DEPARTMENT OF DEFENSE

PHARMACY AND THERAPEUTICS COMMITTEE

MINUTES AND RECOMMENDATIONS

August 2016

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on August 10 and 11, 2016, at the Defense Health Agency (DHA) Formulary Management Branch, San Antonio, Texas.

II. ATTENDANCE

The attendance roster is listed in Appendix A.

A. Review Minutes of Last Meetings

1. **Approval of May 2016 Minutes—**VADM R.C. Bono, MC, USN, Director, DHA, approved the minutes from the May 2016 DoD P&T Committee meeting on July 28, 2016.

2. **Clarification of May 2016 Minutes**

   a) **Basic Core Formulary (BCF) Clarification for Emergency Contraceptives—**The emergency contraceptives were reviewed at the May 2016 DoD P&T Committee meeting, and levonorgestrel 1.5 mg (Plan B One-Step) was added to the BCF. The sole product added to the BCF is the Plan B One-Step branded product for clinic use with the NDC #5128-146-10; generic formulations of levonorgestrel 1.5 mg are designated with Uniform Formulary status, but were not added to the BCF.

   b) **Uniform Formulary (UF) Clarification for Proton Pump Inhibitors—**At the May 2016 DoD P&T Committee meeting, rabeprazole delayed release tablets (Aciphex, generics) were designated as formulary and step-preferred on the UF. There is no change to the current formulary status of rabeprazole sprinkles (Aciphex sprinkles); they remain designated as formulary on the UF and non step-preferred.

III. REQUIREMENTS

All clinical and cost evaluations for new drugs, including innovator drugs, and full drug class reviews included, but were not limited to, the requirements stated in 32 Code of Federal Regulations (CFR) 199.21(e)(1) and (g)(5). 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.

Nonformulary medications are generally restricted to the mail order program according to amended section 199.21, revised paragraphs (h)(3)(i) and (ii), effective August 26, 2015.

IV. UF DRUG CLASS REVIEWS

A. Acne Agents: Topical Acne and Rosacea Agents Subclass

Background—The P&T Committee evaluated the Topical Acne and Rosacea Subclass, which has not been previously reviewed for UF placement. The reviewed products were further categorized based on mechanism of action, and included the topical antibiotics and combinations with benzoyl peroxide, topical retinoids, azelaic acid, dapsone, sodium sulfacetamide/sulfur products, ivermectin, and brimonidine.

There are over 35 products in the subclass, several with respective generics or therapeutic alternatives available in multiple strengths and formulations. The clinical effectiveness review focused on the new branded entrants to the market, and the place in therapy for the products. Meta-analyses and professional treatment guidelines were also reviewed. Military Health System (MHS) provider opinions were solicited and considered in the UF recommendations.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) the following:

- Benzoyl peroxide used in combination with the clindamycin 1% gel or solution is a first-line choice for treatment of mild to moderate acne. Monotherapy with clindamycin is not recommended, due to the risk of bacterial resistance.
- The topical retinoids (tretinoin, adapalene, and tazarotene) are effective when used as monotherapy in patients with comedonal or mild acne, or in combination with other products in patients with inflammatory acne lesions. Tazarotene (Fabior) has a limited role, due to its pregnancy category X rating.
- The 2015 Cochrane Review of rosacea agents reported that there is high quality evidence for use of topical azelaic acid for decreasing inflammatory lesions and erythema; for brimonidine for decreasing facial erythema; and, ivermectin for decreasing inflammatory lesions. There is moderate quality evidence for topical metronidazole for decreasing inflammatory lesions and erythema, but topical metronidazole is widely used as a first line therapy.
- The available clinical data for the newer products, including dapsone 7.5% gel (Aczone) (an innovator drug), brimonidine 0.33% gel (Mirvaso), and ivermectin 1% cream (Soolantra), is limited by the lack of active controls, use of subjective rating scale, and non-rigorous study designs.
    - The acne treatment guidelines recommend topical dapsone for inflammatory acne, particularly in adult females.
    - Brimonidine 0.33% gel has a clinical niche for treatment of persistent facial erythema in rosacea, but will not change the underlying course of the disease. A recent FDA safety alert warned of the risk of hypotension, bradycardia, and

dizziness, particularly in patients with pre-existing cardiovascular disease due to its mechanism as an alpha-2 adrenergic agonist.

- Ivermectin 1% cream has a clinical niche for treating papulopustular rosacea associated with proliferation of Demodex mites.

- Safety profiles for acne and rosacea agents are primarily dermatological in nature with some unique differences, including hypopigmentation with azelaic acid, photosensitivity with retinoids, the potential to induce bacterial resistance with the topical antibiotics, and the rare potential for methemoglobinemia with dapsone 5% gel.

- A variety of agents in different dosage formulations (e.g., cream, gel, etc.) are required on the UF to meet the needs of patients. Additionally, azelaic acid is required on the formulary due to its pregnancy category rating (Category B) and tolerability.

Relative Cost-Effectiveness Analysis and Conclusion—A cost-minimization analysis (CMA) and budget impact analysis (BIA) were performed. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results showed for the topical acne products that generic formulations in the class were the most cost-effective agents, followed by branded formulations of clindamycin/benzoyl peroxide 1.2%/2.5% gel (Acanya), clindamycin/benzoyl peroxide 1.2%/5% gel kit (Neuac), adapalene/benzoyl peroxide 0.1%/2.5% gel (Epiduo), clindamycin/tretinoin (Veltin), adapalene/benzoyl peroxide 0.3%/2.5% gel (Epiduo Forte), dapsone 5% gel and 7.5% gel (Aczone), azelaic acid 20% cream (Azelex), clindamycin cleansing kit (Clindacin ETZ), tazarotene 0.1% foam (Fabior), clindamycin/benzoyl peroxide 1.2%/3.75% gel (Onexton), clindamycin/tretinoin (Ziana), clindamycin cleansing kit (Clindacin PAC), and brand clindamycin 1% gel (Clindagel).

- CMA results also showed that, for rosacea, generic metronidazole 1% gel, 0.75% lotion, and 0.75% cream were the most cost-effective, followed by azelaic acid 15% gel and foam (Finacea), brand metronidazole 0.75% gel and cream cleanser kits (Rosadan), ivermectin 1% cream (Soolantra), brimonidine 0.33% gel (Mirvaso), and brand metronidazole 1% cream (Noritate).

- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating generics as UF, with selected brand agents as UF and non step-preferred, and NF and non step-preferred, demonstrated the largest estimated cost avoidance for the MHS.

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

- **UF and step-preferred**
    - adapalene 0.1% lotion, gel, cream, and 0.3% gel (Differin, generics)
    - clindamycin 1% foam (Evoclin, generics)
    - clindamycin 1% gel, cream, foam, lotion, solution, and med swab (Cleocin T, generics)
    - clindamycin/benzoyl peroxide 1%/5% gel (Benzaclin, generics)
    - clindamycin/benzoyl peroxide 1.2%/5% gel (Duac, generics)
    - clindamycin/benzoyl peroxide 1%/5% gel kit (Duac CS (Kit))
    - metronidazole 0.75% cream (MetroCream, generics)
    - metronidazole 0.75% lotion (MetroLotion, generics)
    - metronidazole 1% gel (Metrogel, generics)
    - sulfacetamide sodium/sulfur 10% lotion (Klaron, generics)
    - tretinoin 0.01% and 0.025% gel (Retin-A, generics)
    - tretinoin 0.025% gel, cream (Avita, generics)
    - tretinoin 0.025%, 0.05%, and 0.1% cream, liquid (Retin-A, generics)
    - tretinoin 0.0375%, 0.075% cream (Tretin-X, generics)
    - tretinoin 0.05% gel (Atralin, generics)

- **UF and non step-preferred**
    - azelaic acid 20% cream (Azelex)
    - azelaic acid 15% gel, foam, kit (Finacea)
    - clindamycin/benzoyl peroxide 1.2% and 2.5% gel (Acanya)

- **NF and non step-preferred**
    - adapalene/benzoyl peroxide 0.1% /2.5% gel (Epiduo)
    - adapalene/benzoyl peroxide 0.3% /2.5% gel (Epiduo Forte)
    - brimonidine tartrate 0.33% gel (Mirvaso)
    - clindamycin 1% cleansing kits (Clindacin ETZ, Clindacin PAC)
    - clindamycin 1% gel (Clindagel)
    - clindamycin/benzoyl peroxide 1.2%/ 3.75% gel (Onexton)
    - clindamycin/benzoyl peroxide 1.2%/5% gel/cream kit (Neuac Kit)
    - clindamycin/tretinoin 1.2% /0.025% gel (Veltin; Ziana, generics)
    - dapsone 5% and 7.5% gel (Aczone)
    - ivermectin 1% cream (Soolantra)
    - metronidazole 1% cream (Noritate)
    - metronidazole 0.75% cream/cleanser kit (Rosadan Cream Kit)
    - metronidazole 0.75% gel/cleanser kit (Rosadan Gel Kit)
    - tretinoin microsphere 0.04%, 0.08%, and 0.1% gel (Retin-A Micro, generics; Retin-A Micro Pump, generics)
    - tazarotene 0.1% foam (Fabior)

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

acne agents previously designated as BCF, prior to the implementation of the UF Rule in 2005, should be retained on the BCF, with two additions. The BCF products recommended are as follows:

- **Added to the BCF:**
  - clindamycin/benzoyl peroxide 1.2% /5% gel (generic Duac)
  - metronidazole 1% gel (generic Metrogel)

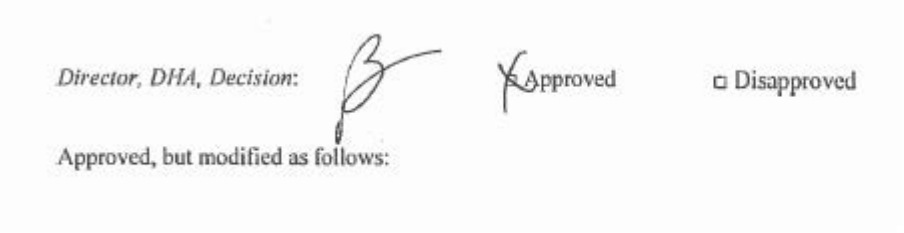
- **Remain on the BCF:**
  - clindamycin phosphate 1% gel, cream, lotion, and solution (generic Cleocin T)
  - sulfacetamide sodium/sulfur 10% lotion (generic Klaron), which has additional uses outside of acne and rosacea
  - tretinoin 0.025% and 0.05% cream (generic Retin-A)

3. ***COMMITTEE ACTION: AUTOMATED PRIOR AUTHORIZATION (PA) (STEP THERAPY) and MANUAL PA CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) step therapy and manual PA criteria for the acne and rosacea drugs. Separate step therapies will be required for acne and rosacea products. Within the acne subclass, there are additional step therapies, based on mechanism of action. All branded formulations are non step-preferred. Step therapy for the acne products generally requires use of at least three step-preferred products first, prior to use of a non-preferred product. For the rosacea products, one generic metronidazole step-preferred formulation is required prior to use of the non step-preferred products. See Appendix C for the full criteria.

4. ***COMMITTEE ACTION: MANUAL PA CRITERIA FOR BENZOYL PEROXIDE—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for legend single-ingredient benzoyl peroxide formulations (e.g., those products that are not in combination with a topical antibiotic). A trial of at least two step-preferred topical acne products will be required prior to use of a prescription benzoyl peroxide product (formulations ranging in concentration from 3% to 10%). See Appendix C for the full criteria.

5. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) MN criteria for the topical acne and rosacea agents. See Appendix B for the full criteria.

6. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday after a 90-day implementation; and, 2) DHA send letters to beneficiaries who are affected by the UF decision. Based on the P&T Committee's recommendation, the effective date is February 8, 2017.



B. Migraine Agents: Triptans

Background—The triptans for migraine headache were previously reviewed for formulary placement in June 2008. There are currently 12 products marketed, with many available in generic oral formulations. Eletriptan (Relpax) has patent expiration expected in December 2016. Four sumatriptan formulations are available only as branded products (Sumavel Dose Pro, Zembrace SymTouch, Onzetra Xsail, and Treximet). Sumatriptan transdermal system (Zecuity) was removed from the market in June 2016 due to safety issues, but is included in the review.

The clinical effectiveness evaluation focused on the triptans approved since the last review, and updated meta-analyses and clinical practice guidelines.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) that:

- Clinical practice guidelines and systematic reviews found that the triptans as a class have quality evidence to support use in the treatment of moderate to severe migraine headache. Compared to placebo, the triptans achieve numbers needed to treat (NNT) ranging from three to six for the preferred endpoints of two-hour pain-free and 24-hour sustained pain-free after dosing.
- Available data suggests all triptans are significantly superior to placebo for treating acute migraine. The oral agents, particularly generically available triptans, are the most convenient and easy to use, and are often preferred by patients and providers as the first choice treatment. The available data is not sufficient to clearly establish relative superiority of one oral triptan over another.
- For patients who are unable to manage their migraines with oral options, alternative delivery options are required on the formulary if the initial choice is not successful.
- While subcutaneous sumatriptan formulations provide the quickest onset of action and highest response rate, they also have the highest incidence of adverse effects and intolerability issues, along with a higher risk of recurrent migraine.
- Naratriptan (Amerge, generics) and frovatriptan (Frova, generics) have a therapeutic niche for treatment of menstrual-associated migraines, but are not specifically FDA-approved for this indication.
- Sumatriptan/naproxen (Treximet) is a fixed-dose combination of a nonsteroidal anti-inflammatory drug (NSAID) with a triptan that has shown efficacy in migraine

headache versus using the individual components alone. However, using any NSAID concurrently with a triptan will likely increase efficacy.

