DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE

MINUTES AND RECOMMENDATIONS

November 2018

I. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on November 7 and 8, 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 August 2018 Minutes—**Mr. Guy Kiyokawa, Deputy Director, DHA, approved the minutes from the August 2018 DoD P&T Committee meeting on November 1, 2018.

2. **Clarification of Previous Minutes**

   a) **May 2018 Meeting—Pancreatic Enzyme Replacement Therapies (PERTs):** Pertzye is currently nonformulary. The implementation for Pertzye, requiring a trial of Creon first, will be delayed from November 7, 2018 to January 2, 2019.

   b) **May 2018 Meeting—Growth Stimulating Agents (GSAs):** The manual prior authorization (PA) criteria for the nonformulary, non-step-preferred GSAs were revised to only require a trial of Norditropin FlexPro first. See Appendix C for full criteria.

   c) **August 2018 Meeting—Implementation Dates**: Implementation for all items scheduled for two weeks after signing of the minutes has been delayed from November 21st to November 28th, due to the volume of changes. Affected actions include the atopic dermatitis PA update, the newly approved drugs formulary status and PAs, utilization management items, and line extensions.

   d) **August 2018 Meeting—Baricitinib (Olumiant) PA:** New manual PA criteria for Olumiant will apply to both new and current users, due to the safety concerns of thrombosis.

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. Gastrointestinal (GI)-2 Agents – Chronic Idiopathic Constipation (CIC) and Constipation-Predominant Irritable Bowel Syndrome (IBS-C) and GI-2 Agents – Miscellaneous Subclasses

Background—The P&T Committee evaluated the relative clinical effectiveness of the drugs used for chronic idiopathic constipation (CIC), constipation-predominant irritable bowel syndrome (IBS-C), and diarrhea-predominant irritable bowel syndrome (IBS-D). The products in the CIC/IBS-C subclass include linaclotide (Linzess), plecanatide (Trulance), and lubiprostone (Amitiza). The agents in the Miscellaneous subclass approved for IBS-D include rifaximin (Xifaxan) and eluxadoline (Viberzi).

The Committee reviewed new data available since the previous formulary decisions in 2011 and 2015. Use of rifaximin for hepatic encephalopathy or traveler's diarrhea and the other products in the Miscellaneous subclass were previously reviewed, and were not a focus of this analysis. Fidaxomicin (Dificid) and nitazoxanide (Alinia) have specific unique indications outside of CIC, IBS-C, and IBS-D and will remain on the formulary, as will the generic products, including alosetron, metronidazole, neomycin, and vancomycin. Tegaserod (Zelnorm) has been discontinued from the market.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 2 absent) the following:

Guidelines

- Guidelines from the American College of Gastroenterology (ACG) were updated for IBS in 2018. The ACG continues to recommend tricyclic antidepressants (TCAs) as a strong recommendation with high quality evidence for treating pain in IBS.
- Guidelines from several other organizations, including the American Gastroenterological Association Institute (AGAI) (2014), the Canadian guidelines published in the Canadian Journal of Gastroenterology and Hepatology (2017), the National Institute for Health and Care Excellence (NICE), and the World Gastroenterology Organization (WGO) (2015) were reviewed for treatment recommendations and for guiding development of the PA criteria.

- Most constipation-related guidelines for IBS-C and CIC include use of fiber, dietary and lifestyle modification, TCAs, antidiarrheals, and laxatives. Antispasmodics remain an option and are included in several guidelines.
- Guidelines for IBS-D include TCAs and antispasmodics/antidiarrheals as key components of therapy. In the 2018 ACG guidelines, TCAs remained a strong recommendation based on high quality evidence, while antispasmodics have a weak recommendation, based on low quality evidence. Other guidelines give a higher recommendation for antispasmodics, based on cost-effectiveness.

CIC and IBS-C Summary

- Linaclotide, plecanatide, and lubiprostone have all shown improvement in treating the constipation symptoms associated with IBS-C and CIC, compared to placebo.
- Lubiprostone (Amitiza) is indicated for CIC; however, its indication for IBS-C is limited to women. It is also indicated for opioid-induced constipation (OIC).
- In a 2018 systematic review from the American Journal of Gastroenterology by Shah and colleagues, linaclotide and plecanatide demonstrated similar efficacy, safety, and adverse effects in treating IBS-C and CIC. Additionally, there was no statistically significant difference between linaclotide 72 mcg and 145 mcg compared to plecanatide 3 mg in terms of efficacy in CIC, occurrence of the adverse effect of diarrhea, or patient withdrawals from the study due to diarrhea.
- The difference in the incidence of diarrhea occurring with plecanatide versus linaclotide cannot be fairly compared because diarrhea was measured differently in the respective studies.

IBS-D Summary

- The ACG 2018 guidelines for IBS-D added eluxadoline as a weak recommendation with moderate quality evidence; this is the same recommendation as for rifaximin.
- FDA approval of rifaximin (Xifaxan) for IBS-D was based on the TARGET 3 trial, which found that rifaximin was modestly more effective than placebo in relieving IBS-D symptoms. Rifaximin appears to have a greater impact on reducing abdominal pain and has less impact on improving stool consistency.
    - Since the last formulary review, there are no new studies for IBS-D for rifaximin.
    - Rifaximin is only approved for a 14-day treatment course for IBS-D, allowing for retreatment up to two times if symptoms recur.
- Rifaximin is not systemically absorbed and is therefore well tolerated with few safety concerns.
- Rifaximin has many potential off-label uses for which there is little or no supporting clinical data.
    - Although there is one systematic review for rifaximin in small intestinal bacterial overgrowth (SIBO) that showed a bacterial eradication rate of 71%, the

results are limited by observational study design, significant heterogeneity of studies, and varied durations of therapy and administered doses.

  - Use of rifaximin in non-alcoholic steatohepatitis (NASH) or non-alcoholic fatty liver disease (NAFLD) is limited due to small numbers of patients, varying doses and dosing regimens, and conflicting results.
  - At this time, unsupportable uses of rifaximin include SIBO, NASH, NAFLD, Crohn's disease, ulcerative colitis, diabetes, cirrhosis, Graft vs Host disease, primary sclerosing cholangitis, chronic abdominal pain, Celiac disease, bowel preparation for colonoscopy, constipation, colorectal cancer prevention, opioid-induced constipation, spontaneous bacterial peritonitis (SBP), and functional dyspepsia.

- Eluxadoline was evaluated in two placebo-controlled trials for IBS-D. Overall, eluxadoline appears to improve stool consistency and has less of an impact on relieving abdominal pain.
- A 2017 United Kingdom NICE technology appraisal of eluxadoline recommended its use only in refractory patients or those with contraindications to other treatments (e.g., antimotility agents, antispasmodics, or TCAs). Additionally, NICE recommends discontinuing eluxadoline if no response is seen after four weeks of therapy.
- The FDA issued a warning for eluxadoline in March 2017 to avoid use in patients who have had a cholecystectomy, due to an increased risk of pancreatitis and death.
- Eluxadoline limitations include numerous drug interactions and contraindications, lack of long-term safety data, and potential for abuse.

Overall Conclusion

- Studies with Linzess, Amitiza, and Trulance for IBS-C and CIC, and Xifaxan and Viberzi for IBS-D showed statistically significant results compared to placebo. However, for all the drugs, the clinical significance of the study results remains unclear, and all studies showed a significant placebo effect.
- At this time, comparative efficacy statements between the GI-2 drugs cannot be made, due to widely differing mechanisms of action, lack of head-to-head studies, lack of consistent diagnostic criteria, and variable subjective endpoints.

Relative Cost-Effectiveness Analysis and Conclusion—Cost-minimization analysis (CMA) and budget impact analysis (BIA) were performed to evaluate the GI-2 agents. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results for the CIC/IBS-C subclass showed that linaclotide (Linzess), lubiprostone (Amitiza), and plecanatide (Trulance) were all cost-effective agents.
- BIA was performed for the CIC/IBS-C subclass to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating linaclotide (Linzess), lubiprostone (Amitiza), and plecanatide

(Trulance) as formulary demonstrated significant cost avoidance for the Military Health System (MHS).

- CMA results for the GI-2 Miscellaneous subclass showed that alosetron (Lotronex), eluxadoline (Viberzi), fidaxomicin (Dificid), nitazoxanide (Alinia), and rifaximin (Xifaxan) were all cost-effective agents.
- BIA was performed for the GI-2 Miscellaneous subclass to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating alosetron (Lotronex, generics), eluxadoline (Viberzi), fidaxomicin (Dificid), nitazoxanide (Alinia), and rifaximin (Xifaxan) as formulary demonstrated significant cost avoidance for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following for the GI-2 agents, as outlined below, based on clinical and cost effectiveness:
    - UF

      CIC/IBS-C Subclass
        - linaclotide (Linzess)
        - lubiprostone (Amitiza)
        - plecanatide (Trulance)

      Miscellaneous Subclass
        - alosetron (Lotronex, generics)
        - eluxadoline (Viberzi)
        - rifaximin (Xifaxan)
        - nitazoxanide (Alinia)
        - fidaxomicin (Dificid)
        - vancomycin oral (generics)
        - neomycin (generics)
        - metronidazole (Flagyl, generics)
    - NF
        - None

      Note that vancomycin 25 and 50 mg oral solution (Firvanq) was reviewed as a new drug at the May 2018 meeting and will remain UF.

2. ***COMMITTEE ACTION: BCF RECOMMENDATION***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) maintaining metronidazole (250 mg and 500 mg) on the BCF. The Committee decided it is not in the best interest of the government to choose a CIC/IBS-C or IBS-D agent for BCF placement at this time based on cost effectiveness.

3. ***COMMITTEE ACTION: MANUAL PRIOR AUTHORIZATION CRITERIA***— New manual PA criteria for lubiprostone (Amitiza) and linaclotide (Linzess) were recommended by the P&T Committee (16 for, 0 opposed, 0 abstained, 0 absent) for all new and current users, requiring a trial of drugs from at least two standard laxative classes first, unless contraindicated. Off-label use of Linzess for opioid-induced constipation (OIC) is allowed. The P&T Committee also recommended updating the current PA criteria for all new users of plecanatide (Trulance) to reflect the criteria for Amitiza and Linzess, with the exception that use of Trulance for OIC is not allowed.

   The Committee also recommended updating the current PAs for rifaximin (Xifaxan) and eluxadoline (Viberzi) to require a trial of lifestyle modifications including dietary fiber and stress reduction. Any non-FDA-approved use for rifaximin is not allowed. There were no changes recommended to the PA criteria for rifaximin for hepatic encephalopathy or traveler's diarrhea. See Appendix C for the full criteria.

4. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) changing the current QLs for rifaximin 550 mg (Xifaxan) to now allow three treatment courses for IBS-D in 365 days and 42 tablets per prescription fill. See Appendix D.

5. ***COMMITTEE ACTION: EXPANDED MILITARY TREATMENT FACILITY (MTF)/MAIL PHARMACY INITIATIVE (EMMPI) REQUIREMENTS—***The P&T Committee agreed that branded agents in this class were suitable for the EMMPI program, with the exception of nitazoxanide (Alinia), Xifaxan 200 mg (the dose used for traveler's diarrhea), and fidaxomicin (Dificid). The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) adding lubiprostone (Amitiza), linaclotide (Linzess), plecanatide (Trulance), rifaximin 550 mg (Xifaxan) for hepatic encephalopathy and IBS-D, and eluxadoline (Viberzi) to the EMMPI program. See Appendix F.

2. ***COMMITTEE ACTION: MAIL ORDER AUTO-REFILL REQUIREMENTS FOR THE GASTROINTESTINAL-2 DRUGS***—The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) excluding lubiprostone (Amitiza), linaclotide (Linzess), plecanatide (Trulance), rifaximin (Xifaxan), and eluxadoline (Viberzi) from the Auto-Refill program administered by Express Scripts, Inc. at the TRICARE Mail Order Pharmacy due to the symptomatic nature of CIC/IBS-C and IBS-D. Fidaxomicin (Dificid) and nitazoxanide (Alinia) were also excluded due to the short treatment courses for infectious diseases.

3. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD—***The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) 1) an effective date of the first Wednesday after a 90-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 May 15, 2019.

B. Neurological Agents Miscellaneous – Movement Disorders Subclass

Background—The P&T Committee evaluated the relative clinical effectiveness of the Movement Disorder subclass, which includes the vesicular monoamine transporter type 2 (VMAT2) inhibitors. The drugs evaluated were tetrabenazine (Xenazine, generics), deutetrabenazine (Austedo), and valbenazine (Ingrezza). Tetrabenazine and deutetrabenazine are approved for treating Huntington's disease chorea, while both deutetrabenazine and valbenazine are indicated for tardive dyskinesia. Deutetrabenazine and valbenazine were previously reviewed as newly approved drugs in 2017, so the clinical review focused on clinical practice guidelines, meta-analyses, and systematic reviews.

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

Huntington's disease (HD) chorea

- Professional clinical practice guidelines from the American Academy of Neurology (AAN) in 2012 listed tetrabenazine as likely effective in decreasing chorea associated with Huntington's disease to a very important degree, based on level B evidence.
- There are no head-to-head trials comparing tetrabenazine with Austedo. However, a published indirect comparison concluded that tetrabenazine and deutetrabenazine (Austedo) do not differ in efficacy, based on low-quality evidence.
- With regard to safety, both tetrabenazine and deutetrabenazine (Austedo) carry a black box warning for increased depression and suicidality when used for Huntington's disease chorea.
- Common adverse effects associated with tetrabenazine include sedation, somnolence, insomnia, and depression. The package insert for Austedo lists fewer neuropsychiatric adverse effects than tetrabenazine.
- There is insufficient evidence to determine whether there is a clinically significant difference in safety between tetrabenazine and deutetrabenazine (Austedo), due to the lack of head-to-head trials and conflicting results from two published indirect comparisons that used the same data.

Tardive dyskinesia

- Guidelines from the AAN in 2016 graded tetrabenazine as having level C evidence that it reduces symptoms and may be considered in treating tardive dyskinesia. Based on level B evidence, clonazepam was considered probably effective in decreasing tardive

dyskinesia symptoms in the short-term, and ginkgo biloba extract was also probably useful, with the data limited to an inpatient population.

- A 2018 systematic review from the Journal of Neurological Science considered deutetrabenazine and valbenazine as effective for tardive dyskinesia, based on level A evidence. The authors also recommended that for patients who have no access to Austedo or Ingrezza, to consider tetrabenazine, despite the lesser evidence available than with clonazepam or ginkgo biloba.
- A report from the Institute for Clinical Effectiveness Research (ICER) found promising but inconclusive data for both deutetrabenazine (Austedo) and valbenazine (Ingrezza). Individual placebo-controlled trials with the two drugs reported statistically significant differences over placebo in measures on the Abnormal Involuntary Movement Scales (AIMS), but inconclusive results on both the Patients' and Clinicians' Global Impression of Change scores.
- There is insufficient evidence to determine whether there is a clinically relevant difference in efficacy between deutetrabenazine (Austedo) and valbenazine (Ingrezza) when used for tardive dyskinesia.
- Based on the ICER report, evidence for tetrabenazine for treating tardive dyskinesia symptoms suggests a possible benefit, but is rated as insufficient.
- In terms of safety, deutetrabenazine (Austedo) lacks a black box warning for depression and suicidality when used for treating symptoms of tardive dyskinesia. Both Austedo and Ingrezza report similar adverse events, including QTc interval prolongation.

Other factors

- There is a high degree of therapeutic interchangeability between tetrabenazine and deutetrabenazine (Austedo) for treating Huntington's disease chorea based on efficacy and safety.
- There is a high degree of therapeutic interchangeability between valbenazine (Ingrezza) and deutetrabenazine (Austedo) for treating tardive dyskinesia based on similar efficacy and safety.

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

- CMA results showed that generic tetrabenazine was the most cost-effective Movement Disorder drug, followed by valbenazine (Ingrezza), deutetrabenazine (Austedo), and brand tetrabenazine (Xenazine).
- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results found that designating generic tetrabenazine, valbenazine (Ingrezza), and deutetrabenazine (Austedo) as formulary demonstrated significant cost avoidance for the MHS.

