EXECUTIVE SUMMARY

Uniform Formulary Beneficiary Advisory Panel (BAP)
January 10, 2019

UNIFORM FORUMULARY DRUG CLASS REVIEWS

I. UF 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

1. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—UF Recommendation

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent based on clinical and cost effectiveness:

- UF

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

  Miscellaneous Subclass

  a) alosetron (Lotronex, generics)
  b) eluxadoline (Viberzi)
  c) rifaximin (Xifaxan)
  d) nitazoxanide (Alinia)
  e) fidaxomicin (Dificid)
  f) vancomycin oral (generics)
  g) neomycin (generics)
  h) metronidazole (Flagyl, generics)

- NF

  a) None

2. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Manual Prior Authorization (PA) 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.

a) Linzess and Amitiza

Manual PA criteria apply to all new and current users of Linzess and Amitiza.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age ≥ 18 years
- 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.

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 (Linzess, Amitiza, Trulance, Symproic, Relistor, or Movantik)

b) Trulance

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
- **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)

c) **Viberzi**

November 2018 updates are in BOLD and strikethrough.

Manual PA criteria apply to all new users of Viberzi.

Manual PA criteria: 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, Donnatal, loperamide
- 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.

Renewal PA Criteria: Coverage will be approved for 1 year if:

- The patient has had documented improvement in IBS-D symptoms

d) **Xifaxan**

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.

Manual PA criteria: 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 one antispasmodic/antidiarrheal agent (e.g., dicyclomine [Bentyl], Librax, hyoscyamine [Levsin], Donnatal, imodium [Loperamide])
- Patient has tried and failed or had intolerance or a contraindication to at least one tricyclic antidepressant (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-D are allowed in 1 year.**

3. **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous—UF and PA Implementation Plan**

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.

4. **Physician's Perspective**

Note that no products were recommended for non-formulary placement. Two products that were previously NF (Trulance and Viberzi) are now recommended for formulary status. There is also no step-therapy required.

For the constipation drugs (Linzess, Amitiza and Trulance), the PAs are very similar. The Committee did consider the recommendations from the guidelines when developing the PA criteria, so a trial of the usual OTC products are recommended first, including laxatives and anti-diarrheals.

We want the PA to apply to current users, which means that a large number of beneficiaries will be affected by the new PA requirements for Linzess and Amitiza. However, we feel it is necessary because we want all patients to have had a trial of recognized therapies recommended from the guidelines. In addition, studies indicate a high placebo rate for these drugs and DoD data shows that only about 50% of patients remain on therapy past 3 months.

For the IBS-D drugs, the PAs will continue to require a trial of TCAs. The reason behind this is that the TCAs were given a strong recommendation based on high quality data in the American College of Gastroenterology (ACG) guidelines. TCAs decrease the abdominal pain associated with constipation and diarrhea. Antispasmodics (like dicyclomine) were also recommended, based on guidelines.

For IBS-D, the Committee did recognize that stress does play a role, and stress reduction therapies were recommended to be tried for the Rifaximin and Viberzi PAs. This was also a recommendation based on DoD and Network expert provider feedback.

The PA for Viberzi and Xifaxan are very different, reflecting the different mechanisms of action for these two drugs. The Viberzi PA also reflects the safety concerns associated with the drug.

5. **Panel Questions and Comments**

Mr. Du Teil asks about the expiration date changes in the PA for Viberzi and and Xifaxan. The PA for Viberzi did not expire and was changed to expire in 4 months. The PA for Xifaxan was expanded from 6 months to 1 year.

Dr. Allerman replied that the PA for Viberzi was changed to 4 months because a patient will know, symptomatically, whether they respond to the drug after the 4 months. Comments from providers supported the P&T Committee decision. If the product is not working the patient normally stops using the drug. We previously had a 6 month PA for Xifaxan but expanded it to 1 year.

Mr. Hostettler asks what documentation was used to approve the off-label use of Linzess for opioid induced constipation.

Dr. Allerman reminded everyone that Amitiza has indications for OIC. There is some data showing that Linzess has benefits for OIC. We did survey providers and they commonly use Linzess for OIC. Linzess is dosed once a day and Amitiza is dosed twice a day. We believe that is the reason providers recommend Linzess for OIC. There was enough data to support the P&T Committee decision.

Mr. Hostettler asks why step therapy, medical necessity or a prior authorization is required to get to the product if they are all cost-effective and uniform formulary.

Dr. Allerman clarifies there is no step therapy. We had some previous recommendations that required a trial of one drug before the other. The rationale behind the prior authorization is based on 2018 guidelines. The guidelines reiterate using antidiarrheal, antispasmodic, or TCA first. Dr. Kugler mentioned that DoD data shows only 50% of patients remain on therapy after 3 months. The P&T Committee believes this is a difficult disease to treat and following these guidelines are best for our patients.

Mr. Hostettler says he appreciates following the guidelines. However, do you believe the OTCs have already been tried before the patient seeks a physician? If they "self-stop" or stop using them on their own, why is a step needed to stop the use of the drug?

Dr. Allerman says they haven't actually had the requirements for Linzess or Amitiza to try one of the traditional products first. We would hope that the patient would've had a trial. If they had have, then the patients meets criteria.

Mr. Hostettler asks if the letters going out will be specifically address the PA changes.

Dr. Allerman replies that Trulance and Viberzi were previously non-formulary. They will be moving to formulary status. The letters mailed to the patients will specifically discuss the need for prior authorization.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for the GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses

- **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Uniform Formulary Recommendation**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

_____ These comments were taken under consideration prior to my final decision

- **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Manual PA Criteria**

  Concur: 6 Non-Concur: 1 Abstain: 0 Absent: 0

Director, DHA:

_____ These comments were taken under consideration prior to my final decision

- **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—UF and PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

_____ These comments were taken under consideration prior to my final decision

B. NEUROLOGICAL AGENTS MISCELLANEOUS – MOVEMENT DISORDERS SUBCLASS

1. Neurological Agents Miscellaneous – Movement Disorders Subclass—Manual PA Criteria

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) updates the current manual PA criteria for Austedo and Ingrezza that have been in place since 2017. 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 first, 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.

a) Austedo

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)

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.**

b) Ingrezza

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)

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.**

2. **Neurological Agents Miscellaneous – Movement Disorders Subclass—UF and PA Implementation Plan**

   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).

3. **Physician's Perspective**

All three drugs were recommended for formulary status. Ingrezza will move from NF to UF status, so patients currently taking it will have a decrease in their copay.

This class is a brand new treatment for tardive dyskinesia, where in the past treatments have not been very successful for patients receiving antipsychotic therapy, and experiencing side effects Austedo and Ingrezza are both under investigation for Tourette's syndrome.

For the PA update for tardive dyskinesia, the Committee recommended removing gingko biloba and clonazepam from the PA, based on the systematic review that these are second-line therapies; plus clonazepam is for short term-use. We only have the Neurology guidelines for tardive dyskinesia; the treatment guidelines from the American Psychiatric Association haven't been updated yet to include the VMAT2 inhibitors.

4. **Panel Questions and Comments**

Mr. Hostettler requests clarification concerning the expiration date change for the Ingrezza PA. Previously the PA didn't expire and it was changed to expire in 1 year. Will the PA expire in one year for the patients currently under the PA?

Dr. Allerman replies the PA will only apply to the new users for the expiration date. The renewal PA for current users is indefinite.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for Neurological Agents Miscellaneous – Movement Disorders Subclass

- **Neurological Agents Miscellaneous – Movement Disorders Subclass—UF Recommendation**

Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

- **Neurological Agents Miscellaneous – Movement Disorders Subclass——Manual PA Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

- **Neurological Agents Miscellaneous – Movement Disorders Subclass——UF and PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

II. NEWLY APPROVED DRUGS PER 32 CFR 199.21(G)(5)

(CDR HELLWIG)

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

1. Newly Approved Drugs per 32 CFR 199.21(g)(5)—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) – Oncologic 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) – Oncologic 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) – Oncologic 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 capsules (Okebo) – Oral Tetracycline Agent
- elagolix sodium (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

2. **Newly Approved Drugs per 32 CFR 199.21(g)(5)—PA Criteria**

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

- 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 Tetracyclines: Applying the same manual PA criteria for doxycycline monohydrate ER 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 immediate release (IR) product, either the hyclate or monohydrate salt (for Okebo) or one generic minocycline IR product (for Minolira).
- CGRP Migraine Headache Prophylaxis Drugs: Applying manual PA criteria to new users of Ajovy and Emgality as is currently in place for erenumab injection (Aimovig).
- 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.

<u>Full PA Criteria for the Newly Approved Drugs per 32 CFR 199.21(g)(5)</u>

a) **adapalene 0.1% topical solution, adapalene 0.1% topical solution external pad/swab (Plixda), and tretinoin 0.05% topical lotion (Altreno)**

Automated PA Criteria:

- The patient has filled a prescription for at least three step-preferred topical acne products 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.

b) amikacin sulfate liposomal inhalation suspension (Arikayce)

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.

c) **butalbital 50 mg/acetaminophen 300 mg capsule**

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 capsules 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.

d) **cannabidiol oral solution (Epidiolex)**

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.

e) **dacomitinib (Vizimpro)**

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.

f) **doxycycline monohydrate ER 50, 75 and 100 mg capsules (Okebo) and minocycline 105 and 135 mg ER tablets (Minolira)**

PA applies to both new and current users of Okebo and Minolira.

Automated PA Criteria:

- Patient has filled a prescription for one generic IR doxycycline (either hyclate or monohydrate salt) **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

- For **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 **Minolira**: The patient has acne with inflammatory lesions AND
  - the patient cannot tolerate generic minocycline IR due to gastrointestinal adverse events

Susceptible Infections

- For **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

g) duvelisib (Copiktra)

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.

h) elagolix (Orilissa)

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)

i) fremanezumab-vfrm injection (Ajovy) and galcanezumab-gnlm injection (Emgality)

Manual PA criteria apply to all new users of Ajovy and Emgality.

Manual PA Criteria: 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.

Renewal Criteria: Coverage will be approved indefinitely for continuation of therapy if:

- The patient has shown improvement in migraine prevention (e.g., reduced migraine headache days, reduced migraine frequency, reduced use of acute abortive migraine medication)

j) glycopyrronium 2.4% topical cloth (Qbrexza)

Manual PA criteria apply to all new and current users of Qbrexza.

Manual PA Criteria: 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.

k) ivosidenib (Tibsovo)

Manual PA criteria apply to all new users of Tibsovo.

Manual PA Criteria: 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.

l) lanadelumab-flyo (Takhzyro)

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.

m) lidocaine 1.8% topical patch (ZTlido)

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.

n) lumacaftor/ivacaftor (Orkambi granules)

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

PA does not expire.

o) lusutrombopag (Mulpleta)

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 109/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.

p) metoprolol succinate ER capsules (Kapspargo Sprinkle)

PA does not apply to patients between the ages of 6 to 18 years.

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

Non-FDA-approved uses are NOT approved.

PA does not expire.

q) migalastat (Galafold)

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.

r) ozenoxacin 1% cream (Xepi)

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 or 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.

s) tildrakizumab (Ilumya)

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.

3. **Physician's Perspective**

We reviewed 31 new drugs at this meeting, which is a new record. There were 19 drugs recommended for UF status, and 12 recommended for non-formulary placement. For the drugs recommended for non-formulary status, several of them fall into classes that have already been reviewed by the P&T Committee, where there are cost effective alternative products already available in the class.

For this review, 23 drugs have PA's recommended. Seven of these drugs fall into classes that already have existing PA requirements.

There were a couple of comments made at the meeting for some of the drugs recommended to have Prior Authorization:

- Ajovy and Emgality (for migraine): These are the 2nd and 3rd drugs in a new therapeutic class. The first drug (Aimovig) was reviewed at the last meeting, and PA criteria were placed soon after drug launch, to avoid having high numbers of patients impacted if a PA were to be implemented several months after market introduction. This was also the case for the two new drugs. The PA does require a trial of commonly used preventive products first, which is consistent with current migraine headache guidelines.

- Orilissa (for endometriosis): This is the first oral drug for endometriosis, however, injectable products are commonly used. PA will apply to both new and current users; the main reason for this is because it is only approved for a 24 month total duration of therapy, due to the risk of decreases in bone mineral density.
- Epidiolex (cannabinoid for seizures): The PA limits use to the actual FDA approved indications, since there is a high potential for off-label use, including autism, anxiety, and bipolar disorder. The product does not contain THC, so there are no psycho-active properties

4. Panel's Questions and Comments

Mr. Du Teil states we are all interested in having the drugs in a formulary status for our beneficiaries. When drugs are placed in a non-formulary status, am I correct in assuming that there are other formulary alternatives available.

Dr. Kugler says absolutely.

Ms. Buchanan questions the rationale for not authorizing a PA renewal for Plixda and Altreno. Is a year going to be enough time to show efficacy?

CDR Hellwig replies the provider can submit a new PA on behalf of the patient. This is not a renewal for the PA criteria. There are many alternatives and products available. It doesn't mean the patient can't get it after the first year. It would be via a new PA rather than a renewal PA. It's a little bit longer for them.

Mr. Hostettler asks for a point of clarification. It states that "the patient has tried and failed at least three step-preferred topical acne products including at least two different strengths of tretinoin and 0.1% adepalene." Is there another adapalene already on the market?

CDR Hellwig answers that there is a cream and ointment. There are multiple forms of this product.

For ZT Lido, Mr. Hostettler states that are other OTC products that deliver more than the 1.8% of the lidocaine.

CDR Hellwig replies the 1.8% formulation has a different delivery mechanism than the 5% patch. It delivers the same amount of lidocaine to the patient as the 5% patch even though it is a different percentage rate.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for Newly Approved Drugs per 32 CFR 199.21(g)(5)

- **Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF Recommendation**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

For Director, DHA:

These comments were taken under consideration prior to my final decision

- **Newly Approved Drugs per 32 CFR 199.21(g)(5)— PA Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

For Director, DHA:

These comments were taken under consideration prior to my final decision

- **Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF and PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

For Director, DHA:

These comments were taken under consideration prior to my final decision

III. UTILIZATION MANAGEMENT

A. UTILIZATION MANAGEMENT – UPDATED MANUAL PA CRITERIA AND STEP THERAPY

1. Updated PA Criteria and Step Therapy

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.

The P&T Committee recommended the following: (15 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for Tresiba, Uloric, Nuplazid, and Hemlibra; and updates to the manual PA criteria and step therapy for the TIBs, and recommended (14 for, 0 opposed, 0 abstained, 2 absent) updates to the manual PA criteria for Dupixent.
The updates are as follows:

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. The NF, non-step-preferred basal insulins include insulin degludec (Tresiba). The PA 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 (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 Uloric 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 Uloric and allopurinol. The Uloric PA criteria were updated to ensure that patients and providers are aware of the results of the trial.

c) **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.

d) **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.

e) **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.