- Overall, the class has mild to moderate adverse effects, which are usually transient. Some of the adverse effects are often unique to the delivery route. Nasal administration typically causes more pronounced nasal-related adverse effects, transdermal routes have been associated with application site reactions, and subcutaneous routes have injection-related concerns.
- The newly-approved triptans do not offer compelling clinical advantages over the older agents.
    - Sumatriptan nasal powder (Onzetra Xsail) does not have clinically or statistically significant differences in efficacy compared with oral sumatriptan and was associated with nasal discomfort.
    - The sumatriptan 3 mg autoinjector (Zembrace SymTouch) provides headache relief at two hours in 60% of patients. In contrast, the sumatriptan 4 mg and 6 mg injection (Imitrex STATdose) achieves headache relief in 57%–60% of patients.
    - The available evidence with sumatriptan transdermal system (Zecuity) suggests it may not be as effective as other triptan formulations; this product is no longer marketed.
- The triptans have a moderate to high degree of therapeutic interchangeability. Some patients will prefer one formulation over another due to their personal headache characteristics and, based on available clinical data, 40% to 50% of patients will not respond to the initial agent chosen. Overall, the majority of patients in the MHS are well served by the available formulary options.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and BIA analyses were performed. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results found the following, ranked from most to least cost-effective: sumatriptan tablets generic, rizatriptan tablets generic, zolmitriptan orally dissolving tablet (ODT) generic, rizatriptan ODT generic, zolmitriptan tablets generic, Relpax, naratriptan tablets (Amerge and generics), Treximet, almotriptan tablets generic, sumatriptan nasal generic, frovatriptan tablets generic, Zomig Nasal Spray, Onzetra Xsail, sumatriptan 4 mg and 6 mg injection (Imitrex STATdose, generic), Sumavel DosePro, Zembrace SymTouch, and Zecuity.

- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. All modeled scenarios show cost avoidance against current MHS expenditures. However, the most cost-effective scenario for the MHS was designating generic formulations of sumatriptan tablets, nasal spray and injection, and rizatriptan and zolmitriptan tablets and ODT, along with branded eletriptan (Relpax), as UF and step-preferred; naratriptan tablets and zolmitriptan nasal (Zomig Nasal Spray) as UF and non step-preferred; and, all

other products as NF and non step-preferred.

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

    - Oral Triptans
        - UF and step-preferred
            - eletriptan tablets (Relpax)
            - rizatriptan tablets and orally dissolving tablets (ODT) (Maxalt, Maxalt MLT, generics)
            - sumatriptan tablets (Imitrex, generics)
            - zolmitriptan tablets and ODT (Zomig, generics; Zomig-ZMT, generics)
        - UF, non step-preferred
            - naratriptan tablets (Amerge, generics)
        - NF, non step-preferred
            - almotriptan (Axert, generics)
            - frovatriptan (Frova, generics)
            - sumatriptan/naproxen tablets (Treximet)

    - Nasal Triptans
        - UF, step-preferred
            - sumatriptan nasal spray (Imitrex, generics)
        - UF, non step-preferred
            - zolmitriptan nasal spray (Zomig Nasal Spray)
        - NF, non step-preferred
            - sumatriptan nasal powder (Onzetra Xsail)

    - Injectable Triptans
        - UF, step-preferred
            - sumatriptan 4 mg and 6 mg injection (Imitrex STATdose, generics)
        - NF, non step-preferred
            - sumatriptan 4 mg and 6 mg needle-free injection (Sumavel DosePro)
            - Sumatriptan 3 mg autoinjector (Zembrace SymTouch)

    - Transdermal Triptans
        - NF, non step-preferred
            - sumatriptan transdermal system (Zecuity), if reintroduced to the market

Note that the NF triptans will be exempt from the requirement to use the Mail Order Pharmacy as the sole source of dispensing, as they fall into the "acute use" exception.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) designating the following drugs with BCF status:

    - Remain on the BCF
        - sumatriptan tablets (generic)
        - rizatriptan tablets and ODT (generic)
    - Add to the BCF
        - zolmitriptan tablets and ODT (Zomig, generic; Zomig-ZMT, generic)

    Note that as part of the BCF recommendation, generic sumatriptan 4 mg and 6 mg injection (Imitrex STATdose) will be designated as BCF when cost-effective multi-source formulations are available.

3. ***COMMITTEE ACTION: AUTOMATED PA (STEP THERAPY) and MANUAL PA CRITERIA—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) step therapy for the triptans in new users. There are three separate step therapies for the oral triptans, injectable triptans, and nasal triptans, respectively. A step-preferred formulation of the same dosage form must be tried first, prior to the use of the NF, non step-preferred product.

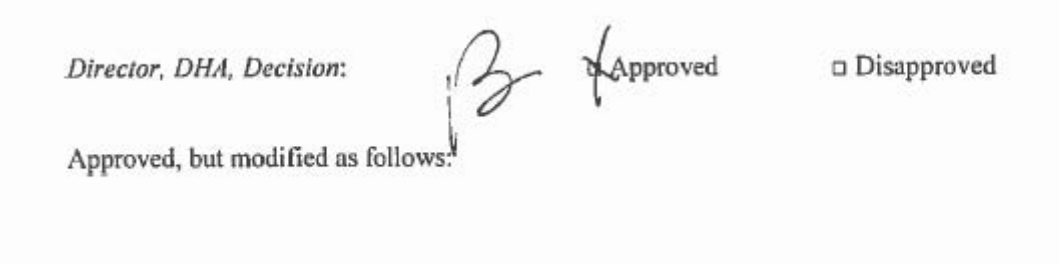
    For the oral and ODT triptans, a trial of at least two different step-preferred products (e.g., two products with differing active ingredients) is required before use of a non step-preferred product. For the nasal and injectable triptans, a trial of one generic formulation is required first. For the withdrawn transdermal system, if the product is reintroduced into the market, it will also be subject to step therapy, requiring use of at least two UF triptans, regardless of formulation, first. See Appendix C for the full criteria.

4. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) MN criteria for almotriptan (Amerge, generics), frovatriptan (Frova, generics), Treximet, Onzetra Xsail, Sumavel DosePro, Zembrace SymTouch, and Zecuity. See Appendix B for the full criteria.

5. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) QLs for the new triptan products Onzetra Xsail, Zembrace SymTouch, and Zecuity. The current QLs for the older triptan products will be

maintained. QLs were determined based on product packaging and FDA-labeled maximum daily dose. See Appendix D for the newly recommended QLs.

6. ***COMMITTEE ACTION: UF, and PA IMPLEMENTATION PERIOD—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday after a 90-day implementation period; and, 2) DHA send a letter to beneficiaries currently receiving Treximet. Based on the P&T Committee's recommendation, the effective date is February 8, 2017



C. Alcohol Deterrents: Narcotic Antagonists

Background—The narcotic antagonists were reviewed for formulary placement. The products all contain naloxone as the active ingredient; their differences lie in the route of administration and delivery device—injectable versus nasal. Two new naloxone formulations approved by the FDA specifically for bystander-administration are the Evzio autoinjector and Narcan Nasal Spray. If opioid overdose is suspected, these products must be administered by someone other than the patient, including a family member or caregiver.

The formulary decision will only apply to naloxone products that are FDA-approved for use in the bystander setting, as part of the outpatient TRICARE pharmacy benefit. Use in the Military Treatment Facility (MTF) clinic setting or for MTF first responders is not affected by this formulary recommendation. Other formulations of naloxone, including the vials, ampules, pre-filled syringes, and luer lock syringes are also not affected by the formulary decision.

Relative Clinical Effectiveness Conclusion—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) the following:

- The Evzio autoinjector and Narcan Nasal Spray are therapeutically equivalent.
- FDA approval of Evzio and Narcan Nasal Spray was via bioequivalence studies to generic naloxone administered intramuscularly (IM) or subcutaneously (SQ). Evzio has a published human factors validation (or ease of use) study, which concluded the autoinjector was easy to administer correctly with minimal training. Narcan Nasal Spray appears easy to use, based on unpublished data submitted to the FDA by the manufacturer.
- There are no trials comparing the effectiveness of Evzio and Narcan Nasal Spray in terms of onset of action or efficacy in the opioid overdose setting.

- For the Evzio autoinjector, advantages include the ease of use, provision of audio and visual administration cues, and the retractable needle, which decreases the risk of accidental exposure. Disadvantages include the short shelf life of 24 months and that patients with needle aversion may be apprehensive about using the device.
- For the Narcan Nasal Spray, advantages include the ease of use and minimal training required, the small size and portability of the device, the fact that it is a needle-free alternative to injectable naloxone, and the low volume of liquid. Disadvantages include the lack of published usability studies, the need for placing patients in the supine position for administration and then the recovery position, and the unknown effect in patients with significant nasal malformations or blockage.
- The Evzio autoinjector and Narcan Nasal Spray provide naloxone formulations that are easy to administer by bystanders to reverse opioid overdose and respiratory depression, but neither product has data showing outcomes in the real world setting or has data in patients receiving prescriptions for opioids. However, data from studies using the intranasal or IM naloxone kits in the community setting to reverse heroin overdose has shown that these products can successfully reverse opioid-induced respiratory depression.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and BIA were performed to evaluate Evzio and Narcan Nasal Spray. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results showed Narcan Nasal Spray was the most cost-effective naloxone formulation specifically approved for bystander-administration, followed by Evzio.

- BIA was performed to evaluate the potential impact of various formulary scenarios. The scenario with Narcan Nasal Spray as formulary, with the Tier 2 copayment reduced to the Tier 1 copayment in the Retail Pharmacy Network and the TRICARE Mail Order Pharmacy, and Evzio designated as NF, was a cost-effective option for the MHS.

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

    - **UF:** naloxone nasal spray (Narcan Nasal Spray)
    - **NF:** naloxone autoinjector (Evzio)

      Note that Evzio will be exempt from the requirement to use Mail Order as the sole source of dispensing, as it falls into the "acute use" exception.

    As part of the UF recommendation, the P&T Committee also recommended that the brand (Tier 2) formulary cost share of $20.00 for Narcan Nasal Spray in the TRICARE Mail Order Pharmacy and $24 in the TRICARE Retail Network Pharmacy be lowered to the generic (Tier 1) formulary cost share of $0 in the TRICARE Mail Order Pharmacy and $10.00 in the Retail Pharmacy Network.

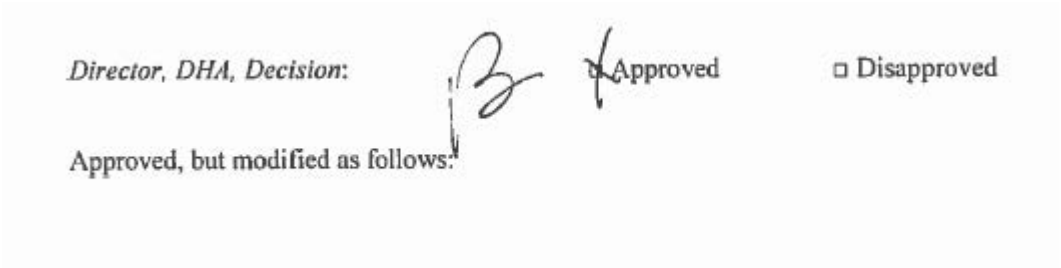
The authority for the last recommendation is codified in 32 CFR 199.21(j)(3), which states that "when a blanket purchase agreement, incentive price agreement, Government contract, or other circumstances results in a brand pharmaceutical agent being the most cost effective agent for purchase by the Government, the P&T Committee may also designate that the drug be cost-shared at the generic rate." Lowering the cost share for the branded product Narcan Nasal Spray will provide a greater incentive for beneficiaries to use Narcan Nasal Spray, rather than the less cost-effective naloxone autoinjector (Evzio) in the purchased care setting.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) designating Narcan Nasal Spray with BCF status.

3. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 2 absent) MN criteria for Evzio, allowing use in those situations where Narcan Nasal Spray would not be appropriate (e.g., for patients with significant nasal malformations or disfiguring injuries or in cases where only a juvenile caregiver/bystander is available). See Appendix B for the full criteria.

4. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs) AND REFILL LIMITS***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 2 absent) QLs for Evzio of 1 carton per prescription and for Narcan Nasal Spray of 2 cartons per prescription at all three points of service (POS). Additionally, the P&T Committee also recommended that no refills be allowed for Evzio and Narcan Nasal Spray; a new prescription will be required for every fill.

5. ***COMMITTEE ACTION: UF IMPLEMENTATION PERIOD—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday after a 60-day implementation period; and, 2) DHA send a letter to beneficiaries currently receiving Evzio. Based on the P&T Committee's recommendation, the effective date is January 11, 2017.



V. INNOVATOR DRUGS

Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions—The P&T Committee agreed (16 for, 0 opposed, 0 abstained, 1 absent) with the relative clinical and cost-effectiveness analyses presented for the innovator drugs. For the complete list of innovator drugs reviewed at the August 2016 P&T Committee meeting, a brief summary of their clinical attributes, and their formulary recommendations, see Appendix E.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended the following:

   - UF (16 for, 0 opposed, 0 abstained, 1 absent):
     - Antihemophilic Agents: antihemophilic (recombinant) Factor VIII injection (Afstyla)
     - Oral Oncology Agents (Renal Cell Carcinoma): cabozantinib (Cabometyx)
     - Antiretroviral Agents: emtricitabine/tenofovir alafenamide (Descovy)
     - Miscellaneous Agents: nitisinone oral suspension (Orfadin)
     - Miscellaneous Agents: obeticholic acid (Ocaliva)
     - Hepatitis C Virus Direct Acting Agents: sofosbuvir/velpatasvir (Epclusa)
     - Oral Oncology Agents (Chronic Lymphocytic Leukemia): venetoclax (Venclexta)

   - NF (16 for, 0 opposed, 0 abstained, 1 absent):
     - Topical Corticosteroids – medium potency: betamethasone dipropionate 0.05% spray (Sernivo)
     - Anticonvulsant and Anti-Mania Agents: brivaracetam tablets and oral solution (Briviact)
     - Topical Antineoplastic and Premalignant Lesions Agents: fluorouracil 4% cream (Tolak)
     - Topical Corticosteroids – high potency: halobetasol propionate 0.05% lotion (Ultravate)
     - Non-Insulin Diabetes Drugs—DPP-4 Inhibitors: linagliptin/metformin XR tablets (Jentadueto XR), which is additionally recommended to be non step-preferred, due to existing step therapy in the class
     - Atypical Antipsychotics: pimavanserin (Nuplazid)
     - Narcotic Analgesics and Combinations: oxycodone extended-release capsules (Xtampza ER)

   - NF (10 for, 6 opposed, 0 abstained, 1 absent):
     - Iron Chelators: deferiprone oral solution (Ferriprox) due to the lack of compelling clinical advantages over other oral iron chelator

products, three times daily dosing, and the risk of agranulocytosis

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) MN criteria for betamethasone dipropionate 0.05% spray (Sernivo), brivaracetam tablets and oral solution (Briviact), deferiprone oral solution (Ferriprox), fluorouracil 4% cream (Tolak), halobetasol propionate 0.05% lotion (Ultravate), linagliptin/metformin XR tablets (Jentadueto XR), oxycodone extended-release capsules (Xtampza ER), and pimavanserin (Nuplazid). See Appendix B for the full criteria.