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) the following:

    - UF
        - tetrabenazine
        - deutetrabenazine (Austedo)
        - valbenazine (Ingrezza)
    - NF
        - None

    Note that as part of this recommendation, a movement disorder drug was not added to the BCF or extended core formulary (ECF) due to the very limited treatment population and varied FDA indications between the drugs in the class.

2. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—Manual PA criteria have been in place for both Austedo and Ingrezza since they were reviewed as new drugs in 2017. The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) updates to manual PA criteria for deutetrabenazine (Austedo) and valbenazine (Ingrezza) in new users. PA was not recommended for generic tetrabenazine.

    For Huntington's disease chorea, the PA for Austedo will still require a trial of generic tetrabenazine first, based on the AAN guidelines and cost-effectiveness. For both Austedo and Ingrezza for tardive dyskinesia, updates to the PA included adding the package insert warning for QTc prolongation; removing the requirement for a trial of gingko biloba and clonazepam, based on the clinical practice guidelines; and adding renewal PA criteria after one year showing efficacy and continued evaluation of the patient for depression and suicidality. See Appendix C for the full criteria.

3. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) quantity limits for deutetrabenazine (Austedo) and valbenazine (Ingrezza) allowing a 30-day supply at all points of service. See Appendix D.

4. ***COMMITTEE ACTION: EXPANDED MILITARY TREATMENT FACILITY (MTF)/MAIL PHARMACY INITIATIVE (EMMPI) REQUIREMENTS—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 0 absent) that the VMAT2 inhibitors not be added to the EMMPI program/Select Maintenance List, due to limited distribution requirements and flat pricing across points of service.

5. ***COMMITTEE ACTION: MAIL ORDER AUTO-REFILL REQUIREMENTS FOR THE MOVEMENT DISORDER DRUGS***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) excluding the VMAT2 drugs from the Auto-Refill program administered by

Express Scripts, Inc.at the TRICARE Mail Order due to the limited distribution requirements.

6. ***COMMITTEE ACTION: UF AND PA IMPLEMENTATION PERIOD—*** The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) an effective date of the first Wednesday 30 days after the signing of the minutes in all points of service (POS). Based on the P&T Committee's recommendation, the effective date is March 6, 2019.

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

Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions—The P&T Committee agreed (15 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 November 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 (15 for, 0 opposed, 0 abstained, 1 absent) the following:

- UF:
    - cannabidiol oral solution (Epidiolex) – Anticonvulsants-Antimania Agent for Lennox-Gastaut Syndrome or Dravet Syndrome
    - dacomitinib (Vizimpro) – Oncological Agent for Non-Small Cell Lung Cancer (NSCLC)
    - darunavir/cobicistat/emtricitabine/tenofovir alafenamide (TAF) (Symtuza) – Combination Antiretroviral for HIV
    - darunavir/lamivudine/tenofovir disoproxil fumarate (TDF) (Delstrigo) – Combination Antiretroviral for HIV
    - doravirine (Pifeltro) – Antiretroviral for HIV
    - duvelisib (Copiktra) – Oncological Agent for Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL)
    - fremanezumab-vfrm injection (Ajovy) – Migraine Agent (calcitonin gene-related peptide [CGRP]) for Migraine Headache Prophylaxis
    - galcanezumab-gnlm injection (Emgality) – Migraine Agent (calcitonin gene-related peptide [CGRP]) for Migraine Headache Prophylaxis
    - glycopyrronium 2.4% topical cloth (Qbrexza) – Antiperspirant for Primary Axillary Hyperhidrosis
    - ivosidenib (Tibsovo) – Oncological Agent for Acute Myelogenous Leukemia (AML)

- lanadelumab (Takhzyro) injection – Corticosteroid-Immune Modulator for Hereditary Angioedema (HAE) Prophylaxis
- lumacaftor/ivacaftor granules (Orkambi) – Cystic Fibrosis Agent
- lusutrombopag (Mulpleta) – Hematologic Agent: Platelets for Thrombocytopenia in Chronic Liver Disease
- metoprolol extended-release (ER) capsules (Kapspargo Sprinkle) – Beta-Blocker
- migalastat (Galafold) – Miscellaneous Metabolic Agent for Fabry Disease
- PEG3350/Na ascorbate/NaSO4/ascorbic acid/NaCl/KCl powder packets (Plenvu) – Laxatives-Cathartics-Stool Softener for Bowel Prep
- pegfilgrastim-jmdb injection (Fulphila) – Hematologic Agent: White Blood Cell Stimulant
- PEGylated Factor VIII (Jivi) – Antihemophilic Factor
- sodium zirconium cyclosilicate packet for oral suspension (Lokelma) – Binders Chelators Overdose Agents Hyperkalemia

- NF:
  - adapalene 0.1% topical solution (external pad/swab) (Plixda) – Topical Acne Agent
  - adapalene 0.1% topical solution – Topical Acne Agent
  - amikacin liposome inhaled suspension (Arikayce) – Aminoglycoside Antibiotic for Mycobacterium Avium Complex (MAC)
  - butalbital 50 mg and acetaminophen 300 mg capsules – Analgesics and Combinations
  - doxycycline monohydrate ER capsules (Okebo) – Oral Tetracycline Agent
  - elagolix (Orilissa) – Luteinizing Hormone-Releasing Hormone (LHRH) Agonists-Antagonists for Endometriosis
  - filgrastim-aafi injection (Nivestym) – Hematologic Agent: White Blood Cell Stimulant
  - lidocaine 1.8% topical patch (ZTlido) – Topical Pain Agent
  - minocycline ER tablets (Minolira) – Oral Tetracycline Agent
  - ozenoxacin 1% cream (Xepi) – Quinolone Antibiotic for Impetigo
  - tildrakizumab-asmn injection (Ilumya) – Targeted Immunomodulatory Biologic (TIB) for Plaque Psoriasis
  - tretinoin 0.05% topical lotion (Altreno) – Topical Acne Agent

B. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) MN criteria for adapalene 0.1% topical solution, Altreno, Arikayce, butalbital 50 mg/acetaminophen 300 mg capsule, Ilumya, Minolira, Nivestym, Okebo, Orilissa, Plixda, Xepi, and ZTlido. See Appendix B for the full criteria.

C. ***COMMITTEE ACTION: PA CRITERIA—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) the following (see Appendix C for the full criteria):

- TIBS: Applying the same manual PA criteria for Ilumya in new users, as is currently in place for the other non-step-preferred TIBs. Patients must first try adalimumab (Humira). Additionally, for Ilumya, a trial of both secukinumab (Cosentyx) and ustekinumab (Stelara) is required if the patient cannot be treated with Humira.
- Topical Acne Agents: Applying the same manual PA criteria for adapalene topical solution, adapalene 0.1% external swab/pad (Plixda), and tretinoin 0.05% topical lotion (Altreno) in new and current users as is currently in place for the other non-step-preferred topical retinoid acne agents. Patients must first try at least three step-preferred topical acne products.
- Oral Tetracycline Agents: Applying the same manual PA criteria for doxycycline monohydrate capsules (Okebo) and minocycline ER 105 mg and 135 mg tablets (Minolira) that is currently in place for the other non-step-preferred oral tetracyclines. Patients must first try one generic doxycycline IR product, either the hyclate or monohydrate salt (for Okebo), or one generic minocycline IR product (for Minolira).
- CGRPs for Migraine Headache Prophylaxis: Applying manual PA criteria to new users of Ajovy and Emgality as is currently in place for erenumab injection (Aimovig).
- Cystic Fibrosis Agents: Applying manual PA criteria to new users of Orkambi granules as is currently in place for Orkambi tablets to include the FDA-approved age range, and to not allow concomitant use of the tablets and granules or concomitant use of Orkambi with other CF drugs, including Kalydeco or Symdeko.
- Applying manual PA criteria to new users of Arikayce, Copiktra, Epidiolex, Kapspargo Sprinkle, Mulpleta, Takhzyro, Tibsovo, Vizimpro, and Xepi.
- Applying manual PA criteria to new and current users of butalbital 50 mg/acetaminophen 300 mg capsule, Galafold, Orilissa, Qbrexza, and ZTlido.

D. ***COMMITTEE ACTION: UF, MN, AND PA IMPLEMENTATION PERIOD***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) an effective date upon the first Wednesday 30 days after signing of the minutes in all points of service.

VI. UTILIZATION MANAGEMENT

A. PA Criteria, Step Therapy, and MN Criteria

1. **Updated Manual PA Criteria, Step Therapy, and MN Criteria**—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 safety. The updated manual PAs outlined below will apply to new users.

   a) **Basal Insulins: Insulin degludec (Tresiba)—**The basal insulin drug class was reviewed for formulary placement in August 2017. Insulin glargine (Lantus) is now the step-preferred basal insulin and is required before use of other products. Insulin glargine 300 U/mL (Toujeo) is UF and non-step-preferred. Insulin degludec (Tresiba) is NF and non-step-preferred. The PA and MN criteria for new users of Tresiba were updated to encourage use of the formulary cost-effective basal insulins, prior to use of non-formulary less cost-effective agents.

   b) **Corticosteroids – Immune Modulators – Atopic Dermatitis Subclass: dupilumab injection (Dupixent)—**Dupixent was most recently reviewed for formulary placement at the August 2018 DoD P&T Committee meeting. Manual PA criteria have been in place since May 2017. In October 2018, The FDA granted Dupixent an additional indication as maintenance treatment in patients with moderate to severe asthma aged 12 years and older. The PA criteria were updated to match the additional FDA indication.

   c) **Anti-Gout Drugs: Febuxostat (Uloric)**—Manual PA criteria were previously recommended for febuxostat at the May 2013 P&T Committee meeting. Results from the recent CARES Trial, a large cardiovascular (CV) outcomes trial in patients with gout at risk for major CV events, showed an increased risk for a secondary endpoint of cardiovascular death for febuxostat compared to allopurinol. The primary endpoint for the study (a composite of the first occurrence of CV death, nonfatal myocardial infarction, or need for urgent revascularization) showed no difference between febuxostat and allopurinol. The febuxostat PA criteria were updated to ensure that patients and providers are aware of the results of the trial.

   d) **Antipsychotic Agents – Atypical: pimavanserin (Nuplazid)—**Nuplazid was reviewed as a new drug in August 2016 with PA criteria due to safety concerns of the black box warning of the increased risk of death in elderly patients with dementia-related psychosis. The FDA recently raised a new safety concern associating pimavanserin with increased mortality and serious adverse drug events when used in combination with antipsychotics or other QT-prolonging agents. The P&T Committee updated the Nuplazid PA criteria to include these new safety concerns.

   e) **Antihemophilic Factors: emicizumab-kxwh (Hemlibra)—**Hemlibra was reviewed as a new drug in February 2018 with manual PA criteria

recommended. In October 2018, the FDA approved Hemlibra in newborns and expanded the treatment population to patients with or without factor VIII inhibitors. The PA criteria were updated to match FDA indications.

f) **Targeted Immunomodulatory Biologics (TIBs)—**The TIBs were most recently reviewed in August 2014, with step therapy requiring a trial of adalimumab (Humira) first. Since then, several new products have entered the market, and there are now 17 TIBs available. The P&T Committee reviewed the PA criteria, the step therapy, and MN forms for all the products to ensure they were updated with current or additional FDA-approved indications, safety warnings, and similar formatting.

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

   - (15 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for Tresiba, Uloric, Nuplazid, and Hemlibra; updates to the manual PA criteria and step therapy for the TIBs; and also recommended updates to the MN criteria for Tresiba, Taltz, and Siliq.
   - (14 for, 0 opposed, 0 abstained, 2 absent) updates to the manual PA criteria for Dupixent.

2. New Manual PA Criteria

a) **Pain Agents—Non-steroidal Anti-inflammatory Drugs (NSAIDs): diclofenac potassium liquid filled capsules (Zipsor), diclofenac submicronized (Zorvolex), indomethacin submicronized (Tivorbex), naproxen CR (controlled-release) (Naprelan/generics), meloxicam submicronized (Vivlodex)**

The NSAIDs were reviewed for UF placement in August 2011, with several generic products designated as UF, including naproxen, diclofenac potassium, diclofenac sodium, indomethacin, and meloxicam. Zipsor, Zorvolex, Tivorbex, and Naprelan are branded products that contain the same active ingredients and have the same indications as the generic UF NSAIDs. These branded products lack data showing improved efficacy or safety over the generic NSAIDs and are not cost-effective. Cost-effective generic formulations of naproxen and several other NSAIDs are available on the UF without PA required.

1. ***COMMITTEE ACTION: DICLOFENAC POTASSIUM LIQUID-FILLED CAPSULES (ZIPSOR), DICLOFENAC SUBMICRONIZED (ZORVOLEX), INDOMETHACIN SUBMICRONIZED (TIVORBEX), NAPROXEN CR (NAPRELAN/GENERICS), MELOXICAM SUBMICRONIZED (VIVLODEX) MANUAL PA CRITERIA***—The

P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for Zipsor, Zorvolex, Tivorbex, Naprelan and naproxen CR generics and Vivlodex due to the significant cost differences and lack of clinically compelling benefits between these products and generic NSAIDs. New and current users of Zipsor, Zorvolex, Tivorbex, Naprelan CR, and Vivlodex are required to try four formulary generic NSAIDs, three of which must include BCF agents, first. See Appendix C for the full criteria.

b) **Skeletal Muscle Relaxants and Combinations: chlorzoxazone 250 mg tablets**

Generic formulations of the skeletal muscle relaxant chlorzoxazone are available in 250 mg tablets and 500 mg scored tablets. Chlorzoxazone 250 mg tablets are from a single source, while several manufacturers produce the 500 mg tablets. Skeletal muscle relaxants are not considered first-line therapy for musculoskeletal conditions. Cost-effective generic formulations of chlorzoxazone and multiple comparable muscle relaxants (e.g., cyclobenzaprine, methocarbamol) are available on the UF without PA required.

1. ***COMMITTEE ACTION: CHLORZOXAZONE 250 MG MANUAL PA CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for new and current users of the single-source chlorzoxazone 250 mg tablets, due to the significant cost differences and lack of clinically compelling benefits compared with administering half of a 500 mg tablet or using other generic muscle relaxants. See Appendix C for the full criteria.

c) **Oncological Agents for unresectable or metastatic melanoma: cobimetinib (Cotellic)**

Cobimetinib (Cotellic) was approved for treating unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. It is used exclusively in combinations of a specific BRAF drug with a specific mitogen-activated extracellular signal regulated kinase (MEK) inhibitor, vemurafenib (Zelboraf). 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.

1. ***COMMITTEE ACTION: COTELLIC MANUAL PA CRITERIA***— The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria in new users of Cotellic to ensure it is used only in combination with vemurafenib (Zelboraf). See Appendix C for the full criteria.

d) **Anti-infectives: Miscellaneous: crotamiton 10% lotion (Eurax and Crotan)**

The committee reviewed two treatments for scabies, Eurax and Crotan, which are both crotamiton 10% generic lotions, and are approved for patients 18 years and older. According to the Centers for Disease Control and Prevention (CDC), first-line treatment for scabies remains permethrin 5% cream. Permethrin 5% cream is indicated for patients 2 months and older and has a lower failure rate than crotamiton. Cost-effective generic formulations of permethrin cream and oral scabies agents (e.g., ivermectin) are available on the UF without a PA required.

2. ***COMMITTEE ACTION: CROTAMITON 10% LOTION (EURAX AND CROTAN) MANUAL PA CRITERIA—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for Eurax and Crotan due to concern regarding the limited age range and higher treatment failure rate of these two products, compared to permethrin 5% cream. New users of Crotan or Eurax must document therapeutic failure of permethrin 5% cream first. See Appendix C for the full criteria.

B. QLs

QLs were reviewed for nine drugs from drug classes where there are existing QLs, including the oncological agents and TIBs. QLs were also discussed for 21 drugs where QLs are not currently in place, including one adjustment to a recently implemented QL for Aimovig to align the CGRP class.

