DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE

MINUTES AND RECOMMENDATIONS

August 2018

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on August 8 and 9, 2018, 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 2018 Minutes—**Mr. Guy Kiyokawa, Deputy Director, DHA, approved the minutes from the May 2018 DoD P&T Committee meeting on August 6, 2018.

III. REQUIREMENTS

All clinical and cost evaluations for new drugs, including newly approved drugs reviewed according to 32 Code of Federal Regulations (CFR) 199.21(g)(5), and full drug class reviews included, but were not limited to, the requirements stated in 32 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. Corticosteroids-Immune Modulators: Atopic Dermatitis Subclass

Background—The P&T Committee evaluated the relative clinical effectiveness of the atopic dermatitis subclass, which has not been previously reviewed for formulary placement. The products in the subclass include tacrolimus 0.03% and 0.01% ointment (Protopic, generics), pimecrolimus 1% cream (Elidel), crisaborole 2% ointment (Eucrisa), and dupilumab injection (Dupixent). Other drugs used for treating atopic dermatitis, such as topical corticosteroids and systemic immunomodulatory agents were not included in this review.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 0 absent) the following:

Professional Treatment Guidelines for Atopic Dermatitis

- The American Academy of Dermatology (AAD) 2014 guidelines recommend topical emollients as the basis for atopic dermatitis therapy. When additional intervention is required, topical corticosteroids are considered first-line therapies for mild to severe atopic dermatitis, while topical calcineurin inhibitors (pimecrolimus and tacrolimus) are considered second-line after topical corticosteroids.
- Concerns regarding adverse effects with topical corticosteroids include adrenal suppression, striae, and skin atrophy. Evidence from large systematic reviews show that mild to moderate potency corticosteroids pose little to no risk to patients when used appropriately. However, "steroid phobia" can affect patient compliance.
- For severe to uncontrolled atopic dermatitis, systemic therapies are options and include cyclosporine, azathioprine, mycophenolate, and methotrexate.
- The AAD 2017 consensus statement regarding the utilization of systemic therapy in patients with moderate to severe atopic dermatitis recommended use of topical treatments and phototherapy, prior to systemic therapy. Overall, no one therapy was preferred over the others, and individual patient factors should guide treatment selection.
- Crisaborole and dupilumab are not yet mentioned in the AAD guidelines.

Topical Calcineurin Inhibitors (TCIs): pimecrolimus and tacrolimus

- Pimecrolimus (Elidel) is FDA-approved for treating mild to moderate atopic dermatitis, while tacrolimus (Protopic) is approved for moderate to severe atopic dermatitis. Both drugs are approved for use in children as young as .two years of age.
- A 2016 AAD meta-analysis concluded that the TCIs and topical corticosteroids show similar rates of improvement of dermatitis and treatment success, but TCIs are associated with a higher incidence of adverse events including skin burning and pruritus on application.
- A 2007 Cochrane review reported moderate- to high-potency corticosteroids and tacrolimus 0.1% were more effective than pimecrolimus.. Similar results were reported in a 2015 Cochrane review that concluded tacrolimus 0.1% was more effective than low-potency corticosteroids, pimecrolimus 1%, and tacrolimus 0.03%.
- The product labeling for TCIs contain a black box warning for rare case reports of malignancy. A study published in JAMA Dermatology (2015) evaluated rates of cancer in over 7,400 pediatric pimecrolimus users. The authors concluded it was unlikely that pimecrolimus was associated with an increased risk of malignancy. No skin-related cancers were reported.

Topical Phosphodiesterase (PDE)-4 inhibitor: crisaborole (Eucrisa)

- Crisaborole (Eucrisa) is a non-steroidal phosphodiesterase (PDE)-4 inhibitor indicated for patients as young as 2 years of age with mild to moderate atopic dermatitis. In the two controlled trials used for FDA approval, crisaborole treatment resulted in statistically significant improvement in atopic dermatitis signs and symptoms, compared to placebo vehicle. Although the results were statistically significant, they were clinically modest at best. There are no trials available comparing crisaborole with topical corticosteroids or the TCIs.
- The 2017 Institute for Clinical and Economic Review (ICER) review of crisaborole noted that there is not an agreed-upon definition of "mild-to-moderate" or "moderate-to-severe" atopic dermatitis. ICER also concluded that for patients with mild to moderate atopic dermatitis, there is inadequate evidence on both the relative efficacy and safety of crisaborole compared to other treatment options.
- Common side effects for crisaborole are burning and itching on application.
- Overall, despite the novel mechanism of action, crisaborole has no compelling advantages over the current formulary drugs used for atopic dermatitis.

Systemic therapy: dupilumab injection (Dupixent)

- Dupilumab is an interleukin-4/interleukin-13 antagonist monoclonal antibody indicated for moderate to severe atopic dermatitis that is not adequately controlled with topical prescription therapies. The 2017 ICER review concluded there was high certainty that dupilumab provides at least a small net health benefit relative to treatment with emollients, with or without continued failed topical treatments. Additionally, there was moderate certainty that the net health benefit of dupilumab is comparable or better than that provided by cyclosporine.
- Limitations to dupilumab include the lack of comparative trials with standard systemic treatments, the lack of long-term safety data, and the fact that it is only approved in adults. Pediatric trials are ongoing.
- The most common side effects for dupilumab are injection-site reactions and conjunctivitis.
- Dupilumab has fewer known side effects and monitoring requirements compared to azathioprine, cyclosporine, methotrexate, and mycophenolate.

Relative Cost-Effectiveness Analysis and Conclusion—Cost-minimization analysis (CMA) and budget impact analysis (BIA) were performed to evaluate the atopic dermatitis agents. The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that generic tacrolimus was the most cost-effective atopic dermatitis drug, followed by pimecrolimus (Elidel), branded tacrolimus (Protopic), crisaborole ointment (Eucrisa), and dupilumab injection (Dupixent).
- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results found that designating pimecrolimus (Elidel),

tacrolimus, and dupilumab (Dupixent) as formulary, with crisaborole (Eucrisa) as NF demonstrated significant cost avoidance for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) maintaining the current formulary status of the atopic dermatitis drugs, as outlined below, based on clinical and cost effectiveness:
    - UF
        - pimecrolimus (Elidel)
        - dupilumab (Dupixent)
        - tacrolimus (Protopic, generics)
    - NF
        - crisaborole (Eucrisa)

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) maintaining pimecrolimus 1% on the BCF, due to existing high utilization in the MHS, and availability in a cream formulation. The Committee also recommended adding generic tacrolimus 0.03% and 0.1% ointment to the BCF, based on cost effectiveness.

3. ***COMMITTEE ACTION: MANUAL PRIOR AUTHORIZATION CRITERIA***—Manual PA criteria for both crisaborole ointment and dupilumab injection were recommended at the May 2017 P&T Committee meeting. The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) updating the current PA criteria for dupilumab (Dupixent), to require a trial of phototherapy, if feasible, in all new users, due to the AAD 2017 consensus statement on systemic therapies. The Committee also recommended maintaining the current manual PA criteria for crisaborole (Eucrisa), which requires a two-week trial of at least two formulary medium to high potency topical corticosteroids or a TCI first. See Appendix C for the full criteria.

4. ***COMMITTEE ACTION: MN CRITERIA—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) maintaining the current MN criteria for crisaborole (Eucrisa). See Appendix B for the full criteria.

5. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) maintaining the current QLs for crisaborole (Eucrisa) and dupilumab (Dupixent) injection. See Appendix B.

6. ***COMMITTEE ACTION: EXPANDED MILITARY TREATMENT FACILITY (MTF)/MAIL PHARMACY INITIATIVE (EMMPI) REQUIREMENTS—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) maintaining dupilumab (Dupixent) on the EMMPI program, and also reaffirmed that there was no reason to exempt crisaborole (Eucrisa), from the mail order requirement. See Appendix F.

7. ***COMMITTEE ACTION: MAIL ORDER AUTO-REFILL REQUIREMENTS FOR THE ATOPIC DERMATITIS DRUGS***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) excluding pimecrolimus, tacrolimus, crisaborole, and dupilumab from the Auto-Refill program administered by Express Scripts, Inc. at the TRICARE Mail Order Pharmacy, due to the fluctuating disease course of atopic dermatitis, and due to the high cost of dupilumab.

8. ***COMMITTEE ACTION: UF, MN, AND PA IMPLEMENTATION PERIOD—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) an effective date upon the first Wednesday two weeks after the signing of the minutes in all points of service Based on the P&T Committee's recommendation, the effective date is November 21, 2018.

B. Hepatitis C Virus (HCV) Direct-Acting Antivirals (DAAs) Subclass

Background—The HCV DAAs subclass has previously been reviewed for formulary placement three times, most recently in February 2017. Two products, glecaprevir/pibrentasvir (Mavyret) and sofosbuvir/velpatasvir/voxilaprevir (Vosevi), were reviewed as new drugs at the November 2017 P&T Committee meeting. Since the last review, simplification of HCV treatment has occurred, including introduction of additional regimens lasting only 8 weeks, FDA approval of additional single-tablet regimens, and the availability of additional pangenotypic therapies.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 0 absent) the following:

- There were no major changes to the clinical effectiveness conclusion from the February 2017 meeting.
- The first-line HCV DAAs are Epclusa, Harvoni, and Mavyret.
- Advantages of Harvoni include approval for treatment courses as short as 8 weeks in treatment-naïve patients with HCV genotype (GT) 1, availability as a single table dosed once daily, and approval for use in patients with decompensated cirrhosis. Patients with GT 4, 5, and 6 require 12-week treatment courses. Harvoni should remain designated as UF, due to existing high utilization in DoD, provider familiarity, and the fact that the majority of MHS patients with HCV have GT 1.
- Advantages of Epclusa include that it was the first pangenotypic HCV DAA marketed, it is dosed as a single tablet once daily, and has an improved resistance profile. It

remains an option of HCV therapy for treatment-naïve patients, but requires a 12-week course of therapy. It can be used in patients with decompensated cirrhosis.

- Mavyret was the third pangenotypic HCV DAA to receive FDA approval. It provides an 8-week course of therapy in treatment-naïve patients and treatment-experienced patients who do not have cirrhosis. Mavyret can also be used in patients with moderate to severe renal disease, including those on dialysis. It is dosed as three tablets once daily, and must be given with food.
- Vosevi was the second pangenotypic HCV DAA approved. It is reserved for use in treatment-experienced patients, and fills a unique niche for this population. It is dosed as a single tablet once daily for 12 weeks in most patients. It is not indicated for patients with moderate to severe renal dysfunction, including those with end stage renal disease (ESRD).
- Daklinza, Olysio, Sovaldi, and Zepatier are no longer the standard of care for HCV, due to their longer treatment courses, limited genotype coverage, unfavorable tolerability and toxicity profiles, and/or higher pill burden.
- In the absence of head-to-head trials with all the DAAs, HCV treatment is based on individual patient characteristics, such as the HCV genotype and subtype, treatment history, stage of hepatic fibrosis, presence or absence of resistance-associated variants, comorbidities, concomitant medications, and cost.

