolac 0.5% (Acular) ▪ Nepafenac (Nevanac)	**Nov 2014** ▪ **Bromfenac 0.07% (Prolensa)**	Pending singing of the minutes / 90 days	▪None	▪ Medical Necessity Criteria apply. See Appendix B

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
Nov 2014	**Ophthalmic Glaucoma Agents**	New Drug Review	▪ Latanoprost, generic ▪ Timolol, generic ▪ Brimonidine 0.15%, 0.2%, generic	**Nov 2014** ▪ **brinzolamide 1% /brimonidine 0.2% (Simbrinza)** **Feb 2007** ▪ Bimatoprost (Lumigan) ▪ Betaxolol (Betoptic, Betoptic-S) ▪ Carteolol (Ocupress) ▪ Levobunolol (Betagan) ▪ Metipranolol (Optipranolol) ▪ Timolol maleate (Timoptic) ▪ Timolol maleate gel forming solution (Timoptic XE) ▪ Dorzolamide (Trusopt) ▪ Dorzolamide / timolol (Cosopt) ▪ Brimonidine purite 0.1% (Alphagan P) ▪ Apraclonidine (Iopidine) ▪ Dipivefrin (Propine) ▪ Acetylcholine (Miochol-E) ▪ Carbachol (Isopto Carbachol) ▪ Pilocarpine (Pilocar, Pilopine HS) ▪ Echothiophate (Phospholine iodide)	▪ travoprost (Travatan and Travatan Z) ▪ tafluprost (Zioptan) ▪ timolol (Betimol) ▪ timolol (Istalol) ▪ brinzolamide (Azopt)	Pending singing of the minutes / 90 days	▪None	▪ None

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
Nov 2014	**Self-Monitoring Blood Glucose System (SMBS) test strips**	UF Class Review	▪ FreeStyle Lite (Abbott) ▪ Precision Xtra (Abbott)	Uniform Formulary and Step-Preferred ▪ FreeStyle Lite (Abbott) ▪ Precision Xtra (Abbott)	Nonformulary and non-step preferred ▪ACCU-CHEK Aviva Plus (Roche) ▪GLUCOCARD 01-SENSOR (Arkray) ▪GLUCOCARD Vital (Arkray) ▪CONTOUR NEXT (Bayer) ▪ FreeStyle InsuLinx (Abbott) ▪NovaMax (Nova) ▪TRUEtest (Nipro) ▪Prodigy No Coding (Prodigy) ▪One Touch Ultra Blue (Lifescan) ▪One Touch Verio (Lifescan) ▪For a V2 (For a) ▪Solus V12 (Biosense) ▪All other test strips listed in Appendix D, with the exception of Freestyle Lite, and Precision Xtra	Pending signing of the minutes / 120 days	Step therapy requires a trial of an FreeStyle Lite, or Precision Xtra in all new and current users of the nonformulary strips	▪ FreeStyle Lite added to the BCF; Precision Xtra remains on the BCF

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

Appendix H—Section 716 Maintenance Medication Program Drug List

- Removed from list due to manufacturer discontinuation:
  - ANTARA 45 mg, 130 mg CAPS
  - CENESTIN 0.3, 0.45 mg TABS
  - LEVATOL 20 mg TABs
  - LUVOX CR 150 mg CAPS
  - SANCTURA 20 mg TABS
  - UNIRETIC 7.5 mg/12.5 mg TABS

- Added to the list, due to consistency with the drug class (new strengths or dosage formulations):
  - ACTONEL 30 mg TABLET
  - ANGELIQ 0.25 mg–0.5 mg TABLET
  - ARICEPT 23 mg TABLET
  - BETAPACE 160 mg TABLET
  - CARAFATE 1 g/10 ml ORAL SUSP
  - CLORPRES 0.1 mg–15 mg TABLET
  - EFFER-K 25 mEq TABLET EFF
  - EXELON 13.3 mg/24 hours PATCH TD24
  - KLOR-CON 20 mEq PACKET
  - K-TAB ER 20 mEq TABLET ER
  - LANOXIN 62.5 mcg and 1875 mcg TABLET
  - LUPRON DEPOT 45 mg SYRINGE KIT
  - LUPRON DEPOT-PED 30 mg and 11.25 mg SYRINGE KIT
  - MINITRAN 0.4 mg/hr PATCH TD24
  - NAPROSYN 250 mg TABLET
  - NEUPRO 1 mg/24 hour, 3 mg/24 hour and 8 mg/24 hour PATCH TD24
  - NEXIUM 2.5 mg and 5 mg SUSPDR PKT
  - NORDITROPIN FLEXPRO 10 mg/1.5 ml PEN
  - NUTROPIN AQ 20 mg/2 ml CARTRIDGE and NUTROPIN AQ NUSPIN 5 mg/2 ml CARTRIDGE
  - RAZADYNE ER 8 mg CAP 24 hour PEL
  - SAIZEN 8.8 mg VIAL and 8.8 mg/1.5 CARTRIDGE
  - SPRYCEL 140 mg TABLET
  - TRELSTAR 3.75 mg/2 ml SYRINGE
  - NAMENDA 5 mg–10 mg TAB DS PK

Appendix I—Table of Abbreviations

ARR	annualized relapse rate
BCF	Basic Core Formulary
BIA	budget impact analysis
CADHT	Canadian Agency for Drugs in Technology and Health
CEA	cost-effectiveness analysis
CMA	cost minimization analysis
COPD	chronic obstructive pulmonary disease
DAAs	direct acting antivirals
DCO	Defense Connect Online
DERP	Oregon Drug Effectiveness Review Project
DHA	Defense Health Agency
DoD	Department of Defense
ECF	Extended Core Formulary
ER	extended release
FDA	U.S. Food and Drug Administration
FEV_1	forced expiration volume in 1 second
GLP1RA	glucagon-like peptide-1 receptor agonist
HCV	hepatitis C virus
IM	intramuscular
IOP	intraocular pressure
ISO	International Organization for Standardization
JIA	juvenile idiopathic arthritis
LABA	long-acting beta agonist
LAMA	long-acting muscarinic agent
MHS	Military Health System
MN	medical necessity
MS	multiple sclerosis
MTF	Military Treatment Facility
NF	nonformulary
NDAA	National Defense Authorization Act
NSAIDs	nonsteroidal anti-inflammatory drugs
P&T	Pharmacy and Therapeutics
PA	prior authorization
POS	points of service
QD	once daily
QLs	quantity limits
SC	subcutaneous
SMBGS	self-monitoring blood glucose system
TIBs	targeted immunomodulatory biologics
TIW	three times a week
UF	Uniform Formulary
V-Go	Valeritas V-Go insulin delivery device

Defense Health Agency (DHA) Determination on TRICARE Pharmacy Benefits Program Coverage for Prescriptions for Compound Pharmaceuticals

Background and Discussion.

The Military Health System's (MHS) top priority is quality and patient safety. Compound drugs are prescribed for MHS beneficiaries; however, over the past several years, there has been a tremendous increase in the number of compound pharmacy prescriptions, many of those lacking clinical or medical evidence of their safety or effectiveness. A system upgrade for pharmacy claim submissions in July 2012 by Express Scripts, Inc. (ESI) (TRICARE's Pharmacy contractor), gave DHA (formerly TRICARE Management Activity (TMA)) visibility of all ingredients contained in a compound drug claim including those bulk drug powders and chemicals that are not approved by the U.S. Food and Drug Administration (FDA) for commercial marketing. ESI completed an in-depth review of compound drug costs and usage in January 2013.

The DHA's highest obligation is to our patients – providing safe and effective care grounded in solid medical science. The Institute for Safe Medication Practices (ISMP), for example, recently reported that patients "may be unaware of the potential dangers" of certain pain cream medications and children may be accidentally exposed to products that are not properly labeled. (Designer Pain Creams and Ointments are Profitable for Compounding Pharmacies but Risky for Patients and Children, ISMP Safe Medicine, January/February 2015, Volume 13, Issue 1 at page 3.) 10 U.S.C. § 1074g(a)(1) mandates "an effective, efficient, integrated pharmacy benefits program" and permits a prior authorization (PA) process under 10 U.S.C. § 1074g(a)(4) for "certain pharmaceutical agents to ensure that the use of such agents is clinically appropriate." The Code of Federal Regulations (C.F.R.) reinforces this mandate providing that the Department of Defense (DoD) establish an effective and efficient pharmacy program under 32 C.F.R. § 199.21(a)(1). Also, consistent with the standards applicable to all products and services under TRICARE, under § 199.4(g)(15), if a drug "cannot be lawfully marketed without the approval" of the FDA "and approval has not been given," the safety and effectiveness of that drug is considered unproven and thus the drug "cannot be cost-shared" by TRICARE.

In addition to the obligation to provide a safe and effective pharmacy program, the DHA has an obligation to demonstrate that it is a responsible steward of taxpayer dollars. Compound drug costs have risen steeply with DoD spending $5 million in fiscal year (FY) 2004, increasing to over $514 million in FY14, and on pace to exceed $2 billion in FY 15. Compound drug costs in the month of January 2015 were $194 million compared to $35 million in January 2014 and $17 million in January 2013. Compound prescriptions account for just 0.5% of all DoD prescriptions but now account for over 20% of the total pharmacy spend. A closer look at the wholesale acquisition cost data reveals a remarkable range. Examples related to some of the leading compounded ingredients are: for flurbiprofen powder, a range from $.32/gram to $42.71/gram; for dextrose powder, a range from $.03/gram to $1,920.50/gram; for fluticasone propionate powder, a range from $123.50/gram to $3,197/gram; for mometasone furoate powder, a range from $147.05/gram to $20,859/gram; and for gabapentin powder, a range from $.70/gram to

$54.40/gram. Overall, the cost data suggest that the recent extraordinary growth in compound prescription costs is not attributable to clinical factors.

In April 2013, TMA decided to implement ESI's new screening capabilities and no longer reimburse for some ingredients found in compound drugs including bulk drug powders and chemicals that the FDA had not approved for commercial marketing. In June 2013, ESI sent letters to approximately 44,000 beneficiaries who had received a compounded medication containing at least one non-FDA-approved ingredient during the previous 90 days. The letter informed these beneficiaries that the new policy regarding compound drugs would be effective July 24, 2013. ESI also developed a telephone script that provided details about this change in response to questions from beneficiaries. Notification of this change regarding payment for compound drugs raised concerns by beneficiaries, industry groups and other stakeholders. Because of these concerns and before the new screening took effect, TMA delayed its implementation from July 2013 to February 2014. TMA updated its website and notified beneficiaries that it was re-examining its policy with respect to compounds. This delay gave TMA an opportunity to conduct further review and study of this proposed policy.

In December 2013, the DHA learned that the FDA intended to publish two lists with respect to compound drugs: one list of approved bulk drug substances and a second list of substances that presented demonstrable difficulties. The FDA sought public comment on these lists and gave the general public until March 4, 2014 to do so. In December 2013, because of this FDA action and the pending publication and review of the FDA qualifying lists, the DHA postponed the February 2014 implementation date of the enhanced screening process. As of March 3, 2015, the FDA has not published these two lists with respect to approved bulk drug substances and demonstrably difficult substances.

The DHA has closely monitored FDA action on compound drugs. This includes the FDA's guidelines and non-binding recommendations regarding compounding under Section 503A of the Federal Food, Drug, and Cosmetic Act (FDCA) and its draft guidance on current good manufacturing practice for registered outsourcing facilities under Section 503B of the FDCA, both of which were published in July 2014. Additionally, the Government Accountability Office (GAO) published a report in October 2014 (GAO-15-64, October 2014) that highlighted that TRICARE continued to pay for non-FDA-approved ingredients in compounds contrary to regulation. The GAO recommended that the DoD align its practices with existing regulations with respect to TRICARE or amend those regulations to allow for payment for some or all bulk drug substances in compounds. The GAO also compared TRICARE to the Department of Veterans Affairs (VA) in that report. The GAO noted on page 22 that the VA has a more restrictive payment practice with respect to compounds than TRICARE and that "VAMC pharmacies dispense a compounded drug prescription only if the beneficiary has a specific medical need that cannot be met by a commercially available drug and an alternative drug from the VA formulary has been given full consideration."

In November 2014, the DoD's Pharmacy and Therapeutics Committee (P&T) unanimously recommended a Prior Authorization (PA) for compound drugs. The P&T found that the PA would maintain accessibility for compound drugs when appropriate while allowing for needed

screening for non-FDA-approved ingredients. The minutes from the P&T's November meeting explained:

> "MHS expenditures for compounded medications are significant and increasing, and compounded medications have a high potential for inappropriate use. From June 2013 through May 2014, 140,000 beneficiaries filled 360,000 compounded prescriptions that totaled over $410 million in expenditures at the Retail Network and Mail Order POS. In an effort to decrease inappropriate use and ensure safety for beneficiaries, PA criteria were proposed." (Minutes at 14.)

The proposed PA criteria considered the diagnosis and the duration of the therapy; whether the patient tried commercially-available products; and whether there was a national drug shortage of an otherwise commercially-available product. On page 15 of the minutes, the PA provided specific criteria for the patient:

> (1) Each active ingredient(s) is/are a chemical entity of an FDA-approved drug for marketing in the United States AND the drugs have not been withdrawn for safety reasons from the U.S. market.
> (2) Each active ingredient(s) used in this compound is indicated by the FDA to treat the diagnosis provided.
> (3) An FDA-approved commercially available product is not appropriate because the patient requires a unique dosage form or concentration (e.g., inability to take a solid dosage form, dose based on age or weight) and/or an FDA-approved product cannot be taken due to allergies or contraindication.

In January 2015, the Beneficiary Advisory Panel (BAP) did not concur with the PA recommendation of the P&T in a 5-2 decision. The BAP members were concerned about the short implementation period and the lack of a clear plan for notification to beneficiaries of changes. It also noted the lack of statistics showing that our beneficiary population was using medications for diagnoses inconsistent with prescriptions. The BAP requested clarifications on some of the questions from industry representatives and noted that the P&T would benefit from a more in-depth analysis of how compounds are handled in other parts of the industry and whether evidence exists that shows adverse effects on persons currently receiving compounded medications. In January 2015, the Director, DHA, disapproved the P&T Committee's recommendation pending additional consideration of the BAP comments.