3. ***COMMITTEE ACTION: PA CRITERIA***—The P&T Committee also recommended (16 for, 0 opposed, 0 abstained, 1 absent) the following:

   - Applying the same step therapy and manual PA criteria for Jentadueto XR as is currently in place for linagliptin/metformin immediate release (IR) (Jentadueto) and the other non step-preferred dipeptidyl peptidase-4 (DPP-4) inhibitor combinations with metformin. Existing step therapy currently applies to the DPP-4 inhibitors, including Jentadueto. Patients must first use metformin or a sulfonylurea, and the preferred DPP-4 inhibitor sitagliptin before using a non step-preferred DPP-4 inhibitor. See Appendix C for the full criteria.
   - Applying manual PA criteria to the following: new users of the hepatitis C virus (HCV) direct acting antiviral agent (DAA) sofosbuvir/velpatasvir (Epclusa), the atypical antipsychotic pimavanserin (Nuplazid), the iron chelator deferiprone oral solution and oral tablet (Ferriprox), and the orphan drug obeticholic acid (Ocaliva). See Appendix C for the full criteria.

4. ***EXPANDED MTF/MAIL PHARMACY INITIATIVE (EMMPI) AND NF TO MAIL ORDER REQUIREMENT***—The P&T Committee reviewed all of the innovator drugs with respect to their status on the EMMPI program and the requirement to use the TRICARE Mail Order Pharmacy as the sole source of dispensing for NF drugs. Refer to the August 2015 DoD P&T Committee meeting minutes for additional information regarding the requirements and exceptions for these two programs, available at http://www.health.mil/PandT.

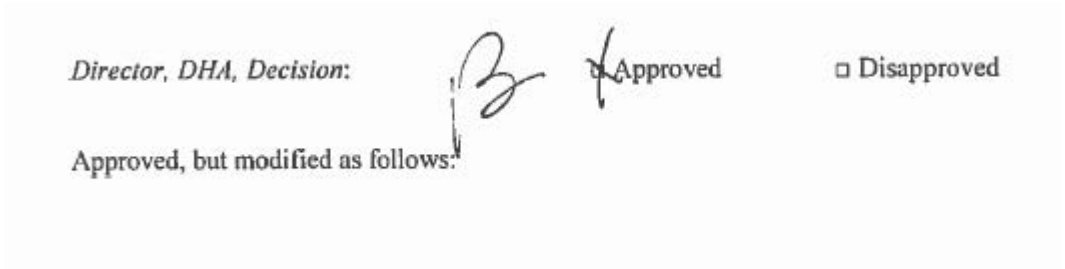
   With respect to the innovator drugs recommended for UF status, the P&T Committee noted that none fall into classes already defined as included on the EMMPI program, most have not yet been filled at mail order, and that more information is needed to determine their suitability.

   With respect to the drugs recommended for NF status, the P&T Committee commented that the previously established exceptions applied to the following: Nuplazid due to the previously established exception for the atypical antipsychotics and Xtampza ER due to the previously established exception for scheduled II medications.

The P&T Committee also recommended creating a specific exception to the requirement for the iron chelators, based on feedback from providers that these products are not appropriate candidates for the Mail Order Pharmacy because of their intermittent use and frequent need for dosage adjustments.

a) ***COMMITTEE ACTION: NF TO MAIL ORDER REQUIREMENT***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) adding deferiprone (Ferriprox) and the iron chelators drug class to the list of medications exempted from the requirement to use Mail Order as the sole point of dispensing.

5. ***COMMITTEE ACTION: UF, MN, AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) an effective date upon signing of the minutes in all POS.



VI. UTILIZATION MANAGEMENT

A. PA Criteria

1. **Analgesics and Combinations: Butalbital/Acetaminophen/Caffeine Oral Liquid (Vanatol LQ) Manual PA Criteria**—Vanatol LQ is an oral liquid formulation containing the same active ingredients as Fioricet and is approved for tension or muscle headaches.

   a) ***COMMITTEE ACTION: BUTALBITAL/ACETAMINOPHEN/CAFFEINE (VANATOL LQ) MANUAL PA CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) manual PA criteria for Vanatol LQ in new and current users, due to cost disadvantages compared to generic Fioricet tablets and capsules. See Appendix C for the full criteria.

2. **Newer Sedative Hypnotics (SED-1s): Suvorexant (Belsomra) Removal of automated PA and new Manual PA Criteria**—Belsomra is a first-in-class orexin receptor antagonist indicated for the treatment of insomnia characterized by difficulties with sleep onset and/or maintenance. The SED-1s Drug Class has automated PA criteria that require a trial of a step-preferred agent (zolpidem IR or zaleplon). Belsomra was designated as NF in August 2015, with step therapy implemented in October 2015. Removal of the automated PA criteria was recommended for Belsomra with the addition of manual PA criteria required for all new users, due to the lack of compelling clinical advantages and cost-disadvantages over the existing formulary SED-1s. Zolpidem ER (Ambien CR) and eszopiclone (Lunesta) have the same FDA

indications as Belsomra.

a) ***COMMITTEE ACTION: SUVOREXANT (BELSOMRA) MANUAL PA CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) removing the automated PA criteria and establishing manual PA criteria for Belsomra in new users. Patients will be required to try zolpidem extended release and eszopiclone before using Belsomra. See Appendix C for the full criteria.

3. **Growth-Stimulating Agents (GSAs) Manual PA Criteria**—GSAs have varying indications including treatment of patients with growth hormone deficiency, Turner Syndrome, patients who are small for gestational age, and for patients with idiopathic short stature, among others. The GSAs were last reviewed in 2007, and Manual PA criteria apply. Idiopathic short stature has not been a covered indication by the MHS. Since the previous review, several agents have been discontinued and new agents approved. All newly-approved GSAs will be subject to the PA criteria, which expires after one year.

   a) ***COMMITTEE ACTION: SOMATROPIN (GSAs) MANUAL PA CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) updating the manual PA criteria for GSAs in new and current users to reflect the current products on the market, and to exclude idiopathic short stature as a covered indication for all products. See Appendix C for the full criteria.

4. **Topical Pain Agents: Diclofenac Sodium 2% Topical Solution (Pennsaid) Manual PA Criteria**—Diclofenac topical solution (Pennsaid) is FDA-approved for the treatment of pain from osteoarthritis of the knee. The originally approved 1.5% branded product is now available as a generic formulation, and the branded product was changed to a 2% concentration. Pennsaid 2% offers no compelling advantages over diclofenac 1.0% gel (Voltaren) or generic 1.5% topical preparations, and was designated as a NF line extension in May 2014. Manual PA criteria were recommended for the branded Pennsaid 2% formulation.

   a) ***COMMITTEE ACTION: DICLOFENAC SODIUM 2% TOPICAL SOLUTION (PENNSAID) MANUAL PA CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) manual PA criteria for new and current users of Pennsaid 2%. Coverage of Pennsaid 2% will be approved if the patient has tried and failed generic diclofenac 1.0% gel (Voltaren generic) and generic 1.5% topical solution, and is unable to take a NSAID due to contraindications or adverse effects. See Appendix C for the full criteria.

B. QLs AND PRECRIPTION REFILL LIMITS

1. **QLs**—Quantity limits were reviewed for 10 drugs: venetoclax (Venclexta) for chronic lymphocytic leukemia (CLL), cabozantinib (Cabometyx) for advanced renal cell carcinoma (RCC), sofosbuvir/velpatasvir (Epclusa), and ombitasvir/paritaprevir/ritonavir/dasabuvir (Viekira XR) for HCV, lidocaine5% patch (Lidoderm) for pain, and for five agents approved to treat hereditary angioedema.

    a) ***COMMITTEE ACTIONS: QLs—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) QLs for Venclexta, Cabometyx, Epclusa, Viekira XR, Lidoderm, and the agents used for hereditary angioedema (Cinryze, Berinert, Ruconest, Firazyr, Kalbitor). See Appendix D for the QLs.

2. **METHYLNALTREXONE (RELISTOR) REMOVAL OF PRESCRIPTION REFILL LIMITS**—In April 2008, methylnaltrexone (Relistor) was originally FDA-approved in a vial formulation intended for treatment of opioid-induced constipation (OIC) in the palliative care setting. The package insert states that use is limited to 4 months, and in May 2009, no refills were recommended by the Committee. Since then, Relistor is now approved in a pre-filled syringe (September 2014), and oral tablets (July 2016) for OIC in patients with non-cancer pain.

    a) ***COMMITTEE ACTION: METHYLNALTREXONE (RELISTOR) VIALS REFILL LIMITS***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) removing the "no refill" requirement for Relistor vials in the palliative care setting. Removing the no refill requirement ensures patients will have the same access to the vials in the palliative care setting as with the pre-filled syringes in the ambulatory care setting.

C. PA and QLs Implementation Periods

1. ***COMMITTEE ACTION: PA AND QLs IMPLEMENTATION PERIODS***—The P&T Committee recommended the following implementation periods:

    - 14 for, 0 opposed, 0 abstained, 3 absent—the manual PAs for butalbital/acetaminophen/caffeine oral liquid (Vanatol LQ), suvorexant (Belsomra), diclofenac sodium 2% topical solution (Pennsaid), and the somatropin GSAs become effective on the first Wednesday after a 90-day implementation period in all POS. Based on the P&T Committee's recommendation, the effective date is February 8, 2017.
    - 14 for, 0 opposed, 0 abstained, 3 absent—the QLs for venetoclax (Venclexta), cabozantinib (Cabometyx), sofosbuvir/velpatasvir (Epclusa), ombitasvir/paritaprevir/ritonavir/dasabuvir (Viekira XR), lidocaine 5% patch (Lidoderm), and agents for hereditary angioedema become effective upon signing of the minutes.

- 14 for, 0 opposed, 0 abstained, 3 absent—removing the current requirement for no refills on the Relistor 12 mg/0.6 mL vials for use in the palliative care setting become effective upon signing of the minutes.

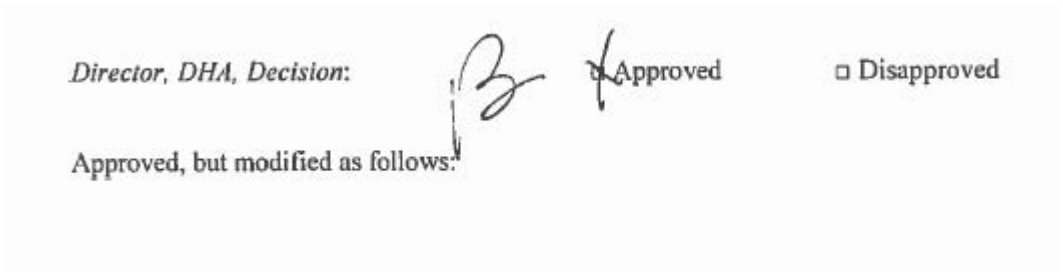
D. Utilization Management for Brand over Generic Authority and PA Criteria

1. **Mandatory Generic Substitution Policy: Removal of PA Requiring Brand over Generic Niacin ER (Niaspan)—**TRICARE policy requires dispensing of generic products at the Retail Network and Mail Order Pharmacy. However, when AB-rated generic formulations for niacin ER (Niaspan) were launched in September 2013, pricing for the branded product was lower than the generic formulations. The manufacturer of Niaspan offered a Voluntary Agreement for Retail Refunds, and the Tier 1 (generic) copayment was assigned to the branded product at the November 2013 P&T Committee meeting. Additionally, PA criteria allowing for a patient to receive generic niacin ER instead of branded Niaspan (i.e., the reverse of the current brand to generic policy) were recommended by the P&T Committee in May 2014.

   In May 2016, the P&T Committee recommended the DHA Pharmacy Operations Division (POD) be given authority, after consulting with the Chair of the P&T Committee, to implement "brand over generic" authorization for drugs with recent generic entrants where the branded product is more cost-effective than generic formulations. In these cases, the branded product will continue to be dispensed, and the generic product will only be available upon prior authorization. Authority was also given to the POD to remove the "brand over generic" requirement when it is no longer cost-effective to the MHS.

   As of June 2016, the AB-rated generic formulations for niacin ER (Niaspan) are cost-effective compared to the branded Niaspan product.

   a) ***COMMITTEE ACTION: REMOVAL OF PA REQUIRING BRAND OVER GENERIC NIACIN ER (NIASPAN)***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) removal of the Brand over Generic PA, and removal of the Tier 1 (generic) co-pay for branded Niaspan. Branded Niaspan will now be available at the Tier 2 (UF) co-pay in the Retail Network and Mail Order Pharmacy, and the requirement for mandatory generic substitution is re-instated.



VII. LINE EXTENSIONS

A. TARGETED IMMUNOMODULATORY BIOLOGICS (TIBs): ABATACEPT (ORENCIA CLICKJECT AUTOINJECTOR)

The TIBs were reviewed for formulary status in August 2014, and step therapy and manual PA criteria were implemented in February 2015, requiring a trial of the step-preferred TIB, adalimumab (Humira). Abatacept (Orencia) pre-filled syringes were designated as NF and non-preferred at that time. Additionally, QLs apply to the TIBs Drug Class.

A new autoinjector formulation of abatacept (Orencia ClickJect Autoinjector) was approved in June 2016. The ClickJect Autoinjector has the same FDA-approved indication (rheumatoid arthritis), and contains the same dosage (125 mg/mL) and dosing frequency (once weekly) as the pre-filled syringes.

1. ***COMMITTEE ACTION: ABATACEPT 125 mg/mL (ORENCIA CLICKJECT AUTOINJECTOR) FORMULARY STATUS CLARIFICATION, MN CRITERIA, STEP THERAPY, MANUAL PA CRITERIA, AND QLs***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) that the Orencia 125 mg/mL Clickject Autoinjector follow the same formulary status, MN criteria, step therapy, and manual PA criteria that are currently in place for the Orencia pre-filled syringes, as outlined in the August 2014 DoD P&T Committee meeting minutes. Additionally, QLs were also recommended, consistent with the class. These recommendations will become effective upon signing of the minutes. See Appendix D.