Relative Cost-Effectiveness Analysis and Conclusion—CMA and BIA were performed to evaluate the HCV DAA agents. The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that glecaprevir/pibrentasvir (Mavyret), velpatasvir/sofosbuvir (Epclusa), and ledipasvir/sofosbuvir (Harvoni) were the most cost-effective HCV DAAs, followed by grazoprevir/elbasvir (Zepatier), paritaprevir/ritonavir/ombitasvir (Technivie), paritaprevir/ritonavir/ombitasvir/dasabuvir (Viekira Pak and Viekira XR), sofosbuvir/velpatasvir/voxilaprevir (Vosevi), daclatasvir (Daklinza), and sofosbuvir (Sovaldi).
- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating Mavyret, Epclusa, Harvoni, Technivie, Viekira, Viekira XR, and Vosevi as formulary, and Daklinza, Olysio, Sovaldi, and Zepatier as NF demonstrated the largest cost avoidance for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) the following:

    - UF
        - sofosbuvir/velpatasvir (Epclusa)
        - ledipasvir/sofosbuvir (Harvoni)

- glecaprevir/pibrentasvir (Mavyret)
- paritaprevir/ritonavir/ombitasvir (Technivie)
- paritaprevir/ritonavir/ombitasvir/dasabuvir tablets pak (Viekira Pak)
- paritaprevir/ritonavir/ombitasvir/dasabuvir XR tablets (Viekira XR)
- sofosbuvir/velpatasvir/voxilaprevir (Vosevi)

- NF
  - daclatasvir (Daklinza)
  - simeprevir (Olysio)
  - sofosbuvir (Sovaldi)
  - grazoprevir/elbasvir (Zepatier)

- Note that as part of this recommendation, the current requirement for a trial of Harvoni prior to another HCV DAA ("step therapy") has been removed. Additionally, no HCV DAA products were recommended for Extended Core Formulary (ECF) addition. For the HCV drug class, ribavirin 200 mg capsules and peginterferon alfa-2a (Pegasys) were designated ECF in November 2012.

2. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—Manual PA criteria is currently required for all the HCV DAAs, including the use of Harvoni as the step-preferred product. The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) revising the manual PA criteria for new users of Daklinza, Epclusa, Harvoni, Mavyret, Olysio, Sovaldi, Technivie, Viekira XR, Viekira Pak, and Zepatier, to remove the Harvoni step therapy requirement, and simplify the PA criteria by having these drugs on the same PA form.

   Additionally, the P&T Committee recommended maintaining separate PA criteria for Vosevi, since it is reserved for treatment-experienced patients. Minor updates to the Vosevi PA criteria were also recommended for new users, including removal of the Harvoni step. Coverage for any HCV DAA is only allowed for the FDA-approved indications or as outlined in the American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD/IDSA) HCV guidelines (www.HCVguidelines.org). See Appendix C for full criteria.

3. ***COMMITTEE ACTION: MN CRITERIA—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) MN criteria for Daklinza, Olysio, Sovaldi, and Zepatier. See Appendix B.

4. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)—***QLs currently apply to all the HCV DAAs. The P&T Committee recommended (14 for, 0 opposed,

0 abstained, 0 absent) maintaining the current QL of a 28-day supply for all the HCV DAAs, consistent with current manufacturer packaging. See Appendix D.

5. ***COMMITTEE ACTION: EXPANDED MILITARY TREATMENT FACILITY (MTF)/MAIL PHARMACY INITIATIVE (EMMPI) REQUIREMENTS—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) that the HCV DAAs were not suitable for the EMMPI program, as they are administered for a limited duration (8-12 weeks). The P&T Committee also agreed that the HCV DAAs recommended for NF status be exempted from the requirement that NF agents generally be available only at mail order. See Appendix F.

6. ***COMMITTEE ACTION: UF, MN, AND PA IMPLEMENTATION PERIOD—***The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) 1) an effective date of the first Wednesday after a 60-day implementation period in all points of service, 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 January 2, 2019.

V. RE-EXAMINATION OF CLINICAL CONCLUSION FROM PREVIOUS UF DRUG CLASS REVIEWS

Corticosteroids-Immune Modulators: Adrenocorticotropic Hormones (ACTH) Subclass

Background—The P&T Committee previously evaluated the ACTH subclass at the February 2018 meeting. The ACTH subclass is comprised solely of injectable corticotropin (H.P. Acthar Gel). The Committee designated H.P. Acthar with UF status, with manual PA allowing use exclusively for infantile spasms or exacerbation of multiple sclerosis (MS) and only after failure of or intolerance to a course of corticosteroids.

at this meeting the P&T Committee reviewed additional information received from providers and the FDA as it relates to the clinical effectiveness and safety of H.P. Acthar. There was no change to the cost effectiveness conclusion, Uniform Formulary recommendation, or PA criteria from the February 2018 P&T Committee meeting.

A comprehensive review of the evidence for H.P. Acthar Gel's efficacy for infantile spasms, multiple sclerosis exacerbation, other uses, and safety and tolerability across all indications and usages was performed for the February 2018 P&T Committee meeting. That comprehensive body of evidence guided the P&T's decision-making in that meeting.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 0 absent) the following for H.P. Acthar Gel:

- Infantile Spasms

- New information was presented that reaffirms and strengthens the clinical conclusions reached by the P&T Committee at the February 2018 meeting, including the following:
    - Patients with infantile spasms require urgent treatment that is better facilitated by oral corticosteroids, which are widely available, rather than the administratively burdensome H.P. Acthar Gel due to the limited distribution requirements by the manufacturer.
    - High-dose oral corticosteroids were reaffirmed as a frontline treatment alongside H.P. Acthar Gel and vigabatrin (Sabril).

- MS Exacerbation
    - Fundamentals of inflammation were reviewed, reaffirming the appropriateness of the requirement that patients try and fail the safer and more effective corticosteroid treatment option prior to approval of H.P. Acthar Gel for each multiple sclerosis exacerbation.
- Other Uses
    - There was no new data to support changing the original recommendation that uses other than infantile spasms and MS exacerbation be excluded from TRICARE coverage.[1]
- Safety
    - No new information was presented that helped allay the concerns of the Committee regarding the safety profile of the H.P. Acthar Gel. New data however, did cause the Committee to have more safety concerns than previously concluded.
- Other Factors
    - A review of coverage of H.P. Acthar Gel by several commercial health care plans performed for the February 2018 P&T Committee meeting found significant limitations or outright exclusions of H.P. Acthar Gel.
    - For the August 2018 meeting, the P&T Committee reviewed an update to several national health care plans and health systems' coverage policies. Of the 50 pharmacy benefit managers (PBMs) reviewed in the update, 9 health care plans did not cover H.P. Acthar Gel for any indication for their respective beneficiaries.
    - Several prominent health care plans and health systems require a trial of oral corticosteroids prior to using H.P. Acthar Gel for infantile spasms. These include Intermountain Health System in Utah and leading Academic Centers of Excellence in Pediatric Neurology, such as Johns Hopkins and UCLA.
    - The P&T Committee reviewed prior decisions in other drug classes where the recommendation was to require a trial of a drug lacking FDA approval for a

[1] As with any drug, an appeal is available for an eligible covered beneficiary or network or uniformed provider on behalf of the beneficiary to establish clinical justification for the use of a pharmaceutical agent that is not on the Uniform Formulary. See 10 U.S.C. § 1074g.

particular diagnosis prior to use of a drug that carries FDA approval for that particular diagnosis. One example is that patients with Duchenne's Muscular Dystrophy are required to try or have intolerance to prednisone prior to using deflazacort (Emflaza) [February 2017 DoD P&T Committee Meeting].

- Overall, the Committee evaluated the additional information presented and agreed that no new evidence was presented that would change the clinical conclusions reached by the P&T Committee at the February 2018 meeting. In fact, additional information for treatment of infantile spasms further confirmed the appropriateness of a trial of corticosteroids and the importance of early treatment, before using H.P. Acthar Gel. Additional safety concerns for H.P. Acthar Gel were raised by the new information. No changes to the existing manual PA criteria for H.P. Acthar Gel were recommended.

VI. NEWLY APPROVED DRUGS PER 32 CFR 199.21(g)(5)

Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions—The P&T Committee agreed (group 1 and group 3: 14 for, 0 opposed, 0 abstained, 0 absent; and group 2: 13 for, 0 opposed, 0 abstained, 1 absent) with the relative clinical and cost-effectiveness analyses presented for the newly approved drugs reviewed according to 32 CFR 199.21(g)(5). See Appendix E for the complete list of newly approved drugs reviewed at the August 2018 P&T Committee meeting, a brief summary of their clinical attributes, and their formulary recommendations; see Appendix F for their restriction to or exemption from the Mail Order Pharmacy.

A. ***COMMITTEE ACTION: UF RECOMMENDATION***—The P&T Committee recommended (group 1 and group 3: 14 for, 0 opposed, 0 abstained, 0 absent and group 2: 13 for, 0 opposed, 0 abstained, 1 absent) the following:

- UF:
    - abiraterone acetate micronized (Yonsa) – Oral Oncologic Agent for Prostate Cancer
    - avatrombopag (Doptelet) – Hematological Agent: Platelets for Thrombocytopenia in Chronic Liver Disease
    - baricitinib (Olumiant) – Targeted Immunomodulatory Biologic (TIB) for Rheumatoid Arthritis
    - binimetinib (Mektovi) – Oral Oncologic Agent for Metastatic Melanoma
    - encorafenib (Braftovi) – Oral Oncologic Agent for Metastatic Melanoma
    - epoetin-alfa-epbx (Retacrit) injection – Hematological Agent: Red Blood Cell Stimulant for Erythropoiesis
    - erenumab-aooe (Aimovig) injection – Migraine Agent (calcitonin gene-related peptide [CGRP]) for Migraine Headache Prophylaxis
    - fostamatinib (Tavalisse) – Hematological Agent: Platelets for Chronic Immune Thrombocytopenia
    - hydroxyurea (Siklos) tablets – Hematological Agent: Sickle Cell Anemia Agent for Pediatrics
    - pegvaliase-pqpz (Palynziq) injection – Miscellaneous Metabolic Agent for Phenylketonuria

- tolvaptan (Jynarque) – Miscellaneous Nephrology Agent for Rapidly Progressing Autosomal Dominant Polycystic Kidney Disease (ADPKD)

- NF:
  - amantadine extended release tablets (Osmolex ER) – Parkinson's Agent
  - estradiol (Imvexxy) vaginal insert – Miscellaneous Gynecological Agent for Dyspareunia
  - levonorgestrel/ethinyl estradiol/ferrous (Balcoltra) – Oral Combined Contraceptive Agent
  - lofexidine (Lucemyra) – Alpha 2 Antagonist for Mitigation of Symptoms of Opioid Withdrawal
  - oxycodone IR (Roxybond) – Narcotic Analgesic Abuse Deterrent Formulation for Pain

B. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) MN criteria for Osmolex ER, Imvexxy, Balcoltra, Lucemyra, and Roxybond. See Appendix B for the full criteria.