It is noteworthy that in December 2014, the President signed the FY 2015 National Defense Authorization Act (NDAA) into law. Section 704 of the NDAA created 10 U.S.C. § 1079c, which authorizes provisional coverage for a service or supply deemed to be widely recognized in the United States as safe and effective, even if it does not meet the normal test of proven safety and effectiveness. The provision includes a range of evidence the DoD can consider when making this determination including clinical trials, technology assessments, and opinions from national professional associations. Furthermore, it allows the DoD to establish or disestablish the terms and conditions of the provisional coverage and requires the DoD to promptly publish

on a publicly-accessible TRICARE website a notice of the provisional coverage for the service or supply including any terms and conditions.

Compound pharmaceuticals are an issue for other Government and commercial health plans as well. A recent GAO report (GAO-15-85, October 2014, page 16) stated: "For private health plans offered in the commercial market, officials from three insurers we spoke with told us that they generally do not pay for bulk drug substances used to make compounded drugs and pay only for those ingredients in the compound that are FDA-approved products under their prescription drug benefit." Regarding Medicare, the GAO (GAO-15-64, October 2014, pages 20-21) noted: "In contrast to TRICARE, [Medicare] Part D's payment practices for compounder drugs are more restrictive. As required by statute, under Part D, federal payments are not available for non-FDA-approved products—including bulk drug substances—and inactive ingredients used to make a compounded drug." Additionally, screens for prescription claims for coverage and cost and the use of a review process to consider individualized requests are widely-used industry practices. Consistent with this standard, TRICARE has a robust PA process for individualized treatment reviews and currently has 86 drugs with a PA option as part of the DoD Pharmacy Benefit Management process.

The DHA's Pharmacy Operations Division (POD) has closely monitored this progression of authorities regarding compounds. The DHA has kept its beneficiaries informed of its actions regarding compound drugs beginning with the June 2013 notification letter and its updated website and ESI phone call scripts to answer beneficiary questions. The POD has consulted with stakeholders and provides this amended Determination with respect to compound drugs. This Determination does not constitute a significant change of the TRICARE benefit. Rather, it adopts a process authorized by current statute and regulations and comparable to that already used for many pharmaceutical products. It modifies the November 2014 P&T recommendation in a number of respects, including implementation of an initial electronic screening for non-FDA-approved ingredients and other information, followed by a PA review process, if requested. This revised process will ensure patients have access to safe and effective medications, including compounds when appropriate, which are best suited to their individual needs. In cases in which a PA is denied, the denial will be an appealable initial determination subject to the usual appeals process including adequate notice of appeal rights and requirements under 32 C.F.R. §199.10.

The DHA's Communications Division has developed key outreach products for thorough notification of stakeholders including beneficiaries, the military services and Military Treatment Facilities (MTF), Congress and the general public. In addition to TRICARE website notification, the DHA will also notify impacted beneficiaries of this Determination via letter in March 2015.

Determination of the Director, DHA:

Following careful consideration, I modify the P&T Committee recommendation for compound prescriptions after considering the needs of our beneficiaries, the safety and efficacy of compounds, our need to be responsible stewards of taxpayer dollars, and the coverage allowed by the TRICARE program. I note the concerns raised by the BAP and approve the following plan that addresses the issues it has raised. In approving this plan, I have also considered input and suggestions from the compounding pharmacy industry.

I approve the following modification to the November 2014 recommendation of the P&T Committee and direct its implementation to ensure beneficiaries have sustainable access to appropriate compound medications. Compound prescription claims will be reviewed by an initial electronic screening and, when necessary, a PA process.

COMPOUND PRESCRIPTION INITIAL SCREENING PROCESS

(1) Each ingredient submitted for payment will be screened to ensure the ingredient is:

a. Lawfully marketed in the United States;
b. Considered safe and effective; and,
c. Appropriate for the patient based on clinical need and cost effectiveness.

(2) ESI, the TRICARE contractor, will conduct this initial electronic screening (which will normally occur within seconds per the contractual agreement between DHA and ESI), of each ingredient submitted for payment in a prescribed compound medication in order to ensure compliance with (1)a., b. and c. above.

(3) ESI will also screen each ingredient submitted for payment in a compound medication claim in order to ensure the submitted cost does not exceed the pricing standard as established by ESI under its network agreement with compounding pharmacies.

In the event that the claim is not approved by the initial electronic screening as described above, the prescriber and/or pharmacist may substitute or remove a non-covered ingredient or adjust the submitted price. For any rejected claim, the prescriber can request a PA review by submitting appropriate documentation and supporting evidence to ESI. The PA process (which will in most cases occur within 5 days following receipt of necessary information per the contractual agreement between DHA and ESI) reviews compound prescription claims with respect to the specific needs of individual patients. The review ensures the ingredients of the compounds in those claims are lawfully marketed, safe and effective, and appropriate for the specific patient.

COMPOUND PRESCRIPTION PA PROCESS

(1) The following information will be required when submitting a request for a PA review:

a. What is the diagnosis?

b. Has the patient tried commercially-available products for the diagnosis provided? Please state all products tried and relevant results of therapy.

c. Is there a current national drug shortage of an otherwise commercially-available product?

d. What is the proposed duration of therapy?

e. Is the prescription cost-effective either because it meets the pricing standard as established between ESI and its network pharmacies or because the cost is reasonable in the context of the clinical indication and circumstances?

f. Other information the requestor believes supportive of the request.

(2) The request will be evaluated to determine whether the ingredient(s) submitted for payment is/are lawfully marketed in the United States and is (are) considered safe and effective, e.g., each ingredient(s) submitted for payment is a chemical entity of a U.S. Food and Drug Administration (FDA)-approved drug for marketing in the United States AND the drug(s) have not been withdrawn for safety reasons from the U.S. market. Ingredients may meet these criteria by complying with a. or b., below.

a. The ingredients submitted for payment are approved by the FDA for commercial marketing; OR

b. (i) Pharmacies performing compounding or acting as outsourcing facilities under the provisions of Sections 503A and 503B, respectively, of the Drug Quality and Security Act will conform with the requirements specified in those provisions; AND

(ii) The ingredients of the compounds are proven safe and effective under TRICARE standards or meet the requirements for being widely recognized in the United States as being safe and effective. The provider and/or pharmacy requesting payment for such a compound will provide evidence to support the determination.

NOTE: Evidence that may be considered for this purpose will be consistent with examples provided in 10 U.S.C. § 1079c to include: clinical trials published in refereed medical literature; formal technology assessments; positions of national medical policy organizations, professional associations, and/or expert opinion organizations. Other sources may be submitted by the provider and/or pharmacy and can be considered as validated evidence as the DHA considers appropriate.

(3) The request will be considered appropriate for the patient based on clinical need if the prescriber submitted evidence supporting the therapy for this patient and that an FDA-approved, commercially-available product is not appropriate because the patient requires a unique dosage form or concentration or other clinical reason (e.g., inability to take a solid dosage form, dose based on age or weight, ineffectiveness of such products for the patient, presence of allergy or contraindication).

IMPLEMENTATION INFORMATION

This adds compound prescriptions to the ESI screening process comparable to that currently used for all other TRICARE prescription claims. The establishment of pricing standards is routinely used by commercial pharmacy payers and is already in place for many drugs covered under the TRICARE Pharmacy Benefit as part of the ESI pharmacy network agreement.

The denial of a PA for compounded pharmaceuticals will be an appealable initial determination that will follow the usual appeals process and will include adequate notice of appeal rights and requirements under 32 C.F.R. §199.10.

This updated claims process is to ensure safety and quality for TRICARE beneficiaries. While not a change in TRICARE benefits, we must inform affected beneficiaries, prescribers and pharmacies so we are best positioned to ensure TRICARE beneficiaries receive, without interruption, safe and effective medications including appropriate compounded products. In order to ensure maximum awareness of this screening process for compound prescriptions, DHA will send a letter to beneficiaries who have received a compound prescription in the last 30 days. This letter will update correspondence first sent to beneficiaries on this subject in June 2013. In addition, I have requested that ESI inform the retail network pharmacies in the network. I have further directed DHA Strategic Communications to provide assistance with informing prescribers and pharmacists in the MTFs and promptly publishing a notice on TRICARE's publically-accessible website of this decision regarding compound drug claims processing procedures.

In order to ensure effective notice, I am directing that notification begin no later than March 6, 2015 and that this enhanced screening process for compound prescriptions begin on May 1, 2015.

Douglas J. Robb, DO, MPH
Lieutenant General, USAF, MC, CFS
Director

Signed: March 11, 2015

DEPARTMENT OF DEFENSE

PHARMACY AND THERAPEUTICS COMMITTEE
MINUTES AND RECOMMENDATIONS

August 2014

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on August 13, 2014, at the Defense Health Agency (DHA) Pharmacoeconomic Branch, Fort Sam Houston, Texas.

II. ATTENDANCE

The attendance roster is listed in Appendix A.

A. Review Minutes of Last Meetings

1. **Approval of May Minutes**—Lt. Gen. Douglas J. Robb, DO, MPH, Director, DHA, approved the minutes for the May 2014 DoD P&T Committee meeting on September 12, 2014.

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—Glucagon-Like Peptide-1 Receptor Agonist (GLP1RA): Albiglutide (Tanzeum)

Background—Albiglutide (Tanzeum) is the fourth GLP1RA and the second product with once weekly dosing. Similar to the other GLP1RAs [(exenatide once weekly (Bydureon), liraglutide (Victoza), and exenatide twice daily (Byetta)], albiglutide has beneficial effects on reducing hemoglobin A1c, blood pressure, weight, and improving lipid lab profiles. Albiglutide has a lower incidence of nausea and vomiting compared to Bydureon, Victoza, or Byetta. However, it has a slightly higher incidence of diarrhea. All four GLP1RAs have the same warnings and contraindications for the risk of serious adverse effects, including medullary thyroid cancer, multiple endocrine neoplasia syndrome type 2, and pancreatitis. There are currently no long-term cardiovascular outcome studies published with any GLP1RA.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) the main benefit of albiglutide is its once weekly dosing regimen and lower incidence of nausea compared to the other GLP1RA drugs. The GLP1RAs will be re-reviewed at an upcoming meeting for UF and potential BCF placement.

Relative Cost-Effectiveness Analysis and Conclusion—Cost minimization (CMA) was performed to evaluate albiglutide (Tanzeum) with the other GLP1RA agents. The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) that albiglutide (Tanzeum) is cost-effective compared with other GLP1RA agents on the UF.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) albiglutide (Tanzeum) be designated formulary on the UF, based on clinical and cost effectiveness.

2. ***COMMITTEE ACTION: PRIOR AUTHORIZATION (PA) CRITERIA*** Existing automated PA (step therapy) criteria for the GLP1RAs requires a trial of metformin or a sulfonylurea first, based on positive long-term outcomes data with metformin and the sulfonylureas. The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) PA criteria for albiglutide, requiring a trial of metformin or a sulfonylurea in all new and current users of albiglutide (Tanzeum), consistent with the PA requirements for the other GLP1RAs. Use of albiglutide is approved only for patients with Type 2 diabetes mellitus, consistent with the FDA-approved indication. (See Appendix C for full criteria.)

3. ***COMMITTEE ACTION: PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday after a 30-day implementation period in all points of service (POS). Based on the P&T Committee's recommendation, the effective date is December 10, 2014.

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Attention Deficit Hyperactivity Disorder (ADHD) Stimulants Subclass: Methylphenidate Extended Release (ER) Oral Suspension (Quillivant XR)

Background—Quillivant XR is FDA-indicated for the treatment of ADHD in children six years of age or older; it is dosed once daily. Quillivant XR delivers medication directly via a suspension, instead of opening capsules and mixing the beads or powder with food, which is required with other long-acting stimulants (e.g., Metadate CD, Ritalin LA, Adderall XR). There are no head-to-head studies comparing Quillivant XR to other ADHD medications. Current clinical practice guidelines suggest that all stimulant compounds indicated for ADHD

have very few differences among them in their ability to improve symptoms, their tolerability profiles, or risk of adverse events.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) that although Quillivant XR offers the convenience of an oral suspension of methylphenidate ER, it failed to demonstrate clinically compelling advantages over existing UF agents for ADHD. Other long-acting stimulant preparations with alternative dosing formulations (e.g., sprinkles) are available on the UF.

Relative Cost-Effectiveness Analysis and Conclusion—CMA was performed to evaluate methylphenidate ER suspension (Quillivant XR) with other long-acting methylphenidate agents on the UF. The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) that Quillivant XR was not cost-effective compared with other long-acting methylphenidate agents on the UF.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) methylphenidate ER oral solution (Quillivant XR) be designated NF due to the lack of compelling clinical advantages and cost disadvantages compared to the UF products.

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) MN criteria for methylphenidate ER oral solution (Quillivant XR). (See Appendix B for the full criteria.)

3. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***
The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in all POS; and, 2) DHA send a letter to beneficiaries affected by the UF decision. Based on the P&T Committee's recommendation, the effective date is February 18, 2014.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

V. UF DRUG CLASS REVIEWS

A. Targeted Immunomodulatory Biologics (TIBs)

Relative Clinical Effectiveness—The P&T Committee evaluated the relative clinical effectiveness of the TIBs Drug Class, which is comprised of the following injectable and oral medications:

- **Anti-tumor necrosis factor (TNF) biologics**: adalimumab (Humira), certolizumab (Cimzia), etanercept (Enbrel), and golimumab (Simponi)
- **Non-TNF biologics**: abatacept (Orencia), anakinra (Kineret), apremilast (Otezla), tocilizumab (Actemra), tofacitinib (Xeljanz), and ustekinumab (Stelara)

The TIBs are FDA-approved for a variety of indications, including rheumatologic, dermatologic, and gastrointestinal inflammatory conditions. The TIBs were reviewed for UF placement in November 2007 and adalimumab (Humira) was recommended as the only multi-indication TIB on the Extended Core Formulary (ECF). Since the 2007 class review, several new TIBs have been marketed. Two oral therapies, tofacitinib (Xeljanz) and apremilast (Otezla) are now available.