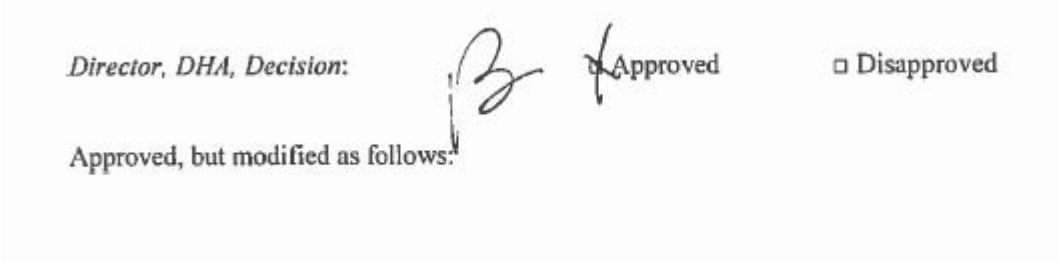
B. PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK-9) INHIBITORS: EVOLOCUMAB PUSHTRONEX (REPATHA)

The PCSK-9 inhibitors have not yet been reviewed for UF status. Evolocumab is an innovator drug that was recommended for NF status at the November 2015 DoD P&T Committee meeting. MN criteria are currently in place. Manual PA and QLs currently apply to the PCSK-9 inhibitor drug class.

A new pre-filled cartridge formulation of evolocumab (Repatha Pushtronex) was approved in July 2016. The Pushtronex device contains evolocumab 420 mg/3.5 mL, which adheres to the skin and is subcutaneously infused over a period of 9 minutes and administered once monthly. The Pushtronix device is only approved for homozygous familial hypercholesterolemia (HoFH). For patients with HoFH, Repatha is also available in pre-filled syringes and single-use prefilled autoinjectors containing140 mg. A dosage of 420 mg/month can be obtained by administering three of the 140 mg injections consecutively with 30 minutes. The Pushtronex device allows for administration of the entire dosage in a single injection.

1. ***COMMITTEE ACTION: REPATHA 420 mg/3.5 mL PUSHTRONEX FORMULARY STATUS CLARIFICATION, MN CRITERIA, MANUAL PA CRITERIA, AND QLs***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) that the Repatha 420 mg/3.5 mL Pushtronex formulation follow the

same formulary status, MN criteria, and manual PA criteria that are currently in place for the Repatha 140 mg single-use pre-filled syringes and autoinjectors, as outlined in the November 2015 DoD P&T Committee meeting minutes. Additionally, QLs were also recommended, consistent with the class. These recommendations will become effective upon signing of the minutes. See Appendix D.



VIII. SECTION 703, NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FOR FISCAL YEAR (FY) 2008

The P&T Committee reviewed three drugs from pharmaceutical manufacturers that were not included on a DoD Retail Refund Pricing Agreement; these drugs were not in compliance with FY08 NDAA, Section 703. The law stipulates that if a drug is not compliant with Section 703, it will be designated NF on the UF and will be restricted to the TRICARE Mail Order Pharmacy, requiring pre-authorization prior to use in the retail POS and medical necessity at MTFs. These NF drugs will remain available in the Mail Order POS without pre-authorization.

A. ***COMMITTEE ACTION: DRUGS DESIGNATED NF***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) the following products be designated NF on the UF:

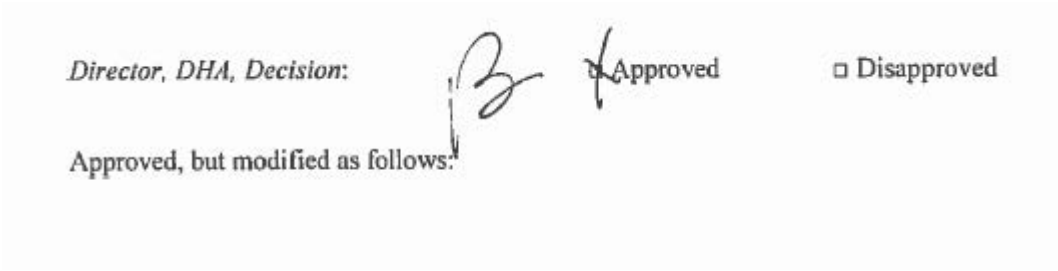
- Veloxis Pharma: tacrolimus ER (Envarsus XR) 1 mg and 4 mg oral tablets
- Lachlan Pharma: benzyl alcohol (Ulesfia) 5% topical lotion
- Mist Pharma: propranolol ER (Inderal XL) 80 mg and 120 mg oral capsules

B. ***COMMITTEE ACTION: PRE-AUTHORIZATION CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) the following pre-authorization criteria for Envarsus XR, Ulesfia, and Inderal XL:

1. Obtaining the product by home delivery would be detrimental to the patient; and,
2. For branded products with products with AB-rated generic availability, use of the generic product would be detrimental to the patient.

These pre-authorization criteria do not apply to any other POS other than retail network pharmacies.

C. *COMMITTEE ACTION: IMPLEMENTATION PERIOD*—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 3 absent) 1) an effective date of the first Wednesday after a 90-day implementation period for Envarsus XR, Ulesfia, and Inderal XL; and, 2) DHA send letters to beneficiaries affected by this decision. Based on the P&T Committee's recommendation, the effective date is February 8, 2017.



IX. OVER-THE-COUNTER (OTC) DRUG BENEFIT: STATUS OF SECOND GENERATION ANTIHISTAMINES

The Deployment Prescription Program requested that the DoD P&T Committee consider adding fexofenadine (generic Allegra) to the UF as part of the OTC pharmacy benefit, which would make it available by mail to deployed Service members in theater.

The final rule implementing the legislative authority for the OTC Drug Program was published on July 27, 2015, and is found at https://www.federalregister.gov/articles/2015/07/27/2015-18290/civilian-health-and-medical-program-of-the-uniformed-services-champustricare-tricare-pharmacy. The OTC medications currently on the UF include omeprazole, loratadine, loratadine/pseudoephedrine, cetirizine, cetirizine/pseudoephedrine, levonorgestrel 1.5 mg (Plan B One-Step and its generics), and doxylamine 25 mg.

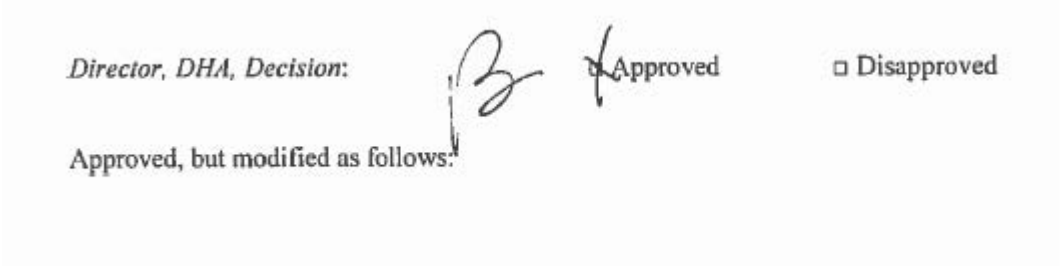
The P&T Committee reviewed the status of the second generation antihistamines on the various Aerospace Medicine lists of medications approved for use by U.S. Air Force, U.S. Army, U.S. Navy, and U.S. Coast Guard flyers. All of the lists include loratadine and all, except for the U.S. Army, list include fexofenadine. Cetirizine is not included on any of the lists since it is more likely to cause sedation than loratadine or fexofenadine.

Generic cetirizine OTC and generic loratadine OTC were the least costly second generation antihistamines, followed by generic fexofenadine OTC, levocetirizine (generic Xyzal), and desloratadine (generic Clarinex). The costs of combination products with pseudoephedrine ranged from 5 to 18 times higher than, and were used less frequently than, their respective single ingredient products. The P&T Committee also noted cetirizine/pseudoephedrine has not been available through the Mail Order POS over the last few months due to the lack of a Trade Agreements Act (TAA) compliant generic product.

A. *COMMITTEE ACTION: UF RECOMMENDATION*—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) the following, effective upon signing of the minutes:

- adding OTC fexofenadine to the UF
- removing OTC cetirizine/pseudoephedrine from the UF

- removing OTC loratadine/pseudoephedrine from the UF



X. REFILLS OF PRESCRIPTION MAINTENANCE MEDICATIONS THROUGH MTF PHARMACIES OR THE NATIONAL MAIL ORDER PHARMACY PROGRAM (EMMPI): PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK-9) INHIBITORS

Two PCSK-9 inhibitors are currently available: alirocumab (Praluent), which is on the UF, and evolocumab (Repatha), which became available after the innovator program went into effect on August 25 2015, and is currently designated NF. The two products have relatively similar FDA approved indications. Both drugs are maintenance medications that are predominantly being filled at mail order. The P&T Committee agreed with adding the PCSK-9 inhibitors, as a subclass under the Antilipidemics-1 Class, to the EMMPI program.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 1 absent) the following, effective upon signing of the minutes:
    - Adding the PCSK-9 inhibitors to the EMMPI list, and
    - Modifying the existing class definition for the Antilipidemics-1 class to include the PCSK-9 inhibitors (First Data Bank GC3 class M4T) and direct that: "Branded, legend products in GC3s M4D, M4E, M4I, M4L, M4M, or M4T that are intended for chronic use be added to the EMMPI list (note that M4E overlaps with Antilipidemics-2 [fenofibrates, fibric acid, omega-3 fatty acids])," allowing for automatic placement of future marketed PCSK-9 inhibitors products on the EMMPI program

XI. RE-EVALUATION OF GENERICALLY AVAILABLE NF AGENTS

The P&T Committee continued the process of implementing the requirement that NF pharmaceutical agents generally be unavailable at MTFs or the Retail Network, but available in the Mail Order program. (See DoD P&T Committee meeting minutes from

August 2015 and May 2016.) Implementation of the mail order requirement for generically available NF agents was temporarily deferred to allow for review of the continued necessity for NF (Tier 3) status, given price decreases typically associated with generic availability.

The P&T Committee reviewed the current utilization, formulary status, generic availability, comparative clinical effectiveness, and relative cost effectiveness, including the weighted average cost per unit, for all generically available NF agents in eight previously reviewed UF drug classes. Utilization trends by POS found limited dispensing of the NF generic products, compared to the UF products in the respective classes.

Clinical Effectiveness Conclusion and Cost-Effectiveness Conclusion—The P&T Committee concluded that for all eight drug classes, there was no new pertinent efficacy or safety information to change the clinical effectiveness conclusion from when the class was originally reviewed for UF placement. The Committee also concluded that the costs of all the NF generic products were significantly higher than the currently available UF products, with two exceptions: generic calcitonin-salmon nasal spray and diclofenac 1.5% topical solution were comparable in price to the UF products in their respective classes. Specific comments are below:

- *Second Generation Antihistamines: Levocetirizine (Xyzal) and Desloratadine (Clarinex)*—Levocetirizine and desloratadine continue to offer no significant, therapeutically meaningful advantage over other similar agents on the UF (loratadine, cetirizine, and fexofenadine).
- *Osteoporosis/Oral Bisphosphonates and Calcitonin: Risedronate (Actonel, Atelvia), Calcitonin-Salmon Nasal Spray (Miacalcin)*
    - The oral bisphosphonates are highly therapeutically interchangeable, and there are no compelling advantages to the delayed release formulation of weekly risedronate (Atelvia). New safety data for the bisphosphonates (osteonecrosis of the jaw, esophageal cancer, atrial fibrillation, and atypical femur fractures), has led to an overall decline in use.
    - There is currently step therapy for the bisphosphonates, with alendronate (generic Fosamax) designated as step-preferred. Generic formulations of ibandronate 150 mg monthly (-) are now available. The P&T Committee noted that generic ibandronate 150 mg is newly available to MTFs and through mail order at substantially decreased cost under a Joint National Contract.
    - Calcitonin nasal spray is considered a third line and/or niche agent in clinical practice guidelines. The cost per 28 days for calcitonin nasal spray was similar for recombinant calcitonin (Fortical) and for generic calcitonin-salmon (generic Miacalcin).
- *Non-Insulin Diabetes Mellitus Drugs/Biguanides: Metformin ER (Fortamet, Glumetza)*—There is no evidence to suggest that differences in the ER formulations of Glumetza and Fortamet confer clinically relevant benefits in

efficacy or safety when compared to generic metformin IR or ER preparations (Glucophage, Glucophage XR, generic).

- *Selective Serotonin Reuptake Inhibitors (SSRIs): Fluoxetine 90 mg Delayed Release (Prozac Weekly) and Products for Premenstrual Dysphoric Disorder (PMDD) (Sarafem)*—Neither the special packaging for PMDD (Sarafem) nor a higher dosing strength for weekly administration (Prozac Weekly) offer significant clinical advantages compared to generic Prozac. Brand Sarafem is now available as tablets instead of capsules; the availability of generics for the tablets is unclear at this time, based on the FDA website.
- *Benign Prostatic Hypertrophy (BPH) Medications/5-Alpha Reductase Inhibitors (ARIs): Dutasteride (Avodart), Dutasteride/Tamsulosin (Jalyn)*—Finasteride (Proscar, generic) and dutasteride are highly therapeutically interchangeable for the treatment of BPH, and the combination product dutasteride/tamsulosin offers no additional benefit compared to the individual components. There is existing step therapy in the class.
- *Alzheimer's Medications: Donepezil 23 mg (Aricept 23 mg)*—Donepezil 23 mg shows statistical improvement in cognition but not global functioning, and tolerability is likely limited by increased adverse effects, compared to donepezil 10 mg.
- *Antilipidemics-1/Statins and Combos: Fluvastatin ER 80 mg (Lescol XR)* Lescol XR remains a moderate low-density lipoprotein (LDL) lowering statin, with LDL-lowering capacity ranging between 30% to <50%. Eight other statins fall into the moderate LDL-lowering category. Step therapy also exists in this class; a trial of a generic step-preferred statin with similar LDL-lowering capacity is required first.
- *Topical Pain Agents: Diclofenac 1.5% Topical Solution (Pennsaid 1.5% Drops)* Topical diclofenac (including the topical solution and gel) was effective for managing superficial pain (e.g., osteoarthritis, sprain, strain, contusions). Gastro-intestinal adverse events were lower with topical therapy compared to oral NSAIDs. Brand Pennsaid is now available as a diclofenac 2% topical solution, with only generic versions of the 1.5% formulation remaining on the market. (See UM section VI on page 16 for information on the PA criteria). Weighted average cost per day for generic diclofenac 1.5% topical solution is comparable to the weighted average cost per day for generic lidocaine 5% patch, providing another alternative in this class both overall and specifically as an alternative to Pennsaid 2% topical solution, which is far more costly.

1. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended the following (16 for, 0 opposed, 0 abstained, 1 absent), effective upon signing of the minutes:
    - The following products will remain NF, with both brand and generics subjected to mail order requirements:

- Second Generation Antihistamines: levocetirizine (Xyzal, generics) and desloratadine (Clarinex, generics)
- Osteoporosis/Oral Bisphosphonates and Calcitonin: risedronate (Atelvia, Actonel, and their generics); these products will remain as non step-preferred
- Non-Insulin Diabetes Mellitus Drugs/Biguanides: metformin ER (Fortamet, Glumetza, and their generics)
- Selective Serotonin Reuptake Inhibitors: fluoxetine 90 mg (Prozac Weekly); generic Sarafem caps; Sarafem tabs
- BPH Medications/5-ARIs: dutasteride (Avodart, generics); dutasteride/tamsulosin (Jalyn, generics); these products will remain as non step-preferred
- Alzheimer's Medications: donepezil 23 mg (Aricept, generics)
- Antilipidemics/Statins and Combos: fluvastatin ER (Lescol XL, generics); will remain non step-preferred

- Return to UF status
  - Osteoporosis/Oral Bisphosphonates and Calcitonin: calcitonin-salmon nasal spray (brand Miacalcin and generics)
  - Topical Pain Agents: diclofenac 1.5% topical solution (generic Pennsaid 1.5%)

- Automated PA (step therapy) Changes
  - Osteoporosis Agents/Oral Bisphosphonates: designate ibandronate 150 mg monthly (Boniva, generics) as step-preferred. Patients must now try either step-preferred alendronate formulations or ibandronate prior to use of Actonel, Atelvia, Binosto, and Fosamax Plus D

    The automated and manual PA criteria for the oral bisphosphonates will now state: "The patient has filled a prescription for alendronate or ibandronate at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days." Manual PA criteria requirements (if the automated PA criteria were not met) for ibandronate will also be removed, effective upon signing of the minutes. See Appendix C.

Director, DHA, Decision: ☒ Approved ☐ Disapproved

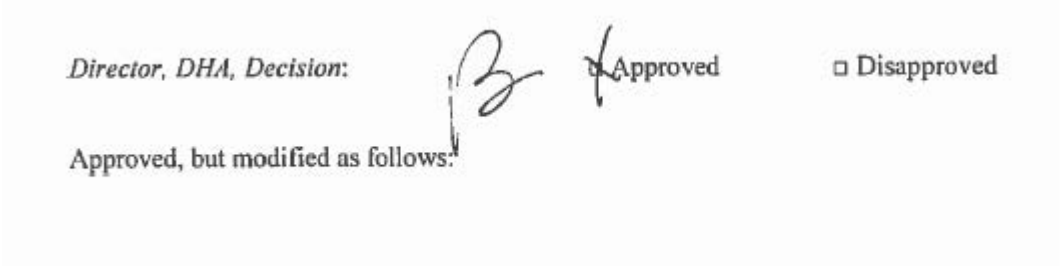
Approved, but modified as follows:

XII. Opiate Safety Edit Review: Comparison to Commercial Standard

The opiate safety edit is an automated medication profile review that warns pharmacies when it detects that an opiate naïve patient is prescribed a high potency opiate. The program has been in place in the MHS since August 2007. Additions to the targeted opioids are currently updated manually by the POD Formulary Management Branch when new products enter the market.

In May 2016, the current DoD and Express Scripts commercial program were compared, and included an evaluation of the medications currently subject to the safety edit, medication daily dose limits, technical parameters to operationalize the edit, and the resulting volume of warnings generated to the dispensing pharmacists. The opiate safety edit program Express Scripts currently offers to their commercial clients was found to be acceptable for DoD use. However, unique aspects of DoD's current program, including such things as a look back period of 60 days (rather than 180 days with Express Scripts) and the alert messaging to the pharmacist (the pharmacist must confirm the patient is opioid tolerant, if there is no documented use of a high potency opioid in the prior 60 days) should be maintained.

1. ***COMMITTEE ACTION: ADOPTION OF COMMERCIAL STANDARD***
   The P&T Committee recommended (13 for, 0 opposed, 1 abstained, and 3 absent) DoD follow the Express Scripts commercial opiate safety edit for the historical qualifying drug list (Step 1) and the inbound drug list (Step 2). Unique aspects of DoD's current program will remain unchanged.


Director, DHA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

XIII. ITEMS FOR INFORMATION

A. Joint Deployment Formulary (JDF) Review

The P&T Committee reviewed the approximately 700 pharmaceutical line items on the JDF and found no significant conflict with items designated as NF (Tier 3) on the UF. In addition, Pharmacy Data Transaction Service theater data for calendar year 2015 showed minimal use of NF (Tier 3) drugs. The P&T Committee concluded that use of medications in theater was consistent with Uniform Formulary NF designations.

B. Non-Insulin Diabetes Drugs: Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs)—MTF Request for Liraglutide (Victoza) to be Added to the UF

The P&T Committee reviewed an MTF request to add liraglutide (Victoza) to the UF. Currently, Victoza is NF and non step-preferred. The GLP1RAs subclass was reviewed in August 2015 and exenatide once weekly (Bydureon) and albiglutide once weekly

(Tanzeum) were designated UF and step-preferred. Patients must first try both Bydureon and Tanzeum prior to use of the NF and non-preferred agents Victoza, dulaglutide (Trulicity), and exenatide twice daily (Byetta).

Based on the comparative clinical and cost-effectiveness analyses previously reviewed, and the information submitted by the requesting MTF (including results of a newly published outcomes trial with Victoza – *LEADER)*, there was a consensus among the DoD P&T Committee members that no formulary status change is recommended at this time. The GLP1RA subclass is expected to be re-reviewed in the next 12-24 months when results from additional cardiovascular outcomes trials are completed with the other products, additional single agents are approved, and combinations with insulin are available.

XIV. ADJOURNMENT

The meeting adjourned at 1215 hours on August 11, 2016. The next meeting will be in November 2016.

Appendix A—Attendance: August 2016 P&T Committee Meeting
Appendix B—Table of Medical Necessity Criteria
Appendix C—Table of Prior Authorization Criteria
Appendix D—Table of Quantity Limits
Appendix E—Table of Innovator Drugs: Formulary Recommendations
Appendix F—Table of Implementation Status of Uniform Formulary Recommendations/Decisions Summary
Appendix G—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.

R.C. Bono
VADM, MC, USN
Director

16 1108
Date

Appendix A—Attendance: August 2016 P&T Committee Meeting

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
CAPT Nita Sood for George Jones, PharmD, MS	Chief, DHA Operations Management Branch
CAPT Edward VonBerg, MSC	Chief, DHA Formulary Management Branch (Recorder)
Col William Hannah, MC (Aug 11)	Air Force, Internal Medicine Physician
Maj Jeffrey Colburn, MC for Col William Hannah, MC (Aug 10)	Air Force, Internal Medicine Physician
Col James Jablonski, MC	Air Force, Physician at Large
CDR Karl Kronmann, MC for CDR Brian King, MC	Navy, Internal Medicine Physician
LCDR Carey Welsh, MC	Navy, Pediatrics Representative
LCDR Richard Koch, MC for CDR Shaun Carstairs, MC	Navy, Physician at Large
MAJ Dausen Harker, MC	Army, Family Practice Physician
MAJ John Poulin, MC	Army, Physician at Large
Maj Larissa Weir, MC	Air Force, OB/GYN Physician
CAPT Thinh Ha, MSC	Navy, Pharmacy Officer
Col Melissa Howard, BSC	Air Force, Pharmacy Officer
LTC Kevin Ridderhoff, MSC for COL John Spain, MSC	Army, Pharmacy Officer
CDR Aaron Middlekauf, USCG	Coast Guard, Pharmacy Officer
Doreen Lounsbery COL (Ret.), MC, USA for Dr. Miguel Montalvo	TRICARE Regional Office-South, Chief of Clinical Operations Division and Medical Director
Ms. Jennifer Zacher for Mr. Joe Canzolino	Department of Veterans Affairs
Nonvoting Members Present	
Mr. David Hurt	DHA, Office of General Counsel
Guests	
MAJ Randall Sweeney	Defense Logistics Agency Troop Support
MAJ Norman Tuala	Defense Logistics Agency Troop Support
CAPT Matt Baker	Indian Health Service
CDR Paul Michaud	U.S. Coast Guard

Appendix A—Attendance (continued)

CAPT Walter Downs, MC	Chief, P&T Section, DHA Formulary Management Branch
Lt Col Ronald Khoury, MC	DHA Formulary Management Branch
MAJ Aparna Raizada, MSC	DHA Formulary Management Branch
Angela Allerman, PharmD, BCPS	DHA Formulary Management Branch
Amy Lugo, PharmD, BCPS	DHA Formulary Management Branch
Shana Trice, PharmD, BCPS	DHA Formulary Management Branch
Ms. Deborah Garcia	DHA Formulary Management Branch Contractor
Mr. Michael Lee	DHA Formulary Management Branch Contractor
Mr. Kirk Stocker	DHA Formulary Management Branch Contractor
Maj Ellen Roska, BSC	DHA Integrated Utilization Branch
Mr. Bill Davies via DCS	Chief, DHA Integrated Utilization Branch
Maj David Folmar, BSC	DHA Integrated Utilization Branch
David Meade, PharmD via DCS	DHA Integrated Utilization Branch
Ingrid Svihla, PharmD via DCS	DHA Integrated Utilization Branch
Robert Conrad, PharmD via DCS	DHA Operations Management Branch
Ms. Melanie Richardson via DCS	DHA Operations Management Branch
LCDR David Sohl, MSC	DHA Purchased Care Branch
LT Teisha Robertson via DCS	DHA Purchased Care Branch
Eugene Moore, PharmD, BCPS	DHA Purchased Care Branch

Appendix B—Table of Medical Necessity (MN) Criteria

Drug / Drug Class	Medical Necessity Criteria
▪ clindamycin 1% kits (Clindacin ETZ; Clindacin PAC) ▪ clindamycin 1% gel (Clindagel) ▪ clindamycin/benzoyl peroxide 1.2% - 3.75% gel (Onexton) ▪ clindamycin/benzoyl peroxide 1.2% - 5% gel/cream kit (Neuac Kit) **Topical Acne and Rosacea Agents: Topical Antibiotics and Combinations**	• Patient has tried and failed or experienced significant adverse effects from at least three formulary agents, including a clindamycin/benzoyl peroxide combination **Formulary Alternatives:** adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and sulfacetamide sodium/sulfur lotion
▪ adapalene/benzoyl peroxide 0.1% - 2.5% gel (Epiduo) ▪ adapalene/benzoyl peroxide 0.3% - 2.5% gel (Epiduo Forte) ▪ clindamycin/tretinoin 1.2% - 0.025% gel (Veltin; Ziana, generics) ▪ tretinoin microsphere 0.04%, 0.08% and 0.1% gel (Retin-A Micro, generics; Retin-A Micro Pump, generics) ▪ tazarotene 0.1% foam (Fabior) **Topical Acne and Rosacea Agents: Topical Retinoids and Combinations**	• Patient has tried and failed or experienced significant adverse effects from at least three formulary agents, including a clindamycin/benzoyl peroxide combination • No alternative formulary agents: ▪ Veltin and Ziana: Patient requires combination clindamycin/tretinoin 1.2% - 0.025% strength **Formulary Alternatives:** adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and sulfacetamide sodium/sulfur lotion
▪ dapsone 5% and 7.5% gel (Aczone) **Topical Acne and Rosacea Agents: Topical Dapsone Products**	• Patient is an adult female with inflammatory acne who has tried AND failed or experienced significant adverse effects from at least three formulary agents, including combination therapy with clindamycin and benzoyl peroxide **Formulary Alternatives:** adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and sulfacetamide sodium/sulfur lotion
▪ metronidazole 1% cream (Noritate) ▪ metronidazole 0.75% cream/ cleanser kit (Rosadan Cream Kit) ▪ metronidazole 0.75% gel/ cleanser kit (Rosadan Gel Kit) **Topical Acne and Rosacea Agents: Topical Metronidazole Products**	• Patient has tried and failed or experienced significant adverse effects from formulary topical metronidazole or azelaic acid **Formulary Alternatives:** metronidazole (1% gel; 0.75% lotion and 0.75% cream) and azelaic acid
▪ brimonidine tartrate 0.33% gel (Mirvaso) ▪ ivermectin 1% cream (Soolantra) **Topical Acne and Rosacea Agents: Miscellaneous Topical Agents**	• Use of preferred formulary agents is contraindicated • Patient has tried and failed metronidazole and azelaic acid • Patient has experienced significant adverse effects from metronidazole and azelaic acid • No formulary alternative ▪ Mirvaso: Patient has non-transient, persistent facial erythema of rosacea ▪ Soolantra: Patient has inflammatory lesions (papulopustular) of rosacea caused by Demodex mites **Formulary Alternatives:** metronidazole (metronidazole (1% gel; 0.75% lotion and 0.75% cream) and azelaic acid

Drug / Drug Class	Medical Necessity Criteria
▪ frovatriptan (Frova, generics) ▪ almotriptan (Axert, generics) ▪ sumatriptan/naproxen (Treximet) **Migraine Agents: Oral Triptans**	• The use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from the formulary alternatives • Formulary alternatives have resulted in therapeutic failure • The patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk **Formulary Alternatives:** rizatriptan (Maxalt, Maxalt MLT, generics), sumatriptan (Imitrex, generics), zolmitriptan (Zomig, Zomig ZMT, generics), eletriptan (Relpax), naratriptan (Amerge)
▪ sumatriptan 4 mg and 6 mg needle-free injection (Sumavel DosePro) ▪ sumatriptan 3 mg autoinjector (Zembrace SymTouch) **Migraine Agents: Injectable Triptans**	• The use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from the formulary alternatives • Formulary alternatives have resulted in therapeutic failure • The patient previously responded to nonformulary agent and changing to a formulary agent would incur unacceptable risk **Formulary Alternatives:** sumatriptan 4 mg and 6 mg injection (Imitrex STATdose, generics)
▪ sumatriptan nasal powder (Onzetra Xsail) **Migraine Agents: Nasal Triptans**	• The use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from the formulary alternatives • Formulary alternatives have resulted in therapeutic failure • The patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk **Formulary Alternatives:** sumatriptan nasal spray (Imitrex, generics), zolmitriptan nasal (Zomig Nasal Spray)
▪ sumatriptan transdermal (Zecuity) **Migraine Agents: Transdermal Triptans**	• The use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from the formulary alternatives • Formulary alternatives have resulted in therapeutic failure • The patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk **Formulary Alternatives:** any step-preferred oral, injectable, or nasal triptan
▪ naloxone autoinjector (Evzio) **Narcotic Antagonists Subclass**	• There is no formulary alternative. ▪ Patient caregiver is unable to administer Narcan Nasal Spray due to the following reason: _____ (the reason must be documented on the PA form; an acceptable reason is that the bystander/caregiver is a juvenile ▪ Patient has a nasal malformation/disfiguring injury that precludes use of Narcan Nasal Spray **Formulary Alternative:** naloxone nasal spray (Narcan Nasal Spray)
▪ pimavanserin (Nuplazid) **Atypical Antipsychotic**	• The use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from the formulary alternatives • Formulary alternatives have resulted in therapeutic failure • The patient previously responded to the nonformulary agent and changing to a formulary agent would incur unacceptable risk **Formulary Alternatives:** quetiapine IR, quetiapine ER, clozapine