1. ***COMMITTEE ACTION: QLs—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) QLs for Aimovig, Ajovy, Arikayce, butalbital and acetaminophen capsules, Copiktra, Emgality, Epidiolex, Fulphila, Galafold, Ilumya, Kalydeco, Mulpleta, Orkambi, Sprix, Symdeko, Takhzyro, Tibsovo, the transmucosal immediate release fentanyl (TIRF) products, Vizimpro, and Xepi. 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:

   - (15 for, 0 opposed, 0 abstained, 1 absent) New PAs for Zipsor, Zorvolex, Tivorbex, Vivlodex, Naprelan and naproxen CR generics, chlorzoxazone 250 mg, Cotellic, and Eurax and Crotan become effective 90 days after the signing of the minutes. DHA will send letters to beneficiaries affected by the new PA requirements for the NSAIDs and chlorzoxazone 250 mg, as new and current users will be subject to the PA.
   - (15 for, 0 opposed, 0 abstained, 1 absent) Updates to the current PA criteria for Tresiba, Uloric, Nuplazid, and Hemlibra; updates to the manual PA criteria and step therapy for the TIBs (Humira, Enbrel, Cimzia, Simponi, Xeljanz/Xeljanz

XR, Orencia, Actemra, Kevzara, Kineret, Stelara, Otezla, Cosentyx, Siliq, Taltz, Tremfya, and Olumiant); and also updates to the MN criteria for Tresiba, Taltz, and Siliq become effective 30 days after the signing of the minutes.

- (14 for, 0 opposed, 0 abstained, 2 absent) Updates to the current PA for Dupixent become effective 30 days after the signing of the minutes.
- (15 for, 0 opposed, 0 abstained, 1 absent) The QLs for the 21 drugs listed in section VI, B, above, and in Appendix D, become effective on the first Wednesday two weeks after the signing of the minutes in all POS.

VII. REMOVAL OF BRAND OVER GENERIC AUTHORITY AND BRAND OVER GENERIC PA CRITERIA AUTHORIZATION FOR SILDENAFIL TABLETS (VIAGRA)

TRICARE policy requires dispensing of generic products at the Retail Network and Mail Order Pharmacy. However, when AB-rated generic formulations for sildenafil (Viagra) were launched in December 2017, pricing for the branded product was significantly lower than the generic formulations. The manufacturer of Viagra offered a Distribution and Pricing Agreement (DAPA) and on January 24, 2018, brand over generic authority was implemented, which allowed for the continued dispensing of the branded product, and required prior authorization prior to dispensing a generic product instead of the brand. Additionally, at that time, the Tier 1 (generic) copayment was assigned to the branded product. PA criteria allowing a patient to receive generic sildenafil instead of branded Viagra (i.e., the reverse of the current brand to generic policy) were also recommended. The Committee was notified of these actions at the February 2018 DoD P&T Committee meeting.

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

As of September 2018, the AB-rated generic formulations for sildenafil (Viagra) are cost-effective compared to the branded Viagra product. On September 20, 2018, the brand over generic requirement was removed for sildenafil. Current PA requirements for the PDE-5 inhibitor class are still in effect.

VIII. 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 Nov 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 non-formulary to mail requirement. The implementation date for all EMMPI

recommendations from the Nov 2018 meeting, including the newly approved drugs affected by the EMMPI, will be effective upon the first Wednesday two weeks after the signing of the minutes.

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

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

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

a) **Add**: none

b) **Do Not Add:**

1. *Agents that are effectively flat-priced across points of service:* the migraine prophylaxis agents fremanezumab-vfrm (Ajovy) and galcanezumab-gnlm (Emgality), the white blood cell stimulant pegfilgrastim-jmdb (Fulphila), glycopyrronium topical cloths (Qbrexza) for axillary hyperhidrosis, metoprolol succinate ER capsules (Kapspargo Sprinkle), sodium zirconium cyclosilicate (Lokelma) for hyperkalemia, and lumacaftor/ivacaftor oral granules (Orkambi granules) for cystic fibrosis.
2. *Not yet clear if feasible to provide through mail order:* cannabidiol (Epidiolex) for Lennox-Gastaut and Dravet syndromes; migalastat (Galafold) for Fabry disease; dacomitinib (Vizimpro) for non-small cell lung cancer; duvelisib (Copiktra) for relapsed or refractory chronic lymphocytic leukemia and small lymphocytic lymphoma; ivosidenib (Tibsovo) for relapsed or refractory acute myeloid leukemia with a susceptible IDH1 mutation; antihemophilic factor (recombinant), PEGylated-aucl (Jivi) for Hemophilia A; and lanadelumab-flyo (Takhzyro) for hereditary angioedema prophylaxis.
3. *Agents for acute or limited duration use:* PEG3350/Na ascorbate/NaSO4/ascorbic acid/NaCl/KCl powder packets (Plenvu), a single-use bowel prep agent and lusutrombopag (Mulpleta) as a 7-day pre-procedure regimen for patients with thrombocytopenia associated with liver disease.
4. *Agents in classes specifically not included on the Select Maintenance List:* three agents for HIV: darunavir ethanolate/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza), doravirine (Pifeltro), and doravirine/lamivudine/tenofovir disoproxil fumarate (Delstrigo).

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

The P&T Committee recommended (15 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: elagolix (Orilissa) for endometriosis pain, the white blood cell stimulant filgrastim-aafi (Nivestym), tildrakizumab-asmn (Ilumya) for plaque psoriasis, lidocaine 1.8% topical patch (ZTlido) for postherpetic neuralgia, and the following five acne agents: adapalene 0.1% topical solution swab (Plixda), adapalene 0.1% topical solution, tretinoin 0.05% topical lotion (Altreno), doxycycline monohydrate ER 50-, 75-, and 100-mg capsules (Okebo), and minocycline 105- and 135-mg ER tablets (Minolira).

b) **Do Not Add:** The P&T Committee recommended exceptions from the mail order requirement for the following medications: ozenoxacin 1% cream (Xepi), a topical antibiotic used as a 5-day course for impetigo and butalbital 50 mg/acetaminophen 300 mg capsule for headache, due to the existing exception for acute use medications. In addition, the P&T Committee recommended not adding amikacin liposome suspension for inhalation (Arikayce), for treatment of *Mycobacterium avium* complex lung disease, pending more information about availability of this product at mail order.

IX. RE-EVALUATION OF NF GENERICS

A. ADHD/Wakefulness: Stimulants Subclass

Background—The DHA Pharmacy Operations Division (POD) Formulary Management Branch (FMB) monitors changes in clinical information, current costs, and utilization trends to determine whether the formulary status of NF drugs that are now available in generic formulations needs to be readdressed. The P&T Committee's process for the reevaluation of NF agents was established at the May 2007 meeting and approved by the Director, TMA, on July 24, 2007. A summary of the criteria is available in Appendix E of the November 2012 P&T Committee minutes.

Attention Deficit Hyperactivity Disorder (ADHD)/wakefulness promoting agents drug class: dexmethylphenidate ER (Focalin XR)—The P&T Committee reviewed the current utilization, formulary status, generic availability, and relative cost-effectiveness, including the weighted average cost per unit, for generic dexmethylphenidate ER (Focalin XR). Currently, the drug has been designated NF since the original ADHD class review in February 2007 and reaffirmed at the most recent class review status in November 2015. The unit cost of generic formulations of dexmethylphenidate ER has dropped significantly from the previous generic and brand cost.

1. ***COMMITTEE ACTION: DEXMETHYLPHENIDATE ER FORMULARY STATUS AND IMPLEMENTATION—***The P&T Committee recommended (13 for, 0 opposed, 0 abstained, 3 absent) returning dexmethylphenidate ER to formulary status, effective the first Wednesday two weeks after the signing of the minutes.

X. DRUGS LOSING RX STATUS AND MOVING TO OTC STATUS (VITAMIN B REPLACEMENT PRODUCTS, IRON REPLACEMENT PRODUCTS, AND URINARY pH MODIFIERS)

The P&T Committee discussed a list containing 387 National Drug Codes (NDCs) that the First DataBank (FDB) drug database will transition from designation as prescription legend products to non-prescription products as of 1 January 2019. This list comprises a subset of products changing status in FDB that was initially discussed by the P&T Committee in August 2017. The original implementation date of January 2018 was delayed by litigation, which has now been resolved for the current list of agents. The list does not include prenatal vitamins, which remain under litigation. None of the products on the list have been approved by the FDA.

The change in status means that, with the exception of pediatric fluoride products, as of January 1, 2019, products on this list will no longer adjudicate as covered products through the Pharmacy Data Transaction Service (PDTS) at mail, retail, or MTF sites where the new electronic health record system (MHS GENESIS) has been implemented. The most commonly dispensed categories on the list include vitamin B preparations (various combinations of vitamin B complex and folic acid, along with vitamins D3, C, biotin, zinc, selenium, etc.), iron replacement products (various combinations of iron with folic acid, along with vitamins C, B, B12, calcium, zinc, biotin, docusate sodium, etc.), and urinary pH modifiers (e.g., sodium and/or potassium citrate with citric acid).

The P&T Committee noted that 1) folic acid 1 mg as a stand-alone product will remain a prescription product; 2) the more commonly used iron replacement products without folic acid (e.g., ferrous sulfate, ferrous gluconate) are already OTC and therefore not covered at retail or mail order; both are on the current MHS GENESIS OTC list; 3) an FDA-approved urinary pH modifier (potassium citrate, Urocit-K and generics) will remain available as a prescription product; and 4) various vitamin B preparations and multivitamin combinations are widely available at low cost as non-prescription products.

The P&T Committee agreed that none of these products are suitable for inclusion on the OTC TRICARE pharmacy benefit for coverage across all points of service, considering their non-FDA-approved status and the ready availability of either prescription alternatives or low-cost non-prescription products. The change will affect beneficiaries across all points of service. Letters are being prepared for delivery to affected beneficiaries.

The P&T Committee considered utilization of the various product categories at MHS GENESIS sites and recommended addition of one product to the MHS GENESIS OTC list: B complex w-C no. 20/folic acid (GSN 033515; e.g., Nephrocaps). A total of 98 prescriptions were filled by MHS GENESIS sites for this product during fourth quarter FY 2018; most of the remaining 420 GENESIS site prescriptions for products on this list were for fluoride products, which remain covered. The P&T Committee noted that further review of products included on the MHS GENESIS OTC list would occur at upcoming meetings.

1. ***COMMITTEE ACTION: PRODUCTS LOSING PRESCRIPTION STATUS IN FIRST DATABANK RECOMMENDATION***—The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) the

following, effective upon signing of the minutes: adding B complex w-C no. 20/folic acid (GSN 033515; e.g., Nephrocaps) to the MHS GENESIS OTC list.

XI. TRICARE MAIL ORDER AUTO-REFILL REQUIREMENTS FOR SELF-MONITORING BLOOD GLUCOSE SYSTEMS (SMBGS) TEST STRIPS AND LANCETS

Background—The Committee was briefed on the Auto-Refill program administered by Express Scripts, Inc. at the TRICARE Mail Order Pharmacy, including opt-in requirements, alert notifications, and auto-refill logic. The SMBGS test strips are in the top ten list of drugs that individual patients request for removal from the program.

The SMBGS test strips were reviewed for formulary status at the November 2014 DoD P&T Committee meeting. The Precision Xtra and FreeStyle Lite test strips are BCF and step-preferred, with all other test strips NF and non-step-preferred. Quantity limits are currently in place. Lancets have not been reviewed for formulary status, but are part of the TRICARE pharmacy benefit, and all popular brands of lancets are available at the TRICARE Mail Order Pharmacy. Mail Order and MTF utilization and refill date trends for the test strips were presented.

A. ***COMMITTEE ACTION: SMBGS TEST STRIPS AND LANCETS AUTO-REFILL PROGRAM RECOMMENDATION—***The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) removing the SMBGS test strips and lancets from the Auto-Refill program administered by Express Scripts, Inc. at the TRICARE Mail Order Pharmacy. Reasons for removing the test strips and lancets include the large volume of patient requests for removal; the fact that both test strips and lancets are widely available OTC; the current QLs exceed typical usage patterns; overrides are available for clinical reasons; and to reduce the potential for wastage, as the test strips do expire. Beneficiary outreach will occur via letters.

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

The P&T Committee reviewed two drugs from pharmaceutical manufacturers that were not included on a DoD Retail Refund Pricing Agreement; these drugs were not in compliance with FY08 NDAA, Section 703. The law stipulates that if a drug is not compliant with Section 703, it will be designated NF on the UF and will be restricted to the TRICARE Mail Order Pharmacy, requiring pre-authorization prior to use in the retail POS and medical necessity at MTFs. These NF drugs will be exempt from movement to the Mail Order POS due to the potential for acute use; and will remain available at the Retail POS with pre-authorization.

A. ***COMMITTEE ACTION: DRUGS DESIGNATED NF***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) that the Section 703 non-compliant NDCs of the following products be designated NF on the UF:

- Genericus, Inc.: tobramycin inhalation solution pak (*New Drug Application-authorized generic; NDC 70644-0899-99*) 300 mg/5 mL ampule-nebulizer
- Genus Lifesciences Pharma: oxycodone hydrochloride solution (*New Drug Application; NDC 64950-0354-50*) 5 mg/5 mL oral solution

B. ***COMMITTEE ACTION: PRE-AUTHORIZATION CRITERIA***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) the following pre-authorization criteria for the Section 703 non-compliant NDCs of tobramycin inhalation solution pak and oxycodone hydrochloride solution:

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

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

C. ***COMMITTEE ACTION: IMPLEMENTATION PERIOD***—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday after a 90-day implementation period for the Section 703 non-compliant NDCs of tobramycin inhalation solution pak and oxycodone hydrochloride solution, and 2) DHA send letters to beneficiaries affected by this decision.

XIII. ITEMS FOR INFORMATION

A. MHS Prescribing and Cost Trends

The Committee was briefed on various aspects of MHS prescribing and cost trends, including overall trends and spends, specialty spend, top 25 drug classes, and cost avoidance from previously conducted drug class reviews.

XIV. ADJOURNMENT

The meeting adjourned at 1500 hours on November 8, 2018. The next meeting will be in February 2019.