C. ***COMMITTEE ACTION: PA CRITERIA—***The P&T Committee recommended (group 1 and group 3: 14 for, 0 opposed, 0 abstained, 0 absent; and group 2: 13 for, 0 opposed, 0 abstained, 1 absent) the following (see Appendix C for the full criteria):

- Applying manual PA criteria to new users of Yonsa, Osmolex ER, Doptelet, Olumiant, Imvexxy, Mektovi, Braftovi, Lucemyra, Aimovig, Siklos, and Palynziq.
- Applying manual PA criteria to new and current users of Tavalisse and Jynarque.

D. ***COMMITTEE ACTION: UF, MN, AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (group 1 and group 3: 14 for, 0 opposed, 0 abstained, 0 absent; and group 2: 13 for, 0 opposed, 0 abstained, 1 absent) an effective date upon the first Wednesday two weeks after signing of the minutes in all points of service.

VII. UTILIZATION MANAGEMENT

A. PA Criteria, Step Therapy, and MN Criteria

1. Updates to the step therapy and manual PA criteria for several drugs were recommended by the P&T Committee due to a variety of reasons, including expanded FDA indications and drug shortages. The updated manual PAs outlined below will apply to new users.

a) **Epinephrine Auto-Injectors: Auvi-Q Temporary Removal of Manual PA Criteria—**The Auvi-Q device includes audible voice instructions and has a needle that automatically retracts following injection. Manual PA criteria were previously recommended for all epinephrine auto-injectors, including Epi-Pen, generic epinephrine auto-injectors, and Auvi-Q, at the February 2017 P&T Committee meeting. The PA requirements for Epi-Pen were administratively removed on May 23, 2018, due to a national shortage. There have been continued shortages of Epi-Pen, and intermittent availability of generic epinephrine auto-injectors.

   Although Auvi-Q is significantly more expensive than Epi-Pen, the manual PA requirements for Auvi-Q will be temporarily lifted, but re-instated administratively when the supply of Epi-Pen and generic epinephrine auto-injectors has stabilized. The Committee acknowledged, however, that it is doubtful that the current Auvi-Q supply will support the volume required to replace Epi-Pen.

b) **Renin Angiotensin Antihypertensive Agents (RAAs): candesartan and candesartan/HCTZ Step-Therapy—**Step therapy in the RAAs class requires a trial of losartan, telmisartan, valsartan, or irbesartan, or their respective combinations with hydrochlorothiazide (HCTZ), prior to use of non-step-preferred angiotensin receptor blockers (ARBs). Two ARBs, candesartan and irbesartan, are approved for treating heart failure with reduced ejection fraction (HFrEF), in addition to hypertension. Candesartan and candesartan/HCTZ are currently designated as UF but non-step-preferred.

   There is currently a national recall of valsartan, due to contamination with a carcinogen. There is no immediate risk to patients currently taking valsartan. However, availability of valsartan lots not affected by the recall are in limited supply, and it remains uncertain as to when the shortage will be resolved.

   A group of MHS cardiologists has requested removing the step therapy requirement for candesartan, due to the valsartan recall. Cost-effective formulations of candesartan and candesartan/HCTZ are now available. Candesartan and candesartan/HCTZ will now be designated as step-preferred, with the step therapy criteria and medical necessity criteria for the remaining non-step-preferred RAAs updated accordingly.

c) **Oncological Agents for unresectable or metastatic melanoma: dabrafenib (Tafinlar), trametinib (Mekinist), and vemurafenib (Zelboraf) Manual PA criteria—**These drugs are approved for treating unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. They are exclusively used in unique pair combinations of a specific BRAF drug with a specific mitogen-activated extracellular signal regulated kinase (MEK) inhibitor. Due to the risk of enhanced toxicity if other combinations of BRAF with MEK inhibitors are administered together, the PA criteria were updated to prevent the use of concurrent therapies outside of the FDA-approved combination.

Criteria were also updated for dabrafenib (Tafinlar) and trametinib (Mekinist) to include the new FDA-approved indication for combination use for locally advanced or metastatic anaplastic thyroid cancer without satisfactory locoregional treatment options.

d) **Oncological Agents: Prostate II - enzalutamide (Xtandi)—**In August 2012, manual PA criteria were recommended for Xtandi. PA criteria were updated in February 2015 to remove the co-administration requirement of docetaxel. Xtandi is now FDA-approved for treatment of castration-resistant prostate cancer, and does not require the presence of metastatic disease. Additionally, the PA criteria were also updated to include new product labeling that requires the patient receive concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog, or have had bilateral orchiectomy.

e) **Targeted Immunomodulatory Biologics (TIBs): Tofacitinib (Xeljanz/Xeljanz XR)—**The TIBs were reviewed in August 2014, with step therapy requiring a trial of adalimumab (Humira) first. Xeljanz was originally approved for treating rheumatoid arthritis. In February 2018, PA criteria were updated to add the indication for active psoriatic arthritis in adults. The PA criteria were further expanded to include a new FDA-approved indication of ulcerative colitis.

1. ***COMMITTEE ACTION: UPDATED MANUAL PA CRITERIA***—The P&T Committee recommended the following: (See Appendix C for the full criteria.)

    - (12 for, 0 opposed, 0 abstained, 2 absent) to temporarily remove the manual PA criteria for Auvi-Q, until adequate supply of the Epi-Pen auto-injector has been established.

    - (14 for, 0 opposed, 0 abstained, 0 absent) updates to the manual PA criteria and step therapy for candesartan and candesartan/HCTZ.

    - (13 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for Tafinlar, Mekinist, Zelboraf, Xeljanz/Xeljanz XR, and Xtandi.

B. QLs

QLs were reviewed for nine drugs from drug classes where there are existing QLs, including the oncologic agents, inhaled corticosteroids, and TIBs. QLs were also discussed for five drugs where QLs are not currently in place, including recommendations for QLs for Cordran Tape, due to a recent significant increase in cost. QLs were removed from three products.

1. ***COMMITTEE ACTION: QLs*—**The P&T Committee recommended (13 for, 0 opposed, 0 abstained, 1 absent) QLs for Stelara, Olumiant, Yonsa, Imbruvica tablets, Braftovi, Mektovi, Aimovig, Lucemyra, Tavalisse, QVAR, QVAR RediHaler, Jynarque, Doptelet, Palynziq, and Cordran Tape. The P&T Committee also recommended removing the QLs from ondansetron tablets and orally disintegrating tablets (Zofran and Zofran ODT) and the oral contraceptive, Jolessa, due to the availability of cost-effective generic formulations for these products. See Appendix D for the QLs.

C. PA and QLs Implementation Periods

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

    - (12 for, 0 opposed, 0 abstained, 2 absent) and (14 for, 0 opposed, 0 abstained, 0 absent) To administratively implement the removal of manual PA requirements for Auvi-Q and to designate candesartan and candesartan/HCTZ as step-preferred.
    - (13 for, 0 opposed, 0 abstained, 1 absent) Updates to the current PAs for Tafinlar, Mekinist, Zelboraf, Xeljanz, Xeljanz XR, and Xtandi become effective on the first Wednesday two weeks after the signing of the minutes.
    - (13 for, 0 opposed, 0 abstained, 1 absent) The QLs for the 14 drugs listed in section VII, B, above, and in Appendix D, become effective on the first Wednesday two weeks after the signing of the minutes in all POS.

VIII. LINE EXTENSIONS

The P&T Committee clarified the formulary status for three product line extensions ("follow-on products") by the original manufacturer. The line extensions have the same FDA indications and pricing as the "parent" drug and retain the same formulary and copayment status as the "parent" drug.

A. ***COMMITTEE ACTION: LINE EXTENSIONS, FORMULARY STATUS CLARIFICATION, AND IMPLEMENTATION***—The P&T Committee recommended (13 for, 0 opposed, 0 abstained, 1 absent) clarifying the formulary status of the following three products to reflect the current formulary status and applicable step therapy, PA criteria, MN criteria, QLs, and EMMPI status for the parent compound. Implementation will occur on the first Wednesday two weeks after signing of the minutes.

- Basal Insulin Analogs—insulin glargine 900 U/mL (Toujeo Max SoloStar pen). This new concentrated formulation contains 900 units of insulin glargine and provides up to 160 units/mL of glargine in a single injection. Insulin glargine 300 U/mL (Toujeo SoloStar pen) is currently designated as UF and non-step-preferred, requiring a trial of insulin glargine 100 U/mL (Lantus) first. The

P&T Committee recommended designating Toujeo Max SoloStar as UF and non-step-preferred, with the same step therapy and manual PA requirements as Toujeo SoloStar pen. Toujeo Max SoloStar pen will also be added to the EMMPI list.

- TIBs—sarilumab (Kevzara) pen is designated as NF and non-step-preferred, with the same MN, PA, and QLs as the Kevzara pre-filled syringe parent agent. There is no reason to exempt Kevzara pen from the EMMPI list. See Appendix D for the QLs.

- TIBs—adalimumab (Humira) is now available in several new formulations, including a starter pen for pediatric Crohn's disease and a pen for psoriasis. These new Humira formulations will be designated as UF and step-preferred, with the same manual PA requirements, and appropriate QLs as Humira. These formulations will also be added to the EMMPI list. See Appendix D for the QLs.

IX. BCF ADDITION—ULIPRISTAL ACETATE (ELLA)

The Committee received an MTF request to consider adding the emergency contraceptive ulipristal acetate (Ella) to the BCF. Ella was originally designated UF at the August 2011 meeting, while levonorgestrel (Plan B One Step) was designated with BCF status in May 2013. Ella is available via a prescription, while Plan B One Step is available without a prescription at MTF and retail pharmacies. The formulary status change was requested in order to allow for availability of an alternative emergency contraceptive with a wider window of efficacy than Plan B One Step.

There was no compelling new data to change the clinical conclusions from the most recent emergency contraceptive drug class review presented at the August 2016 P&T meeting. An updated cost analysis did show that Ella is more cost-effective than Plan B One Step. Based on the provider request and updated cost information, Ella was recommended for BCF addition. Plan B One Step will also remain on the BCF.

A. ***COMMITTEE ACTION: ULIPRISTAL (ELLA) BCF ADDITION***—The P&T Committee recommended (11 for, 1 opposed, 1 abstained, 1 absent) adding ulipristal acetate (Ella) to the BCF. Note that Plan B One Step will remain on the BCF.

B. ***COMMITTEE ACTION: ULIPRISTAL (ELLA) QLs:*** The P&T Committee recommended (12 for, 0 opposed, 1 abstained, 1 absent) maintaining the current QLs for Ella of one tablet per prescription.

C. ***COMMITTEE ACTION: ULIPRISTAL (ELLA) IMPLEMENTATION:*** The P&T Committee recommended (12 for, 0 opposed, 1 abstained, 1 absent) implementation upon signing of the minutes for the BCF addition of Ella.