Relative Clinical Effectiveness Conclusion—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) the following conclusions for the TIBs, based on FDA-approved indications:

1. All the TIBs (adalimumab, etanercept, certolizumab, golimumab, abatacept, tocilizumab, tofacitinib, anakinra, ustekinumab and apremilast) are highly effective for their FDA indications versus placebo, based on randomized controlled trials (RCTs).

2. There are few direct head-to-head trials between the TIBs; the majority of studies are non-inferiority trials. Comparative effectiveness is primarily determined though network meta-analysis (NMA) and indirect comparison; i.e., number needed to treat (NNT). The strength of evidence is typically low.

3. For rheumatoid arthritis, the available evidence is insufficient to clearly show superiority of one TIB over another with regard to the American College of Rheumatology 50 (ACR50) endpoint for response to treatment.

   In three systematic reviews, there was a trend favoring etanercept over the other TIBs in terms of efficacy. The same reviews found anakinra had a statistically significant lower mean response when compared to etanercept and adalimumab, but the strength of evidence was low.

4. For juvenile inflammatory arthritis, there is insufficient evidence to suggest clinically relevant differences between adalimumab and etanercept, the two TIBs approved in pediatric patients.

5. For psoriatic arthritis, due to the lack of head-to-head clinical trials and heterogeneous study populations, there is insufficient evidence to determine comparative efficacy between the four anti-TNFs (adalimumab, certolizumab, etanercept, and golimumab), and the non-TNFs (ustekinumab, and apremilast). Indirect comparisons from RCTs suggest similar NNTs for these drugs.

6. For psoriasis, three products are approved, adalimumab, etanercept, and ustekinumab. In one head-to-head RCT, ustekinumab was superior to etanercept

in achieving response, based on the Psoriasis Activity and Severity Index 75 (PASI 75) score. NMA demonstrated similar efficacy for adalimumab and ustekinumab.

7. For Crohn's disease, a NMA demonstrated that adalimumab and certolizumab are both effective for the induction of response and maintenance of remission and maintenance of response. The same analysis showed adalimumab is superior to certolizumab for induction of remission.

8. For ulcerative colitis, adalimumab and golimumab are effective for inducing clinical response, clinical remission, and mucosal healing. There is insufficient data for direct comparison of these agents.

9. With regard to safety, the overall rates of adverse events (AEs) are similar between the TIBs. In short-term trials, adalimumab and abatacept had a lower risk of serious AEs (serious infections, malignancies, lymphomas, withdrawals and other AEs) compared to other TIBs.

10. Evidence from indirect comparisons of two systematic reviews and one NMA shows the rate of serious infections is higher with certolizumab than the other TIBs. A subgroup analysis from one systematic review and a NMA showed the risk of serious infections was not increased with etanercept, in contrast to the increased risk seen with the other anti-TNF drugs, compared to controls.

11. The risk of tuberculosis (TB) is increased with the TIBs as a group. There is evidence (low strength) that suggests an increased risk with adalimumab, compared with etanercept.

12. The evidence (low strength) from indirect comparisons suggesting a safety benefit with etanercept in terms of serious infections and TB compared to the other anti-TNFs, must be weighed against its lack of efficacy for gastrointestinal conditions (Crohn's disease and ulcerative colitis).

13. Although the strength of evidence is low, there does not appear to be an elevated risk of malignancy with the TIBs. However, the risk of nonmelanoma skin cancer is increased with adalimumab and etanercept, compared to controls.

14. Concurrent use of a TIB with another TIB results in increased AEs and is not recommended by current practice guidelines.

15. Unique safety concerns with the non-TNF biologics include the following:

    - abatacept: Increased risk of chronic obstructive pulmonary disease (COPD) exacerbation in adults with COPD
    - tocilizumab and tofacitinib: gastrointestinal perforation and lab abnormalities, including elevated lipids and transaminases

- apremilast: psychiatric adverse effects such as depression and suicidal ideations

16. Overall, adalimumab has the highest clinical utility within the Military Health System (MHS) given its seven FDA-approved indications and wide spectrum of clinical coverage.

17. Inclusion of a non-TNF biologic on the formulary is required for patients who do not respond to an anti-TNF biologic.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and budget impact analysis (BIA) were performed to evaluate the TIBs used to treat rheumatologic (stratified by rheumatoid arthritis and psoriatic arthritis), dermatologic, and gastrointestinal (stratified by Crohn's disease and ulcerative colitis) inflammatory conditions. The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 0 absent) the following:

1. CMA results for the TIBs showed the following:
    - For rheumatoid arthritis, adalimumab (Humira) was the most cost-effective TIB, followed by certolizumab (Cimzia), anakinra (Kineret), tofacitinib (Xeljanz), golimumab (Simponi), etanercept (Enbrel), abatacept (Orencia), and tocilizumab (Actemra).
    - For psoriatic arthritis, adalimumab was the most cost-effective drug, followed by apremilast (Otezla), certolizumab, golimumab, etanercept, and ustekinumab (Stelara).
    - For dermatologic conditions, adalimumab was the most cost-effective TIB, followed by etanercept, and ustekinumab.
    - For gastrointestinal conditions (Crohn's disease), adalimumab was the most cost-effective agent, followed by certolizumab. For ulcerative colitis, adalimumab was the most cost-effective agent, followed by golimumab.

2. A BIA was performed to evaluate the potential impact of scenarios, with selected agents designated step-preferred and UF or non-preferred and NF.

Robust BIA results showed the scenario with adalimumab designated as formulary and step preferred on the UF; apremilast, golimumab, tofacitinib, and ustekinumab designated as formulary and non-preferred; and, abatacept, anakinra, certolizumab, etanercept, and tocilizumab designated as NF and non-step preferred, was the most cost-effective option for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATIONS***—The P&T Committee recommended (16 for, 1 opposed, 0 abstained, 0 absent) the following for the TIBs, based on clinical effectiveness, and cost effectiveness.

- UF and step-preferred ("in front of the step"): adalimumab (Humira)
- UF and non-preferred ("behind the step"): apremilast (Otezla), golimumab (Simponi), tofacitinib (Xeljanz), and ustekinumab (Stelara)
- NF and non-preferred: abatacept (Orencia), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), and tocilizumab (Actemra)
- This recommendation includes step therapy, which requires a trial of adalimumab for all new users of a TIB.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent), adalimumab (Humira) be designated BCF upon signing of the minutes. The TIBs are now classified as a BCF rather than an ECF drug class. Military Treatment Facilities (MTFs) that do not currently have adalimumab on formulary are required to add it to their local formularies and make it available to beneficiaries on the same basis as any other BCF agent.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) MN criteria for abatacept (Orencia), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), and tocilizumab (Actemra). (See Appendix B for full MN criteria.)

4. ***COMMITTEE ACTION: PA CRITERIA***—Existing manual PA criteria currently apply to all the TIBs. The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) automated (step therapy) criteria for all new users of the non-preferred TIBs [abatacept (Orencia), anakinra (Kineret), apremilast (Otezla), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), tocilizumab (Actemra), tofacitinib (Xeljanz), and ustekinumab (Stelara)], requiring a trial of adalimumab (Humira) before the non-step preferred drugs.

   A trial of Humira is not required if:

   - Contraindications exist to Humira
   - The patient has had an inadequate response to Humira, and requires a different anti-TNF biologic or a non-TNF biologic
   - The patient has experienced adverse reactions to Humira which are not expected to occur with the requested non-preferred TIB
   - There is no formulary alternative for the following:
     - Enbrel: Patient is a child younger than four years of age or the patient has hepatitis C virus

- Non-TNF TIB (Orencia, Actemra, Xeljanz, Kineret, Stelara, and Otezla): Patient has symptomatic chronic heart failure
- Actemra, Orencia or Simponi: Patient has been stable on an intravenous formulation, with continuous use in the past three months and needs to transition to the subcutaneous formulation

The P&T Committee also recommended manual PA criteria for all users of Humira or a non-preferred TIB. Coverage for the TIBs is only allowed for the FDA-approved indications, and coverage is not approved for concomitant use of a TIB with other biologics. (See Appendix C for full criteria.)

5. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)***—QLs currently apply to the TIBs. The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) to continue the current QLs for abatacept, adalimumab, anakinra, apremilast, certolizumab, etanercept, golimumab, tofacitinib, tocilizumab, and ustekinumab, at a maximum of a 28-day supply in the Retail Network and maximum of a 56-day supply in the Mail Order Pharmacy.

6. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in all POS; and, 2) DHA send a letter to beneficiaries affected by the UF decision. Based on the P&T Committee's recommendation, the effective date is February 18, 2014.

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

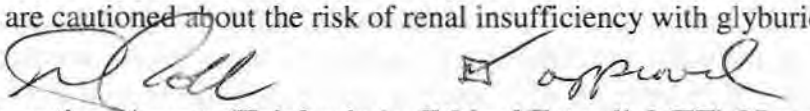
VI. BCF CHANGES

A. Non-Insulin Diabetes Drugs—Sulfonylureas: MTF Request for Glyburide Deletion from the BCF

The P&T Committee reviewed a MTF request to delete glyburide from the BCF. Two sulfonylureas, glyburide (Diabeta, Glynase, generics) and glipizide (Glucotrol, generics) have been maintained on the BCF since 1998. Two other sulfonylureas, glimepiride (Amaryl, generics) and glipizide XL (Glucotrol XL, generics) are designated UF. Glipizide is safer to use than glyburide in diabetic patients with renal insufficiency.

However, glyburide is the sulfonylurea of choice for treating pregnant women, based on an article in the New England Journal of Medicine from 2000. P&T Committee members were concerned about the availability of glyburide for pregnant patients at all MTFs if it was removed from the BCF.

1. ***COMMITTEE ACTION: GLYBURIDE DELETION FROM THE BCF***
   The P&T Committee recommended (0 for, 17 opposed, 0 abstained, 0 absent) to remove glyburide on the BCF. Glyburide will be retained on the BCF. Providers are cautioned about the risk of renal insufficiency with glyburide.



B. Contraceptives Agents (Triphasics): Ethinyl Estradiol (EE) 25 mcg; Norgestimate 0.18/0.215/0.25mg (Ortho Tri-Cyclen Lo, generics) Deletion from the BCF

The P&T Committee reviewed trends in utilization and spend for the Contraceptives Agents. Multiple generic entrants, product discontinuations, and pricing changes frequently occur for the various products. Eleven contraceptive subclasses are on the BCF, including six monophasic, one triphasic, and one progestogen-only formulation; all the contraceptive subclasses have designated UF products.

The triphasic product EE 25 mcg with 0.18/0.215/0.25mg norgestimate (Ortho Tri-Cyclen Lo) has been maintained on the BCF since May 2006. An increase in the Ortho Tri-Cyclen Lo price has been noted over the past two years. Other triphasic products with EE 25 mcg, containing a different progestin (e.g., desogestrel in the formulations of Cyclessa and Velivet) and norgestimate-containing products with EE 35 mcg (e.g., Ortho Tri-Cyclen and Trinessa) are available on the UF at significant cost savings.

1. ***COMMITTEE ACTION: EE 25 MCG; 0.18/0.215/0.25MG NORGESTIMATE (ORTHO TRI-CYCLEN LO) DELETION FROM THE BCF***—The P&T Committee recommended (16 for, 0 opposed, 1 abstained, 0 absent) removing EE 25 mcg; 0.18/0.215/0.25mg norgestimate (Ortho Tri-Cyclen Lo) from the BCF upon signing of the minutes; the drug remains UF.

Director, DHA, Decision: ☒ Approved □ Disapproved

Approved, but modified as follows:

VII. UTILIZATION MANAGEMENT

A. PA and QLs

1. **Valeritas V-Go Insulin Delivery Device**—V-Go is a disposable insulin delivery device approved for patients with Type 2 diabetes mellitus. Unlike an insulin pump, V-Go does not require any tubing or catheters. The device is filled daily with rapid acting insulin, allowing for continuous administration of basal insulin. After 24 hours, the

device is discarded and replaced with a new unit. Advantages of V-Go include convenience to the patient desiring increased control over their blood glucose levels and elimination of the need for multiple daily insulin injections. Additionally, V-Go may reduce prandial glycemic excursions compared to multiple insulin injections. Potential disadvantages of V-Go include the risk of hypoglycemia and infection, the requirement for daily manual filling of the device with insulin, non-adjustable preset basal rates, and the potential for wastage.

The P&T Committee considered PA criteria for V-Go, consistent with the product labeling, including the capacity and purpose of the system (a maximum allowable dose of insulin of 76 units per day), and the meal time bolus insulin dose capability (no less than 2 unit increments of insulin).

a) ***COMMITTEE ACTION: V-GO MANUAL PA CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) manual prior authorization criteria for all new users of V-Go. Coverage will be approved if the patient meets all of the following criteria:

   (1) Patient has Type 2 diabetes mellitus; AND

   (2) Patient does not need more than 40 units of basal insulin daily AND the patient does not need more than 36 units of bolus insulin daily; AND

   (3) Patient does not need less than 2 unit increments of bolus dosing; AND

   (4) Patient has been maintained on stable basal insulin for at least three months (at dosages of 20U, 30U, or 40U); AND

   (5) Patient has been using prandial insulin for at least three months.

b) ***COMMITTEE ACTION: V-GO QLS***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) QLs of 30 units per 30 days, consistent with the product labeling of 1 unit used daily.

c) ***V-GO PA IMPLEMENTATION***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) implementation of the PA upon signing of the minutes.

2. **Newer Sedative Hypnotics (SED-1s): Tasimelteon (Hetlioz)**—Tasimelteon is a melatonin receptor agonist that is approved for treating blind patients who have non-24 hours sleep-wake disorder and have no light perception. It will be reviewed as a new drug at an upcoming meeting. Automated PA (step therapy) currently applies to the SED-1s Drug Class, where a trial of generic zolpidem immediate release (IR) or zaleplon is required first.

a) ***COMMITTEE ACTION: TASIMELTEON (HETLIOZ) PA CRITERIA***
The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) PA criteria for all new users of tasimelteon (Hetlioz) who are blind and have non-24 hour sleep-wake disorder. PA criteria will require a trial of generic zolpidem IR or zaleplon before Hetlioz. (See Appendix C for full criteria.)

b) ***COMMITTEE ACTION: TASIMELTEON (HETLIOZ) PA IMPLEMENTATION***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) an effective date of no later than the first Wednesday after a 30-day implementation period in all POS. Based on the P&T Committee's recommendation, the effective date is December 10, 2014.