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.
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 FEB 2019
Date

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

Voting Members Present	
John Kugler, COL (Ret.), MC, USA	DoD P&T Committee Chair
Col Paul Hoerner for Mr. David Bobb	Chief, DHA Pharmacy Operations Branch
Lt Col Ronald Khoury, MC	Chief, DHA Formulary Management Branch (Recorder)
LTC John Poulin, MC	Army, Physician at Large
COL Kevin Roberts, MC	Army, Pharmacy Officer
MAJ Rosco Gore, MC	Army, Internal Medicine Physician
Col Ruben Salinas, MC	Army, Family Medicine Physician
CDR Austin Parker, MC	Navy, Internal Medicine Physician
CAPT Shaun Carstairs, MC	Navy, Physician at Large
CAPT Brandon Hardin, MSC	Navy, Pharmacy Officer
CDR Paul Michaud, USCG	Coast Guard, Pharmacy Officer
Lt Col Lisa Seltman for Col Melissa Howard	Air Force, Pharmacy Officer
Maj Jeffrey Colburn, MC	Air Force, Internal Medicine Physician
Col James Jablonski, MC	Air Force, Physician at Large
Kelly Echevarria, PharmD for Jennifer Zacher, PharmD	Department of Veterans Affairs
COL Clayton Simon MC	TRICARE Regional Office Representative
Voting Members Absent	
Lt Col Larissa Weir, MC	Air Force, OB/GYN Physician
LCDR Danielle Barnes, MC	Navy, Pediatrics Rep
Nonvoting Members Present	
Mr. Brian Wheeler	DHA, Deputy General Counsel
Eugene Moore, PharmD, BCPS for Dean Valibhai, PharmD	DHA Purchased Care Branch
Guests	
Ms. Kimberlymae Wood	DHA Contract Operations Division
Maj Kevin Bourne, MSC	DLA Troop Support
Ms. Catherine Gilbert	DLA Troop Support
Geannette Green	University of Texas at Austin/University of Texas Health Science Center PharmD Student

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
Robert Conrad, PharmD	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

Appendix B—Table of Medical Necessity (MN) Criteria

Drug / Drug Class	Medical Necessity Criteria
• adapalene 0.1% topical solution • adapalene 0.1% topical solution pad (Plixda) **Acne Agents: Topical Acne and Rosacea**	• Patient has tried and failed or experienced significant adverse effects from at least three formulary agents, including adapalene 0.1% and two different strengths of tretinoin **Formulary Alternatives:** adapalene (cream, gel, lotion), tretinoin (cream, gel, liquid/solution), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel
• amikacin liposome inhalation suspension (Arikayce) **Antibiotics: Aminoglycosides**	• Formulary agents have resulted in therapeutic failure • Use of formulary agents is contraindicated **Formulary Alternatives:** IV amikacin
• butalbital 50 mg/acetaminophen 300 mg capsule **Analgesics and Combinations**	• No alternative formulary agent: Patient requires capsule over tablet **Formulary Alternatives:** butalbital/APAP tablet, butalbital/APAP/caffeine tablet/capsule
• doxycycline monohydrate ER (Okebo) **Antibiotics: Tetracyclines**	• Patient has experienced significant adverse effects from formulary agents – e.g., Gastrointestinal adverse events from generic doxycycline IR AND generic minocycline products **Formulary Alternatives:** Doxycycline IR 50 mg or 100 mg, minocycline IR 50 mg or 100 mg
• elagolix (Orilissa) **Luteinizing Hormone Releasing Hormone (LHRH) Agonists/Antagonists**	• Patient has experienced or is likely to experience significant adverse effects from formulary agents • Formulary agents result or are likely to result in therapeutic failure **Formulary Alternatives:** leuprolide (Lupron Depot) intramuscular kit, nafarelin (Synarel) nasal solution
• filgrastim-aafi (Nivestym) injection **Hematological Agents: White Blood Cell Stimulants**	• Patient has experienced or is likely to experience significant adverse effects from formulary agents • Patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk • **Formulary Alternatives:** Granix, Zarxio, Neupogen
• lidocaine 1.8% patch (ZTlido) **Pain Agents: Pain Topical**	• Formulary agent has resulted in therapeutic failure **Formulary Alternatives:** lidocaine 5% patch (Lidoderm)
• minocycline ER (Minolira) **Antibiotics: Tetracyclines**	• The patient has experienced significant adverse effects from formulary agents – e.g., gastrointestinal adverse events from generic minocycline immediate release products **Formulary Alternatives:** minocycline IR 50 mg or 100 mg

Drug / Drug Class	Medical Necessity Criteria
• Ozenoxacin 1% cream (Xepi) **Antibiotics: Quinolones**	• Use of formulary agents is contraindicated **Formulary Alternatives:** mupirocin 2% cream or ointment, cephalexin PO, dicloxacillin PO, clindamycin PO
• tildrakizumab (Ilumya) injection **Targeted Immunomodulatory Biologics (TIBs)**	• Use of formulary agents is contraindicated • Patient has experienced or is likely to experience significant adverse effects from formulary agents • Formulary agents result or are likely to result in therapeutic failure **Formulary Alternatives:** Humira (BCF), Cosentyx, Stelara
• tretinoin 0.05% topical lotion (Altreno) **Acne Agents: Topical Acne and Rosacea**	• Patient has tried and failed or experienced significant adverse effects from at least three formulary agents, including two different strengths of tretinoin **Formulary Alternatives:** adapalene (cream, gel, lotion), tretinoin (cream, gel, liquid/solution), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel
• guselkumab (Tremfya) injection **Targeted Immunomodulatory Biologics (TIBs)**	**November 2018 updates are in BOLD** • Use of adalimumab (Humira) **and secukinumab (Cosentyx)** are contraindicated • Patient has experienced or is likely to experience significant adverse effects from adalimumab (Humira) **and secukinumab (Cosentyx)** • Adalimumab (Humira) **and secukinumab (Cosentyx)** have resulted in therapeutic failure **Formulary Alternatives:** adalimumab (Humira) **and secukinumab (Cosentyx)**
• insulin degludec (Tresiba) **Insulins: Basal**	**November 2018 updates are in BOLD** • Patient has been adherent to insulin glargine (Lantus) **and Toujeo, and** has failed to achieve glycemic control **Formulary Alternatives:** insulin glargine (Lantus), **insulin glargine (Toujeo)**

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
• linaclotide (Linzess) • lubiprostone (Amitiza) **Gastrointestinal-2 Agents: CIC/IBS-C**	Manual PA criteria apply to all new and current users of Linzess and Amitiza. <u>Manual PA Criteria</u>: Coverage is approved if all criteria are met: • Age ≥ 18 years OR for Amitiza, prescribed in consultation with a pediatric gastroenterologist for ages < 18 y/o • Patient has documented symptoms for ≥ 3 months • Patient has diagnosis of IBS-C or CIC or OIC in adults with chronic, non-cancer pain ▪ Amitiza or Linzess: Patient is currently taking an opioid if used for OIC ▪ Amitiza: Patient is female if used for IBS-C • Patient has documentation of failure of an increase in dietary fiber/dietary modification to relieve symptoms • Patient has absence of GI obstruction • Patient has tried at least 2 standard laxative classes or has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as ▪ osmotic laxative (e.g., lactulose, sorbitol, magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories) ▪ bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids; ▪ stool softener (e.g., docusate); ▪ stimulant laxative (e.g., bisacodyl, sennosides) • Patient is not taking any of these agents concomitantly (Linzess, Amitiza, Trulance, Symproic, Relistor, or Movantik) Linzess: Non-FDA-approved uses other than OIC are NOT approved. Amitiza: Non-FDA-approved uses are NOT approved Prior authorization expires after 1 year. <u>Renewal PA Criteria</u>: Coverage will be approved for 1 year for continuation of therapy if: • Patient has had improvement in constipation symptoms and • Patient is not taking any of these agents concomitantly (Linzess, Amitiza, Trulance, Symproic, Relistor, or Movantik)

Drug / Drug Class	Prior Authorization Criteria
• plecanatide (Trulance) **Gastrointestinal-2 Agents: CIC/IBS-C**	**November 2018 updates are in BOLD and strikethrough** Manual PA criteria apply to all new users of Trulance. Manual PA Criteria: Coverage is approved if all criteria are met: • Patient is ≥ 18 years of age • **Patient has documented symptoms for ≥ 3 months** • Patient has diagnosis of IBS-C or CIC • Patient has absence of GI obstruction • ~~Written by or in consultation with a gastroenterologist~~ • **Patient has documentation of failure of an increase in dietary fiber/dietary modification** • **Patient has tried at least 2 standard laxative classes or has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as** ▪ **osmotic laxative (e.g., lactulose, sorbitol, magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (e.g., docusate)** ▪ **stimulant laxative (e.g., bisacodyl, sennosides)** • **Patient is not taking any of these agents concomitantly (Trulance, Amitiza, Linzess, Symproic, Relistor, or Movantik)** • ~~Must have failed/intolerant to linaclotide (Linzess)~~ • ~~Must have failed/intolerant to lubiprostone (Amitiza)~~ **Non-FDA-approved uses are NOT approved.** Prior authorization expires after 1 year. Renewal PA Criteria: Coverage will be approved for 1 year for continuation of therapy if: • Patient has had improvement in constipation symptoms and • Patient is not taking any of these agents concomitantly (Amitiza, Linzess, Symproic, Trulance, Relistor, or Movantik)

Drug / Drug Class	Prior Authorization Criteria
• eluxadoline (Viberzi) **Gastrointestinal-2 Agents: Miscellaneous**	**November 2018 updates are in BOLD and strikethrough** Manual PA criteria apply to all new users of Viberzi. <u>Manual PA Criteria</u>: Coverage is approved if all criteria are met: • Age ≥ 18 years • Written by or in consultation with a gastroenterologist • Patient has no history of alcoholism, alcohol abuse, or alcohol addiction, or in patients who drink alcohol, they drink < 3 alcoholic beverages per day • Patient has no history of marijuana use or illicit drug use in the previous 6 months • Patient does not have severe hepatic impairment (Child-Pugh C) • Patient has a documented diagnosis of IBS-D • **Patient has tried and failed dietary changes (including fiber), stress reduction, or cognitive behavioral therapy** • Patient has not had a cholecystectomy • The patient has had failure, intolerance, or contraindication to at least one antispasmodic/**antidiarrheal** agent; e.g., dicyclomine, Librax, hyoscyamine **[Levsin],** Donnatal, loperamide [Imodium]) • The patient has had failure, intolerance, or contraindication to at least one TCA (to relieve abdominal pain); e.g., amitriptyline, desipramine, doxepin, imipramine, nortriptyline, protriptyline ~~• The patient has tried and failed rifaximin~~ Non-FDA approved uses are NOT approved. ~~PA does not expire.~~ PA expires after 4 months. <u>Renewal PA Criteria</u>: Coverage will be approved for 1 year if: • The patient has had documented improvement in IBS-D symptoms
• rifaximin 550 mg (Xifaxan) **Gastrointestinal-2 Agents: Miscellaneous**	**November 2018 updates for the indication of IBS-D are in BOLD. No changes for the indications of hepatic encephalopathy or traveler's diarrhea.** Manual PA criteria apply to all new users of Xifaxan 550 mg for IBS-D. <u>Manual PA Criteria</u>: Coverage is approved if all criteria are met: • Age ≥ 18 years • Patient has a diagnosis of IBS-D, without constipation with symptoms of moderate abdominal pain and bloating • **The prescription is written by or in consultation with a gastroenterologist** • **Patient has documentation of failure of dietary changes (including fiber), stress reduction, or cognitive behavioral therapy** • Patient has tried and failed or had intolerance, or a contraindication to at least <u>one antispasmodic/antidiarrheal agent</u> (e.g., dicyclomine [Bentyl], Librax, hyoscyamine [Levsin], Donnatal, loperaimde [Imodium]) • Patient has tried and failed or had intolerance or a contraindication to at least <u>one tricyclic antidepressant</u> (e.g., amitriptyline, desipramine, doxepin, imipramine, nortriptyline, protriptyline) **Non-FDA-approved uses are NOT approved including: small intestinal bacterial overgrowth (SIBO), non-alcoholic steatohepatitis (NASH) or non-alcoholic fatty liver disease (NAFLD), spontaneous bacterial peritonitis (SBP), functional dyspepsia, diabetes, cirrhosis (ascites/alcohol-related), graft vs host disease, primary sclerosing cholangitis, Celiac disease, ulcerative colitis, Crohn's disease, diverticular disease, bowel preparation, constipation, colorectal cancer prevention, opioid-induced constipation, chronic abdominal pain, or other disease states.** ~~PA expires after 6 months~~. **Prior authorization expires after 1 year. No renewal allowed. Note that a maximum of 3 treatment courses for IBS-C are allowed in 1 year.**

Drug / Drug Class	Prior Authorization Criteria
• deutetrabenazine (Austedo) **Neurological Agents Miscellaneous: Movement Disorders**	**Changes from the November 2018 meeting are in bold and strikethrough** Manual PA criteria apply to all new users of Austedo. Manual PA Criteria: Coverage is approved for initial therapy for one year if all criteria are met: • **Patient does not have congenital or acquired long QT syndrome or arrhythmias associated with QT prolongation** • Patient does not have severe hepatic impairment • Patient is not taking any of the following: MAOI within the past 14 days, reserpine, CYP3A4 inducers, or another VMAT2 inhibitor (e.g., tetrabenazine, valbenazine (Ingrezza)) Huntington's Disease Chorea • Prescribed by or in consultation with a neurologist • Patient has a diagnosis of chorea associated with Huntington's disease • Patient does ~~is~~ not have ~~actively~~ suicidal ideation • Patient does not have depression or is being adequately treated for depression • Patient has had an adequate trial of tetrabenazine for 12 weeks and has experienced treatment failure or experienced an adverse event that is not expected to occur with Austedo Tardive Dyskinesia • Age ≥ 18 years • Prescribed by or in consultation with a neurologist or psychiatrist • Patient does not have ~~is actively~~ suicidal ideation • **Patient does not have depression or is being adequately treated for depression** • Patient has moderate to severe tardive dyskinesia **causing functional impairment** along with schizophrenia, schizoaffective disorder, or a mood disorder • ~~Provider has considered gingko biloba or clonazepam~~ • **Provider has considered a dose reduction, tapering, or discontinuation of the dopamine receptor blocking agent suspected of causing the symptoms** PA expires in one year. Non-FDA-approved uses are NOT approved (e.g., Tourette's, ~~tardive dyskinesia,~~ dystonia). Renewal PA Criteria: Coverage is approved indefinitely for continuation of therapy if all criteria are met: • ~~Patient has demonstrated improvement in chorea based on clinician assessment and is being monitored for depression and suicidal ideation~~ • **Huntington's Disease Chorea: Patient has demonstrated improvement in symptoms based on clinician assessment. Patient is being monitored for depression and suicidal ideation.** • **Tardive Dyskinesia: Patient has demonstrated improvement in symptoms based on an improvement of at least 2 on the AIMS. Patient is being monitored for depression and suicidal ideation.**

Drug / Drug Class	Prior Authorization Criteria
• valbenazine (Ingrezza) **Neurological Agents Miscellaneous: Movement Disorders**	**Changes from the November 2018 meeting are in bold and strikethrough** Manual PA criteria apply to all new users of Ingrezza. Manual PA Criteria: Coverage is approved if all criteria are met: • Age > 18 years • Prescribed by or in consultation with a neurologist or psychiatrist • Patient does not have ~~is actively~~ suicidal ideation • **Patient does not have depression, or is being adequately treated for depression** • Patient has moderate to severe tardive dyskinesia **causing functional impairment** along with schizophrenia, schizoaffective disorder, or a mood disorder • ~~Patient has had an adequate trial and has failed or has a contraindication to tetrabenazine or deutetrabenazine~~ • ~~Provider has considered use of clonazepam and gingko biloba~~ • **Provider has considered a dose reduction, tapering, or discontinuation of the dopamine receptor blocking agent suspected of causing the symptoms** • Patient does not have congenital **or acquired** long QT syndrome or arrhythmias associated with QT prolongation • Patient is not taking any of the following: ▪ MAOI, CYP3A4 inhibitors, CYP2D6 inhibitors, CYP3A4 inducers, another VMAT2 inhibitor (e.g., tetrabenazine, deutetrabenazine [Austedo]) Non-FDA-approved uses are NOT approved (i.e., Tourette's, dystonia). ~~PA does not expire~~ **PA expires in one year.** Renewal PA Criteria: **Coverage is approved indefinitely for continuation of therapy if all criteria are met:** • **Patient has demonstrated improvement in symptoms based on an improvement of at least 2 on the Abnormal Involuntary Movement Scale (AIMS). Patient is being monitored for depression and suicidal ideation.** • **Note that patients currently with an approved PA will not be subject to the renewal criteria**

Drug / Drug Class	Prior Authorization Criteria
• adapalene 0.1% topical solution • adapalene 0.1% topical solution external pad/swab (Plixda) • tretinoin 0.05% topical lotion (Altreno) **Acne Agents: Topical Acne and Rosacea Agents: Topical Retinoids and Combinations**	All new and current users of adapalene 0.1% topical solution, Plixda, Altreno and generics are required to try three step-preferred topical acne products, including at least two different strengths of tretinoin and adapalene 0.1% (for Plixda and adapalene 0.1% topical solution). Automated PA Criteria: • The patient has filled a prescription for at least three step-preferred topical acne products (e.g., adapalene, tretinoin, clindamycin, clindamycin/benzoyl peroxide), including at least two different strengths of tretinoin and 0.1% adapalene (for adapalene 0.1% solution and Plixda) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or TRICARE Mail Order Pharmacy) during the previous 180 days. Manual PA Criteria: If automated PA criteria are not met, adapalene 0.1% topical solution, Plixda, and tretinoin 0.05% topical lotion (Altreno) will be approved if: • The patient has a diagnosis of acne vulgaris AND • Patient has tried and failed at least three step-preferred topical acne products, including at least two different strengths of tretinoin and, 0.1% adapalene (for adapalene 0.1% topical solution and Plixda) (e.g., generic formulations of clindamycin, clindamycin/benzoyl peroxide, tretinoin, adapalene, or sulfacetamide sodium/sulfur) OR • The patient has experienced an adverse reaction or an inadequate response with formulary, step-preferred topical tretinoin and adapalene agents that is not expected to occur with the non-formulary, non-step-preferred product Non-FDA-approved uses are NOT approved. PA expires in 1 year. PA renewal is not allowed.
• amikacin sulfate liposomal inhalation suspension (Arikayce) **Antibiotics: Aminoglycosides**	Manual PA criteria apply to all new users of Arikayce. Manual PA Criteria: Arikayce is approved if ALL of the following criteria are met: • Age ≥ 18 • Prescription is written by or in consultation with an Infectious Disease Specialist and/or Pulmonologist. • Patient has a diagnosis of refractory *Mycobacterium avium* complex (MAC) lung disease as defined as a patient who does not achieve negative sputum cultures after a minimum of 6 consecutive months of conventional therapy. • Patient continues to have a susceptible infection to amikacin. • Patient is on a concomitant multidrug background (baseline) regimen therapy. • Provider must explain why the patient cannot use IV amikacin (fill in the blank) • Provider acknowledges and patient has been informed that Arikayce carries a boxed warning for risk of increased respiratory adverse reactions that can lead to hospitalization. • Provider acknowledges and patient has been informed that warnings and precautions of Arikayce include hypersensitivity pneumonitis, hemoptysis, bronchospasm, exacerbation of underlying pulmonary disease, ototoxicity, nephrotoxicity, neuromuscular blockade, and embryo-fetal toxicity. • Provider acknowledges (and patient has been informed) the patient will be monitored for adverse reactions that include but are not limited to: (from package insert occurring at an incidence of ≥ 10% and higher than control) dysphonia, cough, bronchospasm, hemoptysis, ototoxicity, upper airway irritation, musculoskeletal pain, fatigue/asthenia, exacerbation of underlying pulmonary disease, diarrhea, and nausea. Non-FDA-approved uses are NOT approved (including for *Pseudomonas Aeruginosa*). PA does not expire.