X. REFILLS OF PRESCRIPTION MAINTENANCE MEDICATIONS THROUGH MTF PHARMACIES OR THE NATIONAL MAIL ORDER PHARMACY PROGRAM (EMMPI)

See Appendix F for the mail order status of medications designated NF during the August 2018 P&T Committee Meeting. Note that the Add/Do Not Add recommendations listed below pertain to the combined list of drugs (the Select Maintenance List) under the EMMPI program and the nonformulary to mail requirement. The implementation date for all EMMPI recommendations from the August 2018 meeting, including the newly approved drugs affected by the EMMPI, will be effective upon the first Wednesday after the signing of the minutes.

A. Newly Approved Drugs per 32 CFR 199.21(g)(5)

1. ***COMMITTEE ACTION: NEWLY APPROVED DRUGS PER 32 CFR 199.21(g)(5) RECOMMENDED FOR UF STATUS***

   The P&T Committee recommended (group 1 and group 3: 14 for, 0 opposed, 0 abstained, 0 absent; and group 2: 13 for, 0 opposed, 0 abstained, 1 absent):

   a) **Add**: baricitinib (Olumiant) and epoetin alfa-epbx injection (Retacrit); products in these classes have already been designated as suitable for addition to the EMMPI program. In addition, add erenumab-aooe injection (Aimovig), which is used for migraine prophylaxis.

   b) **Do Not Add:** the oral oncology agents binimetinib (Mektovi), encorafenib (Braftovi), and abiraterone acetate (Yonsa); the sickle cell agent hydroxyurea (Siklos), fostamatinib (Tavalisse), for chronic immune thrombocytopenia; pegvaliase-pqpz injection (Palynziq), for phenylketonuria, and tolvaptan (Jynarque), for rapidly progressing autosomal dominant polycystic kidney disease. It is not yet clear if these agents will be feasible to provide through mail order. In addition, do not add avatrombopag (Doptelet), which is approved for treatment of thrombocytopenia in adult patients with chronic liver disease scheduled to undergo a procedure, as it is used for a limited duration only (5 days).

2. ***COMMITTEE ACTION: NEWLY APPROVED DRUGS PER 32 CFR 199.21(g)(5) RECOMMENDED FOR NF STATUS***

   The P&T Committee recommended (group 1 and group 3: 14 for, 0 opposed, 0 abstained, 0 absent; and group 2: 13 for, 0 opposed, 0 abstained, 1 absent):

   a) **Add:** The P&T Committee found no reason to exempt the following drugs from the mail order requirement: the Parkinson's disease agent amantadine ER (Osmolex ER) and estradiol vaginal insert (Imvexxy) for dyspareunia.

b) **Do Not Add:** The P&T Committee recommended exceptions from the mail order requirement for the following medications: levonorgestrel/ethinyl estradiol/iron (Balcoltra), due to the existing exception for contraceptives; oxycodone IR (Roxybond), due to the existing exception for C-II agents; and lofexidine (Lucemyra), which is used for a limited time period for opioid withdrawal.

3. ***COMMITTEE ACTION: MAIL ORDER AUTO-REFILL REQUIREMENTS FOR ESTRADIOL (IMVEXXY) VAGINAL INSERT***—The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 0 absent) excluding estradiol (Imvexxy) vaginal insert from the Auto-Refill program administered by Express Scripts, Inc., at TRICARE Mail Order Pharmacy, to be implemented the first Wednesday after signing of the minutes.

XI. ITEMS FOR INFORMATION

A. UF Sub-Working Group Update: Aligning Over-the-Counter (OTC) Formularies

The P&T Committee was updated on the ongoing efforts to transition to a more uniform list of OTC products available across MTFs, and ultimately across the TRICARE pharmacy benefit. Utilization and costs of two drug classes currently included on the MTF OTC Test List, the topical corticosteroids and topical emollients, were presented to the Committee. There was discussion on several courses of action to take going forward. Refer to the May 2018 DoD P&T Committee meeting minutes for additional information on the MTF OTC Test List.

B. Prior Authorization, Step Therapy, and Utilization Management Effects

The P&T Committee was briefed on the effects of previous drug class formulary recommendations, including step therapy, prior authorization requirements, and QLs, on utilization and cost patterns in the MHS.

C. MHS Genesis Brief

The P&T Committee was briefed on some of the impacts that the new electronic health record system, MHS Genesis, will have on formulary management. MHS Genesis is currently in use at four MTF sites. There are plans for a phased expansion to all MTFs over the next several years. Topics discussed included a description of the claims adjudication process in the pharmacy, new capabilities for provider e-prescribing and electronic prior authorization submissions, and a description of the enterprise-level and local formulary management tools available in the system.

XII. ADJOURNMENT

The meeting adjourned at 1600 hours on August 9, 2018. The next meeting will be in November 2018.

Appendix A—Attendance: August 2018 DoD P&T Committee Meeting

DECISION ON RECOMMENDATIONS

SUBMITTED BY:

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

The Director, DHA:

☐ concurs with all recommendations.

☒ concurs with the recommendations, with the following modifications:

1. For the Hepatitis C drugs recommended for nonformulary status will allow the current users of Daklinza, Sovaldi, Zepatier and Olysio to continue at the formulary copay.
2.
3.

☐ concurs with the recommendations, except for the following:

Mr. Guy Kiyokawa
Deputy Director, DHA
for R.C. Bono, VADM, MC, USN,
Director

1 NOV 2018
Date

Appendix A—Attendance: August 2018 P&T Committee Meeting

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
Lt Col Ronald Khoury, MC	Chief, DHA Formulary Management Branch (Recorder)
Col James Jablonski, MC	Air Force, Physician at Large
LTC John Poulin, MC	Army, Physician at Large
CAPT Shaun Carstairs, MC	Navy, Physician at Large
Maj Jeffrey Colburn, MC	Air Force, Internal Medicine Physician
Lt Col Larissa Weir, MC	Air Force, OB/GYN Physician
CDR Austin Parker, MC	Navy, Internal Medicine Physician
MAJ Rosco Gore, MC	Army, Internal Medicine Physician
Col Ruben Salinas, MC	Army, Family Medicine Physician
Col Melissa Howard, BSC	Air Force, Pharmacy Officer
LTC Bryan R. Bailey, MSC	Army, Pharmacy Officer
CAPT Brandon Hardin, MSC	Navy, Pharmacy Officer
CDR Paul Michaud, USCG	Coast Guard, Pharmacy Officer
Voting Members Absent	
Col Paul Hoerner for Mr. David Bobb	Chief, DHA Pharmacy Operations Branch
Ms. Jennifer Zacher, PharmD	Department of Veterans Affairs
Nonvoting Members Present	
Lt Col Derek Underhill, BSC	DLA Troop Support
Mr. Erik Troff	DHA, Deputy General Counsel
Guests	
Ms. Kimberlymae Wood	DHA Contract Operations Division
Ms. Yvette Dluhos	DHA Contract Operations Division
Ms. Hilary Meckel	DHA Contracting
Simone Donnelly	PharmD Student, University of Texas at Austin

Appendix A—Attendance (continued)

Others Present	
CDR Heather Hellwig, MSC	Chief, P&T Section, DHA Formulary Management Branch
Angela Allerman, PharmD, BCPS	DHA Formulary Management Branch
Shana Trice, PharmD, BCPS	DHA Formulary Management Branch
Amy Lugo, PharmD, BCPS	DHA Formulary Management Branch
CDR Scott Raisor, BCACP	DHA Formulary Management Branch
LCDR Christina Andrade, BCPS	DHA Formulary Management Branch
LCDR Todd Hansen, MC	DHA Formulary Management Branch
MAJ Aparna Raizada, MSC	DHA Formulary Management Branch
MAJ Adam Davies, MSC	DHA Formulary Management Branch
Mr. Kirk Stocker	DHA Formulary Management Branch Contractor
Mr. Michael Lee	DHA Formulary Management Branch Contractor
Ms. Cortney Raymond	DHA Formulary Management Branch Contractor
Robert Conrad, PharmD	DHA Operations Management Branch
Eugene Moore, PharmD, BCPS	DHA Purchased Care Branch

Appendix B—Table of Medical Necessity (MN) Criteria

Drug / Drug Class	Medical Necessity Criteria
• crisaborole (Eucrisa) **Corticosteroids – Immune Modulators –Atopic Dermatitis Subclass**	**No change from February 2017** • Use of formulary agents is contraindicated • Patient has experienced or is likely to experience significant adverse effects from formulary agents • Use of formulary agents has resulted in therapeutic failure **Formulary Alternatives:** high potency (Class 1) corticosteroids (various), tacrolimus (generic), pimecrolimus (Elidel)
• daclatasvir (Daklinza) • simeprevir (Olysio) • sofosbuvir (Sovaldi) • grazoprevir/elbasvir (Zepatier) • **Hepatitis C Virus Direct-Acting Antivirals**	• Patient has experienced or is likely to experience significant adverse effects from formulary agents • Use of formulary agents has resulted or is likely to result in therapeutic failure **Formulary Alternatives:** Epclusa, Harvoni, Mavyret, Viekira Pak, Viekira XR, Vosevi
• amantadine ER (Osmolex ER) tablet **Parkinson's Agents**	• Patient has experienced significant adverse effects from the formulary alternative that are not expected to occur with Osmolex ER **Formulary Alternatives:** amantadine immediate release
• estradiol (Imvexxy) vaginal insert **Gynecological Agents Miscellaneous**	• Patient has experienced significant adverse effects from formulary agents **Formulary Alternatives:** estrogen cream, ospemifene (Osphena), prasterone (Intrarosa)
• levonorgestrel/ethinyl estradiol/ferrous bisglycinate (Balcoltra) **Contraceptive Agents: Monophasics with 20 mcg EE**	• The patient cannot be treated with formulary oral monophasic contraceptive with ethinyl estradiol (EE) 20 mcg AND an iron supplement due to the following reasons: (Prescriber must supply a reason on the Medical Necessity Form.) **Formulary Alternatives:** levonorgestrel 0.1 mg + EE 20 mcg (e.g., Sronyx, Lutera, and equivalent generics)
• lofexidine (Lucemyra) **Narcotic Analgesics and Combinations**	• Patient has experienced significant adverse effects from formulary agents **Formulary Alternatives:** clonidine
• oxycodone IR (Roxybond) **Narcotic Analgesics and Combinations**	• No alternative formulary agents: patient is at high risk of abusing non-abuse-deterrent opioid formulations **Formulary Alternatives:** oxycodone, codeine, morphine, hydrocodone
• sarilumab (Kevzara Pen) **Targeted Immunomodulatory Biologics (TIBs)**	• Use of adalimumab (Humira) is contraindicated • Patient has experienced significant or likely to experience significant adverse effects from adalimumab (Humira) • Adalimumab (Humira) and methotrexate have resulted in therapeutic failure • No alternative formulary agent: The patient has symptomatic congestive heart failure. **Formulary Alternative:** adalimumab (Humira)