2. **Updated PA Criteria and Step Therapy—PA Implementation**

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) updates to the current PA become effective 30 days after the signing of the minutes for the following drugs: the insulin product Tresiba, the gout drug Uloric, the antipsychotic Nuplazid, and the hemophilia drug Hemlibra; and updates to the manual PA criteria and step therapy for the TIBs.
The P&T Committee also recommended (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.

3. **Physician's Perspective**

At every meeting, we present updates to drugs with existing PAs to ensure the latest FDA indications or safety updates are included in our criteria. These updates to the existing PAs will only affect new patients.

For Dupixent, the update was to allow for the new indication for asthma. The other injectable treatments for asthma require administration in the physician's office, so this new indication for self-injection will likely be requested.

The other PA updates were due to safety issues (the gout drug Uloric, and antipsychotic agent Nuplazid), and a new indication for the hemophilia drug Hemlibra.

4. **Panel Questions and Comments**

Mr. Hostettler asks if something was moved from a uniform formulary to a non-formulary status.

Dr. Allerman replies nothing was moved. The Basal Insulin drug class was reviewed for formulary placement in August of 2017. These PAs do not reflect any change in current uniform formulary status.

Mr. Hostettler asks if the changes to the Basal Insulin PA were only for new users.

Dr. Allerman replies yes, only for new users.

Mr. Hostettler asks Dr. Allerman to explain the difference between a PA, step therapy, and medical necessity.

Dr. Allerman replies that it is a typo, in that the medical necessity information should not have been included. According to the Charter, Medical necessity does not fall under the purview of the BAP. If a patient has clinical reasons that meets medical necessity criteria, they can apply for medical necessity and potentially decrease a non-formulary co-pay to a formulary co-pay.

Mr. Hostettler says he won't comment on medical necessity criteria. He asks where the forms are located on the website. The forms for the PA criteria is on the website but he hasn't found any forms that will allow him to lower his copay.

Dr. Allerman replied the medical necessity forms are on the TRICARE Formulary Search Tool. They are only available for non-formulary drug. Occasionally, we do find errors on the search tool. Contact the office if the medical necessity forms are not available for a non-formulary drug.

Mr. Hostettler asks for instructions on how to locate the Formulary Search Tool. Can I google it?

Dr. Allerman says you can google the search tool. She attempts to provide instructions on how to locate the forms but asks Mr. Hostettler to see her after the meeting.

Mr. Hostettler states that beneficiaries are not aware that the forms are available. Perhaps DoD or MHS can provide some education about these about the process. It would help the beneficiary and solve a lot of his concerns. At the end of the process, I've got to be close to medical necessity that will get me back to a Tier 2 cost. That is why that's important to me.

Chair Ostrowski asks if there is a process or someone who checks the site for errors or updates.

Dr. Allerman replies they rely on people in the field, and industry partners. The search tool is managed by Express Scripts and they are very responsive to updates. We do not systematically QA everything. However, the group is very responsive when we find errors.

There were no more questions or comments from the Panel. The Chair called for a vote on the Updated Manual PA Criteria and PA Renewal Criteria and PA Implementation Plan for the Utilization Management Drugs.

- **Updated Manual PA Criteria and PA Renewal Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

- **Updated Manual PA Criteria and PA Renewal Criteria – PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent:

Director, DHA:

These comments were taken under consideration prior to my final decision

B. UTILIZATION MANAGEMENT – NEW MANUAL PA CRITERIA

1. New PA Criteria

New Manual PA Criteria were recommended for the following drugs, which will be discussed below.

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.

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for Zipsor, Zorvolex, Tivorbex, naproxen CR (controlled-release) (Naprelan/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 these products are required to try four formulary generic IR NSAIDs, three of which are BCF agents, first.

Manual PA criteria apply to all new and current users of naproxen CR (Naprelan/generics), Tivorbex, Vivlodex, and Zipsor, and Zorvolex. Coverage will be approved if all a clinical rationale of why the patient cannot take any of the formulary NSAIDs is stated on the PA form. Non-FDA-approved uses are NOT approved.

Prior authorization expires in one year. PA will be renewed for an additional year if a new PA form is completed

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. Cost-effective generic

formulations of chlorzoxazone and multiple comparable muscle relaxants (e.g., cyclobenzaprine, methocarbamol) are available on the UF without PA required.

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.

Manual PA Criteria apply to all new and current users of chlorzoxazone 250 mg. 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 one-half of a 500 mg tablet. Note that no PA is required for the chlorzoxazone 500 mg tablets.

Non-FDA-approved uses are NOT approved

Prior authorization does not expire.

c) **Oncologic Agents for unresectable or metastatic melanoma: cobimetinib (Cotellic)**—Cobimetinib (Cotellic) was approved for treating unresectable or metastatic melanoma with a specific mutation. It is used exclusively in combinations of a specific BRAF drug with a specific 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.

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).

Manual PA Criteria apply to all new uses of Cotellic. Coverage will be approved if all the following are met:

- 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.

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

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.

Manual PA criteria apply to all new users of Eurax/Crotan. Coverage will be approved if all 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.

2. **New PA Criteria – Implementation Plan**

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) new PAs for the NSAIDs (Zipsor, Zorvolex, Tivorbex, Vivlodex, Naprelan and naproxen CR generics), chlorzoxazone 250 mg, the oncology drug Cotellic, and the scabies products 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 new PA requirements.

3. **Physician's Perspective**

NSAIDs (Zipsor, Zorvolex, Tivorbex, Naprelan, Vivlodex)

The products here all contain the same active ingredient of other drugs which are available in cost-effective generic formulations. There is no data to support that these new formulations are either more effective or have a better safety profile than the old generic products. Approximately 900 patients will be affected by the new PA requirements, since the PA will apply to both new and current users. We will be mailing letters to the affected patients.

Chlorzoxazone 250 mg tablet

This is a new product which is from one manufacturer that is significantly less cost effective than generic formulations of the 500 mg tablets. The Committee felt that it is reasonable for a patient to cut the scored 500 mg tablets in half, if a 250 mg dose is required. The 70 patients currently on the product will be receiving letters notifying them of the new PA requirements

Anti-infectives for scabies – Eurax and Crotan

The Committee felt that a PA was required for these two products, as they are actually less effective than the treatment recommended by the CDC (permethrin cream). There is no advantage to using these new products. No letters are required, since the PA will only apply to new users. Also, for existing users, their treatment course will be completed prior to the implementation of the new PA.

4. **Panel Questions and Comments**

There were no questions or comments from the Panel. The Chair called for a vote on the New Manual Criteria and PA Implementation Plan for the Utilization Management Drugs

- **New Manual Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

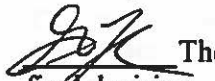
Director, DHA:

These comments were taken under consideration prior to my final decision

- **New Manual PA Criteria – PA Implementation Plan**

Concur: 7 Non-Concur: 0 Abstain: 0 Absent:

Director, DHA:


These comments were taken under consideration prior to my final decision

IV. RE-EVALUATION OF NF GENERICS

A. RE-EVALUATION OF NF GENERICs – ADHD/WAKEFULNESS: STIMULANTS SUBCLASS

Background—The DHA Pharmacy Operations Division Formulary Management Branch 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. A formal process is used to reevaluate NF medications where generic equivalents are available.

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). This product has been designated NF since the original ADHD class review in February 2007 and was reaffirmed at the most recent class review in November 2015. The unit cost of generic formulations of dexmethylphenidate ER has dropped significantly from the previous generic and brand cost.

1. 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.

2. Physician's Perspective

This is a continuing project where we look at drug classes reviewed several years ago to see what the costs are for non-formulary products that now have generic equivalents available.

For Focalin XR, which was reviewed back in November 2015, there are now cost effective generics available with reliable supply. The recommendation is

to move Focalin from NF to UF status. No letters are needed, since patients will be seeing a decrease in their prescription co-pay.

3. **Panel Questions and Comments**

There were no questions or comments from the Panel. The Chair called for a vote on the Re-evaluation of NF Generics – ADHD/Wakefulness: Stimulants Subclass.

- **Re-evaluation of NF Generics – ADHD/Wakefulness: Stimulants Subclass**

Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

_____ These comments were taken under consideration prior to my final decision

V. SECTION 703

(CDR HELLWIG)

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

The P&T Committee reviewed two drugs (tobramycin inhalation solution and oxycodone oral solution) 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 point of service (POS) and medical necessity at MTFs. These two 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.

1. **Drugs Designated as 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 300 mg/5 mL ampule-nebulizer

- Genus Lifesciences Pharma: oxycodone hydrochloride solution 5 mg/5 mL oral solution

2. Preauthorization 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.

3. 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 tobramycin inhalation solution pak and oxycodone hydrochloride solution, and 2) DHA send letters to beneficiaries affected by this decision.

4. Physician's Perspective

By law, the drugs where the manufacturer has not signed the pricing agreement must be designated as NF, and will only be available at the Mail Order, unless pre authorization criteria apply.

Here, the two products will be NF. However, the committee did feel that these two products would be used in acute situations, (tobramycin is an antibiotic often used in patients with cystic fibrosis, and oxycodone is a narcotic), so patients will not be forced to go to the Mail Order point of service. However, since there are alternative products available, the pre-authorization criteria will still apply at the retail network

.

There are currently about 8 patients on the tobramycin product, and 1,400 on the oxycodone oral solution. Letters will be mailed to these patients.

4. **Panel Questions and Comments**

Mr. Hostettler asks if this is in compliance with the law.

CDR Hellwig replies the decision by the P&T Committee is in compliance because we are allowed to make an exception.

There were no more questions or comments from the Panel. The Chair called for a vote on the Drugs Designated NF, Preauthorization Criteria, and Implementation Period for the Section 703, National Defense Authorization Act (NDAA) for Fiscal Year 2008.

- **Drugs Designated NF**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

- **Preauthorization Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

- **Implementation Period**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

Director, DHA:

These comments were taken under consideration prior to my final decision

VI. INFORMATIONAL ITEM

A. INFORMATIONA ITEM – REMOVAL OF BRAND OVER GENERIC AUTHORITY AND PA CRITERIA AUTHORIZATION

1. 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. The Committee was notified of these actions at the February 2018 DoD P&T Committee meeting, and these recommendations were presented to this Panel at the April 5th, 2018, BAP 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. The prior authorization criteria remain in effect for the phosphodiesterase-type 5 (PDE-5) inhibitor class as a whole.

2. Physician's Perspective

Generic formulations of Viagra became available in December of last year. However, the price of the generics were significantly more expensive than the government pricing for brand Viagra, so P&T waived the generic use requirement. Now, the price of the Viagra generic products are very cost effective, so it is time to remove the requirement to use the brand.

We have done formal brand over generic preferences in a few instances to address these unique situations. There is administrative authority for the P&T Committee to react quickly to add the requirement and then remove it, when it is no longer cost effective. Because of the administrative authority, the requirement to use branded Viagra was removed back in September of last year. We will continue to let the BAP know when these actions are implemented and removed.

3. **Panel Questions and Comments**

There were no more questions or comments from the Panel. These are informational items. The Panel is not required to vote.

VII. INFORMATIONAL ITEM

A. INFORMATIONAL ITEM – DRUGS LOSING TX STATUS AND MOVING TO OTC STATUS

1. **Drugs Losing Rx Status and Moving to OTC Status (Vitamin B Replacement Products, Iron Replacement Products, and Urinary pH Modifiers)**

Effective January 1, 2019, any vitamin, dietary supplement or pediatric fluoride product currently listed as requiring a prescription in the First DataBank Database will change to OTC status. The list does not include prenatal vitamins, due to ongoing litigation. OTC pediatric fluoride drops will remain covered. None of the products on the list have been approved by the FDA. The change in status means that, as of January 1, 2019, products on this list will no longer be covered under the TRICARE pharmacy benefit.

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 agreed that none of these products are suitable for inclusion on the OTC pharmacy benefit, since they are not FDA-approved. Additionally these products are widely available as either prescription alternatives that would be covered, or low-cost over the counter products. The change will affect beneficiaries across all points of service. Letters are being prepared for delivery to affected beneficiaries.

2. **Physician's Perspective**

One important thing to note here is that this is not a situation where DoD has any direct control. This decision was made by the FDA. Since affected products have not been formally approved by the FDA, the P&T Committee did not want to include these products as part of the OTC program.

The OTC pediatric fluoride drops will still be covered by TRICARE, even though they are not prescription products.

Also note that there are some vitamins, for example those containing 1 mg of folic acid, that have been formally reviewed by the FDA. These products are not subject to the change and will remain as prescription products, and they will remain covered under the TRICARE pharmacy benefit.

We did want to notify our beneficiaries about this change, and on December 5th approximately 20,000 letters were mailed to patients who are currently taking one of these products.

3. **Panel Questions and Comments**

Mr. Hostettler says there was an OTC demonstration program. Is there still and OTC program in DoD.

CDR Hellwig replies there is an OTC program. We still have several products covered under the OTC program.

Mr. Hostettler asks if there is a mechanisms for some of these products to have been put into that program.

CDR Hellwig replies that it's a little trickier because none of these are FDA approved. The OTC program would target FDA approved products. One could argue that these product are not drugs but dietary supplements.

Mr. Du Teil asks about the people who have rheumatoid arthritis (RA) or on treatment for methotrexate. Would it be advantageous cover folic acid, Vitamin D and products of that nature to be used by prescription?

CDR Hellwig replies absolutely. We do cover Folic acid by prescription.

Mr. Du Teil asks but not vitamin D?

CDR Hellwig says the prescription version of it are covered, but not the non-prescription version.

There were no more questions or comments from the Panel. These are informational items. The Panel is not required to vote.

VIII. INFORMATIONAL ITEM

(CDR HELLWIG)

A. INFORMATIONAL ITEM – TRICARE MAIL ORDER AUTO REFILL REQUIREMENTS

1. 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 P&T Committee recommended 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 quantity limits exceed typical usage patterns; overrides to the current quantity limits are available for clinical reasons; and to reduce the potential for wastage, as the test strips do expire. Beneficiary outreach will occur via letters.

2. Physician's Perspective

This is a situation where we are responding to beneficiary requests. Plus there was also some concern by the Committee that patients are not using all the test strips they are receiving, and the test strips do have expiration dates.

As we mentioned previously, the test strips and lancets are in the top 10 of most requested products by patients, to be removed from automatic refills.

We don't feel that a patient would be in a situation they would run out of a test strip. Plus, both the test strips and lancets are available without a prescription in retail pharmacies and grocery stores.

We will be sending out letters to make patients aware of the change.

3. Panel Questions and Comments

Mr. Hostettler is curious if the patient has to sign up for automatic refill or is it an automatic registration.

Dr. Allerman replies that you would opt-in.

Mr. Hostettler reiterates that you do opt-in.

There were no more questions or comments from the Panel. These are informational items. The Panel is not required to vote.

Chair Ostrowski concludes the meeting. He thanks the staff and the audience for attending. Then thanks the Panel for their time.

