EXECUTUVE SUMMARY

Uniform Formulary Beneficiary Advisory Panel (BAP)
June 24, 2020

UNIFORM FORMULARY DRUG CLASS REVIEWS

I. NEWLY APPROVED DRUGS PER 32 CFR 199.29(g)(5) PRESENTATION

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

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

- UF:

  a. antihemophilic factor (recombinant) glycoPEGylated-exei (Esperoct) injection – Antihemophilic Factor; new recombinant pegylated formulation of factor VIII

  b. avapritinib (Ayvakit) – Oncological agent for gastrointestinal stromal tumors (GIST)

  c. cenobamate (Xcopri) – Anticonvulsants-Antimania Agents; for partial-onset seizures

  d. diazepam nasal spray (Valtoco) – Anticonvulsants-Antimania Agents; new nasal spray formulation of diazepam for seizures

  e. metformin ER suspension (Riomet ER) – Diabetes Non-Insulin Drugs, Biguanides; new extended-release oral suspension formulation of metformin

  f. peanut (Arachis hypogaea) Allergen Powder-dnfp (Palforzia) – Miscellaneous Immunologic Agent for peanut allergy

  g. rimegepant orally disintegrating tablet (Nurtec ODT) – Migraine agent for acute treatment of migraine

  h. tazemetostat (Tazverik) – Oncological agent for epithelioid sarcoma

- NF:

  a. bempedoic acid (Nexletol) – Antilipidemic I (LIP-1) approved as an adjunct to a statin to reduce low density lipoprotein (LDL) cholesterol

b. cetirizine 0.24% ophthalmic solution (Zerviate) – Ophthalmic Allergy Drugs; new ophthalmic formulation of cetirizine

c. lasmiditan (Reyvow) – Migraine Agent for acute treatment of migraine

d. teriparatide (Bonsity) injection – Osteoporosis Agents: Parathyroid Hormone, a biosimilar of Forteo for osteoporosis

e. ubrogepant (Ubrelvy) – Migraine Agent for acute treatment of migraine

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

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

a. Applying the same manual PA criteria to new and current users of Bonsity that currently applies to Forteo and Tymlos.

b. Applying manual PA criteria to new and current users of Reyvow and Zerviate.

c. Applying manual PA criteria to new users of Ayvakit, Caplyta, Nexletol, Nurtec ODT, Palforzia, Tazverik, and Ubrelvy.

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

1. teriparatide injection (Bonsity)

Manual PA criteria applies to all new and current users of Bonsity.

Bonsity is approved if all criteria are met:

- The provider acknowledges that Forteo is the Department of Defense's preferred osteoporosis parathyroid hormone (PTH) analog; the patient must try and fail Forteo prior to use of Bonsity
- Patient is ≥ 18 years old
- The drug is prescribed for treatment of osteoporosis and not for prevention of osteoporosis.
- Patient has one of the following diagnoses:
    - Patient is a postmenopausal female with osteoporosis; OR
    - Patient is a male with primary or hypogonadal osteoporosis; OR

- Patient is a male or female with osteoporosis associated with sustained systemic glucocorticoid therapy (e.g., more than 6 months use of greater than 7.5 mg/day of prednisone or equivalent) AND

- The patient has one of the following:

  - A high risk for fracture due to history of osteoporotic fracture, OR
  - Has multiple risk factors for fracture (e.g., a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)

- Patient has a documented bone mineral density (BMD) with T-score of -2.5 or worse

- Patient is able to take calcium and vitamin D supplements and will continue throughout therapy

- Patient has tried and experienced an inadequate response to, has had therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (e.g., alendronate (Fosamax), ibandronate (Boniva))

- Patient does not have an increased risk for osteosarcoma

- Cumulative treatment with Bonsity, Tymlos, and/or Forteo must not exceed 24 months during the patient's lifetime

Non-FDA approved uses are not approved.

PA expires in 24 months.

2. lumateperone (Caplyta)

Manual PA is required for all new users of Caplyta.