Drug / Drug Class	Medical Necessity Criteria
▪ fluorouracil 4% cream (Tolak) **Topical Antineoplastic & Premalignant Lesions Agents**	• Formulary alternatives have resulted in therapeutic failure **Formulary Alternatives:** fluorouracil 5% cream (Efudex, generic)
▪ linagliptin/metformin XR (Jentadueto XR) **Non-Insulin Diabetes Mellitus: DPP-4 Inhibitors**	• The patient cannot take generic metformin XR and Tradjenta separately or Jentadueto IR **Formulary Alternatives:** Jentadueto IR, Tradjenta, Januvia, Janumet, Janumet XR
▪ halobetasol propionate 0.05% lotion (Ultravate) **High Potency Topical Corticosteroid**	• The use of ALL formulary alternatives is contraindicated • ALL formulary alternatives have resulted in therapeutic failure **Formulary Alternatives:** Topical clobetasol (Clobex, Olux, Temovate, generics), halobetasol (Halonate, generics), flurandrenolide (Cordran tape), desoximetasone (Topicort, generics), fluocinonide (non-Vanos products), betamethasone dipropionate augmented (Diprolene/-AF, generics)
▪ betamethasone dipropionate 0.05% spray (Sernivo) **Medium Potency Topical Corticosteroid**	• The use of ALL formulary alternatives is contraindicated • ALL formulary alternatives have resulted in therapeutic failure **Formulary Alternatives:** medium and high potency topical corticosteroids (See existing MN form for the actual formulary products)
▪ brivaracetam (Briviact) **Anticonvulsant and Anti-Mania Agents**	• The patient has experienced significant adverse effects from the formulary alternatives **Formulary Alternatives**: levetiracetam IR (Keppra, generics), levetiracetam ER (Keppra XR)
▪ oxycodone (Xtampza ER) **Narcotic Analgesics: Long-Acting High Potency Narcotic Analgesics**	• Patient has had therapeutic failure of at last two formulary long acting narcotic analgesics. • No alternative formulary agent due to swallowing difficulties or dysphagia **Formulary Alternatives:** oxycodone controlled release (Oxycontin, generic), and other long acting narcotic analgesics including fentanyl transdermal system (Duragesic, generics), morphine sulfate sustained release (MS Contin, generics)
▪ deferiprone oral solution (Ferriprox) **Iron Chelators**	• The patient has experienced significant adverse effects from the formulary alternatives **Formulary Alternatives:** deferiprone tablet (Ferriprox), deferasirox oral tablet for dispersion (Exjade), deferasirox tablet (Jadenu)

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• benzoyl peroxide 4% to 10% gel, foam, cleanser, towelette, kit (Benzac, Benzac Wash, BenzEFoam, BenzEFoam Ultra, BenzePrO, Benzoyl Peroxide, BP Foam, BPO, BP Wash, Brevoxyl, Brevoxyl-4, Brevoxyl-8, Desquam E, Desquam X, Inova, NuOx, PanOxyl, Panoxyl-10, PR Benzoyl Peroxide, Riax, Sulfoxyl Regular, SE BPO, Vanoxide-HC) **Topical Acne and Rosacea Agents: Legend Benzoyl Peroxide Products**	PA applies to both new and current users of legend benzoyl peroxide products. Manual PA Criteria: • Patient has a diagnosis of acne vulgaris, AND o Patient has failed over-the-counter benzoyl peroxide formulations (e.g., washes, gels, cleansers, lotions), OR o Patient has tried and failed at least 2 step-preferred topical acne agents (generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene or sulfacetamide sodium/sulfur). • PA expires in six months.
• clindamycin 1% kits (Clindacin ETZ; Clindacin PAC) • clindamycin 1% gel (Clindagel) • clindamycin/benzoyl peroxide 1.2% - 3.75% gel (Onexton) • clindamycin/benzoyl peroxide 1.2% - 5% gel/cream kit (Neuac Kit) • clindamycin/benzoyl peroxide 1.2% - 2.5% gel (Acanya) **Topical Acne and Rosacea Agents: Topical Antibiotics and Combinations**	All new and current users of Clindacin ETZ, Clindacin PAC, Clindagel, Onexton, Neuac Kit, and Acanya are required to try three step-preferred topical generic acne products first. Automated PA Criteria: • The patient has filled a prescription for at least three step-preferred topical generic acne products (generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene, or sulfacetamide sodium/sulfur) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or TRICARE Mail Order Pharmacy) during the previous 180 days. Manual PA Criteria: If automated PA criteria are not met, Clindacin ETZ, Clindacin PAC, Clindagel, Onexton, Neuac Kit, or Acanya will be approved if: • The patient has a diagnosis of acne vulgaris AND • Patient has tried and failed or experienced adverse effects to at least three step-preferred topical generic acne products, including combination therapy with clindamycin and benzoyl peroxide products. PA expires in 365 days.
• adapalene/benzoyl peroxide 0.1% - 2.5% gel (Epiduo) • adapalene/benzoyl peroxide 0.3% - 2.5% gel (Epiduo Forte) • clindamycin/tretinoin 1.2% - 0.025% gel (Veltin; Ziana, generics) • tretinoin microsphere 0.04%, 0.08%, and 0.1% gel (Retin-A Micro, generics; Retin-A Micro Pump, generics) • tazarotene 0.1% foam (Fabior)	All new and current users of Epiduo, Epiduo Forte, Veltin, Ziana, Retin-A Micro, Retin-A Micro Pump, Fabior, and generics are required to try three step-preferred topical generic acne products, including at least two different strengths of tretinoin. Automated PA Criteria: • The patient has filled a prescription for at least three step-preferred topical generic acne products (generic formulations of clindamycin, clindamycin/benzoyl peroxide, adapalene, or sulfacetamide sodium/sulfur), including at least two different strengths of tretinoin, at any MHS pharmacy point of service (MTFs, retail network pharmacies or TRICARE Mail Order Pharmacy) during the previous 180 days. Manual PA Criteria: If automated PA criteria are not met, the non step-preferred product will be approved if: • The patient has a diagnosis of acne vulgaris AND • Patient has tried and failed at least three step-preferred topical generic acne products, including at least two different strengths of tretinoin (generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene, or sulfacetamide sodium/sulfur) OR

Drug / Drug Class	Prior Authorization Criteria
Topical Acne and Rosacea Agents: Topical Retinoids and Combinations	• The patient has experienced an adverse reaction/inadequate response with formulary step-preferred topical tretinoin agents that is not expected to occur with the non-preferred product, OR • There is no other formulary agent alternative o For Epiduo, Epiduo Forte: The patient requires a combination topical adapalene/benzoyl peroxide o For Veltin or Ziana: The patient requires this particular strength of combination topical tretinoin 0.025%/clindamycin 1.2% PA expires in 365 days.
• azelaic acid 20% cream (Azelex) • azelaic acid 15% gel, foam, kit (Finacea) **Topical Acne and Rosacea Agents: Topical Azelaic Acid Products**	All new and current users of Azelex and Finacea are required to try three step-preferred topical generic acne products (generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene, or sulfacetamide sodium/sulfur) or metronidazole). <u>Automated PA Criteria:</u> • The patient has filled a prescription for at least three step-preferred topical generic products (generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene, or sulfacetamide sodium/sulfur) at any MHS pharmacy point of service (MTFs, retail network pharmacies or TRICARE Mail Order Pharmacy) during the previous 180 days. <u>Manual PA Criteria:</u> If automated PA criteria are not met, Azelex or Finacea will be approved if: • For Azelex: The patient has a diagnosis of acne vulgaris or rosacea AND o Patient is pregnant, OR o Patient has tried and failed at least three preferred formulary topical acne agents, including combination therapy with clindamycin and benzoyl peroxide • For Finacea: Patient is pregnant, OR o Patient has tried and failed, or cannot tolerate a step-preferred topical generic metronidazole product (1% gel, or 0.75% lotion or 0.75% cream) PA expires in 365 days.
• dapsone 5% gel (Aczone) • dapsone 7.5% gel (Aczone) **Topical Acne and Rosacea Agents: Topical Dapsone Products**	All new and current users of Aczone are required to try three step-preferred topical generic acne products, including combination therapy with clindamycin and benzoyl peroxide. <u>Automated PA Criteria:</u> • The patient has filled a prescription for at least three step-preferred topical generic acne products (generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene or sulfacetamide sodium/sulfur) at any MHS pharmacy point of service (MTFs, retail network pharmacies or TRICARE Mail Order Pharmacy) during the previous 180 days. <u>Manual PA Criteria</u>: If automated PA criteria are not met Aczone will be approved if: • The patient has a diagnosis of acne vulgaris, AND o Patient is an adult female with a diagnosis of inflammatory acne, AND o The patient has tried and failed at least three step-preferred topical generic acne products, including combination therapy with clindamycin and benzoyl peroxide. PA expires in 365 days.

Drug / Drug Class	Prior Authorization Criteria
• metronidazole 1% cream (Noritate) • metronidazole 0.75% cream/ cleanser kit (Rosadan Cream Kit) • metronidazole 0.75% gel/ cleanser kit (Rosadan Gel Kit) **Topical Acne and Rosacea Agents: Topical Metronidazole Products**	All new and current users of Noritate and Rosadan are required to try one generic topical step-preferred metronidazole product (1% gel, or 0.75% lotion or 0.75% cream). Automated PA Criteria: • The patient has filled a prescription for one generic topical step-preferred metronidazole product (1% gel, or 0.75% lotion or 0.75% cream) at any MHS pharmacy point of service (MTFs, retail network pharmacies or TRICARE Mail Order Pharmacy) during the previous 180 days. Manual PA Criteria: If automated PA criteria are not met, Noritate or Rosadan will be approved if: • The patient has a diagnosis of rosacea, AND • The patient has tried and failed one generic step-preferred formulary topical metronidazole product (1% gel, or 0.75% lotion or 0.75% cream). PA expires in 365 days.
• brimonidine tartrate 0.33% gel (Mirvaso) • ivermectin 1% cream (Soolantra) **Topical Acne and Rosacea Agents: Miscellaneous Topical Agents**	All new and current users of Mirvaso and Soolantra are required to try one generic topical step-preferred metronidazole product (1% gel, or 0.75% lotion or 0.75% cream). Automated PA Criteria: • The patient has filled a prescription for one generic topical step-preferred metronidazole product (1% gel, or 0.75% lotion or 0.75% cream) at any MHS pharmacy point of service (MTFs, retail network pharmacies or TRICARE Mail Order Pharmacy) during the previous 180 days. Manual PA Criteria: If automated PA criteria are not met, Mirvaso or Soolantra will be approved if: • Patient is at least 18 years of age and has the following diagnosis: o For Mirvaso: Patient has non-transient, persistent facial erythema of rosacea o For Soolantra: Patient has inflammatory lesions (papulopustular) of rosacea caused by Demodex mites **AND** o Patient has tried and failed one generic step-preferred formulary topical metronidazole product (1% gel, or 0.75% lotion or 0.75% cream). **AND** o Patient has tried and failed topical azelaic acid. PA expires in 365 days.
• naratriptan tablets (Amerge, generic) • almotriptan tablets (Axert, generics) • frovatriptan tablets (Frova, generics) • sumatriptan/naproxen tablets (Treximet) **Migraine Agents: Oral Triptan Subclass**	All new users of naratriptan (Amerge, generics), almotriptan (Axert, generics), frovatriptan (Frova generics), and sumatriptan/naproxen (Treximet) tablets are required to try two different step-preferred generic oral tablets or ODT triptan formulations or Relpax tablets first (e.g., two products with differing active ingredients/chemical entities). Step-preferred oral and ODT triptan formulations include sumatriptan, rizatriptan, zolmitriptan, and Relpax. Automated PA Criteria: • The patient has filled a prescription for at least two different step-preferred oral/ODT triptans with different active ingredients at any MHS pharmacy point of service (MTFs, retail network pharmacies, or the TRICARE Mail Order pharmacy) during the previous 365 days. Manual PA Criteria: If automated PA criteria are not met, naratriptan, almotriptan, frovatriptan, or Treximet will be approved if: • The patient has experienced an adverse reaction, has had an inadequate response, to, or has a medical contraindication to two different (e.g., two different chemical entities) step-preferred oral/ODT triptan formulations of Relpax,

Drug / Drug Class	Prior Authorization Criteria
	rizatriptan, sumatriptan, or zolmitriptan) that is not expected to occur with the non step-preferred product (naratriptan, almotriptan, frovatriptan, or Treximet). Prior Authorization does not expire.
• zolmitriptan (Zomig Nasal Spray) • sumatriptan nasal powder (Onzetra Xsail) **Migraine Agents: Nasal Triptan Subclass**	All new users of zolmitriptan nasal spray (Zomig Nasal Spray) or sumatriptan nasal powder (Onzetra Xsail) are required to try generic sumatriptan nasal spray first. Automated PA Criteria: • The patient has filled a prescription for generic sumatriptan nasal spray at any MHS pharmacy point of service (MTFs, retail network pharmacies, or the TRICARE Mail Order Pharmacy) during the previous 365 days. Manual PA Criteria: If automated PA criteria are not met, Zomig Nasal Spray or Onzetra Xsail will be approved if: • The patient has experienced an adverse reaction, has had an inadequate response to, or has a medical contraindication to generic sumatriptan nasal spray that is not expected to occur with the non step-preferred product (Zomig Nasal Spray or Onzetra Xsail). Prior Authorization does not expire.
• sumatriptan 4 mg/6 mg needle-free injection (Sumavel DosePro) • sumatriptan 3 mg autoinjector (Zembrace SymTouch) **Migraine Agents: Injectable Triptan Subclass**	All new users of sumatriptan 4 mg/6 mg needle-free injection (Sumavel DosePro), or sumatriptan 3 mg autoinjector (Zembrace SymTouch) are required to try sumatriptan injection 4 mg/6 mg (Imitrex STATdose, generics) first. Automated PA Criteria: • The patient has filled a prescription for sumatriptan injection 4 mg/6 mg (Imitrex STATdose, generics) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or the TRICARE Mail Order Pharmacy) during the previous 365 days. Manual PA Criteria: If automated PA criteria are not met, Sumavel DosePro or Zembrace SymTouch will be approved if: • The patient has experienced an adverse reaction, has had an inadequate response, to, or has a medical contraindication to sumatriptan injection 4 mg/6 mg (Imitrex STATdose, generics) that is not expected to occur with the non step-preferred product (Sumavel DosePro or Zembrace SymTouch). Prior Authorization does not expire.
• sumatriptan transdermal system (Zecuity) **Migraine Agents: Transdermal Triptan Subclass**	All users of sumatriptan transdermal (Zecuity), if it is reintroduced to the market, are required to try two different step-preferred triptans with different active ingredients, regardless of dosage formulation first. Automated PA Criteria: • The patient has filled a prescription for at least two different step-preferred triptans with different active ingredients, regardless of dosage formulation, at any MHS pharmacy point of service (MTFs, retail network pharmacies, or the TRICARE Mail Order Pharmacy) during the previous 365 days. Manual PA Criteria: If automated PA criteria are not met, Zecuity will be approved if: • The patient has experienced an adverse reaction, has had an inadequate response to, or has a medical contraindication to two different step-preferred triptans with different active ingredients, regardless of dosage formulation, that is not expected to occur with Zecuity. Prior Authorization does not expire.