3. **Metastatic Melanoma Medications: Trametinib (Mekinist) and Dabrafenib (Tafinlar) Manual PA Criteria**—Mekinist and Tafinlar are oral kinase inhibitors approved for treating patients with unresectable or metastatic melanoma who have documented BRAF V600E or V600K mutations as detected by an FDA-approved test. PA criteria currently apply to other oral kinase inhibitors for this diagnosis.

   a) ***COMMITTEE ACTION: TRAMETINIB (MEKINIST) AND DABRAFENIB (TAFINLAR) PA CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria should apply to all new users of Mekinist and Tafinlar, consistent with the FDA-approved product labeling. The PA will ensure that candidates likely to respond to Mekinist and Tafinlar are identified prior to initiating therapy. (See Appendix C for full criteria.)

4. **Seizure Medications: Topiramate ER capsules (Trokendi XR and Qudexy XR) Manual PA Criteria**—Trokendi XR and Qudexy XR are branded ER formulations of topiramate that are dosed once daily. Generic formulations of topiramate IR have been marketed since 1996, and include both tablets and capsules. Generic topiramate IR is FDA-approved for treating patients with seizures, down to the age of two years, and migraine headache. Topiramate is sometimes used off –label for weight loss.

   Trokendi XR and Qudexy XR are indicated for the treatment of seizures, but are only approved for patients down to the age of six or ten years, depending on the diagnosis.

   a) ***COMMITTEE ACTION: TOPIRAMATE ER (TROKENDI XR AND QUDEXY XR) PA CRITERIA***—The P&T Committee recommended (16 for, 1 opposed, 0 abstained, 0 absent) PA criteria for all new users of Trokendi XR and Qudexy XR consistent with the product's labeling for treatment of seizures, due to the potential for off-label use. Patients will be required to try generic topiramate IR first, unless there is a contraindication or adverse reaction with the generic product. (See Appendix C for full criteria.)

b) ***COMMITTEE ACTION: TOPIRAMATE ER (TROKENDI XR AND QUDEXY XR) PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) an effective date no later than the first Wednesday after a 30-day implementation period in all POS. Based on the P&T Committee's recommendation, the effective date is December 10, 2014.

5. **Oral Chemotherapy Agents: Ibrutinib (Imbruvica), Idealisib (Zydelig), and Everolimus (Afinitor Disperz)**—QLs currently apply to the oral chemotherapy agents.

   a) ***COMMITTEE ACTION: IBRUTINIB (IMBRUVICA), IDEALISIB (ZYDELIG,) AND EVEROLIMUS (AFINITOR DISPERZ)—QLs***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) the following QLs, consistent with the products' packaging and labeling:

      (1) Ibrutinib (Imbruvica): A maximum allowable quantity at the retail network POS of 60 tablets (30-day supply) and 120 tablets at the Mail Order Pharmacy (60-day supply)

      (2) Idealisib (Zydelig): A maximum allowable quantity at the retail network POS of 60 tablets (30-day supply) and 120 tablets at the Mail Order Pharmacy (60-day supply)

      (3) Everolimus (Afinitor Disperz): A maximum allowable quantity at the retail network POS of a 28-day supply, and a 56-day supply at the Mail Order Pharmacy.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

VIII. SECTION 716 OF THE NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FISCAL YEAR 2013 PILOT PROGRAM FOR REFILLS OF MAINTENANCE MEDICATIONS FOR TRICARE FOR LIFE BENFICIARIES THROUGH THE TRICARE MAIL ORDER PROGRAM

A. Medication Drug List for the Pilot Program: Updates—The Medication Drug list for the Pilot Program for TRICARE for Life beneficiaries was recommended at the November 2013 P&T Committee meeting. An update to the drug list is required due to some products being discontinued from the market, availability issues, and to ensure consistency within the drug classes. (See the November 2013 P&T Committee meeting minutes, Appendix F, found at

http://pec.ha.osd.mil/PT_min_charter.php?submenuheader=5
or the TRICARE Formulary Search Tool at
http://pec.ha.osd.mil/TFL_maintenance_drug_list.php for the full medication drug list.)

1. ***COMMITTEE ACTION: MAINTENANCE MEDICATION PROGRAM DRUG LIST UPDATE***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) the following changes to the list of covered maintenance medications for the Section 716 pilot program. Implementation will occur upon signing of the minutes.

    - Remove from list due to manufacturer discontinuation: Cardizem 90 mg tablet; Dilacor XR 240 mg capsule; Estraderm 0.05 mg patch; Exelon 2 mg/mL solution; Lantus 100 units/mL cartridge; Lufyllin-GG elixir; Namenda 5mg–10 mg titration pack; Parcopa 10 mg–100 mg orally dissolving tablet (ODT); Parcopa 25 mg–100 mg ODT; Parcopa 25 mg–250 mg ODT; Potaba 500 mg tablet; Questran Light packet; Sanctura XR 60 mg capsules; Teveten 400 mg tablets; Uniretic 15mg–25 mg tablet
    - Remove from list due to noncompliance with the Trade Agreements Act: Isopoto carpine 2% eye drops; Lopid 600 mg tablet; Pepcid 40 mg tablet
    - Remove from list due to availability issues: Theo24
    - Add to list, due to consistency with the drug class: Humulin 70/30 Kwikpen; Humilin 100 units/mL Kwikpen; Pegasys 180 mcg/0.5 mL syringe
    - Add to list due to consistency with the class and UF changes recommended at the August 2014 P&T Committee meeting: TIBs formulary drugs—Otezla, Simponi, Stelara, and Xeljanz

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

IX. LINE EXTENSIONS

A. Formulary Status Clarification—The P&T Committee clarified the formulary status for one product line extension ("follow-on product") by the original manufacturer. Line extensions have the same FDA indications and pricing as the "parent" drug. The product is a new dosage strength of buprenorphine transdermal system (Butrans).

1. ***COMMITTEE ACTION: LINE EXTENSIONS FORMULARY STATUS CLARIFICATION***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) clarifying the formulary status of the following product to reflect

the current formulary status and step therapy/PA criteria of the parent compound. Implementation will occur upon signing of the minutes.

- Buprenorphine patch (Butrans) 7.5 mcg/hour patch: UF with PA, similar to Butrans patch 5, 10, 15, and 20 mcg/hour

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

X. FISCAL YEAR 2008 NDAA, Section 703

The P&T Committee reviewed drugs from manufacturers that were not included on a DoD Retail Refund Pricing Agreement; these drugs are not in compliance with the Fiscal Year 2008 NDAA, Section 703. The law stipulates that if a drug is not compliant with Section 703, these drugs will be designated NF on the UF and will require pre-authorization prior to use in the Retail POS and medical necessity in the MTFs. These NF drugs will remain available in the Mail Order POS without preauthorization.

1. ***COMMITTEE ACTION: DRUGS DESIGNATED NF***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) that the following products be designated NF on the UF:

Auxilium Pharma:	Robaxin 750, Robaxin, Levatol
Bluepoint Lab:	Nitrofurantoin Mono-M; Nitrofurantoin
Eli Lilly:	Livalo
Kowa:	Livalo
Major Pharma:	sulfasalazine, methotrexate
Orexo:	Zubsolv
Purdue:	Dilaudid, Intermezzo
VistaPharm:	sucralfate
Xenoport:	Horizant
Zylera:	Ulesfia

2. ***COMMITTEE ACTION: PRE-AUTHORIZATION CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) the following pre-authorization criteria for the drugs recommended NF above: 1) obtaining the product by home delivery would be detrimental to the patient; and, 2) for branded products with AB generic availability, use of the generic product would be detrimental to the patient. These pre-authorization criteria do not apply to any POS other than retail network pharmacies.

3. ***COMMITTEE ACTION: IMPLEMENTATION PERIOD FOR PRE-AUTHORIZATION CRITERIA***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in the Retail Network; and, 2) DHA send a letter to beneficiaries affected by these decisions. Based on the P&T Committee's recommendation, the effective date is February 18, 2014.

4. ***COMMITTEE ACTION: DRUG DESIGNATED FORMULARY***—The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 0 absent) retaining the following drugs, due to their unique clinical niches: oxycodone 5 mg/mL solution (VistaPharm); nitrogen mustard topical gel for the treatment of mycosis fungoides-type cutaneous T-cell lymphoma (Valchlor; Actelion); and, typhoid vaccine live oral (Vivotif; Berne Products Crucell).

Director, DHA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

XI. ITEMS FOR INFORMATION

A. Specialty Medications—The P&T Committee was briefed on an initial plan for specialty medications, including a discussion of a proposed definition of a specialty agent. DHA's goal is to provide a standardized means to measure utilization and spend of specialty agents, and to evaluate patient outcomes. Other aspects include providing tools to assist patients, providers, and MTFs in the course of managing drug and associated therapy for these complex disease states. The P&T Committee will receive updates and will review specialty agents eligible for contractor-provided clinical pharmacy services at future meetings.

XII. ADJOURNMENT

The meeting adjourned at 1730 hours on August 13, 2014. The next meeting will be in November 2014.

Appendix A—Attendance: August 2014 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

SUBMITTED BY:

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

DECISION ON RECOMMENDATIONS

Director, DHA, decisions are as annotated above.

Douglas J. Robb, DO, MPH
Lieutenant General, USAF, MC, CFS
Director

13 Nov 2014
Date

Appendix A—Attendance: August 2014 P&T Committee Meeting

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
Dr. George Jones	Chief, DHA Pharmacy Operations Division
LTC Robert Conrad, MS	Chief, DHA Pharmacoeconomic Branch (Recorder)
COL John Spain, MS	Army, Pharmacy Officer
Col Scott Sprenger, BSC	Air Force, Pharmacy Officer
CAPT Deborah Thompson, USCG	Coast Guard, Pharmacy Officer
CAPT Derrik Clay for CAPT Edward Norton, MSC	Navy, Pharmacy Officer (Pharmacy Consultant BUMED)
COL Ted Cieslak, MC	Army, Physician at Large
Col Michael Wynn, MC	Army, Family Practice Physician
LCDR Carey Welsh, MC	Navy, Pediatrics Physician
Col James Jablonski, MC	Air Force, Physician at Large
CDR Brian King, MC	Navy, Internal Medicine Physician
COL Jack Lewi, MC	Army, Internal Medicine Physician
CDR Shaun Carstairs, MC	Navy, Physician at Large
Lt Col William Hannah, MC	Air Force, Internal Medicine Physician
Maj Larissa Weir, MC	Air Force, OB/GYN Physician
Dr. Miguel Montalvo	TRICARE Regional Office-South, Chief of Clinical Operations Division and Medical Director
Voting Members Absent	
Col Michael Spilker, BSC	DHA Deputy Chief, Pharmacy Operations Division
Mr. Joe Canzolino	U.S. Department of Veterans Affairs
Nonvoting Members Present	
Mr. David Hurt	Associate General Counsel, DHA
CDR Brandon Hardin by phone	Medical Logistics Division, DLA
Guests	
Lt Col Dan Castiglia	Defense Logistics Agency Troop Support
Capt Richard Caballero	Defense Logistics Agency Troop Support

Appendix A—Attendance (continued)

Guests—(continued)	
LCDR Robert Selvester, MC	VA/DoD Evidence-Based Practice Guideline Work Group
Mr. Alexander Quinones	Defense Logistics Agency Troop Support
CDR Matthew Baker	Indian Health Service
CDR Brandon Hardin via DCO	Medical Logistics Division, DLA
Ms. Nancy Misel via DCO	Air Force, Pharmacy Officer
CAPT Brittany Latimer via DCO	Army, Pharmacy Officer
MAJ Kevin Ridderhoff via DCO	DHA, Pharmacy Operations Division
LT Kendra Jenkins via DCO	DHA, Pharmacy Operations Division
Others Present	
CAPT Walter Downs, MC	DHA Pharmacoeconomic Branch
CDR Joshua Devine, USPHS	DHA Pharmacoeconomic Branch
CDR Edward Vonberg, BSC	DHA Pharmacoeconomic Branch
LCDR Marisol Martinez, USPHS	DHA Pharmacoeconomic Branch
Maj David Folmar, BSC	DHA Pharmacoeconomic Branch
MAJ Misty Cowan, MC	DHA Pharmacoeconomic Branch
Maj Ronald Khoury, MC	DHA Pharmacoeconomic Branch
Dr. David Meade	DHA Pharmacoeconomic Branch
Dr. Angela Allerman	DHA Pharmacoeconomic Branch
Dr. Eugene Moore	DHA Pharmacoeconomic Branch
Dr. Shana Trice	DHA Pharmacoeconomic Branch
Dr. Teresa Anekwe via DCO	DHA Pharmacoeconomic Branch
Dr. Amy Lugo via DCO	DHA Pharmacoeconomic Branch
Dr. Brian Beck	DHA Pharmacoeconomic Branch
Mr. Kirk Stocker	DHA Pharmacoeconomic Branch contractor
Ms. Deborah Garcia	DHA Pharmacoeconomic Branch contractor
Dr. Esmond Nwokeji	DHA Pharmacoeconomic Branch contractor

Appendix B—Table of Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
• Abatacept (Orencia) • Anakinra (Kineret) • Certolizumab (Cimzia) • Etanercept (Enbrel) • Tocilizumab (Actemra) **Targeted Immunomodulatory Biologics (TIBs)**	• Use of adalimumab (Humira) is contraindicated • The patient has experienced or is likely to experience significant adverse effects from adalimumab (Humira) • Adalimumab (Humira) resulted or is likely to result in therapeutic failure. • The patient previously responded to the nonformulary agent and changing to adalimumab (Humira) would incur unacceptable risk • No alternative formulary agent applies only to: 1. Abatacept (Orencia): The patient is transitioning from IV abatacept or has symptomatic congestive heart failure CHF. 2. Anakinra (Kineret): The patient has neonatal onset multisystem inflammatory disease (NOMID), a subtype of cryopyrin associated periodic syndrome (CAPS). 3. Etanercept (Enbrel): The patient is less than 4 years of age or has hepatitis C infection. 4. Tocilizumab (Actemra): The patient is transitioning from IV abatacept or has symptomatic CHF. **Formulary alternative:** adalimumab (Humira)
• Methylphenidate ER oral suspension (Quillivant XR) **Attention Deficit Hyperactivity Disorder Stimulants**	• The formulary agents resulted in therapeutic failure. • No alternative formulary agent — patient has a G-tube. **Formulary alternatives:** Methylphenidate immediate release, sustained release, or extended release