Caplyta is approved if <u>all</u> criteria are met:

- Age ≥ 18 years

- Patient has a diagnosis of schizophrenia
- Patient has tried and failed at least TWO formulary atypical antipsychotics (e.g. risperidone (Risperdal), aripiprazole (Ability), lurasidone (Latuda), quetiapine (Seroquel))

- Drug is prescribed by or in consultation with a psychiatrist

Non-FDA-approved uses are not approved including disorders, depression, and other neuropsychiatric and neurological disorders.

PA does not expire.

3. bempedoic acid (Nexletol)

Manual PA is required for all new users of Nexletol.

Nexletol is approved if all criteria are met:

- The drug is prescribed by a cardiologist, endocrinologist or lipidologist (e.g., provider is certified through the National Lipid Association or similar organization) AND

- The patient has tried a Department of Defense preferred statin with similar LDL lowering (moderate or low intensity; including atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin or simvastatin) at maximal doses and has not reached LDL goal OR

- The patient has tried a Department of Defense preferred statin with similar LDL lowering (moderate or low intensity; including atorvastatin (Lipitor), fluvastatin (Lescol), lovastatin (Mevacor), pravastatin (Pravacol), rosuvastatin (Crestor) or simvastatin (Zocor)) at maximal doses and has been unable to tolerate it due to adverse effects AND

- The patient will continue on statin therapy, consistent with the package labeling.

Non-FDA-approved uses are not approved.

PA does not expire.

4. cetirizine 0.24% ophthalmic solution (Zerviate)

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

Zerviate is approved if <u>all</u> criteria are met:

- The patient has ocular symptoms of allergic conjunctivitis AND

    - The patient has tried and failed TWO of the following formulary alternatives in the last 90 days, olopatadine 0.1%(generic Patanol), olopatadine 0.7% (Pazeo), azelastine (generic Optivar), or epinastine (generic Elestat) OR
    - The patient has experienced intolerable adverse effects to at least TWO of the following formulary alternatives, olopatadine 0.1%, olopatadine 0.7% (Pazeo), azelastine, or epinastine

Non-FDA-approved uses are not approved.

PA does not expire.

5. peanut (Arachis Hypogaea) Allergen Powder-dnfp (Palforzia)

Manual PA is required for all new users of Palforzia.

Palforzia is approved if all criteria are met:

- Palforzia is prescribed by an allergist or immunologist , or in consultation with an allergist or immunologist, and the provider has satisfied the requirements of the REMS program
- The patient is between the ages of 4 to 17 years
- The patient has a documented history of peanut allergy
- The patient has a history of diagnostic evidence of peanut allergy, including either serum IgE to peanut of ≥0.35 kUA/L (serum testing) and/or positive skin prick test (SPT) for peanut ≥ 3 mm greater than negative control
- The patient does not have uncontrolled asthma; eosinophilic esophagitis or other eosinophilic gastrointestinal diseases
- The patient has not had severe or life-threatening anaphylaxis within the previous 60 days prior to starting therapy
- Provider acknowledges that the patient will be counseled on the following:
    - Avoiding peanut ingestion
    - The need for access to an epinephrine injector
    - Palforzia is not intended to treat emergencies

Non-FDA-approved uses are not approved.

PA does not expire.

6. lasmiditan (Reyvow)

Manual PA is required for all new and current users of Reyvow.

Reyvow is approved if all criteria are met:

- Age ≥ 18

- Reyvow is prescribed by or in consultation with a neurologist
- Reyvow is not approved for patients who have history of hemorrhagic stroke
- Reyvow is not approved for patients with a history of epilepsy or any other condition with increased risk of seizure
- The patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications
    - sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), eletriptan (Relpax)
- The patient has had a contraindication to, intolerability to, or has failed a 2-month trial of Nurtec ODT
- If Reyvow is used with a triptan, provider acknowledges Reyvow and the triptan should not be used within 24 hours of each other
- Reyvow will be used with caution in patients with low heart rate and/or those using beta blockers, such as propranolol

Non-FDA-approved uses are not approved.

PA does not expire.

7. rimegepant orally disintegrating tablet (Nurtec ODT)

Manual PA criteria apply to all new users of Nurtec ODT.