(Meeting Concludes)

Appendix 1 – Table of Implementation Status of UF Recommendations/Decisions Summary
Appendix 2 – Brief Listing of Acronyms Used in this Summary
Appendix 3 – Private Citizen Comments – Restless Leg Syndrome Foundation
Appendix 4 – Private Citizen Comments – The International Foundation of Gastrointestinal Disorders (IFFGD)
Appendix 5 – Dermira
Appendix 6 – The International Hyperhidrosis Society

SUMMARY OF RECOMMENDATIONS AND BENEFICIARY IMPACT

Table of Implementation Status of UF Recommendations/Decisions Summary November 2018

DoD PEC Drug Class	UF Drugs	NF Drugs	Implement Date	Notes and Unique Users Affected
Gastro-Intestinal-2 Agents: CIC/IBS-C Subclass and Miscellaneous Subclass	<u>IBS-C/CIC and IBS-D Subclass</u> ▪ lubiprostone (Amitiza) ▪ linaclotide (Linzess) ▪ plecanatide (Trulance) <u>Miscellaneous Subclass</u> ▪ rifaximin (Xifaxan) ▪ eluxadoline (Viberzi) ▪ alosetron (Lotronex, generic) ▪ nitazoxanide (Alinia) ▪ fidaxomicin (Dificid) ▪ vancomycin oral (generics) ▪ vancomycin solution (Firvanq) ▪ neomycin (generics) ▪ metronidazole (Flagyl, generic)	▪ None	Pending signing of the minutes / 90 days	▪ Eluxadoline (Viberzi) and plecanatide (Trulance) moved from NF to UF ▪ Manual PA currently in place for plecanatide, rifaximin, and eluxadoline. ▪ PA criteria added for linaclotide (Linzess) and lubiprostone (Amitiza) for new and current users ▪ No preferred agent within the CIC/IBS-C subclass ▪ No preferred agent among the IBS-D agents <u>Unique Users Affected for Amitiza and Linzess PA</u> Mail – 12,401 MTF – 7,017 Retail – 7,921 Total – 27,339
Neurological Agents Miscellaneous – Movement Disorders Subclass	▪ deutetrabenazine (Austedo) ▪ tetrabenazine (Xenazine, generics) ▪ valbenazine (Ingrezza)	▪ None	30 days after signing of the minutes	▪ Manual PA criteria applies to all new users for deutetrabenazine (Austedo) and valbenazine (Ingrezza). <u>Unique Users Affected</u> not applicable; current PA requirements

November 2018 Drugs with New Prior Authorization Criteria—Unique Utilizers Affected

Drug	MTF	Mail Order	Retail	Total
NSAIDs Naproxen CR (Naprelan, generics), Tivorbex, Vivlodex, Zipsor, Zorvolex,	36	523	106	912
Skeletal Muscle Relaxants and Combinations Chlorzoxazone 250 mg	0	0	70	70

Brief Listing of Acronyms Used in this Summary

Abbreviated terms are spelled out in full in this summary, when they are first used, the acronym is listed in parentheses immediately following the term. All of the terms commonly used as acronyms in the Panel discussions are listed below for easy reference. The term "Pan" in this summary refers to the "Uniform Formulary Beneficiary Panel," the group who's meeting in the subject of this report.

- AAN – Academy of Neurology
- ACG - American College of Gastroenterology
- ADHD – Attention Deficit Hyperactivity Disorder
- AIMS – Abnormal Involuntary Movement Scale
- AML – Acute Myelogenous Leukemia
- BAP – Beneficiary Advisory Panel
- BCF agents – Brachiocephalic agents
- BIA – Budget Impact Analysis
- BRAF drugs – Human gene that encodes a protein
- CARES Trial – Cardiovascular Safety of Febuxostat and Allopurinol in Participants With Gout and Cardiovascular Comorbidities
- CDC –Center for Disease Control
- CFR – Code of Federal Regulations
- CGRP – Calcitonin Gene-Related Peptide
- CIC – Chronic Idiopathic Constipation
- CLL – Chronic Lymphocytic Leukemia
- CMA – Cost-minimization Analysis
- CMV – Cytomegalovirus
- CR generics – Controlled-Released
- CTFR – Cystic Fibrosis Transmembrane Conductance Regulator
- CV – Cardiovascular
- DAPA – Distribution and Pricing Agreement
- DHA – Defense Health Agency
- DoD – Department of Defense
- DRESS – Drug Rash with Eosinophilia and Systematic Symptoms
- ER – Extended Release
- FDA – Federal Drug Administration
- FL – Follicular Lymphoma
- GI – Gastrointestinal
- GLA gene – Galactosidase Alpha
- HAE – Hereditary Angiodema
- HCG – Human Chorionic Gonadotropin
- HD – Huntington's Disease
- HIV – Human Immunodeficiency Virus
- IBS-C – Constipation-Predominant Irritable Bowel Syndrome
- IBS-D – Diarrhea-Predominant Irritable Bowel Syndrome
- ICER – Institute for Clinical Effectiveness Research

- IDH1 – Isocitrate Dehydrogenase-1
- IV – Intravenous
- LFRH – Luteinizing Hormone-Releasing Hormone
- MAC – Mycobaterium Avium Complex
- MAOI – Monoamine Oxidase Inhibitors
- MEK inhibitors – Chemical or drug that inhibits the mitogen-activated protein kinase enzymes
- Mg – Milligram
- MHS – Military Health Sytem
- MN forms – Medical Necessity Form
- MTF – Military Treatment Facility
- NAFLD – Non-Alcoholic Fatty Liver Disease
- NASH – Non-Alcoholic Steatohepatisis
- NDAA – National Defense Authroization Act
- NDC – Non-Compliant
- NF – Non Formulary
- NSAID – Nonsteroidal Anti-Inflammatory Drugs
- NSCLC – Non-Small Cell Lung Cancer
- OIC – Opioid-Induced Constipation
- OTC –Over the Counter
- P&T – Pharmacy & Therapeutics
- PA – Prior Authorization
- PDE-5 – Phosphodiesterase-Type 5
- pH – Potential Hydrogen
- POD – Pharmacy Operations Division
- POS – Point of Service
- REMS program – Risk Evaluation and Mitigation Strategy
- RX – Medical Prescription
- SBP – Spontaneous Bacterial Peritonitis
- SIBO – Small Intestine Bacterial Overgrowth
- SLL – Small Lymphocytic Lymphoma
- SMBGS – Self-Monitoring Blood Glucose Systems
- TAF – Tenofovir Alafenamide
- TCA – Tricyclic Antidepressants
- TDF – Tenofovir Antifdepressants
- TIB – Targeted Immunomodulatory Biologic
- TRICARE – Healthcare Network
- UF – Uniform Formulary
- VMAT2 – Vesicular Monamine Transporter Type 2
- XR – Extended Release

January 3, 2019

Colonel Paul J. Hoerner
U.S. Air Force
Beneficiary Advisory Panel Chair
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Re: Uniform Formulary Beneficiary Advisory Panel meeting January 10, 2019 [FR Doc No: 2018-26188]

Dear Colonel Hoerner,

Thank you for your work to improve health care access and quality for our nation's active duty service members and their families. The Restless Legs Syndrome Foundation is aware that you will be conducting a therapeutic class review for neurological agents associated with movement disorders. As you work to provide advice and recommendations on the development of the uniform formulary in this regard, please consider the use of low total daily doses of opioid therapies for the treatment of refractory restless legs syndrome (RLS).

Restless Legs Syndrome (RLS) is a neurological movement disorder that causes very uncomfortable sensations in the legs, accompanied by an uncontrollable urge to move them. Symptoms are produced from deep and can drastically disrupt a patient's ability to sleep and live normally. The profound sleep loss often puts RLS patients at risk for developing heart attacks, strokes, significant depression and suicidal ideation, and even Alzheimer's disease. It is a life-long disease, and treatments are imperfect.

Current treatment recommendations for RLS include several medications that do not provide life-long relief. For many patients, after months or a few years of relief, some prescribed medications actually worsen the disease, a phenomenon called "augmentation." When this occurs, low-total daily doses of opioid medications such as methadone are the *only* effective treatment option available. Research continues to show that addiction and dependence are not common complications for affected individuals, as the total daily doses of opioids used to manage RLS is quite low. It is also important to note that RLS is not a chronic pain condition. When indicated, opioids are used to treat underlying neuropathology issues, not a sensation of pain.

As you work with the committee to identify recommendations for the uniform formulary in this regard, please consider indicating low total daily doses of opioid therapies for the treatment of refractory RLS. For more information on the appropriate indication for these therapies, please see the attached mayo clinic treatment guidelines, which reflects the consensus recommendations of the RLS clinical community. If you have any questions, please contact the Foundation's Washington Representatives, Dale P. Dirks and Peter Herzog, at herzog@hmcw.org or (202) 544-7499.

Sincerely,

Karla M. Dzienkowski

Karla Dzienkowski
Executive Director
Restless Legs Syndrome Foundation

STATEMENT OF
Ceciel T. Rooker
President

ON BEHALF OF
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IN RESPONSE TO
Docket No: 2018-26188

SUBMITTED TO
Designated Federal Officer of the TRICARE Beneficiary Advisory Panel (BAP)
Colonel Paul J. Hoerner
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SUBMITTED ON
The 13th Day of December, 2018

SUMMARY

The International Foundation for Gastrointestinal Disorders (IFFGD) commends TRICARE and the Beneficiary Advisory Panel (BAP) for ensuring that those who have pledged themselves in service to the American people and their families are provided with access to necessary treatments and medical care.

Established in 1991, IFFGD is a patient-driven nonprofit organization dedicated to assisting individuals affected by chronic gastrointestinal (GI) illnesses by providing education and support for patients, the family members, healthcare providers, and the public. IFFGD also works to advance critical research aimed at broadening our understanding of the basic mechanisms and clinical care of these conditions and providing patients with better treatment options, and perhaps one day, cures. IFFGD has worked closely with the Department of Defense (DoD) to encourage and support research into GI illnesses affecting active service personnel and veterans, including the Gulf War Illness Research Program (GWIRP).

Today, I am writing to you regarding Docket No. 2018-26188 for "Uniform Formulary Beneficiary Advisory Panel; Notice of Federal Advisory Committee Meeting" to discuss the TRICARE formulary, including "Gastrointestinal-2 Agents – Miscellaneous" and "Gastrointestinal-2 Agents – CIC and IBS-C."

We applaud the efforts of the BAP to provide advice and recommendations on the development of the TRICARE Uniform Formulary and the drugs and supplies covered by this program. We are especially grateful for the guidance of the BAP regarding drugs and other therapies for GI illnesses, including

constipation predominant irritable bowel syndrome (IBS-C) and chronic idiopathic constipation (CIC). IBS-C and CIC are among the most common GI disorders in the general population, striking all demographic groups and resulting in significant human suffering and disability. As "functional disorders," IBS-C and CIC affect the way the muscles and nerves of the bowel work, but the bowel itself does not appear to be damaged on medical tests. Without a definitive diagnostic test, many cases of IBS-C and CIC go undiagnosed or misdiagnosed, sometimes for years. It is not uncommon for those affected to undergo unnecessary treatment courses or even surgical procedures before receiving a proper diagnosis and appropriate care. And even after diagnosis, treatment options are limited, and treatment effectiveness varies widely from patient to patient or even for a single patient over his or her lifespan. Adding to the complexity of these conditions, comorbidities affecting both the GI tract and other systems are common in IBS and CIC. Other functional GI disorders, including functional chest pain, heartburn, dyspepsia, and/or abdominal pain, are common in individuals with IBS-C and CIC and those with IBS-C are more likely to also have other pain-related disorders, including migraine headache, fibromyalgia, and chronic pelvic pain compared with the general population (Whitehead WE, et al. 2002. https://doi.org/10.1053/gast.2002.32392; Frissora CL & Koch KL. 2005. https://doi.org/10.1007/s11894-005-0018-9).

Because of the heterogenous nature of these disorders, research has found that patients respond best to a personalized approach tailored to their predominant symptoms, symptom severity, responsiveness to treatment, and vulnerability to adverse effects (Chey WD, et al. 2015. https://doi.org/10.1001/jama.2015.0954; Ford AC, et al. 2017; https://doi.org/10.1056/NEJMra1607547). No one treatment pathway will effectively address the needs of all patients, and long-term solutions often require a combination of treatment approaches. For this reason, it is critical that patients have access to a variety of approved treatments, both brand name and generic.

We urge the BAP to consider the complexity, heterogeneity, and impact of chronic GI disorders, such as IBS-C and CIC, when evaluating the drugs and supplies covered by the TRICARE Uniform Formulary and ensure that a wide range of drugs and other treatments are covered.

We thank you for the consideration of our comments and welcome the opportunity to work in conjunction with the DoD and TRICARE to obtain input from patients on issues of coverage for military personnel, retirees, and their families.

Dermira

Colonel Paul J Hoerner, USAF
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December 21, 2018

Dear Mr. Hoerner,

Pursuant to 41 CFR 102-3.140, Dermira is providing this written statement to the Uniform Formulary Beneficiary Advisory Panel (BAP) in response to the proposed Department of Defense Phamacy and Therapeutics Committee recommendations for QBREXZA™ (glycopyrronium) cloth, which will be reviewed at the January 10th BAP meeting.

The Department of Defense Pharmacy and Therapeutics Committee recommendation to require patients to have 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) before initiating QBREXZA is inconsistent with current treatment algorithms, prescribing information, and available scientific evidence. Dermira kindly requests that the following information be considered when determining potential prior authorization criteria for QBREXZA:

1) QBREXZA is recommended as **first-line therapy** for primary axillary hyperhidrosis in the treatment algorithm published by the International Hyperhidrosis Society (IHHS).[1] This algorithm was developed by the IHHS, in close collaboration with its Board of Directors (composed of leading dermatologists and researchers in the field of hyperhidrosis).

   The treatment algorithm recommends initiating therapy with topical antiperspirants (aluminum and zirconium salts) or glycopyrronium cloth. If satisfactory response is achieved, continue treatment. If no response is observed, the next step is onabotulinumtoxin A injections, glycopyrronium cloth (if not treated initially with this therapy), or microwave thermolysis. If no response is achieved with any of these therapies, systemic medications such as anticholinergics (e.g., glycopyrrolate, oxybutynin, propantheline, propranolol, clonidine, diltiazem) may be added. If no response is noted, local sweat gland ablation (e.g., curettage or liposuction) may be tried. If still no response is observed, endoscopic thoracic sympathectomy (ETS) can be considered. Prior to ETS, patients should be educated to fully understand the possibility of limited efficacy and the risks of complications, including but not limited to, compensatory sweating.[1]

2) Three treatments have been approved or cleared for use by the Food and Drug Administration (FDA) for the treatment of primary axillary hyperhidrosis—QBREXZA, BOTOX, and miraDry.[2,3,4] **Iontophoresis, oral anticholinergics (e.g., glycopyrrolate, oxybutynin, propantheline), propranolol, clonidine, and diltiazem are not approved by the FDA for treatment of primary axillary hyperhidrosis.**

3) **BOTOX is indicated for severe axillary hyperhidrosis that is inadequately managed by topical agents** in adult patients according to the Prescribing Information for the product.[4] In contrast, the Prescribing Information for QBREXZA does not require patients to fail any other therapies before initiating the product.[2]

4) **QBREXZA is the only treatment for primary axillary hyperhidrosis that is FDA-approved for use in pediatric patients (9 years of age or older).[2]** BOTOX and miraDry are only indicated for use in adults aged 18 years of age and older.[3,4]

5) **Evidence to support use of iontophoresis and oral anticholinergics for the treatment of hyperhidrosis was considered limited, of low quality and at high or unclear risk for bias** according to a recent systematic review published by Wade, et al. in the British Journal of Dermatology.[5] The authors concluded that insufficient evidence is available regarding the relative efficacy and safety of these products for primary hyperhidrosis.[5]

Based on the information provided above, patients suffering from primary axillary hyperhidrosis would not be well served if they were required to try and fail the therapeutic options listed in the proposed Department of Defense Pharmacy and Therapeutics Committee recommendations for QBREXZA. Dermira asks that the advisory panel reconsider the proposed primary authorization criteria for QBREXZA.