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• Adalimumab (Humira) **Targeted Immunomodulatory Biologics (TIBs)**	Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis, active psoriatic arthritis, or active ankylosing spondylitis • Moderate to severe chronic plaque psoriasis who are candidates for systemic or phototherapy, and when other systemic therapies are medically less appropriate • Moderate to severely active Crohn's disease following an inadequate response to conventional therapy, loss of response to Remicade, or an inability to tolerate Remicade • Moderate to severely active ulcerative colitis following inadequate response to immunosuppressants Coverage approved for pediatric patients (age 4-17 years) with: • Moderate to severe active polyarticular juvenile idiopathic arthritis Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Golimumab (Simponi) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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 me, coverage is approved for Simponi if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira is not expected with requested non-step preferred TIB • Patient has been stable on IV Simponi with continuous use in last 3 months and needs to transition to the SC formulation of Simponi AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis in combination with methotrexate • Active psoriatic arthritis or active ankylosing spondylitis • Moderately to severely active ulcerative colitis with an inadequate response or intolerant to prior treatment or requiring continuous steroid therapy Rheumatoid arthritis patients require an active methotrexate script. Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)

Drug / Drug Class	Prior Authorization Criteria
• Certolizumab (Cimzia) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Cimzia if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira not expected with requested non-step preferred TIB AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis, active psoriatic arthritis, or active ankylosing spondylitis • Moderately to severely active Crohn's disease following an inadequate response to conventional therapy. Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Etanercept (Enbrel) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Enbrel if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira not expected with requested non-step preferred TIB • There is no formulary alternative (Enbrel is prescribed for children < 4years of age; Enbrel is prescribed for a patient with hepatitis C virus) AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis, active psoriatic arthritis, or active ankylosing spondylitis • Moderate to severe chronic plaque psoriasis who are candidates for systemic or phototherapy Coverage approved for pediatric patients (age 2–17) with: • Moderate to severe active polyarticular Juvenile Idiopathic Arthritis Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)

Drug / Drug Class	Prior Authorization Criteria
• Anakinra (Kineret) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Kineret if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira not expected with requested non-step preferred TIB • There is no formulary alternative (Kineret for pediatric patient with Neonatal-Onset Multisystem Inflammatory Disease (NOMID), a subset of Cryoprin Associated Period Syndrome (CAPS) NOMID • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis, who have failed ≥ 1 disease modifying anti-rheumatic drugs (DMARDs) Coverage approved for pediatric patients (all ages) with: • Neonatal-Onset Multisystem Inflammatory Disease (NOMID), a subset of Cryoprin Associated Period Syndrome (CAPS) Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Abatacept (Orencia) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Orencia if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira not expected with requested non-step preferred TIB • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF • Patient has been stable on IV Orencia with continuous use in last 3 months and needs to transition to the SC formulation of Orencia AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis • Subcutaneous Orencia is not approved for use in systemic or polyarticular Juvenile Idiopathic Arthritis

Drug / Drug Class	Prior Authorization Criteria
	Abatacept (Orencia)—continued Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Tocilizumab (Actemra) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Actemra if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira not expected with requested non-step preferred TIB • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF • Patient has been stable on an IV TIB with continuous use in last 3 months and needs to transition to the SC formulation of Actemra AND Coverage approved for patients ≥ 18 years with: • Moderate to severe active rheumatoid arthritis who have had an inadequate response to ≥ 1 disease modifying anti-rheumatic drugs (DMARDs) • Subcutaneous Actemra is not approved for use in systemic or polyarticular Juvenile Idiopathic Arthritis Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Tofacitinib (Xeljanz) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Xeljanz if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • Adverse reactions to Humira not expected with requested non-step preferred TIB • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF AND Coverage approved for patients ≥ 18 years with: • Moderate to severely active rheumatoid arthritis who have had an inadequate response or intolerance to methotrexate.

Drug / Drug Class	Prior Authorization Criteria
	Tofacitinib (Xeljanz)—continued Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Apremilast (Otezla) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Otezla if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF • Adverse reactions to Humira not expected with requested non-step preferred TIB AND Coverage approved for patients ≥ 18 years with: • Active psoriatic arthritis Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• Ustekinumab (Stelara) **Targeted Immunomodulatory Biologics (TIBs)**	Automated PA criteria: The patient has filled a prescription for adalimumab (Humira) 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, coverage is approved for Stelara if: • Contraindications exist to Humira • Inadequate response to Humira (need for different anti-TNF or non-TNF) • There is no formulary alternative: patient requires a non-TNF TIB for symptomatic CHF • Adverse reactions to Humira not expected with requested non-step preferred TIB AND Coverage approved for patients ≥ 18 years with: • Active psoriatic arthritis • Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy

Drug / Drug Class	Prior Authorization Criteria
	Ustekinumab (Stelara)—continued Coverage is NOT provided for concomitant use other TIBs including but not limited to adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz), ustekinumab (Stelara), apremilast (Otezla), or rituximab (Rituxan)
• albiglutide once weekly (Tanzeum) **Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs)**	All new and current users of albiglutide (Tanzeum) are required to try metformin or a sulfonylurea (SU) before receiving Tanzeum. Automated PA criteria: The patient has received a prescription for metformin or SU at any Military Health System pharmacy point of 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, albiglutide (Tanzeum) is approved (e.g., trial of metformin or SU is NOT required) if: • The patient has a confirmed diagnosis of Type 2 Diabetes Mellitus • 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 • The patient has a contraindication to metformin or a SU
• Valeritas V-Go Insulin Delivery Device (V-Go) **Insulins**	PA criteria apply to all new users of the V-Go device. Manual PA criteria: (1) Patient has Type 2 diabetes mellitus AND (2) Patient does not need more than 40 units of basal insulin daily AND the patient does not need more than 36 units of bolus insulin daily AND (3) Patient does not need less than 2 unit increments of bolus dosing AND (4) Patient has been maintained on stable basal insulin for at least 3 months (at dosages of 20U, 30U, or 40U) AND (5) Patient has been using prandial insulin for at least 3 months.
• Tasimelteon (Hetlioz) **Newer Sedative Hypnotic-1s**	PA criteria apply to all new users of tasimelteon (Hetlioz). A trial of generic zolpidem IR or zaleplon is required before Hetlioz. Automated PA: The patient has filled a prescription for zolpidem IR or zaleplon at any MHS pharmacy POS (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA: If automated criteria are not met, tasimelteon (Hetlioz) is approved (e.g., trial of zolpidem immediate release or zaleplon is NOT required) if the patient meets criterion #1 below, and one of the other criteria (#2, #3, or #4).

Drug / Drug Class	Prior Authorization Criteria
	Tasimelteon (Hetlioz)—continued (1) The patient is totally blind and has no light perception. AND (2) The patient has received a trial of zolpidem IR or zaleplon and had an inadequate response. OR (3) The patient received a trial of zolpidem IR or zaleplon but was unable to tolerate it due to adverse effects. OR (4) Treatment with zolpidem IR or zaleplon is contraindicated for this patient (e.g., due to hypersensitivity, aberrant behaviors, or intolerable rebound insomnia).
• Trametinib (Mekinist) and Dabrafenib (Tafinlar) **Metastatic Melanoma Medications**	Manual PA criteria apply to all new users of trametinib (Mekinist) and dabrafenib (Tafinlar) Mekinist: • Coverage approved for treatment of patients alone or in combination with dabrafenib (Tafinlar) in patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. • Coverage not approved as a single agent in patients who have received prior BRAF-inhibitor therapy Tafinlar: • Coverage approved as a single agent for treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. • Combination use with Mekinist in the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. • Not approved for patients with wild-type BRAF melanoma
• Topiramate ER (Trokendi XR and Qudexy XR) **Seizure Medications**	Manual PA criteria apply to all new users of Trokendi XR and Qudexy XR: • Coverage approved for o Partial onset seizure and 1° generalized tonic-clonic seizures in patients ≥ 10 years o Lennox-Gastaut seizures in patients ≥ 6 years • Coverage not approved for o Non-FDA approved indications, including migraine headache and weight loss • Patient is required to try topiramate first, unless the following has occurred: o Inadequate response not expected to occur with Trokendi XR or Qudexy XR o Patient has contraindication or adverse reaction to a component of generic topiramate not expected to occur with Trokendi XR or Qudexy XR

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
Aug 2014	**Targeted Immunologic Biologics**	UF class review Previously reviewed	▪ Adalimumab (Humira)	▪ Apremilast (Otezla) ▪ Golimumab (Simponi) ▪ Tofacitinib (Xeljanz) ▪ Ustekinumab (Stelara)	▪ Abatacept (Orencia ▪ Anakinra (Kineret) ▪ Certolizumab (Cimzia) ▪ Etanercept (Enbrel) ▪ Tocilizumab (Actemra)	Pending singing of the minutes / 90 days	▪Step therapy required; see comments ▪Quantity Limits apply; see Formulary Search Tool	▪ Must try Humira first in all new users before the other TIBs. (See Appendix C) ▪ TIBs are no longer an ECF class; Humira now BCF

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

Appendix E—Table of Abbreviations

A1c	hemoglobin A1c
ACR50	American College of Rheumatology 50
ADHD	attention deficit hyperactivity disorder
AE	adverse event
BCF	Basic Core Formulary
BIA	budget impact analysis
CAPS	Cryoprin Associated Period Syndrome
CEA	cost-effectiveness analysis
CHF	congestive heart failure
CMA	cost minimization analysis
COPD	chronic obstructive pulmonary disease
DCO	Defense Connect Online
DHA	Defense Health Agency
DMARDs	disease modifying anti-rheumatic drugs
DoD	Department of Defense
DR	delayed release
EE	ethinyl estradiol
ER	extended release
ECF	Extended Core Formulary
FDA	U.S. Food and Drug Administration
GLP1RA	glucagon-like peptide-1 receptor agonist
IR	immediate release
MHS	Military Health System
MN	medical necessity
MTF	Military Treatment Facility
NF	nonformulary
NDAA	National Defense Authorization Act
NOMID	Neonatal-Onset Multisystem Inflammatory Disease
NMA	network meta-analysis
NNT	number needed to treat
P&T	Pharmacy and Therapeutics
PA	prior authorization
PASI 75	Psoriasis Activity and Severity Index 75
POS	points of service
RCTs	randomized controlled trials
QLs	quantity limits
SED-1s	Newer Sedative Hypnotics Drug Class
SU	sulfonylurea
TB	tuberculosis
TIBs	targeted immunomodulatory biologics
TNF	tumor necrosis factor
UF	Uniform Formulary

DEPARTMENT OF DEFENSE

PHARMACY AND THERAPEUTICS COMMITTEE
MINUTES AND RECOMMENDATIONS

February 2014

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on February 12, 2014, at the Defense Health Agency (DHA) Pharmacoeconomic Branch, Fort Sam Houston, Texas.

II. ATTENDANCE

The attendance roster is listed in Appendix A.

A. Review Minutes of Last Meetings

1. **Approval of August Minutes**—Lt. Gen. Douglas J. Robb, DO, MPH, Director, DHA, approved the minutes for the November 2013 DoD P&T Committee meeting on February 10, 2014.

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. Antidepressants (AD-1s)—Bupropion extended release 450 mg (Forfivo XL), desvenlafaxine extended release (ER) (Khedezla), levomilnacipran (Fetzima), and vortioxetine (Brintellix).

Background and Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 against, 0 absent, 0 abstain) the following with regard to the clinical efficacy and safety of bupropion XL 450 mg (Forfivo XL), desvenlafaxine ER (Khedezla), levomilnacipran (Fetzima), and vortioxetine (Brintellix). All four drugs are indicated solely for the treatment of major depressive disorder (MDD).

1. Forfivo XL
    a) Forfivo XL is an extended-release 450 mg formulation of bupropion, a norepinephrine/dopamine reuptake inhibitor (NDRI). Several generic formulations of bupropion (Wellbutrin, Wellbutrin SR, and Wellbutrin XL) are on the BCF. There are no clinical trials with Forfivo XL; FDA approval was based on demonstrated bioequivalence to three tablets of 150 mg Wellbutrin XL.
    b) Limitations to the product include that patients must be titrated with another bupropion formulation first, and the dose cannot be adjusted in renal or hepatic impairment.
    c) Forfivo XL has similar safety and tolerability concerns as other bupropion agents.
    d) While Forfivo XL offers an alternative treatment option of one tablet administered once daily for patients requiring a high dose of bupropion, it offers no compelling clinical advantages over the other bupropion formulations on the BCF or UF.
2. Desvenlafaxine ER (Khedezla)
    a) Khedezla is a serotonin/norepinephrine reuptake inhibitor (SNRI) that is an extended-release form of desvenlafaxine (Pristiq). Khedezla differs from Pristiq in the salt form (desvenlafaxine base versus desvenlafaxine succinate). Generic desvenlafaxine formulations are now available.
    b) Khedezla has shown bioequivalence to Pristiq in three studies; there are no clinical trials available.
    c) Khedezla offers no clinically relevant advantages over the venlafaxine products (Effexor, Effexor XR, generic) products on the UF.
3. Levomilnacipran (Fetzima)
    a) Levomilnacipran is a SNRI and is an extended-release stereoisomer of milnacipran (Savella). Fetzima is indicated for MDD whereas Savella is indicated for fibromyalgia.
    b) There are no head-to-head studies comparing levomilnacipran with other antidepressants.
    c) In the three placebo-controlled studies used to gain FDA approval, all levomilnacipran doses produced a statistically significant change from baseline in the Montgomery-Asberg Depression Rating Scale (MADRS). However, varying effects on response rates (e.g., a 50% reduction in the MADRS score from baseline) have been reported, depending on the dose and study design. There was no difference from placebo in remission rate at any levomilnacipran dose.

d) The safety profile of levomilnacipran is similar to milnacipran (Savella) and carries the same warnings.

e) Levomilnacipran offers no clinically compelling advantages over the other AD-1s on the UF.