Drug / Drug Class	Prior Authorization Criteria
• butalbital 50 mg/acetaminophen 300 mg capsule **Analgesics and Combinations**	Manual PA criteria apply to all new and current users of butalbital 50 mg/acetaminophen 300 mg capsules. Manual PA Criteria: Coverage will be approved for butalbital 50 mg/acetaminophen 300 mg capsule if all criteria are met: • Patient has a diagnosis of tension or muscle headaches • Patient cannot tolerate generic oral tablet or capsule formulations of butalbital/acetaminophen or butalbital/acetaminophen/caffeine. Non-FDA-approved uses are NOT approved. PA does not expire.
• cannabidiol oral solution (Epidiolex) **Anticonvulsant/Anti-Mania Agents**	Manual PA criteria apply to all new users of Epidiolex. Manual PA Criteria: Epidiolex is approved if all criteria are met: • Must be prescribed by a pediatric neurologist or neurologist • Patient has been diagnosed with either Lennox-Gastaut Syndrome or Dravet Syndrome Non-FDA-approved uses are NOT approved. PA does not expire.
• dacomitinib (Vizimpro) **Oncological Agents: Non-Small Cell Lung Cancer**	Manual PA criteria apply to all new users of Vizimpro. Manual PA Criteria: Vizimpro is approved if all criteria are met: • Patient ≥ 18 years old • Patient has histologically or cytopathologically confirmed stage IIIB/IV or recurrent non-small cell lung cancer with the presence of at least one documented epidermal growth factor receptor exon 19 deletion or exon 21 L858R substitution mutation as detected by an FDA-approved test • Patient has no evidence of active infection, non-infectious pneumonitis, nor interstitial lung disease • Patient has no previous use of an epidermal growth factor kinase inhibitor (e.g., Tarceva, Iressa, Gilotrif, or Tagrisso) • Drug is prescribed by or in consultation with a hematologist/oncologist Non-FDA-approved uses are NOT approved. PA does not expire.

Drug / Drug Class	Prior Authorization Criteria
• doxycycline monohydrate ER 50, 75 and 100 mg capsules (Okebo) • minocycline 105 and 135 mg ER tablets (Minolira) • **Oral Tetracyclines**	PA applies to both new and current users of to Okebo and Minolira. Automated PA Criteria: • Patient has filled a prescription for one generic IR doxycycline (either hyclate or monohydrate salt; does not include doxycycline monohydrate 40 mg IR/DR) **AND** one generic minocycline IR product at any Military Treatment Facility (MTF), retail network pharmacy, or the mail order pharmacy in the previous 180 days Manual PA Criteria: If automated PA criteria are not met, the non-step-preferred product is allowed if: **Acne Vulgaris or Rosacea** • For Acticlate, Doryx, Doryx MPC, Targadox, Monodox, Morgidox, Monodoxyne NL, **or Okebo:** The patient has tried and had an inadequate response to or failed to tolerate the following: ▪ one generic immediate-release doxycycline product (hyclate or monohydrate salt) AND ▪ one generic immediate-release minocycline product • For Solodyn or generic minocycline ER **or Minolira**: The patient has acne with inflammatory lesions AND ▪ the patient cannot tolerate generic minocycline IR due to gastrointestinal adverse events **Susceptible Infections** • For Doryx, Doryx MPC, Acticlate, **and Okebo**: if used for susceptible infections, the patient has failed or had clinically significant adverse events to generic IR doxycycline Non-FDA-approved uses are NOT approved PA expires in 1 year Renewal Criteria: Okebo or Minolira will be approved for an additional year, if: • The patient's therapy has been re-evaluated within the last 12 months • The patient is tolerating treatment, and there is continued medical need for the medication • The patient has had disease stabilization or improvement in disease on therapy

Drug / Drug Class	Prior Authorization Criteria
• duvelisib (Copiktra) **Oncological Agents for Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma**	Manual PA criteria apply to all new users of Copiktra. Manual PA Criteria: Copiktra is approved if all criteria are met: • Patient ≥ 18 years old • Patient has evidence and pathologic confirmation of relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) or relapsed or refractory follicular lymphoma (FL) • Patient has undergone at least two prior systemic therapies • Provider is aware and has informed patient of the risk of serious, life-threatening, and fatal infections, including *Pneumocystis jiroveci* pneumonia (PJP) and cytomegalovirus (CMV); diarrhea; colitis; cutaneous reactions, including drug rash with eosinophilia and systemic symptoms (DRESS) and Stevens Johnson Syndrome spectrum reactions, including Toxic Epidermal Necrolysis; pneumonitis; hepatotoxicity; and neutropenia • Patient has no evidence of active infection, diarrhea, colitis, serious cutaneous disease, pneumonitis, hepatitis, significantly elevated liver-associated enzymes, nor neutropenia • Female patients of childbearing age are not pregnant confirmed by (-) HCG test and agree to use contraception • Male patients are informed that Copiktra may cause male infertility • Drug is prescribed by a hematologist/oncologist • Prescriber agrees to advise patient of the toxicities of the drug, as outlined in the REMS program found at http://www.copiktrarems.com Non-FDA-approved uses are NOT approved. PA does not expire.
• elagolix (Orilissa) **Luteinizing Hormone Releasing Hormone (LHRH) Agonists/Antagonists**	Manual PA applies to all new and current users of elagolix (Orilissa). Manual PA Criteria: Elagolix is approved if all criteria are met: • Age ≥ 18 • Patient is a premenopausal woman with endometriosis • Patient has had inadequate relief after at least three months of first-line therapy with nonsteroidal anti-inflammatory drugs (NSAIDs) and hormonal contraceptives, unless contraindicated • Medication is prescribed by a reproductive endocrinologist or obstetrics/gynecology specialist • Patient is not pregnant. Pregnancy test required. • Patient agrees to use non-hormonal contraception throughout treatment and for one week after discontinuation of treatment • Patient does not have severe hepatic impairment (Child-Pugh Class C) • Patient does not have osteoporosis • Patient is on concurrent calcium supplementation. • Patient is not using Orilissa concomitantly with cyclosporine or gemfibrozil Non-FDA approved uses are NOT approved. PA Expiration 9 months; Renewal expiration 24 months Renewal Criteria: PA will be approved for an additional 15 months (lifetime usage not to exceed 24 months) if all criteria are met • The patient meets the original PA criteria • Patient does not have moderate hepatic impairment (Child-Pugh Class B); • Patient is taking the Orilissa 150 mg dose (note that the 200 mg dose is only approved for up to 6 months)

Drug / Drug Class	Prior Authorization Criteria
• fremanezumab-vfrm injection (Ajovy) injection • galcanezumab-gnlm injection (Emgality) **Migraine Agents**	Manual PA criteria apply to all new users of Ajovy and Emgality. <u>Manual PA Criteria</u>: Ajovy or Emgality 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 • Concurrent use with other CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality) is not allowed • For Emgality, loading doses will be allowed Non-FDA-approved uses are NOT approved. PA expires after 6 months. <u>Renewal Criteria</u>: 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)
• glycopyrronium 2.4% topical cloth (Qbrexza) **Antiperspirants**	Manual PA criteria apply to all new and current users of Qbrexza. <u>Manual PA Criteria</u>: Coverage is approved if all criteria are met: • Age ≥ 9 years • Patient has had a diagnosis of primary axillary hyperhidrosis for ≥ 6 months • Patient has tried and failed at least one topical 20% or higher aluminum salt (either OTC or prescription) and at least one additional option (e.g., Botox, MiraDry, iontophoresis, oral anticholinergics [glycopyrrolate, oxybutynin, propantheline], propranolol, clonidine, or diltiazem) • Prescribed by a dermatologist Non-FDA-approved uses are NOT approved. Not for palmar, plantar, facial, or other forms of hyperhidrosis. PA does not expire.
• ivosidenib (Tibsovo) **Oncological Agents: Acute Myelogenous Leukemia**	Manual PA criteria apply to all new users of Tibsovo. <u>Manual PA Criteria</u>: Tibsovo is approved if all criteria are met: • Patient ≥ 18 years old • Has laboratory evidence of relapsed or refractory acute myeloid leukemia with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test • The patient will be monitored for differentiation syndrome • The patient will be monitored for Guillain-Barre syndrome • Prescribed by or in consultation with a hematologist/oncologist For non-FDA-approved uses, please cite supporting literature. PA does not expire.

Drug / Drug Class	Prior Authorization Criteria
• lanadelumab-flyo injection (Takhzyro) **Corticosteroids-Immune Modulators: Hereditary Angioedema Agents**	Manual PA applies to all new users of Takhzyro. Manual PA Criteria: lanadelumab is approved if all apply: • The patient is ≥ 12 years old • Patient is not pregnant or breastfeeding • The patient must be diagnosed with hereditary angioedema (HAE) Type I, II, or III (HAE with normal C1-esterase inhibitor) • The drug is prescribed by an allergist, immunologist, or rheumatologist or in consultation with an HAE specialist • The patient must experience baseline of ≥ 2 HAE attacks per month • The patient has tried and failed an attenuated androgen (danazol) **OR** ▪ Patient has experienced or is expected to experience serious adverse effects from the use of an androgen (e.g., virilization of women, stroke, myocardial infarction, venous thromboembolism) OR ▪ Patient is female of childbearing age Non-FDA-approved uses NOT approved. PA does not expire.
• lidocaine 1.8% topical patch (ZTlido) **Pain Agents: Pain Topical**	Manual PA applies to all new and current users of lidocaine 1.8% topical patch (ZTlido). Manual PA Criteria: ZTlido is approved if: • The patient has a diagnosis of post-herpetic neuralgia AND • Provider must explain why patient cannot use lidocaine 5% patch (Lidoderm, generics). ▪ Acceptable response: patient has failed an adequate course of Lidoderm ▪ Not an acceptable response: Adhesive issues with Lidoderm is not a valid reason for ZTlido approval. Non-FDA-approved uses are NOT approved. PA does not expire.
• lumacaftor/ivacaftor (Orkambi granules) **Cystic Fibrosis Agents**	Manual PA criteria apply to all new users of Orkambi granules. Manual PA Criteria: Coverage is approved if all criteria are met: • Orkambi is prescribed for the treatment of cystic fibrosis in an age appropriate patient population according to the product label. ▪ For Orkambi granules – the patient is between the ages of 2 to 5 years; or the patient is older than 5 years with documented swallowing difficulties ▪ For Orkambi tablets – the patient is 6 years of age or older • The patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected/confirmed by an FDA-approved test • Concomitant use of Orkambi granules with Orkambi tablets is not allowed. • Concomitant use of Orkambi granules or tablets is not allowed with ivacaftor (Kalydeco) or tezacaftor/ivacaftor (Symdeko). Non-FDA-approved uses are NOT approved, including: • Patients who are heterozygous for the F508del mutation in the CFTR gene Non-FDA approved uses are NOT approved. PA does not expire.

Drug / Drug Class	Prior Authorization Criteria
• lusutrombopag (Mulpleta) **Hematological Agents: Platelets**	Manual PA criteria apply to all new users of Mulpleta. Manual PA Criteria: Mulpleta is approved if all criteria are met: • Patient ≥ 18 years old • Diagnosed with liver disease that has caused severe thrombocytopenia (platelet < 50 x 10^9/L) • Will be undergoing a procedure *with a moderate to high bleeding risk* within 8-14 days • Has no evidence of current thrombosis • Prescribed by or in consultation with a gastroenterologist Non-FDA-approved uses are NOT approved. PA expires in 60 days. PA renewal is not allowed.
• metoprolol succinate ER capsules (Kapspargo Sprinkle) **Beta Blockers**	**PA does not apply to patients less than 18 years of age (age edit).** Manual PA criteria apply to all new users of Kapspargo older than 18 years of age. Manual PA Criteria: Coverage is approved if all criteria are met: • Age > 18 years of age • Diagnosis of hypertension, angina pectoris, or heart failure • Drug will be dosed at a maximum of once daily • Provider must explain why the patient requires metoprolol succinate sprinkle and cannot take alternative formulary beta blockers ▪ Acceptable responses include the following: the patient requires metoprolol succinate and cannot take tablets due to some documented medical condition e.g., dysphagia, oral candidiasis, systemic sclerosis, etc. and not due to convenience, or requires NG tube admin Non-FDA-approved uses are NOT approved. Prior authorization does not expire.
• migalastat (Galafold) **Metabolic Agents-Miscellaneous**	Manual PA applies to all new and current users of migalastat (Galafold). Manual PA Criteria: Migalastat is approved if all criteria are met: • Age ≥ 18 years old • Has laboratory evidence of GLA gene variant based on *in vitro* assay data • Galafold is prescribed by or in consultation with a geneticist, nephrologist, or a physician who specializes in the treatment of Fabry disease • Must not be used concomitantly with Fabrazyme Non-FDA-approved uses are NOT approved. PA does not expire.
• ozenoxacin 1% cream (Xepi) **Antibiotics: Quinolones**	Manual PA criteria apply to all new users of Xepi. Manual PA Criteria: Xepi is approved if ALL criteria are met: • Patient is 2 months of age or older • Patient has a diagnosis of impetigo • Patient has failed a trial of mupirocin 2% ointment or cream (unless contraindicated or clinically significant adverse effects have been experienced) • Patient has a contraindication to or has failed a trial of an oral antibiotic for (e.g., cephalexin, dicloxacillin, clindamycin) • The Xepi dose will not exceed twice daily topical application for 5 days Non-FDA-approved uses are NOT approved. Prior authorization expires after 1 month; renewal will require PA to be completed again.