Nurtec ODT is approved if all criteria are met:

- Age ≥ 18
- Nurtec ODT is prescribed by or in consultation with a neurologist
- Nurtec ODT is not approved for patients who have clinically significant or unstable cardiovascular disease
- The patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications
    - sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), eletriptan (Relpax)

- Concurrent use with any other small molecule CGRP targeted medication (i.e., including Ubrelvy or another “gepant”) is not allowed

Non-FDA-approved uses are not approved.

PA does not expire.

8. ubrogepant (Ubrelvy)

Manual PA is required for all new users of Ubrelvy.

Ubrelvy is approved if all criteria are met:

- Age ≥ 18
- Ubrelvy is prescribed by or in consultation with a neurologist
- Ubrelvy is not approved for patients who have clinically significant or unstable cardiovascular disease
- The patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications
    - sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), eletriptan (Relpax)
- Patient has had a contraindication to, intolerability to, or has failed a 2-month trial of Nurtec ODT
- Concurrent use with any other small molecule CGRP targeted medication (i.e., including Nurtec ODT or another “gepant”) is not allowed

Non-FDA-approved uses are not approved

PA does not expire.

9. avapritinib (Ayvakit)

Manual PA applies to new users of Ayvakit.

Ayvakit is approved if all criteria are met:

- Patient must be ≥ 18 years
- Ayvakit is prescribed by or in consultation with a hematologist/oncologist

- Patient has pathologically confirmed unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation with or without the D842V mutation

- Provider agrees to monitor for intracranial bleeding and other central nervous system adverse effects

- Female patients of childbearing age are not pregnant confirmed by (-) HCG

- Female patients will not breastfeed during treatment and for at least 2 weeks after the cessation of treatment

- Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 6 weeks after the cessation of therapy

- The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis: _____.

Non-FDA-approved uses are not approved except as noted above.

PA does not expire.

10. Tazemetostat (Tazverik)

Manual PA criteria apply to all new users of Tazverik.

Tazverik will be approved if all criteria are met:

- Patient must be ≥ 16 years

- Tazverik is prescribed by or in consultation with a hematologist/oncologist

- Patient has pathologically confirmed metastatic or locally advanced epithelioid sarcoma not eligible for complete resection

- Patient will be monitored for secondary malignancies (especially. T-cell lymphoblastic lymphoma, myelodysplastic syndrome, and acute myeloid leukemia)

- Female patients of childbearing age are not pregnant confirmed by (-) HCG.

- Female patients will not breastfeed during treatment and for at least 1 week after the cessation of treatment

- Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 3 months after cessation of therapy for males and 6 months for females

- The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis: _____.

Non-FDA approved uses are not approved except as noted above.

PA does not expire.

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

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

- **New Drugs Recommended for UF or NF Status:** An effective date upon the first Wednesday two weeks after signing of the minutes in all points of service.

Summary of Physician's Perspective:

The Committee reviewed 14 new drugs, of which 8 were recommended for UF status, and 6 recommended for NF status. Note that there were no products recommended for Tier 4 status.

Prior authorization criteria will apply to 10 of the drugs. Several of the drugs are in classes where PAs are routine, including the 2 oncology drugs (Ayvakit, Tazverik), and the cholesterol drug (Nexletol).

"No grandfathering", where both new and current users must go through the PA was recommended for 2 products. For the osteoporosis drug Bonsity, the class has existing PA requirements, and this drug has the same active ingredient as Forteo, the preferred product. The ophthalmic allergy drug Zerviate also has no grandfathering, as it is no more effective than other products, and requires twice daily dosing.
For the peanut allergy drug (Palforzia), PA was recommended due to safety reasons, as the patient must have an EpiPen available and continue to avoid ingesting peanuts. We did allow grandfathering here, because if there is an interruption of therapy, the patient must re-start the titration process. However, as of June 10th, there have not been any prescriptions yet for this product.

The antipsychotic drug, Caplyta, was recommended for NF status, but the PA will allow for grandfathering. The product has no compelling advantages over the formulary products, and was no more effective than risperidone. As of June 10th there are 6 patients on this drug.