4. Vortioxetine (Brintellix)

a) There have been no head-to-head studies between vortioxetine and other antidepressants. In four of seven placebo-controlled studies, vortioxetine was superior to placebo in improving MADRS or HAMD (Hamilton Depression Rating Scale) scores from baseline.

b) In active comparator studies using duloxetine (Cymbalta) or venlafaxine (Effexor), vortioxetine showed similar clinical results in the endpoints of MADRS, HAMD, response, or remission.

c) The most common adverse events (AEs) with vortioxetine include nausea and vomiting. Vortioxetine has fewer known AEs and warnings compared to desvenlafaxine, duloxetine (Cymbalta), and levomilnacipran. However, vortioxetine is the newest AD-1 to reach the market and additional AEs may increase during post-marketing surveillance.

d) Although vortioxetine offers additional serotonergic effects in its mechanism of action and has fewer AEs overall than some of the other AD-1s, this has not translated into greater efficacy in treating depression.

Relative Cost-Effectiveness Analysis and Conclusion—Cost minimization analysis (CMA) was performed to evaluate new antidepressants bupropion XL 450 mg (Forfivo XL), desvenlafaxine ER (Khedezla), levomilnacipran (Fetzima), and vortioxetine (Brintellix) compared with other AD-1 subclasses, including selective serotonin reuptake inhibitors (SSRIs), SNRIs, and NDRIs. Based on the CMA results, the P&T Committee concluded (16 for, 0 against, 0 absent, 0 abstain) the following:

- For the NDRIs, the current BCF drugs—generic bupropion IR, sustained release and ER formulations—were the most cost-effective agents, followed by the new entrant Forfivo XL and then followed by the NF branded product bupropion hydrobromide (Aplenzin).

- For the SNRIs and SSRIs subclasses, the BCF drugs citalopram and sertaline were the most cost-effective drugs, followed by generic venlafaxine IR and ER, and then followed by generic desvenlafaxine, Khedezla, generic duloxetine (Cymbalta), levomilnacipran (Fetzima), vortioxetine (Brintellix), and branded duloxetine (Cymbalta), ranked in order from most to least cost effective.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (15 for, 0 against, 0 absent, 1 abstain) bupropion XL 450 mg

(Forfivo XL), desvenlafaxine ER (Khedezla), levomilnacipran (Fetzima), and vortioxetine (Brintellix) be designated NF, based on clinical and cost effectiveness. Additionally, the P&T Committee recommended Khedezla, Fetzima, and Brintellix be non-step preferred ("behind the step"), which requires a trial of a formulary AD-1 prior to use in all current and new patients. See Prior Authorization section, below.

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (15 for, 0 against, 0 absent, 1 abstain) MN criteria for bupropion 450 mg XL (Forfivo XL), desvenlafaxine ER (Khedezla), levomilnacipran (Fetzima), and vortioxetine (Brintellix). (See Appendix B for the full criteria.)

3. ***COMMITTEE ACTION: PRIOR AUTHORIZATION (PA) CRITERIA***—The P&T Committee recommended (15 for, 0 against, 0 absent, 1 abstain) PA criteria should apply to Khedezla, Fetzima, and Brintellix. (See Appendix C for the full PA criteria.)

   a) Desvenlafaxine ER (Khedezla): For all new users of Khedezla, patients are required to try venlafaxine immediate release (IR) or ER (Effexor, Effexor XR; generics) first.

   b) Levomilnacipran (Fetzima) and vortioxetine (Brintellix): For new users of Fetzima or Brintellix, patients are required to try a generic SSRI, duloxetine, SNRI (except milnacipran), tricyclic antidepressant, mirtazapine, bupropion, serotonin antagonist reuptake inhibitor (trazodone or nefazodone), or mononamine oxidase inhibitor first.

4. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***
The P&T Committee recommended (15 for, 0 against, 0 absent, 1 abstain) 1) an effective date of the first Wednesday after a 90-day implementation period in all points of service (POS); and, 2) DHA send a letter to beneficiaries affected by the UF decision. Based on the P&T Committee's recommendation, the effective date is August 6, 2014.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

V. UF DRUG CLASS REVIEWS

A. Inhaled Corticosteroids/Long-Acting Beta Agonists (ICS/LABAs) Combinations

Background and Relative Clinical Effectiveness Conclusion—The P&T Committee evaluated the clinical effectiveness of the ICS/LABA combinations, which were last reviewed for UF

status in February 2009. Since the last review, one new drug, fluticasone/vilanterol (Breo Ellipta) has been marketed. Military Health System (MHS) expenditures for the class were $168 million in calendar year 2013. The P&T Committee agreed (16 for, 0 opposed, 0 abstained, 0 absent) with the following conclusions:

1. Fluticasone/salmeterol (Advair) and budesonide/formoterol (Symbicort) are highly therapeutically interchangeable for asthma. For asthma, head-to-head trials and systematic reviews show no significant differences in efficacy.
2. For chronic obstructive pulmonary disease (COPD), there is insufficient evidence to conclude that there are clinically relevant differences in efficacy between Advair and Symbicort.
3. Advair Diskus, Symbicort, and Breo Ellipta are all FDA-approved for maintenance treatment of COPD; however, only Advair Diskus and Breo Ellipta are specifically approved for decreasing COPD exacerbations. Symbicort does have data from observational studies showing decreases in COPD exacerbations.
4. For mometasone/formoterol (Dulera), there are no head-to-head trials with another ICS/LABA in asthma; clinically relevant differences in efficacy are not expected. Dulera is not approved for COPD; two trials have shown benefit in improving spirometric endpoints in COPD.
5. There is only limited data for Breo Ellipta in patients with asthma, and it is not FDA-approved for this indication.
6. Breo Ellipta offers the convenience of once-a-day dosing in COPD. However, the long-term safety of the LABA component vilanterol is not known. One large trial (SUMMIT) evaluating mortality as a primary endpoint is underway.
7. Advair Diskus in the only drug approved for treatment of asthma in children down to the age of four years; however, for this age range, a metered dose inhaler (MDI) with a spacer is more commonly used. It also has the advantage of availability in both a MDI [Advair hydrofluoroalkane (HFA)] and dry powder inhaler (Advair Diskus).
8. For safety, a systematic review did not show clinically relevant differences between Advair and Symbicort in asthma. Advair Diskus, Advair HFA, Symbicort, Dulera, and Breo Ellipta all contain the same black box warnings and precautions. All drugs containing a LABA carry a black box warning for the increased risk of death in asthma.
9. Breo Ellipta and Dulera have a lower degree of interchangeability with Advair and Symbicort, due to their limited FDA-approved indications.
10. The Pharmacy Outcomes Research Team (PORT) presented an analysis of the use of ICS/LABAs by indications and found that asthma represents the majority of MHS use (67% of beneficiaries had ICD-9 diagnosis codes indicative of asthma, while 37% had codes for COPD, and 17% had codes for neither diagnosis). However, there was considerable overlap between the COPD and asthma diagnosis codes.

Relative Cost-Effectiveness Analysis and Conclusion—A pharmacoeconommic analysis and budget impact analysis (BIA) were performed to evaluate the ICS/LABAs. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- The pharmacoeconomic analysis showed that fluticasone/salmeterol (Advair Diskus/Advair HFA) was the most cost-effective agent in this class, followed by mometasone/formoterol (Dulera), budesonide/formoterol (Symbicort), and fluticasone/salmeterol (Breo Ellipta).
- A BIA was performed to evaluate the potential impact of scenarios, with selected agents designated step-preferred and formulary or non-preferred and NF on the UF. BIA results showed that the scenario where Advair Diskus and Advair HFA are designated as step-preferred and formulary, with Dulera, Symbicort, and Breo Ellipta designated as non-preferred and NF, was the most cost-effective option for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) the following for the ICA/LABAs, based on clinical and cost effectiveness:
    - UF and step-preferred: fluticasone/salmeterol (Advair Diskus and Advair HFA)
    - NF and non-preferred: budesonide/formoterol (Symbicort), mometasone/formoterol (Dulera), and fluticasone/vilanterol (Breo Ellipta)
    - This recommendation includes step therapy, which requires a trial of Advair Diskus or Advair HFA in all new and current users of Symbicort, Dulera, and Breo Ellipta who are older than 12 years.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) that fluticasone/salmeterol (Advair Diskus and Advair HFA) remain on the BCF.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) MN criteria for Symbicort, Dulera, and Breo Ellipta. (See Appendix B for full MN criteria.)

4. ***COMMITTEE ACTION: PA CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) automated (step therapy) and manual PA criteria in all new and current users of Symbicort, Dulera, and Breo Ellipta who are older than 12 years of age; a trial of Advair Diskus or Advair HFA is required before the non-step preferred drugs.

5. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)***—QLs currently apply to the ICS/LABAs. The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) QLs for Advair Diskus, Advair HFA, Symbicort, Dulera, and Breo Ellipta of 1 inhaler/30 days in the Retail Network and 3 inhaler/90 days in the Mail Order Pharmacy.

6. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (13 for, 2 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday after a 60-day implementation period in all POS; and, 2) DHA send a letter to beneficiaries affected by the UF decision; and, 3) that the ICS/LABA Drug Class be added to the safety net program (Rapid Response Program). Based on the P&T Committee's recommendation, the effective date is July 9, 2014.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

B. Gastrointestinal-1 (GI-1s) Drug Class: Oral Aminosalicylates Subclass

Background and Relative Clinical Effectiveness Conclusion—The P&T Committee evaluated the relative clinical effectiveness of the oral aminosalicylates, a subclass within the GI-1s Drug Class. The subclass is comprised of generic sulfasalazine and the 5-aminosalicylate (5-ASA) products [balsalazide (generic Colazal and Giazo), olsalazine (Dipentum), and mesalamine (Delzicol, Asacol HD, Pentasa, Lialda, and Apriso)].

The GI-1s were previously reviewed for UF placement in February 2011, and mesalamine delayed release (DR) tablets (Asacol), along with generic sulfasalazine, were recommended for BCF addition. Asacol was discontinued from the market in March 2013 due to safety concerns of dibutyl phthalate (DBP) present in the enteric coating of Asacol tablets. A new phthalate-free mesalamine DR formulation, Delzicol is now available. At the May 2013 meeting, Asacol was removed from the BCF, pending a re-review of the subclass. Currently, the only aminosalicylate on the BCF is sulfasalazine.

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following conclusions for the aminosalicylates drug class:

1. Sulfasalazine remains the first-line oral aminosalicylate. For the induction of remission in active ulcerative colitis (UC), evidence from two systematic reviews found no clinically relevant differences in efficacy between sulfasalazine and the newer 5-ASA formulations.

2. For maintenance of remission in UC, another systematic review showed a therapeutic advantage of sulfasalazine over the 5-ASA formulations. This advantage was offset by an increase in adverse events observed with sulfasalazine, due to the sulfapyridine moiety.
3. The newer 5-ASA formulations employ different release mechanisms, which deliver the active drug to various sites in the GI tract. These differences in drug release and site of release do not confer additional benefits in terms of clinical response.
4. The mesalamine product Delzicol is the phthalate-free replacement for Asacol that is bioequivalent to its predecessor; no clinical trials were conducted to evaluate efficacy or safety.
5. Giazo is a new balsalazide product with a higher strength per unit than the other balsalazide formulations (1,100 mg versus 750 mg with Colazal). It is not approved for use in women, and it offers no compelling advantage to the other balsalazide products commercially available.
6. The safety profile is similar for the 5-ASA products, based on systematic reviews. In clinical trials, females treated with Giazo reported more adverse events than males.
7. Lialda and Apriso are dosed once daily, which provides patient convenience, but have not been shown to have clinically relevant benefits in terms of adherence compared to 5-ASAs dosed twice or three times daily. Lialda and Apriso also have the lowest tablet burden.
8. The 5-ASA products are highly therapeutically interchangeable for treating UC. The choice of 5-ASA for UC will depend on other factors, such as location and extent of disease, as well as patient preference in terms of tablet burden and frequency of dosing.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and BIA were performed to evaluate the GI-1s Aminosalicylate Subclass. The P&T Committee concluded (15 for, 0 opposed, 1 abstained, 0 absent) the following:

- CMA results showed that generic sulfasalazine was the most cost-effective agent in this subclass, followed by balsalazide 750 mg (Colazal, generics), olsalazine (Dipentum), and the branded mesalamine agents Apriso, Lialda, Delzicol, Asacol HD, and Pentasa. Giazo (branded balsalazide 1,100 mg) was not cost-effective relative to other agents in this class.

- BIA was performed to evaluate the potential impact of scenarios with selected agents designated formulary or NF on the UF. BIA results showed the scenario with Apriso, Delzicol, and Lialda designated as formulary on the UF, with Asacol HD and Pentasa designated as NF, was the most cost-effective for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) the following, based on the high degree of therapeutic interchangeability and cost-effectiveness:
    - UF: sulfasalazine, balsalazide 750 mg (Colazal, generics), olsalazine (Dipentum), and the mesalamine products Delzicol, Lialda, and Apriso
    - NF: Pentasa, Asacol HD and the balsalazide 1,100 mg product (Giazo)

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) retaining sulfasalazine on the BCF, and adding mesalamine multimatrix (Lialda) to the BCF.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) MN criteria for Pentasa, Asacol HD, and Giazo. (See Appendix B for full MN criteria.)

4. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in all POS; and, 2) DHA send a letter to beneficiaries affected by the UF decision. Based on the P&T Committee's recommendation, the effective date is August 6, 2014.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

C. Pancreatic Enzyme Products (PEPs)

Background and Relative Clinical Effectiveness—The P&T Committee evaluated the relative clinical effectiveness of the PEPs. The class was previously an extended core formulary (ECF) class and last reviewed in February 2011. The PEPs were reviewed for the FDA-approved indication of exocrine pancreatic insufficiency (EPI) due to cystic fibrosis or other conditions; other uses (e.g., pain relief from pancreatitis) were not reviewed. Since the last review, three new products, Pertzye, Viokace, and Ultresa, have been marketed. The PEPs all contain various amounts of lipase, amylase, and protease.