Drug / Drug Class	Prior Authorization Criteria
• tildrakizumab (Ilumya) **Targeted Immunomodulatory Biologics (TIBs): Non-Tumor Necrosis Factor Inhibitors**	Manual PA criteria apply to all new and current users of Ilumya. The patient must have tried Humira, Cosentyx AND Stelara first. Manual PA Criteria: Ilumya is approved if all criteria are met: • The patient has a contraindication or has had an inadequate response to Humira, Cosentyx, AND Stelara OR • The patient has had an adverse reaction to Humira, Cosentyx, AND Stelara that is not expected with requested non-step-preferred TIB AND • Patient ≥ 18 years old • The patient is diagnosed with moderate to severe plaque psoriasis and is a candidate for systemic therapy or phototherapy • Patient has tried and had an inadequate response to non-biologic systemic therapy) (e.g., methotrexate, aminosalicylates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine]) • Coverage NOT provided for concomitant use with other TIBs • The patient has had a negative TB test result in past 12 months (or TB is adequately managed) Non-FDA-approved uses are NOT approved. PA does not expire.
• chlorzoxazone 250 mg **Skeletal Muscle Relaxants and Combinations**	Manual PA criteria apply to all new and current users of chlorzoxazone 250 mg. Note: Chlorzoxazone 500 mg tablets are scored and available without a PA; providers are encouraged to consider changing the prescription to ½ of a 500 mg tablet if the patient requires a 250 mg dose. Manual PA Criteria: Coverage for chlorzoxazone 250 mg tablets will be approved if: • The provider explains why the patient requires chlorzoxazone 250 mg tablets and why the patient cannot take ½ of a 500 mg tablet • Acceptable responses are approved if ALL of the criteria are met: ▪ The patient has experienced allergic reaction (i.e., hives/anaphylaxis) to one or more inactive ingredients in currently available chlorzoxazone 500 mg tablets Non-FDA-approved uses are NOT approved. Prior authorization does not expire.
• cobimetinib (Cotellic) **Oncological Agents: Melanoma**	Manual PA criteria apply to all new users of Cotellic. Manual PA Criteria: Coverage will be approved if: • Age ≥ 18 years • Has unresectable metastatic melanoma • Has confirmed BRAF V600E or V600K mutation by an FDA-approved test • Cotellic is being taken in combination with vemurafenib (Zelboraf) • Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), nor trametinib (Mekinist) • Prescribed by or in consultation with an oncologist Non-FDA-approved uses are NOT approved. Prior authorization does not expire.

Drug / Drug Class	Prior Authorization Criteria
• crotamiton 10% Lotion (Eurax/Crotan) **Antiinfectives: Miscellaneous**	Manual PA criteria apply to all new users of Eurax/Crotan. Crotan/Eurax is approved if <u>ALL</u> criteria are met: • Age ≥ 18 years • Patient has a diagnosis of scabies caused by *Sarcoptes scabiei* • Patient must have tried and failed permethrin 5% cream in the last 60 days, unless contraindicated or clinically significant adverse effects are experienced Non-FDA-approved uses are NOT approved. Prior authorization expires in 30 days. Renewal of PA is not allowed.
• dupilumab injection (Dupixent) **Corticosteroids – Immune Modulators: Atopic Dermatitis**	**November 2018 updates are in BOLD.** Manual PA criteria apply to all new users of Dupixent. <u>Manual PA Criteria:</u> 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 • **The 200 mg/1.14 mL formulation is NOT approved for atopic dermatitis** **OR** • **Patient has moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid-dependent asthma** • **Patient must be 12 years of age or older** • **Prescribed by a pulmonologist, asthma specialist, allergist, or immunologist** • **Patient has baseline eosinophils ≥ 300 cells/mcL** • **Patient's symptoms are not adequately controlled on stable high-dose inhaled corticosteroid AND either an inhaled Long-Acting Beta Agonist or a Leukotriene Receptor Antagonist for at least 3 months** • **Dupixent will not be used for relief of acute bronchospasm or status asthmaticus** • **Dupixent will be only used as add-on therapy to other asthma controller medications** Non-FDA-approved uses are NOT approved. PA expires after 6 months. <u>Renewal PA Criteria:</u> Coverage will be approved indefinitely for continuation of therapy if: • **Atopic Dermatitis:** 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) • **Asthma: The patient has had a positive response to therapy with a decrease in exacerbations, improvements in FEV_1, or decrease in oral corticosteroid use.**

Drug / Drug Class	Prior Authorization Criteria
• diclofenac potassium liquid filled capsules (Zipsor) • diclofenac submicronized (Zorvolex) • indomethacin submicronized (Tivorbex) • naproxen CR (Naprelan/generics) • meloxicam submicronized (Vivlodex) **Pain Agents: NSAIDs**	Manual PA criteria apply to all new and current users of naproxen CR (Naprelan/generics), Zorvolex, Tivorbex, Vivlodex, and Zipsor. Manual PA Criteria: Coverage for naproxen CR (Naprelan/generics), Zorvolex, Tivorbex, Vivlodex, Zipsor will be approved if: • Note: Multiple formulary NSAIDs are available for DoD beneficiaries without a PA. Please state clinical rationale of why patient cannot take any of the formulary NSAIDs: (blank write in) • Acceptable responses are approved if ALL of the criteria are met (no prompting): ▪ The patient medical history includes trial and failure of four formulary generic NSAIDs, including three of the following BCF agents: ▪ ibuprofen 400 mg, 600 mg, 800 mg, 125 mg/5 mL susp (generic) ▪ indomethacin 25 mg, 50 mg (generic) ▪ meloxicam 7.5 mg, 15 mg (generic) ▪ naproxen IR 250 mg, 500 mg (generic) Non-FDA-approved uses are NOT approved. Prior authorization expires in one year. Renewal criteria: PA will be renewed for an additional year if a new PA form is completed.
• emicizumab-kxwh (Hemlibra) **Antihemophilic Factors**	**Changes from the November 2018 meeting are in BOLD and strikethrough.** Manual PA criteria apply to all new users of Hemlibra. Manual PA Criteria: Coverage will be approved if ALL criteria are met: • ~~The patient must have a documented diagnosis of Hemophilia A~~ • Patients is using Hemlibra as routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients newborn and older with hemophilia A with or without factor VIII inhibitors • ~~The patient must have a history of a high titer of factor VIII inhibitor (greater than or equal to 5 Bethesda units per mL)~~ • The patient must NOT have been treated within the last 12 months for thromboembolic disease or have current signs of thromboembolic disease • The drug is being prescribed by or in consultation with a hematologist • **Medication is not being used in combination with Immune Tolerance Induction (ITI)** Non-FDA-approved uses are NOT approved. Prior authorization does not expire.

Drug / Drug Class	Prior Authorization Criteria
• febuxostat (Uloric) **Anti-Gout Agents: Chronic**	**November 2018 updates are in BOLD.** **Manual PA criteria apply to all new users of Uloric.** <u>Automated PA Criteria:</u> The patient has received a prescription for allopurinol at any Military Health System pharmacy point of service (Military Treatment Facilities, retail network pharmacies, or mail order) during the previous 180 days. AND <u>Manual PA Criteria:</u> If automated criteria are not met, febuxostat (Uloric) is approved (e.g., a trial of allopurinol is not required) if: • The patient has experienced any of the following issues with at least one of the following with allopurinol, which is not expected to occur with febuxostat (Uloric): ▪ The patient has had an inadequate response to allopurinol (failure to achieve serum uric acid levels < 6 mg/day) after an adequate trial (at least 300 mg per day of allopurinol) ▪ The patient has had intolerable adverse effects (e.g., hypersensitivity) to allopurinol ▪ The patient has a contraindication to allopurinol (e.g., renal impairment) • **Patients with major cardiovascular (CV) disease should be informed of the potential CV risks when using this drug** • **The Healthcare provider should consider CV safety information from the CARES trial and the label when prescribing febuxostat** Non-FDA-approved uses are NOT approved. Prior authorization does not expire.
• insulin degludec (Tresiba) **Basal Insulins**	**November 2018 updates are in BOLD.** Manual PA criteria apply to all new users of Tresiba. <u>Manual PA Criteria:</u> Tresiba is approved if <u>ALL</u> criteria are met: • Patient is age ≥ 1 year • **The provider must explain why the patient cannot use Lantus (fill in the blank)** • **The provider must explain why the patient cannot use Toujeo (fill in the blank)** • ~~Patient must have tried and failed or is intolerant to insulin glargine (Lantus)~~ Non-FDA-approved uses are NOT approved. Prior authorization does not expire.

Drug / Drug Class	Prior Authorization Criteria
• pimavanserin (Nuplazid) **Antipsychotic Agents: Atypical**	**November 2018 updates are in BOLD.** Manual PA criteria apply to all new users of pimavanserin. Manual PA Criteria: Nuplazid is approved if all of the following criteria are met: • Patient is age ≥ 18 years. • Patient has a diagnosis of hallucinations and/or delusions associated with Parkinson's disease psychosis. • **Nuplazid is being prescribed by or in consultation with a neurologist, psychiatrist, or gerontologist (i.e., geriatric medicine specialist).** • Prescribing physician has attempted to adjust Parkinson's disease medications in order to reduce psychosis without worsening motor symptoms prior to requesting pimavanserin. • The patient's baseline Mini-Mental State Examination (MMSE) score ≥ 21. • **Patient does NOT have history of known QT prolongation, cardiac arrhythmias, or other circumstances that would increase the risk of Torsades de Pointes and/or sudden death.** • **Patient is NOT taking additional antipsychotics.** Non-FDA approved uses are NOT approved. Prior authorization does not expire.

Drug / Drug Class	Prior Authorization Criteria
Step-Preferred • Norditropin FlexPro **Non-Step-Preferred** • Genotropin • Humatrope • Nutropin AQ Nuspin • Omnitrope • Saizen • Serostim • Zomacton **Growth Stimulating Agents (GSAs)**	**May 2018 changes are bolded.** **Norditropin FlexPro is the preferred Growth Stimulating Agent.** **All new and current users of the non-step-preferred Growth Stimulating Agents must try Norditropin FlexPro first.** Manual PA Criteria: Norditropin FlexPro, Genotropin, Humatrope, Nutropin AQ Nuspin, Omnitrope, Saizen, Serostim, and Zomacton are approved if: • The patient is younger than 18 years of age and has the following indications: ▪ Growth hormone deficiency ▪ Small for Gestational Age ▪ Chronic Renal Insufficiency **associated with growth failure** ▪ Prader-Willi Syndrome **(in patients with a negative sleep study for obstructive sleep apnea)** ▪ Turner Syndrome ▪ Noonan's Syndrome ▪ Short stature homeobox (ShoX) gene mutation • For patients younger than 18 years of age who do not have one of the indications above, document the diagnosis below: _____ • For patients younger than 18 years of age, the prescription is written by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment **OR** • The patient is older than 18 years of age and has the following indications: ▪ Growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy, acquired as an adult or diagnosed during childhood ▪ HIV/AIDS wasting/cachexia ▪ Short Bowel Syndrome • For patients older than 18 years of age, the prescription is written by **or in consultation with an appropriate specialist (endocrinologist, infectious disease specialist, general surgeon, or gastroenterologist)** **AND** For Genotropin, Humatrope, Nutropin AQ Nuspin, Omnitrope, Saizen, Serostim and Zomacton: In addition to the above criteria, the following criteria applies to new and current users of Genotropin, Humatrope, Nutropin AQ Nuspin, Omnitrope, Saizen, Serostim, and Zomacton: • The patient has a contraindication to Norditropin FlexPro OR • The patient has experienced an adverse reaction to Norditropin FlexPro that is not expected with the non-step-preferred product (e.g., because of different preservative) Note that patient preference for a particular device is insufficient grounds for approval of Genotropin, Humatrope, Nutropin AQ Nuspin, Omnitrope, Saizen, Serostim or Zomacton. • Use of a Growth Stimulating Agent is not approved for idiopathic short stature, the normal ageing process, obesity, or depression • Use of a Growth Stimulating Agent is not approved for other non-FDA-approved uses (e.g., non-alcoholic fatty liver disease, cirrhosis, mild cognitive impairment) • Concomitant use of multiple Growth Stimulating Agents is not approved Prior authorization expires in one year.

Appendix D—Table of Quantity Limits (QLs)

Drug / Drug Class	Quantity Limits
▪ amikacin (Arikayce) **Antibiotic: Aminoglycosides**	▪ MTF/Mail/Retail: 28-day supply
▪ butalbital 50 mg and acetaminophen 300 mg capsules **Analgesics and Combinations**	▪ MTF/Mail: 180 caps/90 days ▪ Retail: 60 caps/30 days
▪ cannabidiol oral solution (Epidiolex) **Anticonvulsants-Antimania Agents**	▪ MTF/Mail/Retail: 6 bottles/30 days
▪ dacomitinib (Vizimpro) **Oncological Agents: Lung Cancer**	▪ MTF/Mail: 60-day supply ▪ Retail: 30-day supply
▪ deutetrabenazine (Austedo) ▪ valbenazine (Ingrezza) **Neurological Agents Miscellaneous: Movement Disorders**	▪ MTF/Mail/Retail: 30-day supply
▪ duvelisib (Copiktra) **Oncological Agents: CLL or SLL**	▪ MTF/Mail/Retail: 28-day supply
▪ erenumab-aooe injection (Aimovig) **Migraine Agents**	**Update from August 2018 P&T meeting** ▪ MTF/Mail: 3 syringes or pens/90 days ▪ Retail: 1 syringe or pen/30 days ▪ Adequate trial of lower strength required for 3 months before trying the higher strength (either 2 of the 70 mg syringes or 1 of the 140 mg syringe/30 days)
▪ fremanezumab-vfrm injection (Ajovy) **Migraine Agents**	▪ MTF/Mail: 3 syringes/90 days ▪ Retail: 1 syringe/30 days; multiple co-pays allowed for multiple fills at Retail if patient is using quarterly regimen
▪ galcanezumab-gnlm injection (Emgality) **Migraine Agents**	▪ MTF/Mail: 3 syringes or pens/90 days ▪ Retail: 1 syringe or pen/30 days
▪ fentanyl and fentanyl citrate (Abstral, Actiq, Fentora, fentanyl citrate lozenge (generic), Lazanda, and Subsys) **Narcotic Analgesics and Combinations: Transmucosal Immediate Release Fentanyl (TIRF) Products**	▪ MTF/Mail/Retail: 30-day supply

Drug / Drug Class	Quantity Limits
▪ ivacaftor (Kalydeco) granules **Cystic Fibrosis Agents**	▪ MTF/Mail/Retail: 56 packets/28 days
▪ ivacaftor (Kalydeco) tablets **Cystic Fibrosis Agents**	▪ MTF/Mail/Retail: 60 tablets/30 days
▪ ivosidenib (Tibsovo) **Oncological Agents: Acute Myelogenous Leukemia**	▪ MTF/Mail: 60-day supply ▪ Retail: 30-day supply
▪ ketorolac (Sprix) nasal spray **Pain Agents: NSAID**	▪ MTF/Mail/Retail: 5 bottles/5-day supply
▪ lanadelumab-flyo (Takhzyro) **Corticosteroids-Immune Modulators: Hereditary Angioedema Agents**	▪ MTF/Mail: 6 vials/90 days ▪ Retail: 2 vials/30 days
▪ lidocaine 1.8% (ZTlido) topical system **Pain Agents: Pain Topical**	▪ MTF/Mail: 270 patches/90 days ▪ Retail: 90 patches/30 days
▪ lumacaftor/ivacaftor (Orkambi) granules **Cystic Fibrosis Agents**	▪ MTF/Mail/Retail: 56 packets/28 days
▪ lumacaftor/ivacaftor (Orkambi) tablets **Cystic Fibrosis Agents**	▪ MTF/Mail/Retail: 112 tablets/28 days
▪ lusutrombopag (Mulpleta) **Hematological Agents: Platelets**	▪ MTF/Mail/Retail: 7-day supply
▪ migalastat (Galafold) **Metabolic Agents-Miscellaneous**	▪ MTF/Mail/Retail: 30-day supply
▪ ozenoxacin 1% cream (Xepi) **Antibiotics: Quinolones**	▪ MTF/Mail/Retail: 110-, 30- or 45 mg tube/30 days