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• crisaborole (Eucrisa) **Corticosteroids – Immune Modulators – Atopic Dermatitis Subclass**	**No Changes from the November 2017 meeting** Manual PA criteria apply to all new users of Eucrisa. Manual PA Criteria: Coverage is approved if all criteria are met: • Patient has mild to moderate atopic dermatitis • Prescribed by a dermatologist, allergist, or immunologist • Patient has a contraindication to, intolerability to, or failed treatment with a two-week trial of at least one medium to high potency topical corticosteroid AND • Patient has a contraindication to, intolerability to, or failed treatment with a two-week trial of a second agent including ◦ An additional medium - high potency topical corticosteroid OR ◦ Topical calcineurin inhibitor (i.e., tacrolimus, Elidel) Non-FDA-approved uses are NOT approved. Prior authorization does not expire.
• dupilumab (Dupixent) **Corticosteroids – Immune Modulators – Atopic Dermatitis Subclass**	**August 2018 updates are in BOLD** Manual PA criteria apply to all new users of Dupixent. Manual PA Criteria: coverage will be approved for initial therapy for 6 months if all criteria are met: • Patient has moderate to severe or uncontrolled atopic dermatitis • Patient must be 18 years of age or older • Prescribed by a dermatologist, allergist, or immunologist • Patient has a contraindication to, intolerability to, or failed treatment with at least ONE high potency/class 1 topical corticosteroid • Patient has a contraindication to, intolerability to, or failed treatment with at least ONE systemic immunosuppressant • **Patient has a contraindication to, intolerability to, inability to access treatment, or failed treatment with Narrowband UVB phototherapy** Non-FDA-approved uses are NOT approved. PA expires after 6 months. Renewal PA Criteria: coverage will be approved indefinitely for continuation of therapy if: 1. The patient has had a positive response to therapy, e.g., an Investigator's Static Global Assessment (ISGA) score of clear (0) or almost clear (1)
• daclatasvir (Daklinza) • sofosbuvir/velpatasvir (Epclusa) • ledipasvir/sofosbuvir (Harvoni) • glecaprevir/pibrentasvir (Mavyret) • simeprevir (Olysio) • sofosbuvir (Sovaldi) • paritaprevir/ritonavir/ ombitasvir (Technivie) • paritaprevir/ritonavir/ombitasvir/dasabuvir (Viekira XR and Viekira Pak) • grazoprevir/elbasvir (Zepatier) **HCV DAAs Subclass**	**Changes from the August 2018 meeting will replace current PA criteria in place for the HCV DAAs. Note that the Harvoni step therapy requirement has been removed.** Manual PA criteria apply to all new users of Daklinza, Epclusa, Harvoni, Mavyret, Olysio, Sovaldi, Technivie, Viekira Pak, Viekira XR, and Zepatier. Manual PA criteria: The HCV DAA is approved if all of the following criteria are met: • ≥ 18 years of age • Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician • Patient has laboratory evidence of hepatitis C virus infection • The HCV genotype is documented. (Check box – GT1a, GT1b, GT2, GT3, GT4, GT5, GT6) Coverage for the HCV DAA is only allowed for the FDA-approved indications or as outlined in the AASLD/IDSA HCV guidelines. PA expires in 1 year.

Drug / Drug Class	Prior Authorization Criteria
• sofosbuvir/velpatasvir/ voxilaprevir (Vosevi) **Hepatitis C Virus - Direct Acting Antivirals Subclass (HCV DAAs)**	**August 2018 updates are in BOLD and strikethrough.** Manual PA criteria apply to all new users of Vosevi. Manual PA criteria: Vosevi is approved if all the following criteria are met: • ≥ 18 years of age and diagnosed with chronic hepatitis C virus (HCV) • Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician • Laboratory evidence of chronic hepatitis C • The HCV genotype is documented (Check box – GT1a, GT1b, GT2, GT3, GT4, GT5, GT6) • The patient does not have an estimated glomerular filtration rate (eGFR) ≤ 30 mL/min or end-stage renal disease (ESRD) requiring hemodialysis • The patient will not be receiving concomitant therapy with other hepatitis C drugs or rifampin • The treatment course will not exceed the maximum duration of treatment of 12 weeks • **Patient has one of the following:** ○ **Patient has HCV GT 1, 2, 3, 4, 5 or6 and was previously treated with an HCV regimen containing an NS5A inhibitor (for example, daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir).** **OR** ○ **Patient has HCV GT 1a or 3 and has previously been treated with an HCV regimen containing sofosbuvir with or without an NS5A inhibitor (for example, daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir).** ~~• Patient cannot use Harvoni (due to HCV GT2 or GT3) other agents (due to decompensation, etc.)~~ ~~• AND~~ ~~• Previously treated with an NS5A inhibitor OR~~ ~~• HCV GT-1a or-3 and treated with sofosbuvir without an NS5A inhibitor~~ Coverage for the HCV DAA is only allowed for the FDA-approved indications or as outlined in the AASLD/IDSA HCV guidelines. PA expires after 1 year; complete original PA form for renewal of therapy.
• abiraterone acetate micronized (Yonsa) **Oncological Agents: Prostate II**	Manual PA criteria apply to all new users of Yonsa. Manual PA criteria: Yonsa is approved if all criteria are met: • Provider is aware that Yonsa may have different dosing and food effects than other abiraterone acetate products (medication errors and overdose warning) • Patient has a documented diagnosis of metastatic castration-resistant prostate cancer (mCRPC) • Patient must receive concomitant therapy with methylprednisolone • The patient is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy Non-FDA-approved uses are NOT approved, with exception for treatment in patients with metastatic high-risk castration-sensitive prostate cancer (mHRCSPC). PA does not expire.

• enzalutamide (Xtandi) **Oncological Agents: Prostate II**	**<u>Changes from the August 2018 meeting are in BOLD and strikethrough.</u>** Manual PA criteria apply to all new users of Xtandi. <u>Manual PA criteria</u>: Xtandi is approved if the following criteria are met: • The patient has a documented diagnosis of ~~metastatic~~ castration-resistant prostate cancer • **The patient is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had bilateral orchiectomy** Non-FDA-approved uses are NOT approved. PA does not expire.
• amantadine ER (Osmolex ER) **Parkinson's Agents**	Manual PA criteria apply to all new users of Osmolex ER. <u>Manual PA criteria</u>: Osmolex ER is approved if all criteria are met: • Patient is aged 18 years and older • Patient has a diagnosis of either Parkinson's disease or drug-induced extrapyramidal symptoms • Patient has had therapeutic failure of a trial of amantadine 300 mg per day given in divided doses using immediate release tablets. Non-FDA-approved uses are NOT approved. PA does not expire.
• avatrombopag (Doptelet) **Hematological Agents: Platelets**	Manual PA criteria apply to all new users of Doptelet. <u>Manual PA criteria</u>: Avatrombopag (Doptelet) is approved if all criteria are met: • Age ≥ 18 • Patient is diagnosed with liver disease that has caused severe thrombocytopenia (platelet count less than 50 x 10^9/L) • Patient is scheduled to undergo a procedure with a moderate to high bleeding risk within 10-13 days after starting avatrombopag • Patient has no evidence of current thrombosis • The drug is prescribed by or in consultation with a gastroenterologist Non-FDA-approved uses are NOT approved. PA expires in 60 days.
• baricitinib (Olumiant) **Targeted Immunomodulatory Biologics (TIBs)**	Manual PA criteria apply to all new and current users of Olumiant. <u>Automated PA criteria</u>: The patient has filled a prescription for adalimumab (Humira) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days AND <u>Manual PA criteria</u>: Baricitinib (Olumiant) is approved if all criteria are met: • Provider acknowledges that Humira is the preferred TIB to treat rheumatoid arthritis • Provider acknowledges that if a JAK inhibitor is desired, Xeljanz/Xeljanz XR is an alternative to baricitinib (Olumiant) without the black box warning risk of thrombosis • Age ≥ 18 • Has diagnosis of moderate to severe active rheumatoid arthritis • Has a contraindication, inadequate response, or had an adverse reaction to adalimumab (Humira) • Has a contraindication, inadequate response, or had an adverse reaction to methotrexate • Has no history of thromboembolic disease • Is not receiving other potent immunosuppressants (e.g., azathioprine or cyclosporine) • May not be used concomitantly with other TIB agents except for Otezla • Must be prescribed by or in consultation with a rheumatologist Non-FDA-approved uses are NOT approved. PA does not expire.

• binimetinib (Mektovi) **Oncological Agents**	Manual PA criteria apply to all new users of Mektovi. <u>Manual PA criteria</u>: Mektovi is approved if all criteria are met: • Age ≥ 18 years • Has unresectable or metastatic melanoma • Has confirmed BRAF V600E or BRAF V600K mutation by an FDA-approved test • Mektovi is being taken in combination with Braftovi • Patient is not on concurrent dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), nor cobimetinib (Cotellic) • Prescribed by or in consultation with an oncologist Non-FDA-approved uses are NOT approved. PA does not expire.
• encorafenib (Braftovi) **Oncological Agents**	Manual PA criteria apply to all new users of Braftovi. <u>Manual PA criteria</u>: Braftovi is approved if <u>all</u> criteria are met: • Age ≥ 18 years • Has unresectable or metastatic melanoma • Has confirmed BRAF V600E or BRA FV600K mutation by an FDA-approved test • Braftovi is being taken in combination with Mektovi • Patient is not on concurrent dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), nor cobimetinib (Cotellic) • Prescribed by or in consultation with an oncologist Non-FDA-approved uses are NOT approved. PA does not expire.
• dabrafenib (Tafinlar) **Oncological Agents**	**<u>Changes from the August 2018 meeting are in BOLD.</u>** Manual PA criteria apply to all new users of Tafinlar. <u>Manual PA criteria</u>: Coverage will be approved if: • Utilized as a single agent for treatment of unresectable or metastatic melanoma with **BRAF V600E** or BRAF V600K mutation • Combination use with trametinib (Mekinist) in the treatment of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutations OR • In combination with trametinib (Mekinist), for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation • **Combination with trametinib (Mekinist) for locally advanced or metastatic anaplastic <u>thyroid cancer</u> with BRAF V600E mutation with no satisfactory locoregional treatment options** • **Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), nor cobimetinib (Cotellic)** Non-FDA-approved uses are NOT approved. PA does not expire.
• trametinib (Mekinist) **Oncological Agents**	**<u>Changes from the August 2018 meeting are in BOLD.</u>** Manual PA criteria apply to all new users of Mekinist. <u>Manual PA criteria</u>: • Coverage will be approved if: o Treatment (alone or in combination with dabrafenib [Tafinlar]) of unresectable or metastatic melanoma with BRAF V600E or BRA FV600K mutation OR o In combination with dabrafenib (Tafinlar), for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600Emutation • Coverage not approved as a single agent in patients who have received prior BRAF-inhibitor therapy • **Combination with dabrafenib (Tafinlar) for locally advanced or metastatic anaplastic <u>thyroid cancer</u> with BRAF V600E mutation with no satisfactory locoregional treatment options**

	• **Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), nor cobimetinib (Cotellic)** Non-FDA-approved uses are NOT approved. PA does not expire.