Drug / Drug Class	Prior Authorization Criteria
• pimavanserin (Nuplazid) **Atypical Antipsychotics (AAPs)**	Manual PA criteria apply to all new users of pimavanserin. Manual PA Criteria: Nuplazid is approved if all of the following criteria are met: 1. Patient is age ≥ 18 AND 2. Patient has a diagnosis of hallucinations and/or delusions associated with Parkinson's disease psychosis AND 3. Prescribing physician has attempted to adjust Parkinson's disease medications in order to reduce psychosis without worsening motor symptoms prior to requesting pimavanserin AND 4. Mini-Mental State Examination (MMSE) score ≥ 21 Prior Authorization does not expire. Non-FDA approved uses are not approved.
• obeticholic acid (Ocaliva) for primary biliary cholangitis (PBC) **Miscellaneous**	Manual PA criteria apply to all new users of obeticholic acid (Ocaliva). Manual PA criteria: Ocaliva is approved for 6 months for Primary Biliary Cholangitis (PBC) for initial therapy if the patient meets the following criteria (i, ii, iii, and iv): i. Patient is age ≥ 18 years old; AND ii. Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician; AND iii. Patient has a diagnosis of PBC as defined by at least TWO of the following criteria (a, b, and/or c) according to the prescribing physician: a. alkaline phosphatase (ALP) elevated above the upper limit of normal (ULN) as defined by normal laboratory reference values; AND/OR b. positive anti-mitochondrial antibodies (AMAs); AND/OR c. histologic evidence of PBC from a liver biopsy; AND iv. Patient meets ONE of the following criteria (a or b): a. Patient has been receiving ursodiol therapy (e.g., ursodiol generics, Urso 250,Urso Forte, Actigall) for ≥ 1 year and has had an inadequate response OR b. The patient is unable to tolerate ursodiol therapy. Renewal criteria: Ocaliva is approved indefinitely for PBC for continuation therapy if the patient meets the following criteria (i, ii, iii, and iv): Patients Currently Receiving Therapy (renewal criteria): approve indefinitely if the patient meets the following criteria (i, ii, and iii): i. Age ≥ 18 years old; AND ii. Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician; AND iii. Patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC: e.g., ALP, bilirubin, gamma-glutamyl transpeptidase (GGT), aspartate aminotransferase (AST), alanine aminotransferase (ALT) levels). Expiration date: 6 months or indefinite depending on initial or renewal criteria Non FDA-approved uses are not approved.
• Deferiprone oral solution and oral tablets (Ferriprox) **Iron Chelators**	Manual PA criteria apply to new users of deferiprone oral solution and oral tablets (Ferriprox). Manual PA Criteria: Ferriprox will be approved if:: • The patient has tried Exjade or Jadenu and was unable to tolerate due to adverse effects. Prior Authorization does not expire.

Drug / Drug Class	Prior Authorization Criteria
• linagliptin / metformin XR (Jentadueto XR) Non-Insulin Diabetes Mellitus – DPP-4 Inhibitors	Jentadueto XR will be non step-preferred, similar to the other non step-preferred DPP-4 inhibitors. All new and current users of a DPP-4 inhibitor are required to try metformin or a sulfonylurea before receiving a DPP-4 inhibitor. Additionally, sitagliptin-containing products (Januvia, Janumet, Janumet XR) are the preferred agents in the DPP-4 inhibitors subclass. New users of a DPP-4 inhibitor, including Jentadueto XR, must try a sitagliptin product first. Automated PA Criteria • The patient has filled a prescription for metformin or a sulfonylurea at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. • The patient has received a prescription for a preferred DPP-4 inhibitor (Januvia, Janumet, or Janumet XR) 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, Jentadueto XR is approved if: • The patient has had an in adequate response to metformin or sulfonylurea. • The patient has experienced any of the following adverse events while receiving a sulfonylurea: hypoglycemia requiring medical treatment. • The patient has experienced an adverse event with sitagliptin-containing products, which is not expected to occur with linagliptin-containing products. • The patient has had an inadequate response to a sitagliptin-containing product. • The patient has a contraindication to sitagliptin. PA does not expire.

<table>
<tr><th>Drug / Drug Class</th><th>Prior Authorization Criteria</th></tr>
<tr><td>

- sofosbuvir/velpatasvir (Epclusa)

HCV Direct-Acting Antivirals

</td><td>

- New users of sofosbuvir/velpatasvir (Epclusa) are required to undergo the PA process.
- Current users are not affected by PA; they can continue therapy uninterrupted.
- 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.

<u>Manual PA Criteria</u>:

- Age ≥ 18
- Has laboratory evidence of chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection
  - State the HCV genotype and HCV RNA viral load on the PA form.
- Sofosbuvir/velpatasvir (Epclusa) is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

<u>Treatment Regimens and Duration of Therapy</u>

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

Table of Recommended Treatment Regimens and Duration of Therapy for sofosbuvir/velpatasvir (Epclusa)

<table>
<tr><th>Geno-type</th><th>Patient Population</th><th>Treatment</th><th>Duration</th></tr>
<tr><td rowspan="2">1-6</td><td>Patients without cirrhosis and with compensated (Child-Pugh A) cirrhosis</td><td>SOF / VEL</td><td>12 weeks</td></tr>
<tr><td>Patients with decompensated cirrhosis (Child-Pugh B and C)</td><td>SOF / VEL + RBV</td><td>12 weeks</td></tr>
<tr><td colspan="4">A dosage recommendation cannot be made for patients with severe renal impairment (GFR < 30 mL/min) or with end stage renal disease (ESRD)</td></tr>
</table>

Regimen other than those listed above: Explain the rationale for treatment and duration of therapy.

Consult the AASLD/IDSA HCV guidelines for new updates.

</td></tr>
<tr><td>

- Butalbital/ acetaminophen/ caffeine oral liquid (Vanatol LQ)

Analgesics and Combinations

</td><td>

All new and current users of butalbital/ acetaminophen/ caffeine (Vanatol LQ) are required to undergo manual prior authorization criteria.

<u>Manual PA Criteria</u>: Coverage will be approved if:

- Patient cannot tolerate generic Fioricet oral tablet or capsule formulations due to documented swallowing difficulties.

Prior Authorization expires in 6 months.
Non FDA-approved uses are not approved.

</td></tr>
</table>

Drug / Drug Class	Prior Authorization Criteria
• suvorexant (Belsomra) **SED-1s**	**The current automated prior authorization (step therapy) will be removed.** Manual PA criteria apply to all new users of Belsomra. Manual PA Criteria: Belsomra is approved if: • Patient has documented diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance AND • Non-pharmacologic therapies have been inadequate in improving functional impairment, including but not limited to relaxation therapy, cognitive therapy, sleep hygiene AND • Patient has tried and failed or had clinically significant adverse effects to zolpidem extended-release AND eszopiclone • Patient has no current or previous history of narcolepsy AND • Patient has no current or previous history of drug abuse. Prior Authorization does not expire. Non FDA-approved uses are not approved.
• somatropin (Zomacton, Genotropin, Genotropin MiniQuick, Humatrope, Norditropin FlexPro, Nutropin AQ NuSpin, Nutropin AQ Pen, Omnitrope, Saizen, Serostim, Zorbtive) **Growth-Stimulating Agents (GSAs)**	Manual PA criteria apply to all new and current users of growth-stimulating agents. The following drugs will be added to the existing PA form for the GSAs: Nutropin AQ NuSpin, Nutropin AQ Pen, Genotropin, Humatrope, Omnitrope, Saizen Manual PA Criteria: Criteria #5 - Use for Idiopathic Short Stature is not covered for: Nutropin AQ NuSpin, Nutropin AQ Pen, Genotropin, Humatrope, Omnitrope, Saizen Prescriptions for newly approved GSAs will be subject to the PA criteria currently in place for the class. Prior Authorization expiration: 365 days
• diclofenac sodium 2% topical solution (Pennsaid) **Topical Pain Agents**	Manual PA criteria apply to all new and current users of diclofenac sodium 2% topical solution. Manual PA criteria: Pennsaid 2% topical solution is approved if: • Patient has a documented diagnosis of osteoarthritis of the knee AND o Patient is unable to take oral NSAIDs or acetaminophen due to documented intolerance, contraindication, or adverse reaction OR o The patient is ≥ 75 years old AND • The patient is unable to use preferred generic diclofenac 1.5% topical solution AND diclofenac 1.0% topical gel (Voltaren generics) due to documented inadequate effects. Prior Authorization does not expire. Non-FDA approved uses are not approved.

Drug / Drug Class	Prior Authorization Criteria
~~• **Ibandronate (Boniva, generics)**~~ • risedronate (Actonel) • risedronate delayed release (Atelvia) • alendronate effervescent tablet (Binosto) • alendronate with vitamin D (Fosamax Plus D) **Oral Bisphosphonates**	Ibandronate is now step-preferred. **Changes are highlighted in bold and strikethrough.** PA criteria apply to ~~**all new users of ibandronate, and**~~ all new and current users of Actonel, Atelvia, Binosto, and Fosamax Plus D. Automated PA criteria: The patient has filled a prescription for alendronate or **ibandronate** at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND Manual PA criteria ~~**ibandronate**~~, Actonel, Atelvia, Binosto, and Fosamax Plus D is approved (e.g., trial of alendronate is NOT required) if: • Patient has experienced any of the following issues with alendronate, which is not expected to occur with the non-preferred oral bisphosphonates: o Intolerable adverse effects » ~~**Patient requires once monthly ibandronate or Actonel 150 mg due to gastrointestinal adverse events from alendronate weekly dosing**~~ » Patient has experienced significant adverse effects from formulary agents » For Binosto: No alternative formulary agent and patient has swallowing difficulties and cannot consume 8 oz of water and has no sodium restrictions » For Fosamax Plus D: No alternative formulary agent and patient cannot take alendronate and vitamin D separately o Contraindication

Appendix D—Table of Quantity Limits

Drug / Drug Class	Quantity Limits
• sumatriptan nasal powder (Onzetra Xsail) **Migraine Agents: Nasal Triptans**	▪ Retail: 8 pouches / 30 days ▪ MTF and Mail: 24 pouches / 90 days ▪ Each pouch has 2 nosepieces that provide one dose
• sumatriptan 3 mg autoinjector (Zembrace SymTouch) **Migraine Agents: Injectable Triptans**	▪ Retail: 8 autoinjectors (2 cartons) / 30 days ▪ MTF & Mail: 24 autoinjectors (3 cartons) / 90 days ▪ Each carton contains 4 autoinjectors
• sumatriptan transdermal system (Zecuity) **Migraine Agents: Transdermal Triptans**	▪ Retail: 4 systems (1 carton) / 30 days ▪ MTF & Mail: 12 systems (3 cartons) / 90 days ▪ Each system is contained in a sealed pouch, with 4 systems per carton
• naloxone nasal spray (Narcan Nasal Spray) **Narcotic Antagonists Subclass**	▪ MTF, Mail Order Pharmacy, and Retail Network: 2 cartons (2 nasal spray devices/carton) ▪ No refills allowed; one fill per prescription
• naloxone autoinjector (Evzio) **Narcotic Antagonists Subclass**	▪ MTF, Mail Order Pharmacy, and Retail Network: 1 carton (2 Evzio autoinjectors and one trainer/carton) ▪ No refills allowed; one fill per prescription
• venetoclax (Venclexta) **Oral Oncologic Agent**	For the 100mg: (unit dose/bottle) ▪ Retail: 120 tabs / 30 days ▪ MTF and Mail Order: 240 tabs /60 days ▪ No refills allowed for the starter packs
• cabozantinib (Cabometyx) **Oral Oncologic Agent**	▪ Retail: 30 tabs / 30 days ▪ MTF and Mail Order: 45 tabs / 45 days
• sofosbuvir / velpatasvir (Epclusa) **Hepatitis C Virus (HCV) Direct-Acting Antiviral Agents (DAAs) Subclass**	▪ Retail, MTF, and Mail Order: 28 tablets / 28 days
• ombitasvir / paritaprevir / ritonavir / dasabuvir (Viekira XR) **HCV DAAs Subclass**	▪ Retail, MTF, and Mail Order: 84 tablets / 28 days
• lidocaine 5% patch (Lidoderm) **Topical Pain Agents**	▪ Retail: 30 patches / 30 days ▪ MTF and Mail Order: 90 patches / 90 days
• Cinryze, Berinert, Ruconest, Firazyr, Kalbitor **Hereditary Angioedema (HAE) Agents**	▪ Retail (30 days) / MTF/ Mail Order (90 days) o Cinryze: Retail: 20 vials; MTF and Mail: 60 vials o Berinert: Retail: 30 vials; MTF and Mail: 90 vials o Ruconest: Retail: 60 vials; MTF and Mail: 180 vials o Firazyr: Retail: 4 syringes; MTF and Mail: 12 syringes o Kalbitor: Retail 24 vials; MTF and Mail: 72 vials
• methylnaltrexone tab (Relistor) vials **Drugs for Opioid-Induced Constipation**	Previous requirement limiting the Relistor 12 mg / 0.6 mL vials to one fill per prescription removed