Drug / Drug Class	Quantity Limits
▪ pegfilgrastim-jmdb (Fulphila) **Hematological Agents: White Blood Cell Stimulants**	▪ MTF/Mail: 2 syringes/45 days ▪ Retail: 1 syringe/21 days
• rifaximin 550mg tab (Xifaxan) **Gastrointestinal-2 Agents: Miscellaneous**	For the indication of IBS-D: ▪ MTF/Mail/Retail: 42 tabs per prescription fill; maximum of 3 treatment courses in 365 days
▪ tezacaftor/ivacaftor + ivacaftor (Symdeko) **Cystic Fibrosis Agents**	▪ MTF/Mail/Retail: 56 tablets/28 days
▪ tildrakizumab (Ilumya) **Targeted Immunomodulatory Biologics (TIBs): Non-Tumor Necrosis Factor Inhibitors**	▪ 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
adapalene 0.1% topical solution (external pad/swab) (Plixda)	Acne Agents: Topical Acne & Rosacea	adapalene 0.1% lotion, cream, gel	Acne vulgaris	• New topical pad formulation (Plixda) and new topical solution formulation of adapalene 0.1% initially approved in 2016 and recently launched. • Three different formulations and two different strengths (0.1% & 0.3%) of adapalene are available on the formulary. • Plixda has no unique indications and does not offer any compelling evidence of clinical efficacy relative to existing topical retinoid (e.g., adapalene 0.1% gel, cream, or lotion) on the uniform formulary.	• NF and non-step-preferred • Add to EMMPI list
adapalene 0.1% topical solution	Acne Agents: Topical Acne & Rosacea	adapalene 0.1% lotion, cream, gel	Acne vulgaris	• New formulation of adapalene available in a topical solution. • Three different formulations and two different strengths (0.1% & 0.3%) of adapalene are available on the formulary. Adapalene 0.1% topical solution has no unique indications and does not offer any compelling evidence of clinical efficacy relative to existing topical retinoid (e.g., adapalene 0.1% gel, cream, or lotion) on the uniform formulary.	• NF and non-step-preferred • Add to EMMPI list
amikacin liposome inhaled suspension (Arikayce)	Antibiotics: Aminoglycosides	Amikacin IV and inhaled	Mycobacterium avium complex (MAC)	• New liposomal inhalation formulation of amikacin. • First drug granted approval under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs. • Indicated for adults with limited/no alternatives for MAC lung disease as part of a combination antibacterial regimen in patients who have not achieved negative sputum cultures after a minimum of six consecutive months of treatment. • One clinical efficacy non-RCT found proportion of patients achieving culture conversion by month six was statistically significantly greater for Arikayce plus background regimen compared to background regimen alone. • FDA is requiring a post-marketing study to describe the clinical benefits of Arikayce. • Place in therapy remains unclear; additional data providing clear association with clinically meaningful outcomes, most appropriate treatment population, comparative efficacy, and relative safety versus other currently available options has not been established.	• NF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
butalbital 50 mg with acetaminophen 300 mg capsules	Analgesics & Combinations	• butalbital-acetaminophen-caffeine (Fioricet, generics) • butalbital-acetaminophen (Bupap, generics) • butalbital-acetaminophen (Allzital) tabs	Tension headache	• Another formulation of butalbital and acetaminophen in capsule form. • There are similar strengths of the active ingredients formulated in both tablets and capsules with or without caffeine that are available on the formulary. • No new clinical data to review. • Provides little to no clinical benefit relative to existing formulary agents.	• NF • Do not add to EMMPI list
cannabidiol oral solution (Epidiolex)	Anticonvulsants-Antimania agents	• clobazam • topiramate • lamotrigine	Treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients 2 years of age and older	• 1st cannabidiol approved for refractory seizures disorders (Lennox-Gastaut and Dravet syndromes). • Epidiolex decreases drop seizures in Lennox-Gastaut syndrome by 20% and decreases convulsive seizures in Dravet syndrome by 22%. • Short-term studies show some safety risk; elevated AST/ALT. • Studies show low addiction risks. • Cannabidiol under investigation for several additional indications	• UF • Do not add to EMMPI list
dacomitinib (Vizimpro)	Oncological Agents: Lung Cancer	• afatinib (Gilotrif) • gefitinib (Iressa) • osimertinib (Tagrisso) • erlotinib (Tarceva)	First-line treatment for metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test.	• 5th EGFR kinase inhibitor for NSCLC. • 2nd irreversible 2nd generation inhibitor • Improved progression-free survival over reversible EGFR kinase inhibitor in newly diagnosed advanced disease • Equivalent overall survival relative to reversible EGFR kinase inhibitor in late stage, heavily treated disease • No efficacy over placebo in EGFR kinase inhibitor previously treated disease • Poorly tolerated relative to reversible EGFR kinase inhibitors • Provides an additional treatment option in a subset of patients where clinical benefit may outweigh toxic risk.	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status

darunavir/ cobicistat/ emtricitabine/ tenofovir alafenamide (TAF) (Symtuza)	Antiretrovirals: Combinations	• Odefsey
		• Atripla
			Single-tablet regimen (STR) for HIV-1 infection (for naïve or switching)	• 5th second-line STR treatment option for HIV.
				• Contains a dual nucleoside reverse transcriptase inhibitor (NRTI)-based regimen + protease inhibitor (PI).
				• Approved for initial therapy in adults with HIV; however, the CDC recommends Symtuza as a 2nd-line agent.
				• Evaluated in two phase 3 trials.
				  • AMBER: showed non-inferiority to DRV/c/FTC/TDF
				  • EMERALD: showed non-inferiority to boosted PI + F/TDF
				• Not studied in pediatric, breastfeeding, or pregnant populations.
				• The side effect profile was generally mild, including nausea, headache, diarrhea, and rash.
				• More data on efficacy, safety, and long-term clinical consequences of increased lipid levels is necessary to better characterize strengths and weaknesses.
				• Provides an additional STR option for patients requiring aprotease inhibitor as the 3rd drug in a complete regimen.
					• UF
					• Do not add to EMMPI list

doravirine (Pifeltro)	Antiretrovirals: NNRTIs	• rilpivirine • efavirenz • delavirdine • etravirine • nevirapine	In combination with two other agents for HIV treatment	• Pifeltro is a single-ingredient non-nucleoside reverse transcriptase inhibitor (NNRTI) that should be utilized with two NRTI antiretroviral agents. • Doravirine-treated recipients had much lower rates of adverse effects compared to Atripla specifically with regard to dizziness, sleep disturbances, and other neuropsychiatric symptoms. • More data on switching regimens, resistance patterns, and long-term clinical outcomes of favorable lipid profiles is necessary to better characterize strengths and weaknesses for both drugs.	• UF • Do not add to EMMPI list

doravirine/ lamivudine/ tenofovir disoproxil fumarate (TDF) (Delstrigo)	Antiretrovirals: Combinations	• Atripla
		• Complera
			STR for HIV-1 infection (for naïve or switching)	• Delstrigo is the 6th second-line single tablet complete treatment regimen option for HIV.
				• Delstrigo was evaluated in two phase 3 trials.
				  • DRIVE-FORWARD study, Delstrigo showed non-inferiority to darunavir plus ritonavir plus two NRTIs.
				  • DRIVE-AHEAD study, Delstrigo showed non-inferiority to Atripla.
				• Doravirine-treated recipients had much lower rates of adverse effects compared to Atripla specifically with regard to dizziness, sleep disturbances, and other neuropsychiatric symptoms.
				• More data on switching regimens, resistance patterns, and long-term clinical outcomes of favorable lipid profiles is necessary to better characterize strengths and weaknesses for both drugs.
					• UF
					• Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
doxycycline monohydrate ER capsules (Okebo)	Antibiotics: Tetracyclines	• Generic doxycycline monohydrate IR 75 mg and 100 mg cap/tablet	Susceptible infections	• New formulation of extended-release doxycycline. • Doxycycline monohydrate IR generics and doxycycline hylcalte IR generics are step-preferred in this class. • No new studies were submitted to the FDA. • No studies of added benefit of treatment with a capsule compared to a tablet in acne vulgaris. • Provides little to no clinical benefit relative to existing formulary agents.	• NF and non-step-preferred • Add to EMMPI list
minocycline ER 105 mg and 135 mg tablets (Minolira)	Antibiotics: Tetracyclines	• minocycline IR 50 mg, 75 mg 100 mg • Solodyn • Ximino	Acne 12 years of age and older	• New formulation of extended release minocycline • Minocycline IR generics are step-preferred in this class • No new studies were submitted to the FDA; same formulation as Solodyn. • No studies of added benefit in acne vulgaris of treatment with an extended-release formulation compared to IR were performed. • Provides little to no clinical benefit relative to existing formulary agents.	• NF and non-step-preferred • Add to EMMPI list
duvelisib (Copiktra)	Oncological Agents	• idelalisib (Zydelig) • copanlisib (Aliqopa) • ibrutinib (Imbruvica) • acalabrutinib (Calquence), • venetoclax (Venclexta)	Relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) after at least two prior therapies. Relapsed or refractory follicular lymphoma (FL) after at least two prior systemic therapies.	• 3rd phosphatidylinositol 3-kinase (PI3K) inhibitor indicated for CLL/SLL and/or FL. • Statistically significant superior efficacy to ofatumumab (CD-20 inhibitor), but clinically insignificant progression-free survival advantage. • There is substantial risk for serious toxicity including death warranting a black box warning and a REMS program • The indication is restricted to late-stage, heavily pretreated disease. Copiktra is useful as a last-line treatment option.	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
elagolix sodium (Orilissa)	Luteinizing Hormone-Releasing Hormone Agonists-Antagonists	• nafarelin nasal solution • leuprolide intramuscular kit • goserelin subcutaneous implant • triptorelin intramuscular suspension	GnRH antagonist for pain with endometriosis	• 1st GnRH antagonist and first oral agent for this indication • Evaluated in four phase 3 studies which showed statistically significant reductions in dysmenorrhea and nonmenstrual pelvic pain compared to placebo. Elagolix improved dysmenorrhea more than nonmenstrual pelvic pain and dyspareunia. • Higher dose therapy is superior to placebo for treating dyspareunia and provided greater improvements in pain, quality of life, and decreased use of rescue opioids than lower dose therapy. • Elagolix therapy is limited to 24 months for lower dose treatment and 6 months for higher dose treatment due to bone mineral density loss. • Elagolix effects have been measured only for relatively short periods (up to 12 months). Criteria used to define a clinically meaningful reduction in symptoms has not been previously used or validated. • Elagolix offers the first oral agent for pain associated with endometriosis, however numerous alternative agents are available, place in therapy is unclear, and no benefits in terms of side effect profile.	• NF • Add to EMMPI list
filgrastim-aafi injection (Nivestym)	Hematological Agents: White Blood Cell Stimulants	• filgrastim (Neupogen) • filgrastim-sndz (Zarxio) • tbo-filgrastim (Granix)	Biosimilar to Neupogen, like Granix and Zarxio	• Nivestym is a new biosimilar formulation of filgrastim. • 6th agent in the white blood cell stimulant subclass. • No new clinical data • Offers no clinically compelling advantages over existing formulary agents.	• NF • Add to EMMPI list
pegfilgrastim-jmdb injection (Fulphila)	Hematological Agents: White Blood Cell Stimulants	• pegfilgrastim (Neulasta, Neulasta OnPro)	Biosimilar to Neulasta	• Fuphila is a new biosimilar formulation of pegfilgrastim. • 7th agent in the white blood cell stimulant subclass. • No new clinical data • No clinically compelling advantages over existing agents.	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
fremanezumab-vfrm (Ajovy)	Migraine Agents: CGRP Preventative	• erenumab-aooe (Aimovig) • topiramate IR and ER • galcanezumab-gnlm (Emgality)	Preventive treatment of migraine in adults	• 2nd CGRP inhibitor for chronic and episodic migraine prevention. • Pivotal trials with baseline monthly migraine days < 15 ▪ Difference between fremanezumab and placebo ranged from 1.3 and 1.5 fewer migraine headache days per month. ▪ There was significant placebo effect. • Pivotal trial with baseline headache days > 15 ▪ Difference between fremanezumab and placebo ranged from 1.8 to 2.1 fewer migraine headache days per month. • Botulinum toxin is also approved for chronic migraine. • Ajovy and current preventive therapy (e.g., generic anticonvulsants, beta blockers or antidepressants) decrease the number of migraine days at similar rates of two per month. • Ajovy is approved as 225 mg monthly dose or 675 mg quarterly dose. Trial data showed similar efficacy and safety between both dosing regimens. • ICER concludes that in patients with chronic or episodic migraine who have other treatment options available, cost-effectiveness will likely exceed commonly accepted thresholds. • Current study data showed minor safety issues, but longer duration studies are needed to validate long-term safety and efficacy.	• UF • Do not add to EMMPI list
galcanezumab-gnlm (Emgality)	Migraine Agents: CGRP Preventative	• erenumab-aooe (Aimovig) • topiramate IR and ER • fremanezumab-vfrm (Ajovy)	Preventive treatment of migraine in adults	• 3rd CGRP inhibitor for chronic and episodic migraine prevention. • Pivotal trials with baseline monthly migraine days < 15 ▪ Difference between galcanezumab and placebo ranged from 1.9 and 2.0 fewer migraine headache days per month. ▪ There was significant placebo effect. • Pivotal trial with baseline headache days > 15 ▪ The difference between galcanezumab and placebo was 2.1 fewer migraine headache days per month. • Botulinum toxin is approved for chronic migraine. • Emgality and current preventive therapy (e.g., generic anticonvulsants, beta blockers or antidepressants) decrease the number of migraine days at similar rates of two per month. • Emgality is approved as a 120 mg monthly dose in a pen or syringe. • ICER concludes that in patients with chronic or episodic migraine who have other treatment options available, cost-effectiveness will likely exceed commonly accepted thresholds. • Current study data showed minor safety issues, but longer duration studies are needed to validate long-term safety and efficacy.	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
glycopyrronium 2.4% topical cloth (Qbrexza)	Antiperspirants	• aluminum chloride hexahydrate (Drysol 20%, Xerac AC 6.25%) • glycopyrrolate tab • onabotulinum toxin A (Botox)	Primary axillary hyperhidrosis	• New topical formulation of glycopyrronium indicated for primary axillary hyperhidrosis. • Evaluated in two Phase 3 studies in which one study showed a statistically significant decrease in perspiration and the other study did not. • No head-to-head studies with other agents indicated for hyperhidrosis. • Most common adverse effects include dry mouth, mydriasis, oropharyngeal pain, and headache. • Not studied beyond 4 weeks, in pregnancy, breastfeeding, or renal failure. • Provides another treatment option for primary axillary hyperhidrosis.	• UF • Do not add to EMMPI list
ivosidenib (Tibsovo)	Oncological Agents: Acute Myelogenous Leukemia (AML)	• none	AML with IDH1 mutation	• New class known as isocitrate dehydrogenase-1 inhibitor (IDH1) for treatment of AML with the specific IDH1 mutation. • Increases survival in ~40% of patients by ~6 months. • High adverse event rate including QTc prolongation (hERG K^+ channel blocker). • Discontinuation rate is approximately 30%, and the combined discontinuation rate plus dose modification rate is ~50%.	• UF • Do not add to EMMPI list
lanadelumab injection (Takhzyro)	Corticosteroids-Immune Modulators: Hereditary Angioedema Agents (HAE)	• C1-INH (Cinryze) • C1-INH (Haegarda)	For prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 12 years and older	• Takhzyro is superior to placebo in preventing attacks. • First kallikrein inhibitor and first monocloncal antibody for HAE prophylaxis. • Similar adverse events as other HAE agents with the exception of 60% reporting injection site reactions. • Another option for prophylaxis with indirect comparison showing relatively similar efficacy in attack frequency with othe HAE drugs • Easier to administer compared to IV. • Providers feel Takhzyro could be a first-line treatment for HAE prophylaxis.	• UF • Do not add to EMMPI list
lidocaine 1.8% topical system (ZTlido)	Pain Agents: Pain Topical	• lidocaine 5% patch (Lidoderm, generics)	For relief of pain associated with post-herpetic neuralgia	• New formulation of lidocaine patch. • One ZTlido 1.8% patch provides equivalent lidocaine exposure to one Lidoderm 5% patch. • Different absorption but equivalent area under the curve (AUC) and maximal plasma concentrations (Cmax) as Lidoderm. • No new clinical data to review. • Provides little to no clinical benefit relative to existing formulary agents.	• NF • Add/Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
lumacaftor/ ivacaftor (Orkambi granules)	Cystic Fibrosis agents	• lumacaftor/ ivacaftor (Orkambi tablets)	Treatment of CF in patients 2 years and older who are homozygous for the F508del mutation in the CFTR gene	• New oral granule formulation of Orkambi for pediatrics ages 2-5 years. Orkambi tablets are approved for ages ≥ 6 years. • A 24-week, open-label safety and pharmacokinetic study of Orkambi granules in patients 2-5 years found the safety profile was similar to that observed in similar patients ≥ 6 years. • Efficacy was extrapolated from studies of patients ≥ 12 years; population pharmacokinetic analyses showed similar drug exposure levels in patients ≥ 12 years & ages 2-11 years. • Orkambi granules have a niche for pediatric patients < 6 years or those with swallowing difficulty.	• UF • Do not add to EMMPI list
lusutrombopag (Mulpleta)	Hematological Agents: Platelets	• avatrombopag (Doptelet)	Thrombocytopenia associated with chronic liver disease (CLD)	• 4th thrombopoietin indicated for patients with CLD and severe thrombocytopenia 9-14 days prior to a planned procedure. • Most useful for procedures with an intermediate to high bleeding risk.	• UF • Do not add to EMMPI list
metoprolol extended-release (ER) capsules (Kapspargo Sprinkle)	Beta Blockers & HCTZ Combinations	• metoprolol succinate ER tablets • metoprolol tartrate • atenolol	200 mg ER metoprolol for hypertension (HTN), angina pectoris, and heart failure	• 2nd once daily metoprolol succinate ER formulation and 1st "sprinkle" formulation. • Approved via 505(b)(2) for treatment of hypertension (HTN), angina pectoris, and heart failure; no clinical trials conducted • Capsules contain a multitude of controlled release pellets; each coated pellet is a separate drug delivery unit, which releases drug over 24 hours. • Pediatric HTN dosing for ≤ 6 years contained in label (similar to metoprolol succinate ER tabs). • Can open capsules, sprinkle contents into applesauce, pudding, or yogurt, and consume within 1 hour. • Nasogastric administration information in label • Kapspargo provides no advantages compared to generic metoprolol succinate ER other than convenience to patients who cannot take tablets.	• UF • Do not add to EMMPI list
migalastat (Galafold)	Metabolic Agents-Miscellaneous	• agalsidase beta (Fabrazyme) IV infusion	Fabry disease	• 1st FDA-approved oral medication indicated for Fabry disease. • Eevaluated in one study, AT1001, and the primary endpoint was not statistically significant in comparison to placebo. • Fabrazyme and supportive renal care are the only other therapies currently available for Fabry disease. • Galafold currently provides an additional option for the treatment of Fabry disease relative to Fabrazyme.	• UF • Do not add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
Ozenoxacin 1% cream (Xepi)	Antibiotics: Quinolones	• mupirocin ointment • retapamulin ointment	Impetigo	• New non-fluorinated topical quinolone antibiotic indicated for impetigo. • 3rd topical antibiotic option for impetigo (bullous and non-bullous). • Provides additional treatment option for *S. aureus* and *S. pyogenes*, including MRSA which is a bacteria not commonly associated with impetigo. • While Xepi offers an additional option for the treatment of impetigo, alternative formulary agents are available, its use is limited to a single indication, and there is no comparative efficacy data with mupirocin.	• NF • Do not add to EMMPI list
PEG3350/Na ascorbate/NaSO4/a scorbic acid/NaCl/KCl powder packets (Plenvu)	Laxatives-Cathartics-Stool Softeners	• MoviPrep • GoLytely • ClenPiq • OsmoPrep	Bowel cleansing prior to colonoscopy	• Polyethylene glycol (PEG) bowel prep with added ascorbic acid to reduce total volume. • Two packets each mixed with 500 mL water that must be followed with an additional 500 mL. The total volume is 2 L. • Same manufacturer and ingredients as MoviPrep but contains 6-fold more ascorbic acid which allows for 2 L total volume compared to 3 L with MoviPrep. • Lowest-volume PEG solution, 4th low volume bowel prep, and 13th bowel prep regimen available. • Clinical trials showed similar efficacy to MoviPrep and a trisulfate preparation (Suprep). • No clinically compelling advantages over other bowel regimens.	• UF • Do not add to EMMPI list
PEGylated factor VIII (Jivi)	Antihemophilic Factors	• PEGylated Factor VIII (Adynovate)	Hemophilia A	• Jivi is a new formulation of pegylated factor VIII. • 2nd pegylated formulation (extended half-life) and 13th agent in the antihemophilic factor class. • Jivi was studied in an unpublished phase 2/3 multi-center, open-label partially RCT in patients with severe Hemophilia A. • No clinically compelling advantages over formulary agents.	• UF • Do not add to EMMPI list
sodium zirconium cyclosilicate (Lokelma)	Binders-Chelators-Antidotes-Overdose Agents	• patiromer (Veltassa) • sodium polystyrene sulfonate (Kayexalate)	Hyperkalemia	• Lokelma is the 3rd available potassium binder. • Study pool limited and no head-to-head studies with other potassium-lowering agents. • Faster efficacy may not be beneficial. • No known risk of bowel necrosis. • Provides another treatment option for hyperkalemia.	• UF • Do not add to EMMPI list
tildrakizumab-asmn injection (Ilumya)	TIBSs: Non-TNF Inhibitors	• adalimumab (Humira) • secukinumab (Cosentyx) • ustekinumab (Stelara) • guselkumab (Tremfya) • brodalumab (Siliq)	Plaque psoriasis	• Ilumya is the 2nd IL-23 inhibitor for moderate to severe plaque psoriasis and 6th agent in the IL-17/23 subclass. • 17th TIB marketed • Superior efficacy to etanercept; however, no head-to-head trial with appropriate comparator (i.e., Tremfya). • No significant safety concerns. • Provides no additional benefit relative to the other TIBs currently on the formulary.	• NF and non-step-preferred • Add to EMMPI list