There are 3 new oral drugs evaluated at this meeting that are approved to treat a migraine headache (Nurtec, Ubrelvy, and Reyvow). Other drug classes, including the triptans, are very effective and widely used for this same indication, at a much lower cost than these new products. Recall that all new drugs are placed in a nonformulary status, pending review by the Committee until otherwise placed on the formulary, by the Director, DHA. One of the drugs, Nurtec, was recommended to revert to formulary status, to allow use in patient who can't take triptans.

- The Committee recommended that all 3 new migraine drugs would require a PA, showing that the patient has tried 2 triptans, or has a contraindication to a triptan, such as cardiovascular disease. This is in line with other commercial health care plans that require use of the cost effective triptans before these new products are used. A review of PAs from several commercial plans, including United Healthcare and Medical Mutual, found that they were more restrictive than DoD, as a trial of three triptans is required. The Committee chose to have these products available as Formulary or Nonformulary, and did not elect to move any to Tier 4 status.

- No grandfathering, was recommended for Reyvow due to safety issues, including the fact that it can cause significant driving impairment up to 8 hours after administration; it is a controlled substance with a potential for dependence; and it can slow down the heart rate. Additionally, the potential impact on readiness for our active duty members is a concern with Reyvow.

- We did receive public comment from two organizations, the Headache and Migraine Policy Forum, and the Alliance for Patient Access. These letters were emailed to you. To summarize, the letters centered around ensuring patients having access to these 3 new migraine drugs.

    1) The DoD P&T Committee recognizes the importance of patient advocacy and ensures that the issue of patient access is discussed as part of the formulary and PA recommendations.

    2) All newly approved drugs are designated as nonformulary when they are launched, pending the decision of the Director. A review of prescription claims does show utilization for all three agents, therefore we have not prevented access to these drugs and in fact we are increasing access to these drugs with the formulary recommendation.

    3) The P&T Committee's recommendations align with the overall mission of the MHS to ensure readiness, better health, better outcomes, and better spending.

Summary of Panel Questions and Comments:

Mr. Hostettler asked about the mechanism of action for the new migraine products. What is the efficacy of the newer products in comparison to the triptans?

CDR Raisor responded there were no head-to-head trials between the new oral CGRP and triptans, but there was comparative analysis conducted by ICER that looked at their effectiveness. Their conclusion shows that triptans were more effective unless the patient had contraindications using the triptans. The new oral CGRP and lasmiditan were less effective than triptans.

Mr. Hostettler inquired about the adverse effects of the triptans in comparison to the newer products. The newer products appear to have less adverse effects than the triptans. There is a history of cardiovascular and other risks with the triptans.

CDR Raisor commented, I'd like to highlight there were no head-to-head trials comparing the triptans with the newer agents. Of the newer agents, Reyvow has more adverse events with blood pressure lowering and risk of driving impairment. It was noted that patients with driving impairment were unaware of their impairment. He argues that Reyvow has greater side effects. With the oral CGRPs, there were adverse drug events noted during the clinical trials. Granted, these trials were shorter term and we would have preferred longer term data to evaluate the full safety of the products. They did effectively eliminate the most severe cardiovascular patients within those trials with Ubrelvy and Nurtec ODT. Based on the limited trial population which excluded certain cardiovascular high risk patient, the newer agents do have fewer documented cardiovascular risks compared to the triptans.

Mr. Hostettler requested information regarding the utilization of the newer products and the number of patients are impacted by the decision. Especially Reyvow because the decision impacts new and current users? If I am not mistaken, the decision for Ubrelvy and Nurtec ODT Nurtec only affects new users.

CDR Raisor responded there are 70 current users for Reyvow, 217 for Nurtec ODT, and 1206 for Ubrelvy.

Mr. Hostettler said it seems the providers have chosen Ubrelvy but the Committee chose the others for formulary rather than non-formulary. Other than cost, were there any clinical reason for placing Ubrelvy as NF and Nurtec ODT as formulary?

CDR Raisor responds that every drug that the Committee reviews there is a clinical and cost analysis. It's a composite of clinical and cost review that drives the decision. Ubrelvy was the first to market and launch. Historically, often the first to launch has an advantage in the number of patients on the drug in the initial analysis.