• vemurafenib (Zelboraf)
 	
Oncological Agents
	Changes from the August 2018 meeting are in BOLD.
	
	Manual PA criteria apply to all new users of Zelboraf.
	
	Manual PA criteria:
	• Coverage will be approved if:
	  • Documented diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation AND
	  • Detected by an FDA-approved test (Cobas 4800)
	  OR
	  • Patient has Erdheim-Chester Disease with BRAF V600 mutation
	  • **Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), nor trametinib (Mekinist)**
	
	Non-FDA-approved uses are NOT approved.
	PA does not expire.

• erenumab-aooe (Aimovig)
 	
Migraine Agents
	Manual PA criteria apply to all new users of Aimovig.
	
	Manual PA criteria: Aimovig is approved if all criteria are met:
	• Patient ≥ 18 years old and not pregnant
	• Must be prescribed by or in consultation with a neurologist
	• Patient has a migraine diagnosis with at least 8 migraine days per month for 3 months
	• Patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE drug from TWO of the following migraine prophylactic drug classes:
	  ○ Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate
	  ○ Prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol
	  ○ Prophylactic antidepressants: amitriptyline, venlafaxine
	
	Non-FDA-approved uses are NOT approved.
	PA expires after 6 months.
	
	Renewal criteria: coverage will be approved indefinitely for continuation of therapy if:
	• The patient has shown improvement in migraine prevention (e.g., reduced migraine headache days, reduced migraine frequency, reduced use of acute abortive migraine medication)

• estradiol (Imvexxy) vaginal insert
 	
Gynecological Agents Miscellaneous
	Manual PA criteria apply to all new users of Imvexxy.
	
	Manual PA criteria: Imvexxy is approved for 1 year if all criteria are met:
	• Patient is a postmenopausal woman with a diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy
	• Patient has tried and failed or has a contraindication to a low-dose vaginal estrogen preparation (e.g., Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem)
	• Patient does not have any of the following:
	  ○ Undiagnosed abnormal genital bleeding
	  ○ Pregnant or breastfeeding
	  ○ History of breast cancer or currently has active breast cancer
	  ○ History of thromboembolic disease or currently have thromboembolism
	
	Non-FDA-approved uses are NOT approved.
	PA expires in 1 year.
	
	Renewal criteria: Coverage is approved for an additional year if:
	• Patient has an improvement in dyspareunia symptom severity

• fostamatinib (Tavalisse) **Hematological Agents: Platelets**	Manual PA criteria apply to all new and current users of Tavalisse. Manual PA criteria: Fostamatinib (Tavalisse) is approved if all criteria are met: • Age ≥ 18 • Has diagnosis of chronic primary idiopathic thrombocytopenic purpura (ITP) whose disease has been refractory to at least one previous therapy (including IVIG, thrombopoietin(s), corticosteroids, and/or splenectomy) • Has laboratory evidence of thrombocytopenia with average [platelet] count less than 30 x 10^9/L over three discrete tests • Has no evidence of active or chronic infection • Has no evidence of secondary thrombocytopenia • Does not have uncontrolled hypertension • Has had no cardiovascular event (including but not limited to MI, unstable angina, PE, CVA, and/or NYHA Stage III or IV CHF) within the last 6 months • Has no evidence of neutropenia or lymphocytopenia • Prescribed by or in consultation with a hematologist/oncologist • Tavalisse is not being used concomitantly with other chronic ITP therapy Non-FDA-approved uses are NOT approved. PA expires in 120 days. **Fostamatinib (Tavalisse)** can be renewed for an additional year if all criteria are met: • Has demonstrated a response to fostamatinib (Tavalisse) as defined by a sustained platelet count > 50 x 10^9/L or an increase in [platelet count] by ≥ 20 x 10^9/L above baseline. Sustained is defined by two separate tests (at least 2 or more weeks apart) meeting either or both of the aforementioned criteria • Has no evidence of active or chronic infection • Has no evidence of secondary thrombocytopenia • If patient carries a diagnosis of hypertension, it is well controlled according to national guidelines (e.g., JNC 8) • Has had no cardiovascular event (including but not limited to MI, unstable angina, PE, CVA, and/or NYHA Stage III or IV CHF) within the last 6 months • Has no evidence of neutropenia or lymphocytopenia • Prescribed by or in consultation with a hematologist/oncologist
• hydroxyurea (Siklos) **Hematological Agents: Sickle Cell Anemia Agents**	Manual PA criteria apply to all new users of Siklos older than 18 years of age. Automated PA criteria: Siklos will be approved for patients ≤ 18 years of age. Manual PA criteria: Siklos is approved if all criteria are met: • Age ≥ 19 years • The provider documents a patient-specific reason why the patient cannot use the preferred product (generic hydroxyurea or Droxia). • Acceptable responses would include ○ The patient has a diagnosis of sickle cell disease AND has swallowing difficulties • Note that use of Siklos for malignancy (e.g., chronic myelocytic leukemia or other cancers) is not approved Non-FDA-approved uses are NOT approved. PA expires after 1 year. Renewal criteria: Coverage will be approved indefinitely if all of the following apply: • Patient continues to have swallowing difficulties that preclude the use of hydroxyurea 200 mg, 300 mg, 400 mg, or 500 mg capsules • Patient has been monitored and has had at least two laboratory draws in the last year and has not developed hematologic toxicity (Toxic hematologic ranges: Neutrophils < 2,000/mm3; platelets < 80,000/mm3; hemoglobin < 4.5 g/dL; and reticulocytes < 80,000/mm3 if hemoglobin is < 9 g/dL) • Patient has achieved a stable dose with no hematologic toxicity for 24 weeks

• lofexidine (Lucemyra) **Narcotic Analgesics and Combinations**	Manual PA criteria apply to all new users of Lucemyra. <u>Manual PA criteria</u>: Lucemyra is approved if all criteria are met: • Lucemyra is prescribed for mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation • Patient is ≥ 18 years old • Lucemyra will not be prescribed for longer than 14 days • The provider documents a patient-specific reason why the patient cannot use the preferred product, clonidine. Acceptable responses include that the patient has experienced orthostatic hypotension or severe bradycardia with previous clonidine use Non-FDA-approved uses are NOT approved (e.g., blood pressure control, nicotine withdrawal, Tourette syndrome, or ADHD). PA expires after 3 months. <u>Renewal criteria</u>: Renewal of therapy will not be allowed
• pegvaliase-pqpz (Palynziq) **Metabolic Agents Miscellaneous**	Manual PA criteria apply to all new users of Palynziq. <u>Manual PA criteria</u>: Palynziq is approved for initial therapy if all criteria are met: • Patient is ≥ 18 years of age • Patient has uncontrolled blood phenylalanine concentrations > 600 micromol/L on at least one existing treatment modality (e.g., restriction of dietary phenylalanine and protein intake, or prior treatment with Kuvan [sapropterin dihydrochloride tablets and powder for oral solution]) • Palynziq is prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses on the treatment of metabolic diseases) • Provider acknowledges and has educated the patient on the risk of anaphylaxis • Patient has a prescription for self-administered SQ epinephrine • Patient is not using Palynziq concomitantly with Kuvan Non-FDA-approved uses are NOT approved. PA expires in 6 months. <u>Renewal criteria (maintenance/continuation therapy)</u>: Coverage will be approved for 1 year if: • The patient's blood phenylalanine concentration is ≤ 600 micromol/L OR • The patient has achieved a ≥ 20% reduction in blood phenylalanine concentration from pre-treatment baseline (i.e., blood phenylalanine concentration before starting Palynziq therapy) AND • Patient is not using Palynziq concomitantly with Kuvan
• tolvaptan (Jynarque) **Nephrology Agents Miscellaneous**	Manual PA criteria apply to all new and current users of Jynarque. <u>Manual PA criteria</u>: Jynarque is approved if all criteria are met: • Age ≥ 18 • Jynarque is prescribed by or in consultation with a nephrologist • Provider acknowledges that Jynarque requires liver function monitoring with evaluation of transaminases and bilirubin before initiating treatment, at 2 weeks and 4 weeks after initiation, then continuing monthly for the first 18 months and every 3 months thereafter • Patient has rapidly progressing autosomal dominant polycystic kidney disease (ADPKD, defined as reduced or declining renal function [i.e., glomerular filtration rate {GFR} less than or equal to 65 mL/min/1.73 m^2] and high total kidney volume [i.e., greater than or equal to 750ml]) • Patient does not have Stage 5 chronic kidney disease (CKD) [GFR < 15 mL/min/1.73 m^2] • Patient is not receiving dialysis • Patient is not currently taking Samsca (tolvaptan) Non-FDA-approved uses are NOT approved. PA does not expire.

• tofacitinib (Xeljanz/Xeljanz XR)
 	
Targeted Immunomodulatory Biologics (TIBs)
	<u>Changes from the August 2018 meeting are in BOLD.</u>
	
	<u>Manual PA criteria</u>: Xeljanz/Xeljanz XR is approved if **ALL** of the following criteria are met:
	• Patient has diagnosis of:
	  • Moderately to severely active rheumatoid arthritis who has had an inadequate response or intolerance to methotrexate OR
	  • Active psoriatic arthritis OR
	  • **Moderately to severely active ulcerative colitis, and not in combination with biological therapies for ulcerative colitis**
	  • Not approved for use in combination with other biologics or potent immunosuppressants (e.g., azathioprine and cyclosporine)
	• ≥ 18 years of age
	• Contraindication/inadequate response to Humira
	• Adverse reactions to Humira not expected with requested non-step-preferred TIB
	• Medication will not be used concomitantly with other TIBs
	
	Non-FDA-approved uses are NOT approved.
	PA does not expire.