Dermira, Inc. recommends the use of QBREXA only in accordance with the Food and Drug Administration (FDA)-approved Prescribing Information. Please refer to the full QBREXZA Prescribing Information for approved product labeling and the Important Safety Information. The medical information presented is intended as information to healthcare professionals in clinical practice within the United States and not as medical advice.

Indications and Usage
Qbrexza is an anticholinergic indicated for topical treatment of primary axillary hyperhidrosis in adults and pediatric patients 9 years of age and older.

Important Safety Information
Please see Important Safety Information in the enclosed Qbrexza Prescribing Information for complete product information, including Contraindications, Warnings, and Precautions.

Please contact me should you require additional information.

Sincerely,

Kristen Mosdell, Pharm.D.
Ex. Dir, Medical Information
650-395-0386
Kristen.Mosdell@Dermira.com

References:

1. International Hyperhidrosis Society. Primary focal hyperhidrosis. https://www.sweathelp.org/treatments-hcp/clinical-guidelines/primary-focal-hyperhidrosis.html. Accessed Dec 19, 2018.
2. QBREXZA™ (glycopyrronium) cloth, 2.4% [prescribing information]. Dermira, Inc. Menlo Park, CA. 2018.
3. miraDry®. Miramar Labs, Inc., Santa Clara, CA. Available at: https://miradry.com/about-miradry/. Accessed Dec 19, 2018.
4. BOTOX® (onabotulinumtoxinA) [prescribing information]. Allergan USA, Inc., Madison, NJ. 2018.
5. Wade R, Llewellyn A, Jones-Diette J, et al. Interventional management of hyperhidrosis in secondary care: a systematic review. *Br J Dermatol* 2018;179:599-608.

INTERNATIONAL HYPERHIDROSIS SOCIETY
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January 3, 2019

Colonel Paul J. Hoerner, USAF
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042–5101
(via email: dha.ncr.j-6.mbx.baprequests@mail.mil)

Dear Colonel Hoerner:

The International Hyperhidrosis Society is at your service to provide any background, deeper understanding and support as your Department reviews new drug coverage for service members and their families who suffer from hyperhidrosis.

By way of introduction, hyperhidrosis is excessive and uncontrollable sweating that is four to five times greater than what is needed for thermoregulation, or as a response to stress. Hyperhidrosis presents in childhood years, and is a chronic, lasting condition. It has been shown to cause significant emotional, social and functional impairment.

We applaud your efforts to provide guidance and treatments for sufferers to manage their condition, and realize to their full potential. To this end, we respectfully provide our Treatment Guidelines for Axillary (underarm) Hyperhidrosis. These guidelines were thoughtfully developed and approved by our Board of Directors, who are internationally-renowned physician leaders in hyperhidrosis research, care and advocacy. The design of the algorithm is to carefully balance benefit and risk so that patients and their caregivers are given the opportunity to have optimal outcomes based on their individual response to treatments, and combinations of therapies. We also provide this guideline so that any clinician can provide diagnosis and treatment, thus enabling sufferers access to care through their preferred provider. With a stigmatized condition such as hyperhidrosis, relationship and comfort is critically important.

We stand at the ready to provide anything whatsoever that may support your investigation and evaluation. It is our life's work to alleviate the struggles of those living with hyperhidrosis and we are indebted to you for recognizing the importance of providing such care.

Respectfully yours,

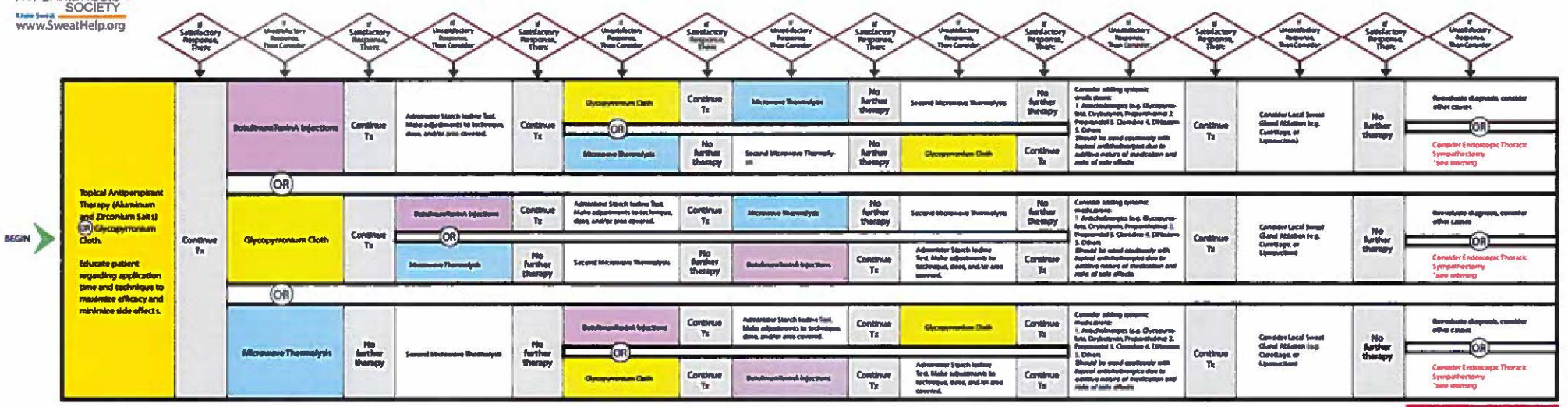
Lisa J Pieretti
Co-Founder, Executive Director

Attachment: Axillary IHhS Algorithm 2018 PDF

INTERNATIONAL HYPERHIDROSIS SOCIETY
www.SweatHelp.org

Primary Axillary Hyperhidrosis

To maximize efficacy and minimize side effects, consider combination therapy adjusted to patient needs, preferences and disease presentation.



Updated: September 23, 2018

*Patients must be carefully selected and educated to fully understand the possibility of limited efficacy and the risks of complications including, but not limited to, compensatory sweating.

Uniform Formulary Beneficiary Advisory Panel (BAP)

Meeting Summary
January 10, 2019
Washington, D.C.

Present Panel Members

- Mr. Jon Ostrowski, Non Commissioned Officers Association, Chairperson
- Dr. Sarika Joshi, HealthNet Federal Services
- Mr. Charles Hostettler, AMSUS, The Society of Federal Health Professionals
- Ms. Theresa Buchanan, National Military Family Association
- Mr. John Du Teil, US Army Warrant Officers Association
- Mr. Richard Bertin, Commissioned Officers Association of the USPHS
- Ms. Suzanne Walker, Military Officers Assocition of America

The meeting was held at Naval Heritage Center Theater, 701 Pennsylvania Ave., N.W., Washington D.C., and Col Paul Hoerner called the meeting to order at 9:00 A.M.

Agenda

The Agenda for the meeting of the Panel is as follows:

- Welcome
- Public Citizen Comments
- Therapeutic Class Reviews

1. Drug Class Reviews

    a) Gastrointesinal-2 Agents – Chronic Idiopathic Constipation)CIC) and Constipation-Predominant Irritable Bowel Syndrome (ICS-C) and Gastrointestinal-2 Agents – Miscellaneous Subclasses
    b) Neurological Agents Miscellaneous – Movement Disorders Subclass

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

    a) adapalene 0.1% topical solution (external pad/swab) (Plixda) – Topical Acne Agent
    b) adapalene 0.1% topical solution – Topical Acne Agent
    c) amikacin liposome inhaled suspension (Arikayce) – Aminoglycoside Antibiotic for Mycobacterium Avium Complex (MAC)
    d) butalbital 50 mg and acetaminophen 300 mg capsules – Analgesics and Combinations
    e) cannabidiol oral solution (Epidiolex) – Anticonvulsants-Antimania Agent for Lennox-Gastaut Syndrome or Dravet Syndrome

f) dacomitinib (Vizimpro) – Oncologic Agent for Non-Small Cell Lung Cancer (NSCLC)
g) darunavir/cobicistat/emtricitabine/tenofovir alafenamide (TAF) (Symtuza) – Combination Antiretroviral for HIV
h) darunavir/lamivudine/tenofovir disoproxil fumarate (TDF) (Delstrigo) – Combination Antiretroviral for HIV
i) doravirine (Pifeltro) – Antiretroviral for HIV
j) doxycycline monohydrate extended release (ER) capsules (Okebo) – Oral Tetracycline Agent
k) duvelisib (Copiktra) – Oncologic Agent for Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL)
l) elagolix (Orilissa) – Luteinizing Hormone-Releasing Hormone (LHRH) Agonists-Antagonists for Endometriosis
m) filgrastim-aafi injection (Nivestym) – Hematologic Agent: White Blood Cell Stimulant
n) fremanezumab-vfrm injection (Ajovy) – Migraine Agent (calcitonin gene-related peptide [CGRP]) for Migraine Headache Prophylaxis
o) galcanezumab-gnlm injection (Emgality) – Migraine Agent (CGRP) for Migraine Headache Prophylaxis
p) glycopyrronium 2.4% topical cloth (Qbrexza) – Antiperspirant for Primary Axillary Hyperhidrosis
q) ivosidenib (Tibsovo) – Oncologic Agent for Acute Myelogenous Leukemia (AML)
r) lanadelumab injection (Takhzyro) – Corticosteroid-Immune Modulator for Hereditary Angioedema (HAE) Prophylaxis
s) lidocaine 1.8% topical patch (ZTlido) – Topical Pain Agent
t) lumacaftor/ivacaftor granules (Orkambi) – Cystic Fibrosis Agent
u) lusutrombopag (Mulpleta) – Hematologic Agent: Platelets for Thrombocytopenia in Chronic Liver Disease
v) metoprolol ER capsules (Kapspargo Sprinkle) – Beta-Blocker
w) migalastat (Galafold) – Miscellaneous Metabolic Agent for Fabry Disease
x) minocycline ER tablets (Minolira) – Oral Tetracycline Agent
y) ozenoxacin 1% cream (Xepi) – Quinolone Antibiotic for Impetigo
z) PEG3350/Na ascorbate/NaSO4/ascorbic acid/NaCl/KCl powder packets (Plenvu) –Laxatives-Cathartics-Stool Softener for Bowel Prep
aa) pegfilgrastim-jmdb injection (Fulphila) – Hematologic Agent: White Blood Cell Stimulant
bb) PEGylated Factor VIII (Jivi) – Antihemophilic Factor
cc) sodium zirconium cyclosilicate packet for oral suspension (Lokelma) – Binders Chelators Overdose Agents Hyperkalemia
dd) tildrakizumab-asmn injection (Ilumya) – Targeted Immunomodulatory Biologic (TIB) for Plaque Psoriasis

3. Utilization Management

a) Prior Authorization Criteria – Updated Criteria

- Basal Insulins: Insulin degludec (Tresiba)
- Corticosteroids – Immune Modulators – Atopic Dermatitis Subclass: dupilumab (Dupixent) injection
- Anti-Gout Drugs: Febuxostat (Uloric)
- Antipsychotic Agents – Atypical: pimavanserin (Nuplazid)
- Antihemophilic Factors: emicizumab-kxwh (Hemlibra)
- Targeted Immunomodulatory Biologics (TIBs)

b) Prior Authorization Criteria – New Criteria

- 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)
  Skeletal Muscle Relaxants and Combinations: chlorzoxazone 250 mg tablets
  Oncological Agents for unresectable or metastatic melanoma: cobimetinib
- (Cotellic)
- Antiinfectives: Miscellaneous: crotamiton 10% lotion (Eurax and Crotan)

4. Re-evaluation of NF Generics—ADHD/Wakefulness: Stimulants Subclass

5. Section 703, National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008

6. Informational Items

   a) Removal of Brand over Generic Authority and Brand over Generic PA Criteria Authorization for Sildenafil Tablets (Viagra)
   b) Drugs Losing Rx Status and Moving to OTC Status (Vitamin B Replacement Products, Iron Replacement Products, and Urinary pH Modifiers)
   c) TRICARE Mail Order Auto Refill Requirements for Self-Monitoring Blood Glucose Systems (SMBGS) Test Strips and Lancets

7. Panel Discussion

The Beneficiary Advisory Panel members will have the opportunity to ask questions to each of the presenters. Upon completion of the presentation and any questions, the Panel will discuss the recommendations and vote to accept or reject them. The Panel will provide comments on their vote as directed by the Panel Chairman.

Opening Remarks

Col Paul Hoerner introduced himself as the Designated Federal Officer (DFO) for the Uniform Formulary (UF) Beneficiary Advisory Panel (BAP). The Panel has convened to comment on the recommendations of the DoD Pharmacy and Therapeutics (P&T) Committee meeting, which occurred on November 7-9, 2018.

Col Hoerner indicated Title 10, United States, (U.S.C.) section 1074g, subsection b requires the Secretary of Defense to establish a DoD Uniform Formulary (UF) of the pharmaceutical agent and established the P&T committee to review the formulary on a periodic basis to make additional recommendations regarding the formulary as the committee determines necessary and appropriate.

In addition, 10 U.S.C. Section 1074g, subsection c, also requires the Secretary to establish a UF Beneficiary Advisory Panel (BAP) to review and comment on the development of the Uniform Formulary. The Panel includes members that represent non-governmental organizations and associations that represent the views and interests of a large number of eligible covered beneficiaries. The Panel's comments must be considered by the Director of the Defense Health Agency (DHA) before establishing the UF or implementing changes to the UF.

The Panel's meetings are conducted in accordance of the Federal Advisory Committee Act (FACA).

The duties of the Uniform Formulary Beneficiary Advisory Panel include the following:

- To review and comment on the recommendations of the P&T Committee concerning the establishment of the UF and subsequently recommending changes. Comments to the Director of the DHA regarding recommended formulary status, pre-authorizations and the effective dates for changing drugs from "formulary" to "non-formulary" status must be reviewed by the Director before making a final decision.