Comments regarding the PA criteria:

Mr. Hostettler stated that he'd like to see what the possibility is that Ubrelvy - which seems to be, for whatever reason, maybe because it was the first to market, and if that is the reason, I don't know. I would hope doctors would make a better decision than ones based on first to market. Is there anyway Ubrelvy would not have to go through an extra step after failing two Triptans. Once the provider/patient makes a decision that the

triptans have failed, moving on to the product with the highest utilization could be used and might make good clinical sense...maybe Ubrelvy would be in the non-formulary cost bucket (tier 3) but have the opportunity to be used behind the triptans. Just putting the question out there as a suggestion.

Dr. Khoury stated that the comment will be is taken for the record as he is unable to make a modification of that type at this point.

Comments regarding the Implementation Plan:

Mr. Hostettler states there were 200 patients on the migraine product that has new and current users. The implementation plan will go into effect 2 weeks after the signing of the minutes. Is this enough time to notify the affected population?

Dr. Khoury clarifies that the question is whether to grandfather patients and/or delay the implementation. As previously stated, there is no grandfathering for Reyvow. The total population affected by the Reyvow decision is 70 patients, new and current users, not 200. The recommendation impacts new and current users because there is a safety concern for this population from the Committee's judgement. Due to the safety concern, the Committee believes it is important to implement as soon as feasible.

Mr. Hostettler asked can we expedite the notification of the change to the affected population.

Dr. Khoury responded that there is no way to expedite the notification due to the short time frame of 2 weeks.

Mr. Hostettler stated that he is concerned that patients will show up at the Pharmacy for a refill and be turned away because they had no notification of the new PA. He is further concerned that the implementation plan does not allow the patient time to make an appointment with their provider to make the change before the treatment is needed.

Dr. Khoury responded the Committee considers how the implementation plan will impact patient's access as part of every decision. It is a balance of ensuring there is access to the medication from the cost perspective and trying to implement the decision as soon as feasible. In this case, the safety concern for Reyvow was pressing enough that the committee was concerned about the safety over the delay. Keep in mind, the patient may not have followed the proper protocols to select this agents and there are readiness concerns for this population that is consistent with the data showing an adverse effect of driving impairment. I understand the concern about having somebody show up at the pharmacy for a refill, but the Committee is concerned with readiness of the active duty patients and readiness superseded ensuring rapid access to the product. The committee wants to make sure the patient is on an appropriate therapy that ensures readiness and safety in addition to all the other clinical and cost-effectiveness concerns that were part of the analysis.

Mr. Hostettler stated that it appears the 70 patients have been identified. You would know the active duty and could deal with those very easily since they're in your population and at hand.

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

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

  - *Mr. Hostettler asked is there anyway Ubrelvy would not have to go through an extra step after failing two Triptans.*

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

  - *Mr. Hostettler non-concurs with Reyvow but has not issues or concerns with the Nurtec ODT and Ubrelvy. The implementation plan for Reyvow should be a longer time frame to make sure to notify patients that they may go without their medicine. That don't see their provider again.*

  Director, DHA:

  _____These comments were taken under consideration prior to my final decision.

Appendices:

- Appendix 1– Brief list of Acronyms used in this Summary
- Appendix 2: Private Comments: The Alliance for Patient Access.
- Appendix 3: Private Comments: The Headache and Migraine Policy Forum

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.

- BAP – Beneficiary Advisory Panel
- BCF – Basic Core Formulary
- BMD – Bone Mineral Density
- CDR – Commander
- CFR – Code Federal Regulations
- CGRP – Calcitonin Gene-Related Peptide
- COVID-19 – Corona Virus Disease 2019
- DFO – Designated Federal Officer
- DHA – Defense Health Agency
- DoD – Department of Defense
- FACA – Federal Advisory Committee Act
- FMB – Formulary Management Branch
- GIST – Gastrointestinal Stromal Tumors
- HCG – Human Chorionic Gonadotropin
- LDL – Low Density Lipoprotein
- LIP-1 – Antilipidemic I
- NCCN – National Comprehensive Cancer Network
- NF – Non-Formulary
- ODT – Orally Disintegrating Tablet
- P&T – Pharmacy and Therapeutics
- PA – Prior Authorization
- PDGFRA – Platelet-Driven Growth Factor Receptor Alpha
- PTH – Parathyroid Hormone
- SPT – Skin Prick Test
- UF – Uniform Formulary