Appendix D—Table of Quantity Limits (QLs)

Drug / Drug Class	Quantity Limits
• Crisaborole (Eucrisa) **Corticosteroids – Immune Modulators – Atopic Dermatitis Subclass**	**No change from May 2017 meeting** ▪ MTF/Mail: 240 gm (4 tubes) in 56 days ▪ Retail: 120 gm (2 tubes) in 28 days
• Dupilumab (Dupixent) **Corticosteroids – Immune Modulators – Atopic Dermatitis Subclass**	**No change from May 2017 meeting** ▪ MTF/Mail: 56-day supply ▪ Retail: 28-day supply
• daclatasvir (Daklinza) • sofosbuvir/velpatasvir (Epclusa) • ledipasvir/sofosbuvir (Harvoni) • glecaprevir/pibrentasvir (Mavyret) • simeprevir (Olysio) • sofosbuvir (Sovaldi) • paritaprevir/ritonavir/ombitasvir (Technivie) • dasabuvir tablets pak (Viekira Pak) • paritaprevir/ritonavir/ombitasvir/dasabuvir XR tablets (Viekira XR) • sofosbuvir/velpatasvir/voxilaprevir (Vosevi) • grazoprevir/elbasvir (Zepatier) **Hepatitis C Virus - Direct Acting Antivirals Subclass (HCV DAAs)**	**No change from Feb 2017 meeting, or Nov 2017 meeting (Mavyret and Vosevi)** ▪ MTF/Mail/Retail: 28-day supply
• abiraterone acetate (Yonsa) **Oncological Agents: Prostate II**	▪ MTF/Mail: 180 tablets/45 days ▪ Retail: 120 tablets/30 days
• adalimumab (Humira Pediatric Crohn's Start, Humira Pen-CD/UC/HS starter, Humira Pen-Ps/UV Pens) **Targeted Immunomodulatory Biologics (TIBs)**	▪ MTF/Mail: 60-day supply ▪ Retail: 30-day supply
• avatrombopag (Doptelet) **Hematological Agents: Platelets**	▪ MTF/Mail/Retail: 5-day supply
• baricitinib (Olumiant) **Targeted Immunomodulatory Biologics (TIBs)**	▪ MTF/Mail: 60-day supply ▪ Retail: 30-day supply
• beclomethasone (QVAR & QVAR RediHaler) **Pulmonary-1 Agents: Inhaled Corticosteroids**	▪ MTF/Mail: 3 inhalers /90 days ▪ Retail: 1 inhaler /30 days
• binimetinib (Mektovi) **Oncological Agents**	▪ MTF/Mail: 60-day supply ▪ Retail: 30-day supply

Drug / Drug Class	Quantity Limits
• encorafenib (Braftovi) **Oncological Agents**	▪ MTF/Mail: 60-day supply ▪ Retail: 30-day supply
• erenumab-aooe (Aimovig) **Migraine Agents**	▪ MTF/Mail/Retail: 1 syringe (70mg)/30 days ▪ Adequate trial of lower strength required for 3 months before trying the higher strength
• flurandrenolide (Cordran) Tape **Corticosteroids-Immune Modulators: High Potency**	▪ MTF/Mail/Retail: 1 roll of tape per prescription fill ▪ No refills allowed
• fostamatinib (Tavalisse) **Hematological Agents: Platelets**	▪ MTF/Mail/Retail: 30-day supply
• ibrutinib (Imbruvica) 420 mg tablets **Oncological Agents**	▪ MTF/Mail/Retail: 28 tabs/28-day supply
• levonorgestrel/EE (Jolessa) **Contraceptive Agents: Extended Cycle/ Continuous Use Regimen**	▪ QLs removed at all POS
• lofexidine (Lucemyra) **Narcotic Analgesics and Combinations**	▪ MTF/Mail/Retail: 96 tabs/14 days
• ondansetron ODT and oral tablet (Zofran) **Antiemetic-Antivertigo Agents**	▪ QLs removed at all POS
• pegvaliase-pqpz (Palynziq) **Metabolic Agents Miscellaneous**	▪ MTF/Mail: 45-day supply ▪ Retail: 30-day supply
• sarilumab (Kevzara Pen) **Targeted Immunomodulatory Biologics (TIBs)**	▪ MTF/Mail: 56-day supply ▪ Retail: 28-day supply
• tolvaptan (Jynarque) **Nephrology Agents Miscellaneous**	▪ MTF/Mail/Retail: 30-day supply
• ustekinumab (Stelara) **Targeted Immunomodulatory Biologics (TIBs)**	Dosing for Crohn's disease, plaque psoriasis, and psoriatic arthritis ▪ MTF/Mail: 2 syringes/84 days ▪ Retail: 1 syringe/28 days

Appendix E—Formulary Recommendations for Newly Approved Drugs Per 32 CFR 199.21(g)(5)

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
abiraterone acetate micronized (Yonsa)	Oncological Agents: Prostate II	• abiraterone acetate (Zytiga) • enzalutamide (Xtandi)	Metastatic castration-resistant prostate cancer (mCRPC)	• New micronized formulation of abiraterone acetate • Approved via 505(b)(2) pathway with no new clinical studies performed • Bioequivalence/dose-finding study completed comparing Yonsa to Zytiga and effects on testosterone levels and PSA-50 response • Has easier dosing with regards to food compared to Zytiga, but provides no additional benefit relative to current formulary agents	• UF • Do not add to EMMPI list
amantadine ER tablets (Osmolex ER)	Parkinson's Agents	• amantadine IR • amantadine ER (Gocovri ER)	Parkinson's disease drug-induced extra-pyramidal reactions in adults	• Second ER once daily amantadine formulation, with no clinically significant differences between either IR or ER • Extended-release amantadine tablet formulation marketed to reduce nocturnal side effects in patients who may experience adverse effects from immediate-release (IR) medication • FDA approval based on pharmacokinetic comparison to the IR amantadine formulation with no new clinical efficacy and safety data	• NF • Add to EMMPI list
avatrombopag (Doptelet)	Hematological Agents: Platelets	• eltrombopag (Promacta) • romiplostim (Nplate)	Thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure	• 3rd thrombopoietin marketed • Indicated for patients with chronic liver disease (CLD) and severe thrombocytopenia to be given 10-13 days prior to a planned procedure • Most useful for procedures with an intermediate to high bleeding risk • Clinically useful for a subset of patients	• UF • Do not add to EMMPI list
baricitinib (Olumiant)	TIBs: Miscellaneous	• Xeljanz • Xeljanz XR • Kevzara • Actemra • Kineret • Orencia • Otezla	Moderate to severe active rheumatoid arthritis (RA) that has had an inadequate response to one or more TNF antagonist therapies	• 2nd oral JAK inhibitor for RA • Only approved for RA in patients refractory to tumor necrosis factor (TNF) inhibitors • Efficacy superior to a DMARD alone • Similar efficacy to Xeljanz by indirect comparison • Black box warning includes unique safety risk for thrombosis	• UF • Add to EMMPI list
binimetinib (Mektovi)	Oncological Agents	• see encorafenib below	Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation	• Only used in combination with Braftovi (see encorafenib below)	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
encorafenib (Braftovi)	Oncological Agents	• dabrafenib (Tafinlar) plus trametinib (Mekinist) • vemurafenib (Zelboraf) plus cobimetinib (Cotellic)	Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation	• Only used in combination with binimetinib (Mektovi) • Braftovi/Mektovi is the third unique combination to treat *BRAF*(+) metastatic melanoma • No properly designed head-to-head trials to determine superiority, non-inferiority, or inferiority between the three combinations for *BRAF*(+) metastatic melanoma • Braftovi/Mektovi demonstrates progression-free survival in *BRAF*(+) metastatic melanoma and appears to have a fairly comparable adverse event profile to other BRAF/MEK inhibitor combinations	• UF • Do not add to EMMPI list
epoetin-alfa-epbx injection (Retacrit)	Hematological Agents: Red Blood Cell Stimulants	• epoetin alfa (Procrit, Epogen)	Anemia due to: CKD, zidovudine treatment, or myelosuppressive chemotherapy; reduction of allogeneic RBC transfusions in patients undergoing elective, non-cardiac, nonvascular surgery	• Biosimilar of epoetin alfa, human recombinant erythropoietin • Approved via 351(k) biosimilar pathway • No new trials; identical efficacy and safety profiles • Black box warning for increased mortality, myocardial infarction, stroke, VTE, tumor progression/recurrence in cancer, seizure risk in CKD; must control HTN prior to initiation and during therapy; may cause severe cutaneous reactions; contains phenylalanine	• UF • Add to EMMPI list