- To hold quarterly meetings in an open forum. The panel may not hold meetings except at the call or with the advance approval of the DFO and in consultation with the chairperson of the Panel.

- To prepare minutes of the proceedings and prepared comments of the Secretary or his designee regarding the Uniform Formulary or changes to the Formulary. The minutes will be available on the website, and comments will be prepared for the Director of DHA. As guidance to the Panel regarding this meeting, Col Hoerner said the role of the BAP is to comment on the UF recommendations made by the P&T Committee at their last meeting. While the department appreciates that the BAP maybe interested in the drug class they selected for review, drugs recommended for the basic core formula (BCF) or specific pricing data, these items do not fall under the purview of the BAP.

- The P&T Committee met for approximately 16 hours conducting this review of the drug class recommendation presented today. Since this meeting is considerably shorter, the Panel will not receive the same extensive information as presented to the P&T Committee members. However, the BAP will receive an abbreviated version of each presentation and its discussion. The materials provided to the Panel are available on the TRICARE website. Detailed minutes of this meeting are being prepared. The BAP minutes, the DoD P&T Committee minutes, and the Director's decisions will be available on the TRICARE website in approximately four to six weeks.

The DFO provided ground rules for the meeting.

- All discussions take place in an open public forum. There is to be no committee discussion outside the room, during breaks, or at lunch.

- Audience participation is limited to private citizens who signed up to address the Panel.

- Members of the Formulary Management Branch and P&T Committee are available to answer questions related to the BAP's deliberations. Should a misstatement be made, these individuals may interrupt to ensure the minutes accurately reflect relevant facts, regulations, or policy.

Col Hoerner introduced the individual Panel members (see list above) and noted house-keeping considerations.

There were 4 individuals signed up this morning to provide comments to the BAP. Their submissions are attached:

1. The International Foundation Gastrointestinal Disorders (IFFGD)

2. Restless Legs Syndrome Foundation

3. Dermira

4. International Hyperhidrosis Society (Letter and Guidelines)

Chairman's Opening Remarks

Mr. Ostrowski welcomes everyone and wishes everyone a new year. He thanks the Panel for their time to represent the BAP. He states he has no further comments and starts the meeting.

DRUG CLASS REVIEW PRESENTATION

(POD Script – CDR HELLWIG)

GOOD MORNING. I am CDR Heather Hellwig, Chief of the P&T Section of the Formulary Management Branch of the DHA Pharmacy Operations Division. Joining me is doctor and retired Army Colonel John Kugler, the Chairman of the Pharmacy and Therapeutics Committee, who will provide the physician perspective and comments on the recommendations made by the P&T Committee. Also joining us from the Formulary Management Branch today is Dr. Angela Allerman, one of the clinical pharmacists at the Formulary Management Branch. I would also like to recognize Mr. Bryan Wheeler, Deputy General Counsel.

The DoD Formulary Management Branch supports the DoD P&T Committee by conducting the relative clinical effectiveness analyses and relative cost effectiveness analyses of the drugs and drug classes under review and consideration by the DoD P&T Committee for the Uniform Formulary (relative meaning in comparison to the other agents defined in the same class).

We are here to present an overview of the analyses presented to the P&T Committee. 32 Code of Federal Regulations (CFR) establishes procedures for inclusion of pharmaceutical agents on the Uniform Formulary based upon both relative clinical effectiveness and relative cost effectiveness.

The goal of this presentation is not to provide you with the same in-depth analyses presented to the DoD P&T Committee but a summary of the processes and analyses presented to the DoD P&T Committee. These include:

- A brief overview of the relative clinical effectiveness analyses considered by the DoD P&T Committee. All reviews include but are not limited to the sources of information listed in 32 CFR 199.21 (e)(1) and (g)(5). Also note that 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.
- A brief general overview of the relative cost effectiveness analyses. This overview will be general in nature since we are unable to disclose the actual costs used in the economic models. This overview will include the factors used to evaluate the costs of the agents in relation to the safety, effectiveness, and clinical outcomes.
- The DoD P&T Committee's Uniform Formulary recommendation is based upon the Committee's collective professional judgment when considering the analyses from both the relative clinical and relative cost effectiveness evaluations.

The Committee reviewed the following:

1. The P&T Committee reviewed two Uniform Formulary Drug Classes

   a) the Gastrointestinal-2 (GI-2) Chronic Idiopathic Constipation (CIC) and Constipation-Predominant Irritable Bowel Syndrome (IBS-C) Subclass and the GI-2 Miscellaneous Subclass and
   b) the Neurological Agents Miscellaneous – Movement Disorders Subclass.

   A summary table of the UF drug class recommendations and the numbers of affected utilizers is found on page 35 of the background document.

   c) The P&T Committee also evaluated 31 newly approved drugs per 32 CFR 199.21 (g)(5), which are currently in pending status and available under terms comparable to nonformulary drugs.

   and

   d) We also discussed prior authorizations (PAs) for 31 drugs in 10 drug classes.

      - Basal Insulins
      - Corticosteroids – Immune Modulators – Atopic Dermatitis subclass
      - Anti-Gout drugs
      - Atypical Antipsychotic Agents
      - Antihemophilic Factors
      - Targeted Immunomodulatory Biologics
      - Pain Agents
      - Skeletal Muscle Relaxants and Combinations
      - Oncological Agents for unresectable or metastatic melanoma
      - Antiinfectives Miscellaneous subclass

   e) The Committee re-evaluated the nonformulary status of dexmethylphenidate ER (Focalin XR) in the Attention Deficit Hyperactivity Disorder (ADHD)/Wakefulness Promoting Agents drug class.

   f) We discussed two National Defense Authorization Act (NDAA) Section 703 non-compliant drugs.

   g) We discussed one product for brand over generic authorization removal

   h) We also discussed drugs losing prescription status and moving to over-the-counter status

   and

i) We discussed TRICARE mail order auto refill requirements for the self-monitoring blood glucose systems (SMBGS) test strips and lancets.

The DoD P&T Committee will make a recommendation as to the effective date of the agents being changed from the Uniform Formulary tier to Non-formulary tier. Based on 32 CFR 199.21, such change will not be longer than 180 days from the final decision date but may be less.

UNIFORM FORUMULARY DRUG CLASS REVIEWS

I. UF 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

(DR. ALLERMAN)

1. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Relative Clinical Effectiveness Analysis and Conclusion

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.

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, were reviewed for treatment recommendations and for guiding development of the PA criteria.
- Most constipation-related guidelines 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 (Linzess), plecanatide (Trulance), and lubiprostone (Amitiza) have all shown improvement in treating the constipation symptoms associated with IBS-C and CIC, compared to placebo.
- 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, linaclotide (Linzess) and plecanatide (Trulance) demonstrated similar efficacy, safety, and adverse effects in treating IBS-C and CIC. Additionally, there was no statistically significant difference between Linzess compared to Trulance 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 Trulance versus Linzess 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 (Viberzi) as a weak recommendation with moderate quality evidence; this is the same recommendation as for rifaximin (Xifaxan).
- FDA approval of Xifaxan for IBS-D was based on the TARGET 3 trial, which found it 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.
- 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. At this time, unsupportable uses of rifaximin include small intestine bacterial overgrowth (SIBO), non-alcoholic fatty liver disease (NAFLD), non-alcoholic steatohepatitis (NASH), 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 (Viberzi) was evaluated in two placebo-controlled trials for IBS-D. Overall, it appears to improve stool consistency and has less of an impact on relieving abdominal pain.
- A 2017 United Kingdom National Institute for Clinical Effectiveness technology appraisal of Viberzi recommended its use only in refractory patients or those with contraindications to other treatments (e.g.,

antimotility agents, antispasmodics, or TCAs). Additional recommendations include discontinuing Viberzi if no response is seen after four weeks of therapy.

- The FDA issued a warning for Viberzi in March 2017 to avoid use in patients who have had a cholecystectomy, due to an increased risk of pancreatitis and death.
- Viberzi 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.

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.

2. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—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:
CIC/IBS-C Subclass

- 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).

GI-2 Miscellaneous Subclass

- 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.

3. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—UF Recommendation

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent based on clinical and cost effectiveness:

- UF

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

  Miscellaneous Subclass

  a) alosetron (Lotronex, generics)
  b) eluxadoline (Viberzi)
  c) rifaximin (Xifaxan)
  d) nitazoxanide (Alinia)
  e) fidaxomicin (Dificid)
  f) vancomycin oral (generics)
  g) neomycin (generics)
  h) metronidazole (Flagyl, generics)

- NF

  a) None

4. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Manual Prior Authorization (PA) 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.

a) Linzess and Amitiza

Manual PA criteria apply to all new and current users of Linzess and Amitiza.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age ≥ 18 years
- 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.

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 (Linzess, Amitiza, Trulance, Symproic, Relistor, or Movantik)

b) Trulance

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
- **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)

c) Viberzi

November 2018 updates are in BOLD and strikethrough.

Manual PA criteria apply to all new users of Viberzi.

Manual PA criteria: 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, Donnatal, loperamide
- 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.

Renewal PA Criteria: Coverage will be approved for 1 year if:
- The patient has had documented improvement in IBS-D symptoms

d) Xifaxan

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.

Manual PA criteria: 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 one antispasmodic/antidiarrheal agent (e.g., dicyclomine [Bentyl], Librax, hyoscyamine [Levsin], Donnatal, imodium [Loperamide])
- Patient has tried and failed or had intolerance or a contraindication to at least one tricyclic antidepressant (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-D are allowed in 1 year.**

5. GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous—UF and PA Implementation Plan

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.

6. Physician's Perspective

Note that no products were recommended for non-formulary placement. Two products that were previously NF (Trulance and Viberzi) are now recommended for formulary status. There is also no step-therapy required.

For the constipation drugs (Linzess, Amitiza and Trulance), the PAs are very similar. The Committee did consider the recommendations from the guidelines when developing the PA criteria, so a trial of the usual OTC products are recommended first, including laxatives and anti-diarrheals.

We want the PA to apply to current users, which means that a large number of beneficiaries will be affected by the new PA requirements for Linzess and Amitiza. However, we feel it is necessary because we want all patients to have had a trial of recognized therapies recommended from the guidelines. In addition, studies indicate a high placebo rate for these drugs and DoD data shows that only about 50% of patients remain on therapy past 3 months.

For the IBS-D drugs, the PAs will continue to require a trial of TCAs. The reason behind this is that the TCAs were given a strong recommendation based on high quality data in the American College of Gastroenterology (ACG) guidelines. TCAs decrease the abdominal pain associated with constipation and diarrhea. Antispasmodics (like dicyclomine) were also recommended, based on guidelines.

For IBS-D, the Committee did recognize that stress does play a role, and stress reduction therapies were recommended to be tried for the Rifaximin and Viberzi PAs. This was also a recommendation based on DoD and Network expert provider feedback.

The PA for Viberzi and Xifaxan are very different, reflecting the different mechanisms of action for these two drugs. The Viberzi PA also reflects the safety concerns associated with the drug.

7. Panel Questions and Comments

Mr. Du Teil asks about the expiration date changes in the PA for Viberzi and and Xifaxan. The PA for Viberzi did not expire and was changed to expire in 4 months. The PA for Xifaxan was expanded from 6 months to 1 year.

Dr. Allerman replied that the PA for Viberzi was changed to 4 months because a patient will know, symptomatically, whether they respond to the drug after the 4 months. Comments from providers supported the P&T Committee decision. If the product is not working the patient normally stops using the drug. We previously had a 6 month PA for Xifaxan but expanded it to 1 year.

Mr. Hostettler asks what documentation was used to approve the off-label use of Linzess for opioid induced constipation.

Dr. Allerman reminded everyone that Amitiza has indications for OIC. There is some data showing that Linzess has benefits for OIC. We did survey

providers and they commonly use Linzess for OIC. Linzess is dosed once a day and Amitiza is dosed twice a day. We believe that is the reason providers recommend Linzess for OIC. There was enough data to support the P&T Committee decision.

Mr. Hostettler asks why step therapy, medical necessity or a prior authorization is required to get to the product if they are all cost-effective and uniform formulary.

Dr. Allerman clarifies there is no step therapy. We had some previous recommendations that required a trial of one drug before the other. The rationale behind the prior authorization is based on 2018 guidelines. The guidelines reiterate using antidiarrheal, antispasmodic, or TCA first. Dr. Kugler mentioned that DoD data shows only 50% of patients remain on therapy after 3 months. The P&T Committee believes this is a difficult disease to treat and following these guidelines are best for our patients.

Mr. Hostettler says he appreciates following the guidelines. However, do you believe the OTCs have already been tried before the patient seeks a physician? If they "self-stop" or stop using them on their own, why is a step needed to stop the use of the drug?

Dr. Allerman says they haven't actually had the requirements for Linzess or Amitiza to try one of the traditional products first. We would hope that the patient would've had a trial. If they had have, then the patients meets criteria.

Mr. Hostettler asks if the letters going out will be specifically address the PA changes.

Dr. Allerman replies that Trulance and Viberzi were previously non-formulary. They will be moving to formulary status. The letters mailed to the patients will specifically discuss the need for prior authorization.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for the GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses

- **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Uniform Formulary Recommendation**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—Manual PA Criteria**

  Concur: 6 Non-Concur: 1 Abstain: 0 Absent: 0

- **GI-2 Agents – CIC and IBS-C and GI-2 Agents – Miscellaneous Subclasses—UF and PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

B. NEUROLOGICAL AGENTS MISCELLANEOUS – MOVEMENT DISORDERS SUBCLASS

(DR. ALLERMAN)

1. Neurological Agents Miscellaneous – Movement Disorders Subclass—Relative Clinical Effectiveness Analysis and Conclusion

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 Austedo are approved for treating Huntington's disease chorea, while both Austedo and Ingrezza are indicated for tardive dyskinesia.

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 the two drugs do not differ in efficacy, based on low-quality evidence.

- With regard to safety, both tetrabenazine and 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 Austedo and Ingrezza 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 Austedo and Ingrezza. Individual placebo-controlled trials with the two drugs reported statistically significant differences over placebo in measures on the Abnormal Involuntary Movement Scale (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 Austedo and Ingrezza when used for tardive dyskinesia.

- In terms of safety, 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.

2. Neurological Agents Miscellaneous – Movement Disorders Subclass— 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.

3. Neurological Agents Miscellaneous – Movement Disorders Subclass— Manual PA Criteria

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) updates the current manual PA criteria for Austedo and Ingrezza that have been in place since 2017. 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 first, 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.

a) Austedo

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)

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.**

b) Ingrezza

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)

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.**

4. Neurological Agents Miscellaneous – Movement Disorders Subclass—UF and PA Implementation Plan

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).

5. Physician's Perspective

All three drugs were recommended for formulary status. Ingrezza will move from NF to UF status, so patients currently taking it will have a decrease in their copay.

This class is a brand new treatment for tardive dyskinesia, where in the past treatments have not been very successful for patients receiving antipsychotic therapy, and experiencing side effects Austedo and Ingrezza are both under investigation for Tourette's syndrome.