Alliance for Patient Access

June 17, 2020

Colonel Paul J. Hoerner
Beneficiary Advisory Panel
Defense Health Agency (DHA)
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042

Re: Review of Acute Therapies for Migraine Disease

Dear Colonel Hoerner:

On behalf of the Alliance for Patient Access (AfPA) and our clinician members, I am writing regarding the DoD Pharmacy and Therapeutics (P&T) Committee coverage review for acute therapies for migraine disease. We appreciate the opportunity to provide comment in advance of the Beneficiary Advisory Panel meeting and respectfully urge the Committee to recommend including the full range of acute migraine therapies on the Uniform Formulary.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the physician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA's Headache and Migraine Disease Working Group, a unique network of clinicians treating headache and migraine disease, works to ensure that the clinician's perspective informs policy discussions around care for patients living with headache disorders or migraine disease.

As you know, headache and migraine disease is debilitating, negatively impacting patients' ability to live, work, and perform daily tasks. This disease robs patients of their quality of life and comes with significant co-morbidities, including anxiety and depression. Migraine disease also has a substantial negative impact on workplaces; United States workers with migraine that manifests more than 15 days a month lose approximately 14% of their annual productivity.[1] Research shows that direct and indirect migraine costs in the U.S. are estimated at $78 billion.[2] Therefore, innovative treatments such as the acute therapies under consideration hold immense promise for these patients.

It has come to our attention that the P&T Committee has recommended limited coverage for new acute migraine therapies, including – with step therapy requirements – only one acute therapy on its Uniform Formulary, while considering several others "non-formulary," only available after additional step therapy requirements. We are very concerned that these recommended restrictions will hinder access

[1] JOEM. 2010;52:8.

[2] Gooch C, Pracht E, Borenstein A. The burden of neurological disease in the United States: A summary report and call to action. Ann Neurol. 2017;81:479-484.

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to effective, FDA-approved and appropriate treatments for patients; as such, we urge you to reconsider this proposal. Limiting treatment options would place an undue burden on patients already managing a debilitating condition and, in many cases, lead to disease chronification and additional health care expenditures.

Allowing access to all treatment options will allow more opportunities for a patient-centered care approach, one that allows for tailored treatment of each patient and their individual needs. A patient-centered approach gives the ability to change course, as needed, and allows patients the opportunity to access innovative medications that could drastically improve their quality of life – but it is only possible by providing patients and clinicians with the full range of treatment options.

On behalf of the Alliance for Patient Access and our clinician members, I urge you to ensure that the full range of acute therapies for migraine disease are included on the Uniform Formulary. Doing so will support timely access to appropriate medical care for military personnel and their families and support a patient-centered system of care.

Thank you for the opportunity to provide comment and we appreciate your attention to this matter. If AfPA can provide further details or be of assistance in this matter, please contact us at 202-499-4114.

Sincerely,

Josie Cooper
Executive Director

June 17, 2020

Colonel Paul J. Hoerner
Beneficiary Advisory Panel
Defense Health Agency (DHA)
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042

Via Email

Re: Beneficiary Advisory Panel Consideration of Acute Treatments for Migraine Disease

Dear Colonel Hoerner:

The Headache and Migraine Policy Forum (HMPF) is a national stakeholder coalition of more than two dozen patient, clinician, and research organizations that seek to advance public policies and practices that promote accelerated innovation and improved treatments for persons living with headache disorders and migraine disease. HMPF also works to ensure access to appropriate prevention and treatment options for all patients and has a practice of making comment on policy and coverage determinations that impact patient access and safety. On behalf of our stakeholder members, we appreciate the opportunity to comment on the findings of the DoD Pharmacy and Therapeutics ("P&T") Committee meeting on May 6th, specifically in regard to new acute therapies for the treatment of migraine disease. We are hopeful that the Beneficiary Advisory Panel will recognize the value in providing patients access to the full range of acute treatment options their physician may prescribe rather than forcing active duty military members and their beneficiaries to undergo onerous step therapy.