Relative Clinical Effectiveness Conclusion—The P&T Committee recommended (15 for, 1 opposed, 0 abstained, 0 absent) the following conclusions:

1. Based on clinical efficacy alone, Creon, Pancreaze, Zenpep, Viokace, Ultresa, and Pertzye are effective at increasing coefficient of fat absorption in patients with EPI, compared to placebo. Only limited clinical trial data is available.
2. Creon has the most indications and highest MHS utilization. Among the PEPs, Creon has an additional indication for EPI due to pancreatitis or pancreatetcomy, without requiring use of a proton pump inhibitor.
3. Zenpep has the most dosage strengths available.
4. Zenpep and Viokace have information for gastrostomy tube administration.
5. Viokace is an uncoated tablet that is not approved for use in pediatrics; it requires administration with a proton pump inhibitor, to prevent degradation in the stomach.
6. Creon, Pancreaze, and Zenpep have dosing recommendations for infants as young as 12 months of age while Pancreaze has dosing information in infants as young as 6 months.
7. Pertzye and Ultresa have limited data regarding efficacy in treating EPI and have limited dosage strengths available.
8. With regards to safety, the available evidence suggests there are no clinically relevant differences between any of the PEPs.
9. There is a high degree of therapeutic interchangeability among the class.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and BIA were performed to evaluate the PEP Drug Class. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that Creon was the most cost-effective agent in this class, followed by Zenpep, Pancreaze, and Viokace. Ultresa and Pertzye were not cost-effective relative to other agents in this class.
- BIA was performed to evaluate the potential impact of scenarios with selected agents designated formulary or NF on the UF. BIA results showed the scenario with Creon, Zenpep, Pancreaze, and Viokace designated as formulary on the UF, with Ultresa and Pertzye designated as NF on the UF, was the most cost-effective for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee, recommended (13 for, 2 opposed, 1 abstained, 0 absent) Creon, Pancreaze, Zenpep, and Viokace remain on the UF, and that Pertzye and Ultresa be designated as NF.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) reclassifying the PEPs as a BCF class instead of an ECF class, and adding Creon to the BCF. As a result of this action, Pancreaze is removed from the ECF.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) MN criteria for Pertzye. (See Appendix B for the full MN criteria.)

4. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-day implementation period in all POS; and, 2) DHA send a letter to beneficiaries affected by the UF decision. Based on the P&T Committee's recommendation, the effective date is August 6, 2014.

Director, DHA, Decision: ☒ Approved □ Disapproved

Approved, but modified as follows:

VI. RE-EVALUATION OF NF AGENTS: DULOXETINE (CYMBALTA)

On an ongoing basis, the DHA Pharmacoeconomic Branch monitors changes in the clinical information, current costs, and utilization trends to determine whether the UF status of agents designated as NF needs to be readdressed. The P&T Committee's process for reevaluating NF agents was established at the May 2007 meeting and approved by the Director, TMA, on June 24, 2007.

The P&T Committee reevaluated the UF status of duloxetine (Cymbalta) in light of recent price reductions in generic formulations across all three POS. Additionally, automated PA (step therapy) requires a trial of a generic formulary antidepressant or generic non-opioid pain syndrome drug before receiving Cymbalta. As of the meeting, the generic duloxetine products were not cost-effective relative to the price of branded Cymbalta.

1. ***COMMITTEE ACTION: DULOXETINE UF RECOMMENDATION AND IMPLEMENTATION***—The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) maintaining Cymbalta as NF and continuing the current step therapy. When generic formulations of Cymbalta become cost-effective relative to the step-preferred agents, generic duloxetine will move to UF status, become step-preferred (e.g., "in front of the step"), and existing PA criteria will be removed without further action by the P&T Committee, Beneficiary Advisory

Panel, or Director, DHA. A generic agent is cost-effective relative to step-preferred agents when the generic agent's total weighted average cost per day of treatment is less than or equal to the total weighted average cost per day of treatment for the step-preferred agent.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

VII. UTILIZATION MANAGEMENT

A. PAs

1. **Overactive Bladder (OAB) Drugs: Mirabegron (Myrbetriq)**—Mirabegron was FDA-approved for OAB in June 2012 and launched in October 2013. It will be reviewed as a new drug at an upcoming meeting. Mirabegron is a beta-3 agonist, which is a unique mechanism compared to the antimuscarinic OAB drugs (darifenacin, fesoterodine, tolterodine, oxybutynin, solifenacin, and trospium). In placebo-controlled trials, the efficacy of mirabegron on OAB symptoms appears similar to that of the other OAB drugs; however, mirabegron causes less anticholinergic AEs (dry mouth, constipation). The OAB drugs were reviewed for UF placement in November 2012, and automated PA (step therapy) was implemented, requiring a trial of a generic OAB drug or Detrol LA in all new and current users of an OAB drug.

   a) ***COMMITTEE ACTION: MIRABEGRON (MYRBETRIQ) PA CRITERIA*** The P&T Committee recommended (13 for, 1 opposed, 1 abstained, 1 absent) PA criteria for all new users of mirabegron (Myrbetriq) for OAB. (See Appendix C for full criteria.)

   b) ***COMMITTEE ACTION: MIRABEGRON (MYRBETRIQ) UF IMPLEMENTATION***—The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 1 absent) 1) an effective date of the first Wednesday after a 30-day implementation period in all POS. The effective date is June 11, 2014.

2. **Phosphodiesterase-5 (PDE-5) Inhibitor: Avanafil (Stendra)**—Avanafil is a new PDE-5 inhibitor approved by the FDA in April 2012, but not launched until January 2014. It is only approved for erectile dysfunction (ED). Currently, automated PA (step therapy) applies to the class for ED; Viagra is the step-preferred PDE-5 for ED.

   a) ***COMMITTEE ACTION: AVANAFIL (STENDRA) PA CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 1 absent) PA

criteria for all users of Avanafil (Stendra) for ED. A trial of sildenafil (Viagra) for ED is required prior to using Stendra. Uses other than ED, including benign prostatic hypertrophy, following prostatectomy, pulmonary arterial hypertension, or Raynaud's phenomenon are not allowed. (See Appendix C for full criteria.)

B. QLs

1. **Hepatitis C Drugs: Sofosbuvir (Sovaldi)**—Sofosbuvir (Sovaldi) is a new direct acting agent for hepatitis C approved on December 18, 2013. QLs currently apply to the hepatitis C drugs, including the direct acting antiviral agents. Sofosbuvir efficacy was established in patients with genotype 1, 2, 3, or 4 infection, including those with hepatocellular carcinoma awaiting liver transplantation and those co-infected with HIV. It can be used without interferon in patients with genotype 1, 2, or 3 hepatitis C virus.

   a) ***COMMITTEE ACTION: SOFOSBUVIR (SOVALDI) QLs***—The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 1 absent) QLs for sofosbuvir of 28 tablets per 28 days in all POS [Medical Treatment Facility (MTF), Retail Network, and Mail Order Pharmacy], consistent with the FDA-approved product dosing of one tablet given once daily.

2. **PDE-5 Inhibitors: Avanafil (Stendra)**—QLs currently apply to the PDE-5 inhibitors. The P&T Committee evaluated QLs for avanafil for treatment of ED.

   a) ***COMMITTEE ACTION: AVANAFIL (STENDRA) QLs***—The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 1 absent) QLs for Avanafil of 6 tablets per 30 days in the Retail Network and 18 tablets for 90 days in the Mail Order Pharmacy, consistent with the other PDE-5 inhibitors. This is a collective QL, a maximum of 6 tablets (Retail Network) or 18 tablets (Mail Order Pharmacy) of any PDE-5 is allowed.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

VIII. OVERVIEWS

Overviews of the ICS and Nasal Allergy Drugs (nasal antihistamines, nasal corticosteroids, and nasal anticholinergics) drug classes were presented to the P&T Committee. The P&T

Committee provided expert opinion regarding those clinical outcomes considered most important for use in contract solicitation and for completing the clinical effectiveness review and developing the appropriate cost-effectiveness modes. The clinical and economic analyses of these classes will be presented at an upcoming meeting.

IX. ITEMS FOR INFORMATION

A. Medication Adherence—The PORT updated the P&T Committee regarding progress in formulating a process and algorithm for measuring medication adherence. The algorithm is intended for use as a DHA quality measure and in coordination with the DHA Health Information Technology Branch for potential inclusion in the Population Health Portal as a practical tool for clinicians and clinic managers at point of care. The overall DHA metrics follow recommendations from the Pharmacy Quality Alliance/National Committee for Quality Assurance and will allow comparison to Center for Medicare Services Star Rating measures for health plans.

X. ADJOURNMENT

The meeting adjourned at 1650 hours on February 12, 2014. The next meeting will be in May 2014.

Appendix A—Attendance: February 2014 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

SUBMITTED BY:

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

DECISION ON RECOMMENDATIONS

Director, DHA, decisions are as annotated above.

Douglas J. Robb, DO, MPH
Lieutenant General, USAF, MC, CFS
Director

12 May 2014
Date

Appendix A—Attendance: February 2014 P&T Committee Meeting

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
LTC Robert Conrad, MS	Chief, DHA Pharmacoeconomic Branch (Recorder)
COL John Spain, MS	Army, Pharmacy Officer
Col Scott Sprenger, BSC	Air Force, Pharmacy Officer
CAPT Deborah Thompson, USCG	Coast Guard, Pharmacy Officer
CAPT Derrik Clay for CAPT Edward Norton, MSC	Navy, Pharmacy Officer (Pharmacy Consultant BUMED)
LTC Dan Hsu for COL Ted Cieslak, MC	Army, Physician at Large
Col Michael Wynn, MC	Army, Family Practice Physician
LCDR Carey Welsh, MC	Navy, Pediatrics Physician
Col Lowell Sensintaffer, MC	Air Force, Physician at Large
CDR Brian King, MC	Navy, Internal Medicine Physician
COL Jack Lewi, MC	Army, Internal Medicine Physician
CDR Shaun Carstairs, MC	Navy, Physician at Large
Lt Col William Hannah, MC	Air Force, Internal Medicine Physician
Dr. Miguel Montalvo	TRICARE Regional Office-South, Chief of Clinical Operations Division and Medical Director
Mr. Vincent Calebrese for Mr. Joe Canzolino	U.S. Department of Veterans Affairs
Voting Members Absent	
Col Michael Spilker, BSC	DHA Deputy Chief, Pharmacy Operations Division
Nonvoting Members Present	
Mr. David Hurt	Associate General Counsel, DHA
LT Col Dan Castiglia	Defense Logistics Agency Troop Support
LCDR Bob Selvester, MC	VA/DoD Evidence-Based Practice Guideline Work Group
CDR Brandon Hardin by phone	Medical Logistics Division, DLA

Appendix A—Attendance (continued)

Guests	
Mr. Bill Davies via DCO	Defense Health Agency, Pharmacy Operations Division
Capt Richard Caballero, via DCO	Defense Logistics Agency Troop Support
Mr. Alexander Quinones	Defense Logistics Agency Troop Support
CAPT Travis Watt	Vice Chair, IHS National P&T Committee
Others Present	
CAPT Walter Downs, MC	DHA Pharmacoeconomic Branch
LCDR Marisol Martinez, USPHS	DHA Pharmacoeconomic Branch
LCDR Joshua Devine, USPHS	DHA Pharmacoeconomic Branch
LCDR Linh Quach, MSC	DHA Pharmacoeconomic Branch
Maj David Folmar, BSC	DHA Pharmacoeconomic Branch
MAJ Misty Cowan, MC	DHA Pharmacoeconomic Branch
Dr. David Meade	DHA Pharmacoeconomic Branch
Dr. Angela Allerman	DHA Pharmacoeconomic Branch
Dr. Shana Trice	DHA Pharmacoeconomic Branch
Dr. Jeremy Briggs	DHA Pharmacoeconomic Branch
Dr. Brian Beck	DHA Pharmacoeconomic Branch
Dr. Amy Lugo via DCO	DHA Pharmacoeconomic Branch
Dr. Teresa Anekwe via DCO	DHA Pharmacy Operations Division
Ms. Deborah Garcia	DHA Pharmacoeconomic Branch contractor
Dr. Esmond Nwokeji	DoD Pharmacoeconomic Branch contractor
Mr. Kirk Stocker	DoD Pharmacoeconomic Branch contractor
Ms. Linda Paul	University of Incarnate Word, Feik School of Pharmacy student
Ms. Jennifer Miller via DCO	Lake Erie College of Osteopathic Medicine, School of Pharmacy student
Ms. Anna Humg via DCO	University of Maryland, School of Pharmacy student

Appendix B—Table of Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
• Budesonide/formoterol (Symbicort) • Mometasone/formoterol (Dulera) • Fluticasone/vilanterol (Breo Ellipta) **Inhaled Corticosteroids/ Long-Acting Beta Agonists (ICS/LABAs) Combinations**	• Use of Advair Diskus or Advair HFA is contraindicated • The patient has experienced or is likely to experience intolerable adverse effects to Advair Diskus or Advair HFA. • The patient has had an inadequate response to Advair Diskus or Advair HFA. • The patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk.
• Bupropion 450 mg XL (Forfivo XL) **Antidepressant-1s (AD-1s)**	• Use of formulary agents (bupropion, bupropion SR, bupropion XL) is contraindicated and treatment with other formulary antidepressants is not clinically appropriate. Provider must state why the patients cannot take generic bupropion, bupropion SR, or bupropion XL.
• desvenlafaxine ER (Khedezla) **Antidepressant-1s (AD-1s)**	• Use of the formulary agents venlafaxine IR or venlafaxine ER are contraindicated • The patient has experienced or likely to experience significant adverse effects from the formulary agents venlafaxine IR or venlafaxine ER. • Formulary agents resulted or are likely to result in therapeutic failure. • Patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk.
• Levomilnacipran (Fetzima) **Antidepressant-1s (AD-1s)**	• Use of formulary AD-1s are contraindicated • Patient has experienced or is likely to experience significant adverse effects from formulary AD-1s. • Formulary AD-1s resulted or are likely to result in therapeutic failure. • Patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk. • No alternative formulary agent **Formulary alternatives:** (selective serotonin reuptake inhibitors, serotonin/norepinephrine reuptake inhibitor (except milnacipran), tricyclic antidepressants, mirtazapine, bupropion, serotonin antagonist reuptake inhibitors, mononamine oxidase inhibitors)
• Brintellix (Vortioxetine) **Antidepressant-1s (AD-1s)**	• Use of formulary AD-1s are contraindicated • Patient has experienced or is likely to experience significant adverse effects from formulary AD-1s. • Formulary AD-1s resulted or are likely to result in therapeutic failure • Patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk • No alternative formulary agent **Formulary alternatives:** (selective serotonin reuptake inhibitors, serotonin/norepinephrine reuptake inhibitor (except milnacipran), tricyclic antidepressants, mirtazapine, bupropion, serotonin antagonist reuptake inhibitors, mononamine oxidase inhibitors)