For the PA update for tardive dyskinesia, the Committee recommended removing gingko biloba and clonazepam from the PA, based on the systematic review that these are second-line therapies; plus clonazepam is for short term-use. We only have the Neurology guidelines for tardive dyskinesia; the treatment guidelines from the American Psychiatric Association haven't been updated yet to include the VMAT2 inhibitors.

6. Panel Questions and Comments

Mr. Hostettler requests clarification concerning the expiration date change for the Ingrezza PA. Previously the PA didn't expire and it was changed to expire in 1 year. Will the PA expire in one year for the patients currently under the PA?

Dr. Allerman replies the PA will only apply to the new users for the expiration date. The renewal PA for current users is indefinite.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA

Implementation Plan for Neurological Agents Miscellaneous – Movement Disorders Subclass

- **Neurological Agents Miscellaneous – Movement Disorders Subclass—UF Recommendation**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Neurological Agents Miscellaneous – Movement Disorders Subclass——Manual PA Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Neurological Agents Miscellaneous – Movement Disorders Subclass——UF and PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

II. NEWLY APPROVED DRUGS PER 32 CFR 199.21(G)(5)

(CDR HELLWIG)

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

1. 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).

2. Newly Approved Drugs per 32 CFR 199.21(g)(5)—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) – Oncologic 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) – Oncologic 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) – Oncologic 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 capsules (Okebo) – Oral Tetracycline Agent
- elagolix sodium (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

3. Newly Approved Drugs per 32 CFR 199.21(g)(5)—PA Criteria

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

- 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 Tetracyclines: Applying the same manual PA criteria for doxycycline monohydrate ER 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 immediate release (IR) product, either the hyclate or monohydrate salt (for Okebo) or one generic minocycline IR product (for Minolira).
- CGRP Migraine Headache Prophylaxis Drugs: Applying manual PA criteria to new users of Ajovy and Emgality as is currently in place for erenumab injection (Aimovig).
- 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.

<u>Full PA Criteria for the Newly Approved Drugs per 32 CFR 199.21(g)(5)</u>

a) adapalene 0.1% topical solution, adapalene 0.1% topical solution external pad/swab (Plixda), and tretinoin 0.05% topical lotion (Altreno)

Automated PA Criteria:

- The patient has filled a prescription for at least three step-preferred topical acne products 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.

b) amikacin sulfate liposomal inhalation suspension (Arikayce)

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.

c) butalbital 50 mg/acetaminophen 300 mg capsule

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 capsules 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.

d) **cannabidiol oral solution (Epidiolex)**

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.

e) dacomitinib (Vizimpro)

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.

f) doxycycline monohydrate ER 50, 75 and 100 mg capsules (Okebo) and minocycline 105 and 135 mg ER tablets (Minolira)

PA applies to both new and current users of Okebo and Minolira.

Automated PA Criteria:

- Patient has filled a prescription for one generic IR doxycycline (either hyclate or monohydrate salt) **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

- For **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 **Minolira**: The patient has acne with inflammatory lesions AND
  - the patient cannot tolerate generic minocycline IR due to gastrointestinal adverse events

Susceptible Infections

- For **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

g) duvelisib (Copiktra)

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.

h) elagolix (Orilissa)

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)

i) fremanezumab-vfrm injection (Ajovy) and galcanezumab-gnlm injection (Emgality)

Manual PA criteria apply to all new users of Ajovy and Emgality.

Manual PA Criteria: 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.

Renewal Criteria: Coverage will be approved indefinitely for continuation of therapy if:

- The patient has shown improvement in migraine prevention (e.g., reduced migraine headache days, reduced migraine frequency, reduced use of acute abortive migraine medication)

j) glycopyrronium 2.4% topical cloth (Qbrexza)

Manual PA criteria apply to all new and current users of Qbrexza.

Manual PA Criteria: 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.

k) ivosidenib (Tibsovo)

Manual PA criteria apply to all new users of Tibsovo.

Manual PA Criteria: 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.

l) lanadelumab-flyo (Takhzyro)

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.

m) lidocaine 1.8% topical patch (ZTlido)

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.

n) lumacaftor/ivacaftor (Orkambi granules)

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

PA does not expire.

o) lusutrombopag (Mulpleta)

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 109/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.

p) metoprolol succinate ER capsules (Kapspargo Sprinkle)

PA does not apply to patients between the ages of 6 to 18 years.

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

Non-FDA-approved uses are NOT approved.

PA does not expire.

q) migalastat (Galafold)

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.

r) ozenoxacin 1% cream (Xepi)

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 or 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.

s) tildrakizumab (Ilumya)

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.

4. Physician's Perspective

We reviewed 31 new drugs at this meeting, which is a new record. There were 19 drugs recommended for UF status, and 12 recommended for non-formulary placement. For the drugs recommended for non-formulary status, several of them fall into classes that have already been reviewed by the P&T Committee, where there are cost effective alternative products already available in the class.

For this review, 23 drugs have PA's recommended. Seven of these drugs fall into classes that already have existing PA requirements.

There were a couple of comments made at the meeting for some of the drugs recommended to have Prior Authorization:

- Ajovy and Emgality (for migraine): These are the 2nd and 3rd drugs in a new therapeutic class. The first drug (Aimovig) was reviewed at the last meeting, and PA criteria were placed soon after drug launch, to avoid having high numbers of patients impacted if a PA were to be implemented

several months after market introduction. This was also the case for the two new drugs. The PA does require a trial of commonly used preventive products first, which is consistent with current migraine headache guidelines.

- Orilissa (for endometriosis): This is the first oral drug for endometriosis, however, injectable products are commonly used. PA will apply to both new and current users; the main reason for this is because it is only approved for a 24 month total duration of therapy, due to the risk of decreases in bone mineral density.
- Epidiolex (cannabinoid for seizures): The PA limits use to the actual FDA approved indications, since there is a high potential for off-label use, including autism, anxiety, and bipolar disorder. The product does not contain THC, so there are no psycho-active properties

5. Panel's Questions and Comments

Mr. Du Teil states we are all interested in having the drugs in a formulary status for our beneficiaries. When drugs are placed in a non-formulary status, am I correct in assuming that there are other formulary alternatives available.

Dr. Kugler says absolutely.

Ms. Buchanan questions the rationale for not authorizing a PA renewal for Plixda and Altreno. Is a year going to be enough time to show efficacy?

CDR Hellwig replies the provider can submit a new PA on behalf of the patient. This is not a renewal for the PA criteria. There are many alternatives and products available. It doesn't mean the patient can't get it after the first year. It would be via a new PA rather than a renewal PA. It's a little bit longer for them.

Mr. Hostettler asks for a point of clarification. It states that "the patient has tried and failed at least three step-preferred topical acne products including at least two different strengths of tretinoin and 0.1% adepalene." Is there another adapalene already on the market?

CDR Hellwig answers that there is a cream and ointment. There are multiple forms of this product.

For ZT Lido, Mr. Hostettler states that are other OTC products that deliver more than the 1.8% of the lidocaine.

CDR Hellwig replies the 1.8% formulation has a different delivery mechanism than the 5% patch. It delivers the same amount of lidocaine to the patient as the 5% patch even though it is a different percentage rate.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for Newly Approved Drugs per 32 CFR 199.21(g)(5)

- **Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF Recommendation**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Newly Approved Drugs per 32 CFR 199.21(g)(5)— PA Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF and PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

III. UTILIZATION MANAGEMENT

A. UTILIZATION MANAGEMENT – UPDATED MANUAL PA CRITERIA AND STEP THERAPY

(DR. ALLERMAN)

1. Updated PA Criteria and Step Therapy

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.

The P&T Committee recommended the following: (15 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for Tresiba, Uloric, Nuplazid, and Hemlibra; and updates to the manual PA criteria and step therapy for the TIBs, and recommended (14 for, 0 opposed, 0 abstained, 2 absent) updates to the manual PA criteria for Dupixent.
The updates are as follows:

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. The NF, non-step-preferred basal insulins include insulin degludec (Tresiba). The PA 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 (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 Uloric 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 Uloric and allopurinol. The Uloric 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.

2. Updated PA Criteria and Step Therapy—PA Implementation

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) updates to the current PA become effective 30 days after the signing of the minutes for the following drugs: the insulin product Tresiba, the gout drug Uloric, the antipsychotic Nuplazid, and the hemophilia drug Hemlibra; and updates to the manual PA criteria and step therapy for the TIBs.

The P&T Committee also recommended (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.

3. Physician's Perspective

At every meeting, we present updates to drugs with existing PAs to ensure the latest FDA indications or safety updates are included in our criteria. These updates to the existing PAs will only affect new patients.

For Dupixent, the update was to allow for the new indication for asthma. The other injectable treatments for asthma require administration in the physician's office, so this new indication for self-injection will likely be requested.

The other PA updates were due to safety issues (the gout drug Uloric, and antipsychotic agent Nuplazid), and a new indication for the hemophilia drug Hemlibra.

4. Panel Questions and Comments

Mr. Hostettler asks if something was moved from a uniform formulary to a non-formulary status.

Dr. Allerman replies nothing was moved. The Basal Insulin drug class was reviewed for formulary placement in August of 2017. These PAs do not reflect any change in current uniform formulary status.

Mr. Hostettler asks if the changes to the Basal Insulin PA were only for new users.

Dr. Allerman replies yes, only for new users.

Mr. Hostettler asks Dr. Allerman to explain the difference between a PA, step therapy, and medical necessity.

Dr. Allerman replies that it is a typo, in that the medical necessity information should not have been included. According to the Charter, Medical necessity does not fall under the purview of the BAP. If a patient has clinical reasons that meets medical necessity criteria, they can apply for medical necessity and potentially decrease a non-formulary co-pay to a formulary co-pay.

Mr. Hostettler says he won't comment on medical necessity criteria. He asks where the forms are located on the website. The forms for the PA criteria is on the website but he hasn't found any forms that will allow him to lower his copay.

Dr. Allerman replied the medical necessity forms are on the TRICARE Formulary Search Tool. They are only available for non-formulary drug. Occasionally, we do find errors on the search tool. Contact the office if the medical necessity forms are not available for a non-formulary drug.

Mr. Hostettler asks for instructions on how to locate the Formulary Search Tool. Can I google it?

Dr. Allerman says you can google the search tool. She attempts to provide instructions on how to locate the forms but asks Mr. Hostettler to see her after the meeting.

Mr. Hostettler states that beneficiaries are not aware that the forms are available. Perhaps DoD or MHS can provide some education about these about the process. It would help the beneficiary and solve a lot of his concerns. At the end of the process, I've got to be close to medical necessity that will get me back to a Tier 2 cost. That is why that's important to me.

Chair Ostrowski asks if there is a process or someone who checks the site for errors or updates.

Dr. Allerman replies they rely on people in the field, and industry partners. The search tool is managed by Express Scripts and they are very responsive to updates. We do not systematically QA everything. However, the group is very responsive when we find errors.

There were no more questions or comments from the Panel. The Chair called for a vote on the Updated Manual PA Criteria and PA Renewal Criteria and PA Implementation Plan for the Utilization Management Drugs.

- **Updated Manual PA Criteria and PA Renewal Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Updated Manual PA Criteria and PA Renewal Criteria – PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

B. UTILIZATION MANAGEMENT – NEW MANUAL PA CRITERIA

(DR. ALLERMAN)

1. New PA Criteria

New Manual PA Criteria were recommended for the following drugs, which will be discussed below.

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.

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for Zipsor, Zorvolex, Tivorbex, naproxen CR (controlled-release) (Naprelan/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 these products are required to try four formulary generic IR NSAIDs, three of which are BCF agents, first.

Manual PA criteria apply to all new and current users of naproxen CR (Naprelan/generics), Tivorbex, Vivlodex, and Zipsor, and Zorvolex. Coverage will be approved if all a clinical rationale of why the patient cannot take any of the formulary NSAIDs is stated on the PA form. Non-FDA-approved uses are NOT approved.

Prior authorization expires in one year. PA will be renewed for an additional year if a new PA form is completed

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. Cost-effective generic formulations of chlorzoxazone and multiple comparable muscle relaxants (e.g., cyclobenzaprine, methocarbamol) are available on the UF without PA required.

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.

Manual PA Criteria apply to all new and current users of chlorzoxazone 250 mg. 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 one-half of a 500 mg tablet. Note that no PA is required for the chlorzoxazone 500 mg tablets.

Non-FDA-approved uses are NOT approved
.
Prior authorization does not expire.

c) **Oncologic Agents for unresectable or metastatic melanoma: cobimetinib (Cotellic)**—Cobimetinib (Cotellic) was approved for treating unresectable or metastatic melanoma with a specific mutation. It is used exclusively in combinations of a specific BRAF drug with a specific 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.

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).

Manual PA Criteria apply to all new uses of Cotellic. Coverage will be approved if all the following are met:

- 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.

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

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.

Manual PA criteria apply to all new users of Eurax/Crotan. Coverage will be approved if all 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.

2. New PA Criteria – Implementation Plan

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) new PAs for the NSAIDs (Zipsor, Zorvolex, Tivorbex, Vivlodex, Naprelan and naproxen CR generics), chlorzoxazone 250 mg, the oncology drug Cotellic, and the scabies products 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 new PA requirements.

3. Physician's Perspective

NSAIDs (Zipsor, Zorvolex, Tivorbex, Naprelan, Vivlodex)

The products here all contain the same active ingredient of other drugs which are available in cost-effective generic formulations. There is no data to support that these new formulations are either more effective or have a better safety profile than the old generic products. Approximately 900 patients will be affected by the new PA requirements, since the PA will apply to both new and current users. We will be mailing letters to the affected patients.

Chlorzoxazone 250 mg tablet

This is a new product which is from one manufacturer that is significantly less cost effective than generic formulations of the 500 mg tablets. The Committee felt that it is reasonable for a patient to cut the scored 500 mg tablets in half, if a 250 mg dose is required. The 70 patients currently on the product will be receiving letters notifying them of the new PA requirements

Anti-infectives for scabies – Eurax and Crotan

The Committee felt that a PA was required for these two products, as they are actually less effective than the treatment recommended by the CDC (permethrin cream). There is no advantage to using these new products. No letters are required, since the PA will only apply to new users. Also, for existing users, their treatment course will be completed prior to the implementation of the new PA.

4. Panel Questions and Comments

There were no questions or comments from the Panel. The Chair called for a vote on the New Manual Criteria and PA Implementation Plan for the Utilization Management Drugs

- **New Manual Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **New Manual PA Criteria – PA Implementation Plan**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

IV. RE-EVALUATION OF NF GENERICS

(DR. ALLERMAN)

A. RE-EVALUATION OF NF GENERICs – ADHD/WAKEFULNESS: STIMULANTS SUBCLASS

Background—The DHA Pharmacy Operations Division Formulary Management Branch 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. A formal process is used to reevaluate NF medications where generic equivalents are available.