Appendix E—Table of Innovator Drugs: Formulary Recommendations

Generic (Trade)	UF Class	Comparators	Indications	Place in Therapy	Recommended UF Status
antihemophilic factor VIII (recombinant) injection (Afstyla)	Antihemophilic Agents	Eloctate	Hemophilia	• Additional Factor VIII with potential for reduced dosing frequency	• UF
betamethasone dipropionate 0.05% spray (Sernivo)	Topical Corticosteroid – Medium Potency	Betamethasone 0.05% (generics) lotion, cream, oint, gel	Plaque psoriasis in adults	• 505 (b) approval – Spray • Effective in treating plaque psoriasis • Sprays cover larger areas • Within potency classes (high, medium, low) and vehicle, the topical steroids are highly interchangeable • UF has several generic medium potency topical steroids options including sprays	• NF
brivaracetam tablets and oral solution (Briviact)	Anticonvulsant and Anti-Mania	Keppra IR and XR and generics	Adjunctive therapy in the treatment of partial-onset seizures in pts ≥16 yo	• Adjuvant for partial onset seizures in patients 16 or older	• NF
cabozantinib (Cabometyx)	Oral Oncologic Agent	Inlyta, Nexavar, Sutent, Votrient, Afinitor	Renal cell carcinoma (RCC)	• Small molecule tyrosine kinase (TK) inhibitor targeting multiple pathways • For advanced RCC patients who have received at least one prior antiangiogenic therapy • National Cancer Care Network (NCCN) Category 1 for subsequent therapy in RCC	• UF
deferiprone oral solution (Ferriprox)	Iron Chelators	Exjade, Jadenu	Iron chelators, iron overdose	• Provides an additional oral solution option in treatment of iron overload • TID dosing, agranulocytosis • PA applies	• NF

Generic (Trade)	UF Class	Comparators	Indications	Place in Therapy	
emtricitabine/ tenofovir alafenamide (Descovy)	Antiretrovirals	Truvada	HIV	• Alternative NNRTI-based regimen option only for patients with pre-treatment HIV RNA <100,000 copies/ml and CD4 cell count >200 cells/mm^3	• UF
fluorouracil 4% cream (Tolak)	Topical Antineoplastic & Premalignant Lesions Agents	Generic FU 5% cream, Efudex 5% cream	Topical treatment of actinic keratosis of the face	• Approved via NDA with 2 randomized, double-dummy 4-week studies with Tolak versus vehicle • No head-to-head studies versus 5% cream • Class not previously reviewed • Efudex 5% cream approved in 1970 • 5% topical solution generic also available	• NF
halobetasol propionate 0.05% lotion (Ultravate)	Topical Corticosteroid - High Potency	Generic halobetasol propionate 0.05% cream and ointment	Plaque psoriasis in adults	• 505 (b) approval – Lotion • Ultravate lotion is effective in treating plaque psoriasis • Gels, lotions, and solutions: greaseless, drying, and easier to apply to hairy area • Within potency classes (high, medium, low) and vehicle, the topical steroids are highly interchangeable • UF has several generic high potency topical steroids options including lotions	• NF
linagliptin/ metformin XR (Jentadueto XR)	Non-Insulin Diabetes Drugs DPP-4 Inhibitor	Jentadueto, Tradjenta, Metformin XR, Janumet XR	Diabetes	• Once daily metformin XR combination • Step therapy exists in this class • Sitagliptin family is BCF and step-preferred • Linagliptin family is UF and non step-preferred	• NF
nitisinone oral suspension (Orfadin)	Miscellaneous	No clinical comparators	Hereditary type 1 tyrosinemia	• Treatment is standard of care for high mortality genetic disease • Capsules, approved in 2002, can be used in suspension	• UF
obeticholic acid (Ocaliva)	Miscellaneous	No clinical comparators	Primary biliary cholangitis (PBC)	• First in class farnesoid X receptor (FXR) agonist • Used in combo with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA • PA applies	• UF

Generic (Trade)	UF Class	Comparators	Indications	Place in Therapy	Recommended UF Status
oxycodone extended-release capsules (Xtampza ER)	Narcotic Analgesics and Combinations	Oxycontin, generics	For pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate	• 505(b)(2) approval • Abuse-deterrent oxycodone • Capsule strengths may cause dosing confusion	• NF
pimavanserin (Nuplazid)	Atypical Antipsychotic (AAP)	Quetiapine Clozapine	Hallucinations and delusions associated with Parkinson's disease psychosis	• First AAP approved for psychosis in Parkinson's disease • 5-HT_{2A} inverse agonist which lacks dopamine receptor interaction and the associated motor function effects • FDA agreed in 2013 to approve NDA on 1 positive study despite three failed trials • Black Box Warning like other AAPs, many drug interactions • Use after quetiapine and clozapine according to current standard of care • No head-to-head studies with other AAPs • PA applies	• NF
sofosbuvir/ velpatasvir (Epclusa)	HCV Direct-Acting Antiviral (DAA)	Zepatier, Viekira Pak, Harvoni	Pangenomic HCV	• Pangenomic, 12-week and almost completely ribavirin (RBV)-free regimens • Sustained virologic response (SVR) >95% in all genotypes • RBV added only in decompensated cirrhosis • Advancement in treating genotypes 2, 3, and decompensated cirrhosis • Simplified regimen • PA applies	• UF
venetoclax (Venclexta)	Oral Oncologic Agent	Zydelig, Imbruvica	Chronic lymphocytic leukemia (CLL)	• 1st selective inhibitor of BCL-2 protein for CLL • Indicated for those who have failed one prior therapy • Approval contingent on additional confirmatory studies	• UF

Appendix F—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 2016	**Topical Acne & Rosacea Agents**	Subclass not previously reviewed	▪ Clindamycin phosphate 1% gel, cream, lotion and solution (Cleocin T, generics) ▪ clindamycin/benzoyl peroxide 1.2% - 5% gel (Duac, generics) ▪ metronidazole 1% gel (MetroGel, generics) ▪ sulfacetamide sodium/sulfur 10% lotion (Klaron, generics) tretinoin 0.025% and 0.05% cream (Retin-A, generics)	**UF step-preferred** ▪ adapalene 0.1% lotion, gel, cream; 0.3% gel (Differin, generics) ▪ clindamycin 1% foam (Evoclin, generics) ▪ clindamycin 1% foam, med swab (Cleocin T, generics) ▪ clindamycin/benzoyl peroxide 1% - 5% gel (Benzaclin, generics) ▪ clindamycin/ benzoyl peroxide 1% - 5% gel kit (Duac CS (Kit) ▪ metronidazole 0.75% cream & 0.75% lotion (MetroCream, MetroLotion generics) ▪ tretinoin 0.01%, 0.025% gel (Retin-A, generics) ▪ tretinoin 0.025% gel, cream (Avita, generics) ▪ tretinoin 0.1% cream, liquid (Retin-A, generics) ▪ tretinoin 0.0375%, 0.075% cream (Tretin-X, generics) ▪ tretinoin 0.05% gel (Atralin, generics) **UF non step-preferred** ▪ azelaic acid 20% cream (Azelex) ▪ azelaic acid 15% gel, foam, kit (Finacea) ▪ clindamycin/benzoyl peroxide 1.2% - 2.5% gel (Acanya)	**NF non step-preferred** ▪ adapalene/ benzoyl peroxide 0.1% - 2.5% gel (Epiduo) ▪ adapalene/ benzoyl peroxide 0.3% - 2.5% gel (Epiduo Forte) ▪ brimonidine tartrate 0.33% gel (Mirvaso) ▪ clindamycin 1% kits (Clindacin ETZ/PAC) ▪ clindamycin 1% gel (Clindagel) ▪ clindamycin/ benzoyl peroxide 1.2% - 3.75% gel (Onexton) ▪ clindamycin/ benzoyl peroxide 1.2% - 5% gel/cream kit (Neuac Kit) ▪ clindamycin/ tretinoin 1.2% - 0.025% gel (Veltin; Ziana, generics) ▪ dapsone 5% and 7.5% gel (Aczone) ▪ ivermectin 1% cream (Soolantra) ▪ metronidazole 1% cream (Noritate) ▪ metronidazole 0.75%	Pending signing of the minutes / 90 days The effective date is Feb 8, 2017	▪ Step therapy applies to the class See Appendix C.	▪ Two additions to BCF: Duac, and MetroGel generics ▪ Non step-preferred: Acanya, Azelex, Finacea ▪ Azelex is indicated for acne ▪ Finacea is indicated for rosacea

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
					cream/cleanser kit (Rosadan Cream Kit) ▪ metronidazole 0.75% gel/cleanser kit (Rosadan Gel Kit) ▪ tretinoin microsphere 0.04%, 0.08%, and 0.1% gel (Retin-A Micro, Retin-A Micro Pump, and generics) ▪ tazarotene 0.1% foam (Fabior)			
Aug 2016	**Migraine Agents Triptans**	UF class previously reviewed Jun 2008	▪sumatriptan tablets (Imitrex, generics) ▪rizatriptan tablets and ODT (Maxalt, Maxalt MLT, generics) ▪zolmitriptan tablets and ODT (Zomig, Zomig ZMT, generics)	**UF – Step-preferred:** ▪ sumatriptan nasal spray (Imitrex, generics) ▪ sumatriptan 4 mg and 6 mg injection (Imitrex STATdose, generics) ▪ eletriptan (Relpax) **UF – Non Step-preferred**: ▪ naratriptan (Amerge, generics) ▪ zolmitriptan nasal (Zomig Nasal Spray)	**NF and non step-preferred** ▪ sumatriptan/ naproxen(Treximet) ▪ almotriptan (Axert, generics) ▪ frovatriptan (Frova, generics) ▪ sumatriptan nasal powder (Onzetra Xsail) ▪ sumatriptan 4 mg and 6 mg needle-free injection (Sumavel DosePro) ▪ sumatriptan3mg autoinjector (Zembrace SymTouch) ▪ sumatriptan transdermal system (Zecuity)	Pending singng of the minutes / 90 days The effective date is Feb 8, 2017	▪Step therapy applies to new users of non-preferred oral, nasal, injectable, and transdermal formulations See Appendix C ▪QL for Onzetra Xsail, Zembrace SymTouch, and Zecuity See Appendix D	▪Note: sumatriptan 4 mg/6 mg injection (Imitrex STATdose) will be added to the BCF once multi-source cost-effective generics are available ▪Note zolmitriptan oral tabs & ODT were added to the BCF; eletriptan (Relpax) was made UF and step-preferred; naratriptan (Amerge) was made UF and non step-preferred; and Treximet was made NF.

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 2016	**Narcotic Antagonists**	UF class review	▪naloxone nasal spray (Narcan Nasal Spray)		▪ naloxone autoinjector (Evzio)	Pending signing of the minutes / 60 days The effective date is Jan 11, 2017	▪QLs for both products. See Appendix D ▪No refills allowed; 1 fill per prescription	-

TRICARE Formulary Search tool: http://www.express-scripts.com/tricareformulary

BCF: Basic Core Formulary
ECF: Extended Core Formulary
ER: extended release
IR: immediate release

Appendix G—Table of Abbreviations

5-ARIs	5-alpha reductase inhibitors
AAP	Atypical Antipsychotic Drug Class
ALP	alkaline phosphatase
ALT	alanine aminotransferase
AMA	anti-mitochondrial antibodies
AST	aspartate aminotransferase
BAP	Beneficiary Advisory Panel
BCF	Basic Core Formulary
BIA	budget impact analysis
BID	twice daily
BLA	Biologic License Application
BPH	benign prostatic hypertrophy
CD	controlled delivery
CFR	Code of Federal Regulations
CLL	chronic lymphocytic leukemia
CMA	cost minimization analysis
DAA	direct acting antiviral agent
DCS	Defense Collaboration Services
DHA	Defense Health Agency
DoD	Department of Defense
DPP-4	dipeptidyl peptidase-4 inhibitors
DR	delayed release
ECF	Extended Core Formulary
EMMPI	The Expanded MTF/Mail Pharmacy Initiative
ER/LA	extended release/long acting
FDA	U.S. Food and Drug Administration
FY	fiscal year
GCN	generic code number
GGT	gamma-glutamyl transpeptidase
GLP1RA	glucagon-like peptide-1 receptor agonist
GSA	Growth-Stimulating Agents Subclass
HCV	hepatitis C virus
HoFH	homozygous familial hypercholesterolemia
IM	intramuscular
IR	immediate release
JDF	Joint Deployment Formulary
LDL	low-density lipoprotein
MHS	Military Health System
MN	medical necessity
MTF	Military Treatment Facility
NCCN	National Cancer Care Network
NDA	New Drug Application
NDAA	National Defense Authorization Act
NF	nonformulary
NSAIDs	non-steroidal anti-inflammatory drugs
ODT	orally dissolving tablet

OIC	opioid-induced constipation
OTC	over-the-counter
P&T	Pharmacy and Therapeutics
PA	prior authorization
PBC	primary biliary cholangitis
PMDD	premenstrual dysphoric disorder
POD	Defense Health Agency Pharmacy Operations Division
POS	point of service
PCSK-9	proprotein convertase subtilisin/kexin type 9 inhibitors
QD	once daily
QLs	quantity limits
RBV	ribavirin
RCC	renal cell carcinoma
SQ	subcutaneous
SSRIs	selective serotonin reuptake inhibitors
SVR	sustained virologic response
TAA	Trade Agreements Act
TIBs	targeted immunomodulatory biologics
TK	tyrosine kinase
UCDA	ursodeoxycholic acid
UF	Uniform Formulary
ULN	upper limit of normal
VA	U.S. Department of Veterans Affairs
XR	extended release