Drug / Drug Class	Medical Necessity Criteria
• Balsalazide 1100 mg (Giazo) • Mesalamine high dose (Asacol HD) • Mesalamine (Pentasa) **Gastrointestinal-1 Drugs (GI-1s), aminosalicylates**	• Use of formulary oral aminosalicylates are contraindicated
• Pertzye • Ultresa **Pancreatic Enzyme Products (PEPs)**	• Use of formulary oral PEPs are contraindicated • No alternative formulary agent; patient requires a strength that is not available with the formulary PEPs

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• Budesonide/formoterol (Symbicort) • Mometasone/formoterol (Dulera) • Fluticasone furoate/vilanterol (Breo Ellipta) **Inhaled Corticosteroids/Long-Acting Beta Agonists (ICS/LABAs) Combinations**	PA criteria apply to all new and current users of Symbicort, Dulera, and Breo Ellipta who are older than 12 years of age. Automated PA criteria: The patient has filled a prescription for Advair or Advair HFA at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA criteria—Symbicort, Dulera, or Breo Ellipta is approved (e.g., trial of Advair Diskus or Advair HFA is NOT required) if: • Patient has experienced any of the following issues with either Advair Diskus or Advair HFA, which is not expected to occur with the non-preferred ICS/LABA combination drug: o inadequate response to Advair Diskus or Advair HFA o intolerable adverse effects o contraindication o patient previously responded to nonformulary agent and changing to a formulary agent would incur unacceptable risk
• Desvenlafaxine ER (Khedezla) **Antidepressant1-s (AD-1s)**	PA criteria apply to all new users of Khedezla Automated PA criteria The patient has filled a prescription for venlafaxine IR or venlafaxine ER 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, Khedezla is approved in new users (e.g., trial of venlafaxine IR or venlafaxine ER is NOT required) if: • Use of the formulary SNRI (venlafaxine) is contraindicated (e.g., hypersensitivity to a dye or other inert ingredient) and use of any other formulary antidepressant is not clinically appropriate. • The patient has previously responded to Khedezla, and changing to a formulary medication would incur unacceptable risk (e.g., the patient is currently stabilized on therapy with Khedezla and changing to a formulary medication would present a risk of destabilization). • The patient is being treated for depression, requires treatment with a SNRI (e.g., due to failure of SSRI therapy), and has failed an adequate trial of venlafaxine. Note: an adequate trial is generally considered to be at least 4–8 weeks in duration, due to the delay in achieving maximal benefit. • The patient requires treatment with a SNRI (e.g., due to failure of SSRI therapy), and has been unable to tolerate venlafaxine.

• Levomilnacipran (Fetzima) **Antidepressant1-s (AD-1s)**	PA criteria apply to all new users of Fetzima. Automated PA criteria • The patient has filled a prescription for a formulary SSRI, duloxetine, SNRIs (except milnacipran), TCA, mirtazapine, bupropion, trazodone or nefazodone, or an MAOI at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA criteria—For new users, Fetzima is approved (e.g., trial of a formulary AD-1 listed above is NOT required) if: • Use of a formulary antidepressant (SSRI, duloxetine, SNRI (except milnacipran), TCA, mirtazapine, bupropion, trazodone or nefazodone, or, MAOI) is contraindicated (e.g., hypersensitivity to a dye or other inert ingredient) and use of any other formulary antidepressant is not clinically appropriate. • The patient has previously responded to Fetzima, and changing to a formulary medication would incur unacceptable risk (e.g., the patient is currently stabilized on therapy with Fetzima and changing to a formulary medication would present a risk of destabilization). • The patient is being treated for depression and has failed therapy with the formulary antidepressants (SSRI, duloxetine, SNRI (except milnacipran), TCA, mirtazapine, bupropion, trazodone or nefazodone, or, MAOI). Note: an adequate trial is generally considered to be at least 4–8 weeks in duration, due to the delay in achieving maximal benefit. • The patient is being treated for depression and has been unable to tolerate the formulary antidepressants (SSRI, duloxetine, SNRI (except milnacipran), TCA, mirtazapine, bupropion, trazodone or nefazodone, or, MAOI).

Drug / Drug Class	Prior Authorization Criteria
• Vortioxetine (Brintellix) **Antidepressant1-s (AD-1s)**	PA criteria apply to all new users of Brintellix. Automated PA criteria • The patient has filled a prescription for a formulary SSRI, duloxetine, SNRIs (except milnacipran), TCA, mirtazapine, bupropion, trazodone or nefazodone, or an MAOI at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA criteria—For new users, Brintellix is approved (e.g., trial of a formulary AD-1 listed above is NOT required) if: • Use of a formulary antidepressant (SSRI, duloxetine, SNRI except milnacipran, TCA, mirtazapine, bupropion, trazodone or nefazodone, or, MAOI) is contraindicated (e.g., hypersensitivity to a dye or other inert ingredient) and use of any other formulary antidepressant is not clinically appropriate. • The patient has previously responded to Brintellix, and changing to a formulary medication would incur unacceptable risk (e.g., the patient is currently stabilized on therapy with Brintellix and changing to a formulary medication would present a risk of destabilization). • The patient is being treated for depression and has failed therapy with the formulary antidepressants (SSRI, duloxetine, SNRI except milnacipran, TCA, mirtazapine, bupropion, trazodone or nefazodone, or, MAOI). Note: an adequate trial is generally considered to be at least 4–8 weeks in duration, due to the delay in achieving maximal benefit. • The patient is being treated for depression and has been unable to tolerate the formulary antidepressants (SSRI, duloxetine, SNRI except milnacipran, TCA, mirtazapine, bupropion, trazodone or nefazodone, or, MAOI).

Drug / Drug Class	Prior Authorization Criteria
• Mirabegron (Myrbetriq) **Overactive Bladder (OAB) Drugs**	PA criteria apply to all new users of Myrbetriq <u>Automated PA criteria</u> • The patient has filled a prescription for tolterodine ER (Detrol LA), oxybutynin ER, oxybutynin IR, or generic trospium IR (Sanctuary) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. <u>Manual PA criteria</u>—If automated criteria are not met, Myrbetriq is approved if: • Coverage is only approved for the FDA-approved indication of OAB with symptoms of urge incontinence, urgency, and urinary frequency • Patient has failed a 12-week trial with at least one of the following step-preferred OAB drugs (Detrol LA, oxybutynin ER, oxybutynin IR, or trospium IR) due to a treatment failure or intolerable adverse effects. • Patient has experienced central nervous system (CNS) adverse effects with oral OAB medications or is at increased risk for such CNS effects due to comorbid conditions or other medications.
• Avanafil (Stendra) **Phosphodiesteraise-5 (PDE-5) Inhibitor**	PA applies to all new and current users of avanafil (Stendra). <u>Automated PA criteria</u> • The patient has received a prescription for sildenafil (Viagra) at any MHS point of service (MTFS, Retail Network or Mail Order) during the previous 180 days. • The patient is a male, aged 40 years of older with ED. <u>Manual PA criteria</u>—if automated criteria are not met. Stendra is approved if • The patient has tried sildenafil (Viagra) and has had an inadequate response or was unable to tolerate treatment due to adverse effects. • Treatment with Viagra is contraindicated. Note: Coverage is approved only for erectile dysfunction (ED). Use for benign prostatic hyperplasia (BPH), following prostatectomy, pulmonary arterial hypertension, and Raynaud's phenomenon is not allowed. Additionally, use is not allowed for treatment of ED in males younger than age 18, for ED due to psychogenic origin, or in women for female sexual dysfunction.

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
Feb 2014	**Inhaled Corticosteroids/ Long-Acting Beta Agonists (ICS/LABAs) Combinations**	UF class review Previously reviewed	▪ Fluticasone/ salmeterol (Advair Diskus) ▪ Fluticasone/ salmeterol (Advair HFA)	▪ None (Advair Diskus and Advair HFA BCF)	▪ Budesonide/formoterol (Symbicort) ▪ Mometasone/formoterol (Dulera) ▪ Fluticasone/vilanterol (Breo Ellipta)	Pending singing of the minutes / 60 days	▪ Step therapy required; see comments ▪ Quantity Limits apply; see Minutes	▪ Must try Advair before Symbicort, Dulera, or Breo Ellipta in all current and new users older than 12 years. (See Appendix C)
Feb 2014	**GI-1s** **5-Amino Salicylate Subclass**	UF Class review Previously reviewed	▪ Sulfasalazine ▪ Mesalamine multimatrix (Lialda)	▪ Balsalazide 750 mg (Colazal, generic) ▪ Olsalazine (Dipentum) ▪ Mesalamine DR (Delzicol) ▪ Mesalamine (Apriso)	▪ Balsalazide 1100 mg (Giazo) ▪ Mesalamine high dose (Asacol HD) ▪ Mesalamine (Pentasa)	Pending signing of the minutes / 90 days	▪ None	▪ None
Feb 2014	**Pancreatic Enzyme Products (PEPs)**	UF class review	▪ Creon	▪ Pancreaze ▪ Viokace ▪ Zenpep	▪ Pertzye ▪ Ultresa	Pending signing of the minutes / 90 days	▪ None	▪ Note Pancreaze removed from the ECF.

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
Feb 2014	**Depression and Non-Opioid Pain Syndrome Agents** **Antidepressant-1s Subclass** Previous review: Aug 2011	New Drug in Already Reviewed Class Bupropion 450 mg (Forfivo XL) Desvenlafax-ine ER (Khedezla) Levomilnaci-pran (Fetzima) Vortioxetine (Brintellix)	No change from previous review **SSRIs:** citalopram fluoxetine sertaline **SNRIs:** venlafaxine IR venlafaxine ER **SARIs:** trazodone **NDRIs:** bupropion HCl IR bupropion HCl SR bupropion HCl ER **GABA analogs:** gabapentin **TCAs:** amitriptyline doxepin imipramine HCl nortriptyline	**SSRIs:** citalopram fluoxetine escitalopram fluvoxamine paroxetine HCl IR paroxetine HCl CR paroxetine mesylate sertraline **SNRIs:** venlafaxine IR venlafaxine ER venlafaxine ER tablets **SARIs:** nefazodone trazodone **NDRIs:** bupropion HCl IR bupropion HCl SR bupropion HCl ER **TCAs:** amitriptyline desipramine doxepin imipramine HCl imipramine pamoate nortriptyline protriptyline **A2RAs:** mirtazapine tablets mirtazapine ODT **GABA analogs:** gabapentin	*Feb 2014* ▪ **bupropion 450 mg (Forfivo XL)** ▪ **desvenlafaxine ER (Khedezla)** ▪ **levomilnacipran (Fetzima)** ▪ **vortioxetine (Brintellix)** *Nov 2011* **SSRIs:** fluoexetine (Sarafem) fluoxetine weekly (Prozac Weekly) **SNRIs:** desvenlafaxine (Pristiq) duloxetine (Cymbalta) milnacipran (Savella) **SARIs:** trazodone ER (Oleptro) **SPARIs:** vilazodone (Viibryd) **NDRIs:** bupropion HBr (Aplenzin) **GABA analogs:** pregabalin (Lyrica)	Pending signing of minutes/ 90 days	Step therapy required; see comments	▪ Khedezla: Must try venlafaxine IR or ER first ▪ Fetzima and Brintellix: Must try a formulary AD-1 first. (See Appendix C)

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

Appendix E—Table of Abbreviations

5-ASA	5-aminosalicylate
AD-1s	Antidepressants Drug Class
AEs	adverse events
BCF	Basic Core Formulary
BIA	budget impact analysis
CMA	cost minimization analysis
COPD	chronic obstructive pulmonary disease
DBP	dibutyl phthalate
DCO	Defense Connect Online
DHA	Defense Health Agency
DoD	Department of Defense
DR	delayed release
ED	erectile dysfunction
EPI	exocrine pancreatic insufficiency
ER	extended release
FDA	U.S. Food and Drug Administration
GI-1s	Gastrointestinal-1 Drug Class
HAMD	Hamilton Depression Rating Scale
HFA	hydrofluoroalkane
ICS/LABAs	Inhaled Corticosteroids/Long-Acting Beta Agonists Drug Class
IR	immediate release
MADRS	Montgomery-Asberg Depression Rating Scale
MAOI	mononamine oxidase inhibitor
MDD	major depressive disorder
MDIs	metered-dose inhalers
MHS	Military Health System
MN	medical necessity
MTF	Military Treatment Facility
NDRI	norepinephrine/dopamine reuptake inhibitor
NF	nonformulary
OAB	overactive bladder
P&T	Pharmacy and Therapeutics
PA	prior authorization
PDE-5	phosphodiesterase-5 inhibitor
PEPs	Pancreatic Enzyme Products
PORT	Pharmacy Outcomes Research Team
POS	points of service
QLs	quantity limits
SARIs	serotonin antagonist reuptake inhibitor
SNRI	serotonin/norepinephrine reuptake inhibitor
SSRIs	serotonin reuptake inhibitors
UC	ulcerative colitis
UF	Uniform Formulary
XL	extended release