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). This product has been designated NF since the original ADHD class review in February 2007 and was reaffirmed at the most recent class review in November 2015. The unit cost of generic formulations of dexmethylphenidate ER has dropped significantly from the previous generic and brand cost.

1. 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.

2. Physician's Perspective

This is a continuing project where we look at drug classes reviewed several years ago to see what the costs are for non-formulary products that now have generic equivalents available.

For Focalin XR, which was reviewed back in November 2015, there are now cost effective generics available with reliable supply. The recommendation is to move Focalin from NF to UF status. No letters are needed, since patients will be seeing a decrease in their prescription co-pay.

3. Panel Questions and Comments

There were no questions or comments from the Panel. The Chair called for a vote on the Re-evaluation of NF Generics – ADHD/Wakefulness: Stimulants Subclass.

- **Re-evaluation of NF Generics – ADHD/Wakefulness: Stimulants Subclass**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

V. SECTION 703

(CDR HELLWIG)

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

The P&T Committee reviewed two drugs (tobramycin inhalation solution and oxycodone oral solution) 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 point of service (POS) and medical necessity at MTFs. These two 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.

1. **Drugs Designated as 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 300 mg/5 mL ampule-nebulizer
   - Genus Lifesciences Pharma: oxycodone hydrochloride solution 5 mg/5 mL oral solution

2. **Preauthorization 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.

3. **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 tobramycin inhalation solution pak and oxycodone hydrochloride solution, and 2) DHA send letters to beneficiaries affected by this decision.

4. **Physician's Perspective**

   By law, the drugs where the manufacturer has not signed the pricing agreement must be designated as NF, and will only be available at the Mail Order, unless pre authorization criteria apply.

   Here, the two products will be NF. However, the committee did feel that these two products would be used in acute situations, (tobramycin is an antibiotic often used in patients with cystic fibrosis, and oxycodone is a narcotic), so patients will not be forced to go to the Mail Order point of service. However, since there are alternative products available, the pre-

authorization criteria will still apply at the retail network
.
There are currently about 8 patients on the tobramycin product, and 1,400 on the oxycodone oral solution. Letters will be mailed to these patients.

4. Panel Questions and Comments

Mr. Hostettler asks if this is in compliance with the law.

CDR Hellwig replies the decision by the P&T Committee is in compliance because we are allowed to make an exception.

There were no more questions or comments from the Panel. The Chair called for a vote on the Drugs Designated NF, Preauthorization Criteria, and Implementation Period for the Section 703, National Defense Authorization Act (NDAA) for Fiscal Year 2008.

- **Drugs Designated NF**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Preauthorization Criteria**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

- **Implementation Period**

  Concur: 7 Non-Concur: 0 Abstain: 0 Absent: 0

VI. INFORMATIONAL ITEM

(CDR HELLWIG)

A. INFORMATIONA ITEM – REMOVAL OF BRAND OVER GENERIC AUTHORITY AND PA CRITERIA AUTHORIZATION

1. 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. The Committee was notified of these actions at the February 2018 DoD P&T Committee meeting, and these recommendations were presented to this Panel at the April 5th, 2018, BAP 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. The prior authorization criteria remain in effect for the phosphodiesterase-type 5 (PDE-5) inhibitor class as a whole.

2. Physician's Perspective

Generic formulations of Viagra became available in December of last year. However, the price of the generics were significantly more expensive than the government pricing for brand Viagra, so P&T waived the generic use requirement. Now, the price of the Viagra generic products are very cost effective, so it is time to remove the requirement to use the brand.

We have done formal brand over generic preferences in a few instances to address these unique situations. There is administrative authority for the P&T Committee to react quickly to add the requirement and then remove it, when it is no longer cost effective. Because of the administrative authority, the requirement to use branded Viagra was removed back in September of last year. We will continue to let the BAP know when these actions are implemented and removed.

3. Panel Questions and Comments

There were no more questions or comments from the Panel. These are informational items. The Panel is not required to vote.

VII. INFORMATIONAL ITEM

(CDR HELLWIG)

A. INFORMATIONAL ITEM – DRUGS LOSING TX STATUS AND MOVING TO OTC STATUS

1. Drugs Losing Rx Status and Moving to OTC Status (Vitamin B Replacement Products, Iron Replacement Products, and Urinary pH Modifiers)

Effective January 1, 2019, any vitamin, dietary supplement or pediatric fluoride product currently listed as requiring a prescription in the First DataBank Database will change to OTC status. The list does not include prenatal vitamins, due to ongoing litigation. OTC pediatric fluoride drops will remain covered. None of the products on the list have been approved by the FDA. The change in status means that, as of January 1, 2019, products on this list will no longer be covered under the TRICARE pharmacy benefit.

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 agreed that none of these products are suitable for inclusion on the OTC pharmacy benefit, since they are not FDA-approved. Additionally these products are widely available as either prescription alternatives that would be covered, or low-cost over the counter products. The change will affect beneficiaries across all points of service. Letters are being prepared for delivery to affected beneficiaries.

2. Physician's Perspective

One important thing to note here is that this is not a situation where DoD has any direct control. This decision was made by the FDA. Since affected products have not been formally approved by the FDA, the P&T Committee did not want to include these products as part of the OTC program.

The OTC pediatric fluoride drops will still be covered by TRICARE, even though they are not prescription products.

Also note that there are some vitamins, for example those containing 1 mg of folic acid, that have been formally reviewed by the FDA. These products are not subject to the change and will remain as prescription products, and they

will remain covered under the TRICARE pharmacy benefit.

We did want to notify our beneficiaries about this change, and on December 5th approximately 20,000 letters were mailed to patients who are currently taking one of these products.

3. Panel Questions and Comments

Mr. Hostettler says there was an OTC demonstration program. Is there still and OTC program in DoD.

CDR Hellwig replies there is an OTC program. We still have several products covered under the OTC program.

Mr. Hostettler asks if there is a mechanisms for some of these products to have been put into that program.

CDR Hellwig replies that it's a little trickier because none of these are FDA approved. The OTC program would target FDA approved products. One could argue that these product are not drugs but dietary supplements.

Mr. Du Teil asks about the people who have rheumatoid arthritis (RA) or on treatment for methotrexate. Would it be advantageous cover folic acid, Vitamin D and products of that nature to be used by prescription?

CDR Hellwig replies absolutely. We do cover Folic acid by prescription.

Mr. Du Teil asks but not vitamin D?

CDR Hellwig says the prescription version of it are covered, but not the non-prescription version.

There were no more questions or comments from the Panel. These are informational items. The Panel is not required to vote.

VIII. INFORMATIONAL ITEM

(CDR HELLWIG)

A. INFORMATIONAL ITEM – TRICARE MAIL ORDER AUTO REFILL REQUIREMENTS

1. 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 P&T Committee recommended 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 quantity limits exceed typical usage patterns; overrides to the current quantity limits are available for clinical reasons; and to reduce the potential for wastage, as the test strips do expire. Beneficiary outreach will occur via letters.

2. Physician's Perspective

This is a situation where we are responding to beneficiary requests. Plus there was also some concern by the Committee that patients are not using all the test strips they are receiving, and the test strips do have expiration dates.

As we mentioned previously, the test strips and lancets are in the top 10 of most requested products by patients, to be removed from automatic refills.

We don't feel that a patient would be in a situation they would run out of a test strip. Plus, both the test strips and lancets are available without a prescription in retail pharmacies and grocery stores.

We will be sending out letters to make patients aware of the change.

3. Panel Questions and Comments

Mr. Hostettler is curious if the patient has to sign up for automatic refill or is it an automatic registration.

Dr. Allerman replies that you would opt-in.

Mr. Hostettler reiterates that you do opt-in.

There were no more questions or comments from the Panel. These are informational items. The Panel is not required to vote.

Chair Ostrowski concludes the meeting. He thanks the staff and the audience for attending. Then thanks the Panel for their time.

(Meeting Concludes)

Appendix 1 – Table of Implementation Status of UF Recommendations/Decisions Summary
Appendix 2 – Brief Listing of Acronyms Used in this Summary
Appendix 3 – Private Citizen Comments – Restless Leg Syndrome Foundation
Appendix 4 – Private Citizen Comments – The International Foundation of Gastrointestinal Disorders (IFFGD)
Appendix 5 – Dermira
Appendix 6 – The International Hyperhidrosis Society

Mr. Jon Ostrowski
UF BAP Chairperson

SUMMARY OF RECOMMENDATIONS AND BENEFICIARY IMPACT

Table of Implementation Status of UF Recommendations/Decisions Summary November 2018

DoD PEC Drug Class	UF Drugs	NF Drugs	Implement Date	Notes and Unique Users Affected
Gastro-intestinal-2 Agents: CIC/IBS-C Subclass and Miscellaneous Subclass	**IBS-C/CIC and IBS-D Subclass** ▪ lubiprostone (Amitiza) ▪ linaclotide (Linzess) ▪ plecanatide (Trulance) **Miscellaneous Subclass** ▪ rifaximin (Xifaxan) ▪ eluxadoline (Viberzi) ▪ alosetron (Lotronex, generic) ▪ nitazoxanide (Alinia) ▪ fidaxomicin (Dificid) ▪ vancomycin oral (generics) ▪ vancomycin solution (Firvanq) ▪ neomycin (generics) ▪ metronidazole (Flagyl, generic)	▪ None	Pending signing of the minutes / 90 days	▪ Eluxadoline (Viberzi) and plecanatide (Trulance) moved from NF to UF ▪ Manual PA currently in place for plecanatide, rifaximin, and eluxadoline. ▪ PA criteria added for linaclotide (Linzess) and lubiprostone (Amitiza) for new and current users ▪ No preferred agent within the CIC/IBS-C subclass ▪ No preferred agent among the IBS-D agents Unique Users Affected for Amitiza and Linzess PA Mail – 12,401 MTF – 7,017 Retail – 7,921 Total – 27,339
Neurological Agents Miscellaneous – Movement Disorders Subclass	▪ deutetrabenazine (Austedo) ▪ tetrabenazine (Xenazine, generics) ▪ valbenazine (Ingrezza)	▪ None	30 days after signing of the minutes	▪ Manual PA criteria applies to all new users for deutetrabenazine (Austedo) and valbenazine (Ingrezza). Unique Users Affected not applicable; current PA requirements

November 2018 Drugs with New Prior Authorization Criteria—Unique Utilizers Affected

Drug	MTF	Mail Order	Retail	Total
NSAIDs Naproxen CR (Naprelan, generics), Tivorbex, Vivlodex, Zipsor, Zorvolex,	36	523	106	912
Skeletal Muscle Relaxants and Combinations Chlorzoxazone 250 mg	0	0	70	70

Brief Listing of Acronyms Used in this Summary

Abbreviated terms are spelled out in full in this summary, when they are first used, the acronym is listed in parentheses immediately following the term. All of the terms commonly used as acronyms in the Panel discussions are listed below for easy reference. The term "Pan" in this summary refers to the "Uniform Formulary Beneficiary Panel," the group who's meeting in the subject of this report.

- AAN – Academy of Neurology
- ACG - American College of Gastroenterology
- ADHD – Attention Deficit Hyperactivity Disorder
- AIMS – Abnormal Involuntary Movement Scale
- AML – Acute Myelogenous Leukemia
- BAP – Beneficiary Advisory Panel
- BCF agents – Brachiocephalic agents
- BIA – Budget Impact Analysis
- BRAF drugs – Human gene that encodes a protein
- CARES Trial – Cardiovascular Safety of Febuxostat and Allopurinol in Participants With Gout and Cardiovascular Comorbidities
- CDC –Center for Disease Control
- CFR – Code of Federal Regulations
- CGRP – Calcitonin Gene-Related Peptide
- CIC – Chronic Idiopathic Constipation
- CLL – Chronic Lymphocytic Leukemia
- CMA – Cost-minimization Analysis
- CMV – Cytomegalovirus
- CR generics – Controlled-Released
- CTFR – Cystic Fibrosis Transmembrane Conductance Regulator
- CV – Cardiovascular
- DAPA – Distribution and Pricing Agreement
- DHA – Defense Health Agency
- DoD – Department of Defense
- DRESS – Drug Rash with Eosinophilia and Systematic Symptoms
- ER – Extended Release
- FDA – Federal Drug Administration
- FL – Follicular Lymphoma
- GI – Gastrointestinal
- GLA gene – Galactosidase Alpha
- HAE – Hereditary Angiodema
- HCG – Human Chorionic Gonadotropin
- HD – Huntington's Disease
- HIV – Human Immunodeficiency Virus
- IBS-C – Constipation-Predominant Irritable Bowel Syndrome

- IBS-D – Diarrhea-Predominant Irritable Bowel Syndrome
- ICER – Institute for Clinical Effectiveness Research
- IDH1 – Isocitrate Dehydrogenase-1
- IV – Intravenous
- LFRH – Luteinizing Hormone-Releasing Hormone
- MAC – Mycobaterium Avium Complex
- MAOI – Monoamine Oxidase Inhibitors
- MEK inhibitors – Chemical or drug that inhibits the mitogen-activated protein kinase enzymes
- Mg – Milligram
- MHS – Military Health Sytem
- MN forms – Medical Necessity Form
- MTF – Military Treatment Facility
- NAFLD – Non-Alcoholic Fatty Liver Disease
- NASH – Non-Alcoholic Steatohepatisis
- NDAA – National Defense Authroization Act
- NDC – Non-Compliant
- NF – Non Formulary
- NSAID – Nonsteroidal Anti-Inflammatory Drugs
- NSCLC – Non-Small Cell Lung Cancer
- OIC – Opioid-Induced Constipation
- OTC –Over the Counter
- P&T – Pharmacy & Therapeutics
- PA – Prior Authorization
- PDE-5 – Phosphodiesterase-Type 5
- pH – Potential Hydrogen
- POD – Pharmacy Operations Division
- POS – Point of Service
- REMS program – Risk Evaluation and Mitigation Strategy
- RX – Medical Prescription
- SBP – Spontaneous Bacterial Peritonitis
- SIBO – Small Intestine Bacterial Overgrowth
- SLL – Small Lymphocytic Lymphoma
- SMBGS – Self-Monitoring Blood Glucose Systems
- TAF – Tenofovir Alafenamide
- TCA – Tricyclic Antidepressants
- TDF – Tenofovir Antifdepressants
- TIB – Targeted Immunomodulatory Biologic
- TRICARE – Healthcare Network
- UF – Uniform Formulary
- VMAT2 – Vesicular Monamine Transporter Type 2
- XR – Extended Release

January 3, 2019

Colonel Paul J. Hoerner
U.S. Air Force
Beneficiary Advisory Panel Chair
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042
Email: dha.ncr.health-it.mbx.bapreguests@mail.mil

Re: Uniform Formulary Beneficiary Advisory Panel meeting January 10, 2019 [FR Doc No: 2018-26188]

Dear Colonel Hoerner,

Thank you for your work to improve health care access and quality for our nation's active duty service members and their families. The Restless Legs Syndrome Foundation is aware that you will be conducting a therapeutic class review for neurological agents associated with movement disorders. As you work to provide advice and recommendations on the development of the uniform formulary in this regard, please consider the use of low total daily doses of opioid therapies for the treatment of refractory restless legs syndrome (RLS).