Generic (Trade)	UF Class	Comparators	Indications	Clinical Summary	Recommended UF Status
tretinoin 0.05% topical lotion (Altreno)	Acne Agents: Topical Acne and Rosacea	tretinoin 0.05% solution, cream, gel	Acne vulgaris	• Altreno is the 11th topical tretinoin. • Whilethe tretinoin lotion formulation is indicated for once daily treatment of acne vulgaris, an alternative topical retinoid combination product, adapalene plus benzoyl peroxide (Epiduo Gel, generics) is also available to treat acne in patient ages 9 years and older. • Multiple other topical retinoids (e.g., tretinoin, tazarotene, adapalene) formulations and strengths are available on the uniform formulary. • This drug offers no other advantages in clinical efficacy relative to existing topical tretinoin formulations on the uniform formulary.	• NF and non-step-preferred • Add to EMMPI list

Appendix F—Mail Order Status of Medications Designated Nonformulary During the November 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)
November 2018	**Gastrointestinal-2 Agents: CIC/IBS-C and Miscellaneous** Add the following UF drugs to the EMMPI ▪ linaclotide (Linzess) ▪ plecanatide (Trulance) ▪ lubiprostone (Amitiza) ▪ rifaximin 550 mg (Xifaxan) ▪ eluxadoline (Viberzi) **Newly Approved Drugs per 32 CFR 199.21(g)(5)** ▪ adapalene 0.1% solution ▪ adapalene 0.1% external pad (Plixda) ▪ doxycycline monohydrate (Okebo) ▪ elagolix (Orilissa) ▪ filgrastim-aafi (Nivestym) ▪ lidocaine 1.8% topical system (ZTlido) ▪ minocycline ER (Minolira) ▪ tildrakizumab (Ilumya) ▪ tretinoin 0.05% topical lotion (Altreno)	**Gastrointestinal-2 Agents: CIC/IBS-C and Miscellaneous** ▪ nitazoxanide (Alinia) ▪ fidaxomicin (Dificid) ▪ rifaximin 200 mg (Xifaxan) **Neurological Agents Miscellaneous: Movement Disorders** ▪ deutetrabenazine (Austedo) ▪ valbenazine (Ingrezza) **Newly Approved Drugs per 32 CFR 199.21(g)(5)** Acute use exception applies: ▪ butalbital/acetaminophen 50 mg/300 mg capsules ▪ ozenoxacin (Xepi) Do not add pending more information about availability at mail order: ▪ Amikacin liposome suspension for inhalation (Arikayce)

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

Date	DoD PEC Drug Class	Type of Action	BCF/ECF Medications MTFs must have BCF meds on formulary	UF Medications MTFs may have on formulary	Nonformulary Medications MTFs may not have on formulary	Decision Date / Implement Date	PA and QL Issues	Comments
Nov 2018	**Gastro-intestinal-2 Agents: CIC/IBS-C Subclass and Miscellaneous Subclass**	UF Class Review Class previously reviewed in Nov 2015, Nov 2012, Feb 2011	▪ metronidazole 250mg and 500mg (Nov 2015)	<u>IBS-C/CIC Subclass</u> ▪ lubiprostone (Amitiza) ▪ linaclotide (Linzess) ▪ plecanatide (Trulance) <u>GI-Miscellaneous Subclass</u> ▪ rifaximin (Xifaxan) ▪ eluxadoline (Viberzi) ▪ alosetron (Lotronex, generic) ▪ nitazoxanide (Alinia) ▪ fidaxomicin (Dificid) ▪ vancomycin oral (generics) ▪ neomycin (generics) ▪ metronidazole (Flagyl, generic)	▪ None	Pending signing of the minutes / 90 days The effective date is May 15, 2019.	▪ Manual PA required for linaclotide, lubiprostone, plecanatide, rifaximin, and eluxadoline. ▪ QLs apply for rifaximin 550mg	▪ Eluxadoline (Viberzi) and plecanatide (Trulance) moved from NF to UF ▪ PA criteria added for linaclotide (Linzess) and lubiprostone (Amitiza) ▪ No preferred agent within the CIC/IBS-C subclass ▪ No preferred agent among the IBS-D agents ▪ See Appendix C for PA criteria.
Nov 2018	**Neurological Agents Miscellaneous – Movement Disorders Subclass**	UF Class Review	▪ None	▪ deutetrabenazine (Austedo) ▪ tetrabenazine (Xenazine, generics) ▪ valbenazine (Ingrezza)	▪ None	30 days after signing of the minutes The effective date is March 6, 2019.	▪ Manual PA criteria applies to all new users for deutetrabenazine (Austedo) and valbenazine (Ingrezza). ▪ QLs apply to both Austedo and Ingrezza	▪ See Appendix C for PA criteria.

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

Appendix H—Table of Abbreviations

AAN	American Academy of Neurology
ACG	American College of Gastroenterology
ADHD	Attention Deficit Hyperactivity Disorder
AE	adverse event
AGAI	American Gastroenterological Association Institute
AIDS	acquired immunodeficiency syndrome
AIMS	Abnormal Involuntary Movement Scale
ALT	alanine aminotransferase
AML	Acute Myelogenous Leukemia
AS	ankylosing spondylitis
AST	aspartate aminotransferase
BBW	black box warning
BCF	Basic Core Formulary
BIA	budget impact analysis
CAP	chronic abdominal pain
CAPS	Cryoprin Associated Period Syndrome
CD	Crohn's Disease
CDC	Centers for Disease Control and Prevention
CF	cystic fibrosis
CFR	Code of Federal Regulations
CFTR	cystic fibrosis transmembrane conductor regulator
CGIC	Clinical Global Impression of Change
CGRP	calcitonin gene-related peptide
CHF	congestive heart failure
CIC	chronic idiopathic constipation
CLD	chronic liver disease
CLL	chronic lymphocytic leukemia
CMA	cost minimization analysis
CMV	cytomegalovirus
CR	controlled release
CSBM	complete spontaneous bowel movement
CV	cardiovascular
CYP	cytochrome P450
DAPA	Distribution and Pricing Agreement
DHA	Defense Health Agency
DMARD	disease-modifying anti-rheumatic drug
DoD	Department of Defense
DR	delayed release
DRESS	Drug reaction with eosinophilia and systemic symptoms
ECF	Extended Core Formulary
EGFR	epidermal growth factor receptor
EMMPI	The Expanded MTF/Mail Pharmacy Initiative
ER	extended release
FDA	U.S. Food and Drug Administration
FDB	First DataBank
FEV_1	forced expiratory volume in one second

FL	follicular lymphoma
FMB	Formulary Management Branch
FY	fiscal year
GCA	giant cell arthritis
GI	gastrointestinal
GLA	galactosidase alpha
GnRH	gonadotropin-releasing hormone
GSA	growth stimulating agent
HAE	hereditary angioedema
HCG	Human Chorionic Gonadotropin
HCTZ	hydrochlorothiazide
Hgb	hemoglobin
HIV	human immunodeficiency virus
HS	hidradenitis suppurativa
HTN	hypertension
IBS-C	constipation-predominant irritable bowel syndrome
IBS-D	diarrhea-predominant irritable bowel syndrome
ICER	Institute for Clinical and Economic Review
IDH1	isocitrate dehydrogenase-1 inhibitor
IR	immediate release
ISGA	Investigator's Static Global Assessment
ITI	Immune Tolerance Induction
IV	intravenous
JIA	juvenile idiopathic arthritis
MAC	Mycobacterium avium complex
MAOI	monoamine oxidase inhibitor
MEK	mitogen-activated extracellular signal regulated kinase
Mg	magnesium
MHS	Military Health System
MMD	monthly migraine days
MMSE	mini-mental state examination
MN	medical necessity
MRSA	Methicillin-resistant Staphylococcus aureus
MTF	Military Treatment Facility
NAFLD	non-alcoholic fatty liver disease
NASH	non-alcoholic steatohepatitis
NDAA	National Defense Authorization Act
NDC	National Drug Code
NF	nonformulary
NG	nasogastric
NICE	National Institute for Health and Care Excellence
NNRTI	non-nucleoside reverse transcriptase inhibitor
NOMID	Neonatal-Onset Multisystem Inflammatory Disease
NRTI	nucleoside reverse transcriptase inhibitor
NSAID	nonsteroidal anti-inflammatory drug
NSCLC	non-small cell lung cancer
OIC	opioid-induced constipation

OTC	over-the-counter
P&T	Pharmacy and Therapeutics
PA	prior authorization
PDE-5	phosphodiesterase-5
PDTS	Pharmacy Data Transaction Service
PEG	polyethylene glycol
PERT	Pancreatic Enzymes Replacement Therapy drug class
PGIC	Patient's Global Impression of Change
PI	protease inhibitor
PI3K	phosphatidylinositol 3-kinase
PJIA	polyarticular juvenile idiopathic arthritis
PJP	*Pneumocystis jiroveci* pneumonia
POD	Pharmacy Operations Division
POS	point of service
PsA	psoriatic arthritis
PT	patient
QL	quantity limit
RA	Rheumatoid arthritis
RCT	randomized controlled trial
REMS	Risk Evaluation and Mitigation Strategies
RS	rectal suppositories
SBP	spontaneous bacterial peritonitis
SIB	suicidal ideation and behavior
SIBO	small intestinal bacterial overgrowth
SJIA	systemic juvenile idiopathic arthritis
SLL	small lymphocytic lymphoma
SMBG	self-monitoring blood glucose system
SQ	subcutaneous
STR	single-tablet regimen
TAF	tenofovir alafenamide fumarate
TB	tuberculosis
TCA	tricyclic antidepressant
TD	tardive dyskinesia
TDF	tenofovir disoproxil fumarate
TIBs	targeted immunomodulatory biologics
TIRF	transmucosal immediate release fentanyl
TNF	tumor necrosis factor
UC	Ulcerative colitis
UF	Uniform Formulary
ULN	upper limit normal
VMAT2	vesicular monoamine transporter type 2
WGO	World Gastroenterology Organization
XR	extended release