erenumab-aooe injection (Aimovig)	Migraine Agents	• divalproex
		• metoprolol
		• atenolol
		• amitriptyline
		• venlafaxine
		• propranolol
		• nadolol
		• topiramate IR tabs
		• topiramate ER (Qudexy XR)
		• topiramate ER (Trokendi XR)
			Calcitonin gene-related peptide (CGRP) antagonist for migraine prophylaxis	• Aimovig is the first approved CGRP inhibitor for migraine prevention.
				• Approved for prevention of episodic migraine (EM) and chronic migraine (CM) in adults.
				• Guidelines recommend preventive treatment of headaches starting at ≥ 4 monthly migraine days (MMD).
				• Baseline MMD averages were 8 for EM and 18 for CM in Aimovig clinical trials.
				• Episodic Migraine
				  • Treatment led to about 3 to 4 fewer migraine headache days/month.
				  • Significant placebo effect
				  • The difference between erenumab and placebo was approximately 2 fewer migraine headache days/month.
				• Chronic Migraine
				  • Phase 2 study showed similar efficacy as that of botulinum toxin; erenumab decreased MMD by 7 from a baseline of 18 MMD
				  • Can treat with current preventive therapy (topiramate, etc.)
				  • Botulinum toxin is approved for chronic migraine
				• Aimovig and current preventive therapy decrease the number of migraine headache days at similar rates of 2 per month.
					• UF
					• Add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
				• The 140-mg dose was not more effective than the 70-mg dose; 70-mg and 140-mg doses have a relatively flat dose response. • ICER concludes the cost-effectiveness of Aimovig is likely below the upper bound of commonly accepted thresholds.	
estradiol vaginal insert (Imvexxy)	Gynecological Agents Miscellaneous	• estradiol cream (Premarin) • ospemifene (Osphena) • prasterone (Intrarosa)	Dyspareunia	• New vaginal insert formulation of estradiol FDA-approved for dyspareunia. • Unlike vaginal creams, Imvexxy cannot be titrated • There are no head-to-head comparisons of Imvexxy with other estradiol formulations or similar drugs with an indication for dyspareunia; only one placebo-controlled trial available. • Contains the usual warning for increased risk of endometrial cancer in women who have an intact uterus who use unopposed systemic estrogen therapy • Provides little to no clinical benefit relative to other estradiol formulations or similar drugs for the treatment of dyspareunia	• NF • Add to EMMPI list • No auto refill
fostamatinib (Tavalisse)	Hematological Agents: Platelets	• eltrombopag (Promacta) • romiplostim (Nplate)	Chronic immune thrombocytopenia (ITP) in patients who have had an insufficient response to a previous treatment	• 1st SYK inhibitor to treat thrombocytopenia in chronic ITP • Multiple other agents for chronic ITP, but only one other pharmacy benefit agent (Promactra), a thrombopoietin • Indicated in patients with chronic ITP who have had an insufficient response to a previous treatment • FIT 1 & 2 trials showed statistically and clinically significant benefits over placebo in a discrete (and small) subset of patients • Responders declare themselves early with a robust and sustained response • Significant adverse effects exist; however, in this treatment-refractory population, for responsive patients, benefits may outweigh risks	• UF • Do not add to EMMPI list
hydroxyurea tablets (Siklos)	Hematological Agents: Sickle Cell Anemia Agents	• hydroxyurea (generics) • l-glutamine (Endari)	Reduce the frequency of painful crises caused from sickle cell anemia and to reduce need for blood transfusions in pediatric patients ≥ 2 years of age, with recurrent moderate to severe painful crises	• New formulation of hydroxyurea specifically approved for sickle cell disease in pediatric patients for which it was given orphan drug designation • Other hydroxyurea formulations have been used off-label in pediatric populations with sickle cell disease • Hydroxyurea is routinely recommended in clinical practice guidelines for sickle cell disease • New strength of hydroxyurea (1000 mg tablet has 3 score lines allowing dosing in 250 mg increments; 100 mg tablet not scored); tablets can be dissolved in water for administration • Other hydroxyurea formulations are used in the oncology setting, including treatment of chronic myelocytic leukemia • Siklos has little to no clinical benefit relative to other hydroxyurea UF formulations	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
levonorgestrel/ ethinyl estradiol/ ferrous (Balcoltra)	Contraceptive Agents: Monophasics with 20 mcg EE	• Lessina • Loestrin FE	Prevention of pregnancy	• Levonorgestrel-containing combined oral contraceptive (COC) drug with iron-containing inert pills, which as stated in the package insert, "do not provide any therapeutic purpose." • Indications, efficacy, and safety comparable to multiple COCs on the formulary • No compelling advantage over existing COCs available on the BCF and UF	• NF • Do not add to EMMPI list
lofexidine (Lucemyra)	Narcotic Analgesics and Combinations	• clonidine 0.1 mg	Mitigation of abrupt opioid withdrawal symptoms	• 1st drug FDA-approved to treat opioid withdrawal symptoms, but clonidine is widely used off label for this purpose • Only placebo-controlled trials available; lofexidine is statistically superior to placebo at day 7 • Lofexidine has been approved in Europe since 1992 and has been indirectly compared to clonidine with similar efficacy but with claims of fewer side effects • An FDA clinical reviewer stated that there is no basis for claiming safety advantages of lofexidine over clonidine • No advantages over current therapies for managing symptoms of opioid withdrawal	• NF • Do not add to EMMPI list
oxycodone IR (Roxybond)	Narcotic Analgesics and Combinations	• oxycodone IR • morphine IR • OxyContin	Pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate	• 10th narcotic abuse deterrent formulation (ADF) and 1st short-acting (IR) abuse deterrent agent marketed • Bioequivalent to oxycodone; no additional efficacy studies conducted • Associated with lower "drug liking" and "take drug again" scores • CPGs do not recommend for or against ADFs • ICER committee voted there was insufficient information to recommend Roxybond • Provides little to no clinical benefit relative to other oxycodone formulations or other narcotic analgesics	• NF • Do not add to EMMPI list
pegvaliase-pqpz injection (Palynziq)	Metabolic Agents Miscellaneous	• sapropterin (Kuvan 100 mg tab and 500 mg powder)	Reduce blood phenylalanine concentrations in adult patients with phenylketonuria (PKU) who have uncontrolled blood phenylalanine concentrations > 600 micromol/L on existing management	• Novel agent approved for PKU to lower phenylalanine levels in adults with inadequate control on existing therapy • Palynziq replaces the PAL enzyme, which converts the accumulated phenylalanine into excretable byproducts • Reasonably effective in reducing the serum phenylalanine concentrations • Treatment with pegvaliase does not require residual enzyme activity to be effective • Study patients were not required to adhere to a strict phenylalanine-restricted diet • Kuvan was the first agent FDA-approved for PKU, but only 25% to 50% of patients with PAH deficiency are Kuvan-responsive • Contains a boxed warning for the risk of anaphylaxis; only available through a restricted REMS program	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
				• Palynziq has a unique place in therapy for the treatment of PKU, by potentially fulfilling an unmet need in patients with uncontrolled phenylalanine levels who have not adequately responded to dietary restrictions and/or Kuvan therapy	
tolvaptan (Jynarque)	Nephrology Agents Miscellaneous	• tolvaptan (Samsca)	Rapidly progressing autosomal dominant polycystic kidney disease (ADPKD)	• Jynarque is another formulation of tolvaptan, a vasopressin antagonist, approved for rapidly progressing ADPKD • Two published studies showed statistically significant differences in total kidney volume, fewer ADPKD-related events, and slower renal function decline with tolvaptan compared to placebo • While statistically significant in most endpoints, study results were not clinically significant • Safety concerns include risk of liver injury that requires frequent monitoring and a stringent REMS • Most common ADRs leading to discontinuation (15.4%) were aquaretic effects (pollakiuria, polyuria, nocturia) • Few alternatives currently exist for ADPKD; however, it is unclear the exact patient who will benefit from tolvaptan, and long-term benefits have not been established	• UF • Do not add to EMMPI list

Appendix F—Mail Order Status of Medications Designated Nonformulary During the August 2018 DoD P&T Committee Meeting

DoD P&T Meeting	ADD to the Mail Order Requirement (NOT Excepted from Mail Order Requirement)	Do NOT Add to the Mail Order Requirement (Excepted from Mail Order Requirement)
August 2018	**Corticosteroids – Immune Modulators: Atopic Dermatitis** crisaborole (Eucrisa) (maintain on list) **Newly Approved Drugs per 32 CFR 199.21(g)(5)** ▪ amantadine ER (Osmolex ER) ▪ estradiol (Imvexxy)	**HCV DAAs** Limited duration of use (acute use exception applies): ▪ daclatasvir (Daklinza) ▪ simeprevir (Olysio) ▪ sofosbuvir (Sovaldi) ▪ grazoprevir/elbasvir (Zepatier) **Newly Approved Drugs per 32 CFR 199.21(g)(5)** Acute use exception applies: ▪ lofexidine (Lucemyra) Existing exceptions apply: ▪ oxycodone IR (Roxybond), C-II exception ▪ levonorgestrel/ethinyl estradiol/iron (Balcoltra), contraceptive exception

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

Date	DoD PEC Drug Class	Type of Action	BCF/ECF Medications MTFs must have BCF meds on formulary	UF Medications MTFs may have on formulary	Nonformulary Medications MTFs may not have on formulary	Decision Date / Implement Date	PA and QL Issues	Comments
Aug 2018	**Corticosteroids-Immune Modulators: Atopic Dermatitis Subclass**	UF Class Review	BCF ▪ pimecrolimus (Elidel) remains BCF ▪ tacrolimus generic added to the BCF	UF ▪dupilumab injection (Dupixent)	NF ▪ crisaborole (Eucrisa)	Pending signing of the minutes - 2 weeks after signing The effective date is November 21, 2018.	▪ Manual PA criteria applies to all new users for dupilumab (Dupixent) and crisaborole (Eucrisa).	▪ Updates made to the Dupixent PA ▪ Tacrolimus added to the BCF ▪ See Appendix C for PA criteria.
Aug 2018	**Hepatitis C Virus (HCV) Direct-Acting Antivirals Subclass (DAAs)**	UF Class Review Class previously reviewed in Feb 2017, May 2015, Nov 2012; New drug review in Nov 2017	Extended Core Formulary (ECF) No DAA selected ▪peginterferon alfa-2a (Pegasys) Nov 2012 ▪ribavirin 200 mg capsules (generics); excludes RibaPak formulation Nov 2012	UF ▪sofosbuvir/velpatasvir (Epclusa) ▪ledipasvir/sofosbuvir (Harvoni) ▪glecaprevir/ pibrentasvir (Mavyret) ▪paritaprevir/ritonavir/ ombitasvir (Technivie) ▪paritaprevir/ritonavir/ ombitasvir/dasabuvir XR (Viekira XR) ▪paritaprevir/ritonavir/ ombitasvir/dasabuvir Pak (Viekira Pak) ▪sofosbuvir/velpatasvir/ voxilaprevir (Vosevi)	NF ▪ daclatasvir (Daklinza) ▪ simeprevir (Olysio) ▪ sofosbuvir (Sovaldi) ▪ grazoprevir/elbasvir (Zepatier)	Pending signing of the minutes / 60 days The effective date is January 2, 2018.	▪ Manual PA required. ▪ QLs apply; 28-day supply.	▪ Previous requirement for step therapy with Harvoni removed ▪ PA criteria simplified for all the DAAs except Vosevi ▪ Vosevi separate PA form due to unique FDA indication ▪ See Appendix C for PA criteria.

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

Appendix H—Table of Abbreviations

AAD	American Academy of Dermatology
AASLD	American Association for the Study of Liver Diseases
ACTH	adrenocorticotropic hormone
AD	atopic dermatitis
ADF	abuse deterrent formulation
ADHD	Attention Deficit Hyperactivity Disorder
ADPKD	autosomal dominant polycystic kidney disease
ADR	adverse drug reaction
ARB	angiotensin receptor blocker
BCF	Basic Core Formulary
BIA	budget impact analysis
CFR	Code of Federal Regulations
CGRP	calcitonin gene-related peptide
CHF	congestive heart failure
CKD	chronic kidney disease
CLD	chronic liver disease
CM	chronic migraine
CMA	cost minimization analysis
COC	combined oral contraceptive
CPG	Clinical Practice Guidelines
CVA	cerebral vascular accident
DAA	Direct Acting Antivirals drug class
DHA	Defense Health Agency
DMARD	disease-modifying anti-rheumatic drug
DoD	Department of Defense
ECF	Extended Core Formulary
EE	ethinyl estradiol
eGFR	estimated glomerular filtration rate
EM	episodic migraine
EMMPI	The Expanded MTF/Mail Pharmacy Initiative
ER	extended release
ESRD	end stage renal disease
FDA	U.S. Food and Drug Administration
GnRH	gonadotropin-releasing hormone
GT	genotype
HCTZ	hydrochlorothiazide
HCV	Hepatitis C virus
HFpEF	heart failure with preserved ejection fraction
HTN	hypertension
ICER	Institute for Clinical and Economic Review
IDSA	Infectious Diseases Society of America
IR	immediate release
ISGA	Investigator's Static Global Assessment
ITP	immune thrombocytopenia
IVIG	intravenous immunoglobulin
JAK	Janus kinase

JAMA	Journal of the American Medical Association
JNC	Joint National Committee
mCRPC	metastatic castration-resistant prostate cancer
mHRCSPC	metastatic high-risk castration-sensitive prostate cancer
MEK	
MHS	Military Health System
MI	myocardial infarction
MMD	monthly migraine days
MN	medical necessity
MS	multiple sclerosis
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act
NF	nonformulary
NSAID	nonsteroidal anti-inflammatory drug
NSCLC	non-small cell lung cancer
NYHA	New York Heart Association
ODT	orally dissolving tablet
OTC	over-the-counter
P&T	Pharmacy and Therapeutics
PA	prior authorization
PAL	phenylalanine ammonia lyase
PBM	pharmacy benefit manager
PDE-4	phosphodiesterase-4
PE	pulmonary embolism
PERT	Pancreatic Enzymes Replacement Therapy drug class
PKU	phenylketonuria
POS	point of service
PPI	proton pump inhibitor
PSA	prostate-specific antigen
PT	patient
QL	quantity limit
RA	Rheumatoid arthritis
RAAs	Renin Angiotensin Antihypertensive Agents class
RAV	resistance-associated variant
RBC	red blood cell
RCT	randomized controlled trial
REMS	Risk Evaluation and Mitigation Strategies
SQ	subcutaneous
TCI	topical calcineurin inhibitor
TIBs	targeted immunomodulatory biologics
TNF	tumor necrosis factor
UCLA	University of California, Los Angeles
UF	Uniform Formulary
VTE	venous thromboembolism
XR	extended release