Restless Legs Syndrome (RLS) is a neurological movement disorder that causes very uncomfortable sensations in the legs, accompanied by an uncontrollable urge to move them. Symptoms are produced from deep and can drastically disrupt a patient's ability to sleep and live normally. The profound sleep loss often puts RLS patients at risk for developing heart attacks, strokes, significant depression and suicidal ideation, and even Alzheimer's disease. It is a life-long disease, and treatments are imperfect.

Current treatment recommendations for RLS include several medications that do not provide life-long relief. For many patients, after months or a few years of relief, some prescribed medications actually worsen the disease, a phenomenon called "augmentation." When this occurs, low-total daily doses of opioid medications such as methadone are the *only* effective treatment option available. Research continues to show that addiction and dependence are not common complications for affected individuals, as the total daily doses of opioids used to manage RLS is quite low. It is also important to note that RLS is not a chronic pain condition. When indicated, opioids are used to treat underlying neuropathology issues, not a sensation of pain.

As you work with the committee to identify recommendations for the uniform formulary in this regard, please consider indicating low total daily doses of opioid therapies for the treatment of refractory RLS. For more information on the appropriate indication for these therapies, please see the attached mayo clinic treatment guidelines, which reflects the consensus recommendations of the RLS clinical community. If you have any questions, please contact the Foundation's Washington Representatives, Dale P. Dirks and Peter Herzog, at herzog@hmcw.org or (202) 544-7499.

Sincerely,

Karla Dzienkowski
Executive Director
Restless Legs Syndrome Foundation

STATEMENT OF

Ceciel T. Rooker
President

ON BEHALF OF
The International Foundation for Gastrointestinal Disorders (IFFGD)
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IN RESPONSE TO
Docket No: 2018-26188

SUBMITTED TO
Designated Federal Officer of the TRICARE Beneficiary Advisory Panel (BAP)
Colonel Paul J. Hoerner
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SUBMITTED ON
The 13th Day of December, 2018

SUMMARY

The International Foundation for Gastrointestinal Disorders (IFFGD) commends TRICARE and the Beneficiary Advisory Panel (BAP) for ensuring that those who have pledged themselves in service to the American people and their families are provided with access to necessary treatments and medical care.

Established in 1991, IFFGD is a patient-driven nonprofit organization dedicated to assisting individuals affected by chronic gastrointestinal (GI) illnesses by providing education and support for patients, the family members, healthcare providers, and the public. IFFGD also works to advance critical research aimed at broadening our understanding of the basic mechanisms and clinical care of these conditions and providing patients with better treatment options, and perhaps one day, cures. IFFGD has worked closely with the Department of Defense (DoD) to encourage and support research into GI illnesses affecting active service personnel and veterans, including the Gulf War Illness Research Program (GWIRP).

Today, I am writing to you regarding Docket No. 2018-26188 for "Uniform Formulary Beneficiary Advisory Panel; Notice of Federal Advisory Committee Meeting" to discuss the TRICARE formulary, including "Gastrointestinal-2 Agents – Miscellaneous" and "Gastrointestinal-2 Agents – CIC and IBS-C."

We applaud the efforts of the BAP to provide advice and recommendations on the development of the TRICARE Uniform Formulary and the drugs and supplies covered by this program. We are especially grateful for the guidance of the BAP regarding drugs and other therapies for GI illnesses, including

constipation predominant irritable bowel syndrome (IBS-C) and chronic idiopathic constipation (CIC). IBS-C and CIC are among the most common GI disorders in the general population, striking all demographic groups and resulting in significant human suffering and disability. As "functional disorders," IBS-C and CIC affect the way the muscles and nerves of the bowel work, but the bowel itself does not appear to be damaged on medical tests. Without a definitive diagnostic test, many cases of IBS-C and CIC go undiagnosed or misdiagnosed, sometimes for years. It is not uncommon for those affected to undergo unnecessary treatment courses or even surgical procedures before receiving a proper diagnosis and appropriate care. And even after diagnosis, treatment options are limited, and treatment effectiveness varies widely from patient to patient or even for a single patient over his or her lifespan. Adding to the complexity of these conditions, comorbidities affecting both the GI tract and other systems are common in IBS and CIC. Other functional GI disorders, including functional chest pain, heartburn, dyspepsia, and/or abdominal pain, are common in individuals with IBS-C and CIC and those with IBS-C are more likely to also have other pain-related disorders, including migraine headache, fibromyalgia, and chronic pelvic pain compared with the general population (Whitehead WE, et al. 2002. https://doi.org/10.1053/gast.2002.32392; Frissora CL & Koch KL. 2005. https://doi.org/10.1007/s11894-005-0018-9).

Because of the heterogenous nature of these disorders, research has found that patients respond best to a personalized approach tailored to their predominant symptoms, symptom severity, responsiveness to treatment, and vulnerability to adverse effects (Chey WD, et al. 2015. https://doi.org/10.1001/jama.2015.0954; Ford AC, et al. 2017; https://doi.org/10.1056/NEJMra1607547). No one treatment pathway will effectively address the needs of all patients, and long-term solutions often require a combination of treatment approaches. For this reason, it is critical that patients have access to a variety of approved treatments, both brand name and generic.

We urge the BAP to consider the complexity, heterogeneity, and impact of chronic GI disorders, such as IBS-C and CIC, when evaluating the drugs and supplies covered by the TRICARE Uniform Formulary and ensure that a wide range of drugs and other treatments are covered.

We thank you for the consideration of our comments and welcome the opportunity to work in conjunction with the DoD and TRICARE to obtain input from patients on issues of coverage for military personnel, retirees, and their families.

Colonel Paul J Hoerner, USAF
7700 Arlington Blvd, Suite 5101
Falls Church, VA 22042-5101
dha.ncr.j-6.mbx.baprequests@mail.mil

December 21, 2018

Dear Mr. Hoerner,

Pursuant to 41 CFR 102-3.140, Dermira is providing this written statement to the Uniform Formulary Beneficiary Advisory Panel (BAP) in response to the proposed Department of Defense Phamacy and Therapeutics Committee recommendations for QBREXZA™ (glycopyrronium) cloth, which will be reviewed at the January 10th BAP meeting.

The Department of Defense Pharmacy and Therapeutics Committee recommendation to require patients to have 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) before initiating QBREXZA is inconsistent with current treatment algorithms, prescribing information, and available scientific evidence. Dermira kindly requests that the following information be considered when determining potential prior authorization criteria for QBREXZA:

1) QBREXZA is recommended as **first-line therapy** for primary axillary hyperhidrosis in the treatment algorithm published by the International Hyperhidrosis Society (IHHS).[1] This algorithm was developed by the IHHS, in close collaboration with its Board of Directors (composed of leading dermatologists and researchers in the field of hyperhidrosis).

   The treatment algorithm recommends initiating therapy with topical antiperspirants (aluminum and zirconium salts) or glycopyrronium cloth. If satisfactory response is achieved, continue treatment. If no response is observed, the next step is onabotulinumtoxin A injections, glycopyrronium cloth (if not treated initially with this therapy), or microwave thermolysis. If no response is achieved with any of these therapies, systemic medications such as anticholinergics (e.g., glycopyrrolate, oxybutynin, propantheline, propranolol, clonidine, diltiazem) may be added. If no response is noted, local sweat gland ablation (e.g., curettage or liposuction) may be tried. If still no response is observed, endoscopic thoracic sympathectomy (ETS) can be considered. Prior to ETS, patients should be educated to fully understand the possibility of limited efficacy and the risks of complications, including but not limited to, compensatory sweating.[1]

2) Three treatments have been approved or cleared for use by the Food and Drug Administration (FDA) for the treatment of primary axillary hyperhidrosis—QBREXZA, BOTOX, and miraDry.[2,3,4] **Iontophoresis, oral anticholinergics (e.g., glycopyrrolate, oxybutynin, propantheline), propranolol, clonidine, and diltiazem are not approved by the FDA for treatment of primary axillary hyperhidrosis.**

3) **BOTOX is indicated for severe axillary hyperhidrosis that is inadequately managed by topical agents** in adult patients according to the Prescribing Information for the product.[4] In contrast, the Prescribing Information for QBREXZA does not require patients to fail any other therapies before initiating the product.[2]

4) **QBREXZA is the only treatment for primary axillary hyperhidrosis that is FDA-approved for use in pediatric patients (9 years of age or older).[2]** BOTOX and miraDry are only indicated for use in adults aged 18 years of age and older.[3,4]

5) **Evidence to support use of iontophoresis and oral anticholinergics for the treatment of hyperhidrosis was considered limited, of low quality and at high or unclear risk for bias** according to a recent systematic review published by Wade, et al. in the British Journal of Dermatology.[5] The authors concluded that insufficient evidence is available regarding the relative efficacy and safety of these products for primary hyperhidrosis.[5]

Based on the information provided above, patients suffering from primary axillary hyperhidrosis would not be well served if they were required to try and fail the therapeutic options listed in the proposed Department of Defense Pharmacy and Therapeutics Committee recommendations for QBREXZA. Dermira asks that the advisory panel reconsider the proposed primary authorization criteria for QBREXZA.

Dermira, Inc. recommends the use of QBREXA only in accordance with the Food and Drug Administration (FDA)-approved Prescribing Information. Please refer to the full QBREXZA Prescribing Information for approved product labeling and the Important Safety Information. The medical information presented is intended as information to healthcare professionals in clinical practice within the United States and not as medical advice.

Indications and Usage
Qbrexza is an anticholinergic indicated for topical treatment of primary axillary hyperhidrosis in adults and pediatric patients 9 years of age and older.

Important Safety Information
Please see Important Safety Information in the enclosed Qbrexza Prescribing Information for complete product information, including Contraindications, Warnings, and Precautions.

Please contact me should you require additional information.

Sincerely,

Kristen Mosdell, Pharm.D.
Ex. Dir, Medical Information
650-395-0386
Kristen.Mosdell@Dermira.com

References:

1. International Hyperhidrosis Society. Primary focal hyperhidrosis. https://www.sweathelp.org/treatments-hcp/clinical-guidelines/primary-focal-hyperhidrosis.html. Accessed Dec 19, 2018.
2. QBREXZA™ (glycopyrronium) cloth, 2.4% [prescribing information]. Dermira, Inc. Menlo Park, CA. 2018.
3. miraDry®. Miramar Labs, Inc., Santa Clara, CA. Available at: https://miradry.com/about-miradry/. Accessed Dec 19, 2018.
4. BOTOX® (onabotulinumtoxinA) [prescribing information]. Allergan USA, Inc., Madison, NJ. 2018.
5. Wade R, Llewellyn A, Jones-Diette J, et al. Interventional management of hyperhidrosis in secondary care: a systematic review. *Br J Dermatol* 2018;179:599-608.

INTERNATIONAL HYPERHIDROSIS SOCIETY
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January 3, 2019

Colonel Paul J. Hoerner, USAF
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042–5101
(via email: dha.ncr.j-6.mbx.baprequests@mail.mil)

Dear Colonel Hoerner:

The International Hyperhidrosis Society is at your service to provide any background, deeper understanding and support as your Department reviews new drug coverage for service members and their families who suffer from hyperhidrosis.

By way of introduction, hyperhidrosis is excessive and uncontrollable sweating that is four to five times greater than what is needed for thermoregulation, or as a response to stress. Hyperhidrosis presents in childhood years, and is a chronic, lasting condition. It has been shown to cause significant emotional, social and functional impairment.

We applaud your efforts to provide guidance and treatments for sufferers to manage their condition, and realize to their full potential. To this end, we respectfully provide our Treatment Guidelines for Axillary (underarm) Hyperhidrosis. These guidelines were thoughtfully developed and approved by our Board of Directors, who are internationally-renowned physician leaders in hyperhidrosis research, care and advocacy. The design of the algorithm is to carefully balance benefit and risk so that patients and their caregivers are given the opportunity to have optimal outcomes based on their individual response to treatments, and combinations of therapies. We also provide this guideline so that any clinician can provide diagnosis and treatment, thus enabling sufferers access to care through their preferred provider. With a stigmatized condition such as hyperhidrosis, relationship and comfort is critically important.

We stand at the ready to provide anything whatsoever that may support your investigation and evaluation. It is our life's work to alleviate the struggles of those living with hyperhidrosis and we are indebted to you for recognizing the importance of providing such care.

Respectfully yours,

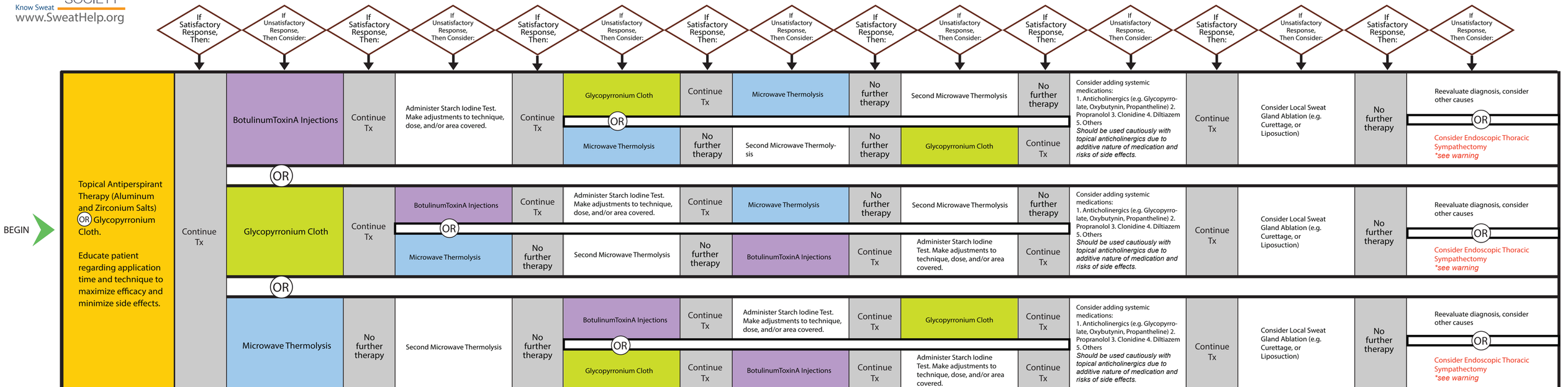
Lisa J Pieretti
Co-Founder, Executive Director

Attachment: Axillary IHhS Algorithm 2018 PDF

INTERNATIONAL HYPERHIDROSIS SOCIETY
Know Sweat
www.SweatHelp.org

Primary Axillary Hyperhidrosis

To maximize efficacy and minimize side effects, consider combination therapy adjusted to patient needs, preferences and disease presentation.



Updated: September 23, 2018

*Patients must be carefully selected and educated to fully understand the possibility of limited efficacy and the risks of complications including, but not limited to, compensatory sweating.