Migraine Disease is Disproportionately Burdensome to TriCare Recipients and Has a Substantial Impact on the Health and Readiness of Our Active Military.

Without question, migraine disease places a disproportionately high disease burden on the health of our servicemen and women and their families.[1] The prevalence of migraine attacks occur in roughly 1 out of every 7 Americans annually, approximately 1.5 million of the lives covered by active duty TriCare members and

[1] Concussion in the Military: an Evidence-Base Review of mTBI in US Military Personnel Focused on Posttraumatic Headache. Holtkamp MD, Grimes J, Ling G.Holtkamp MD, et al.Curr Pain Headache Rep. 2016 Jun;20(6):37. doi: 10.1007/s11916-016-0572-x.Curr Pain Headache Rep. 2016.PMID: 27084376Review.

their beneficiaries.[2] Moreover, the relationship of traumatic brain injury and concussion in the military is well-known; post-traumatic headache is the most common symptom after TBI in US service members, most often presenting as migraine-like headaches. For example, in a study of new patients seen between August 2008 and December 2009 assessed by a civilian headache specialist at the TBI Center at Womack Army Medical Center, Fort Bragg, NC, it was found that more than two-thirds of subjects recalled the onset of headache within 7 days of injury and the most commonly diagnosed headache was a continuous type with migraine features (n = 31 (18.7%)).[3]

Military personnel are also likely to encounter numerous physiological and psychological factors that are known to precipitate migraine attacks and exacerbate migraine disease. The factors include disrupted sleep and meal patterns, fatigue, psychological stress, emotional strain, heat, noise and other environmental exposures. The effects of migraine have specific consequences for military personnel in that migraine can impair their ability to function and may result in soldiers being non-deployable or discharged from military service.[4] Finally, the U.S. active-duty military population is composed chiefly of young adults, which is the age group at highest risk for migraine. Unsurprisingly, therefore, the reported rates are higher than those of similar age and gender in the general U.S. population.

The Beneficiary Advisory Panel Should Recommend the P&T Committee Provide Parity of Coverage for All New Acute Treatments for Migraine Disease Rather Than Force Patients to Undergo Burdensome Step Therapy.

We were therefore disappointed to learn that the P&T Committee recommended that migraine patients undergo a burdensome process by which they must first be failed by a two-step triptan therapy and then try one specific type of acute therapy before being able to access the therapy prescribed by the patient's physician. This decision runs contrary to the P&T Committee's mission to meet the clinical needs of DoD beneficiaries in an effective, efficient and fiscally responsible manner. HMPF therefore respectfully urges the Beneficiary Advisory Panel to recommend that the P&T Committee review its decision and instead provide full parity to the new class of medicines for these patients.

Thank you for your further consideration and we would welcome the opportunity to discuss the impact of these policies.

Sincerely,

Lindsay Videnieks, JD
Executive Director
The Headache and Migraine Policy Forum

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[2] The prevalence and burden of migraine and severe headache in the United States: updated statistics from government health surveillance studies, Burch RC, Loder S, Loder E, Smitherman TA.Burch RC, et al.Headache. 2015 Jan;55(1):21-34. doi: 10.1111/head.12482.Headache. 2015.PMID: 25600719Review.

[3] Headache in military service members with a history of mild traumatic brain injury: A cohort study of diagnosis and classification. Finkel AG, Yerry JA, Klaric JS, Ivins BJ, Scher A, Choi YS.Finkel AG, et al.Cephalalgia. 2017 May;37(6):548-559. doi: 10.1177/0333102416651285. Epub 2016 May 20.Cephalalgia. 2017.PMID: 27206963

[4] Wiley-Blackwell. "Army Personnel Show Increased Risk For Migraine; Condition Underdiagnosed, Mistreated." ScienceDaily. ScienceDaily, 28 August 2008. Available at: www.sciencedaily.com/releases/2008/08/080827164041.htm

On behalf of the following co-signers:
Alliance for Balanced Pain Management
Alliance for Patient Access
Association for Migraine Disorders
Chronic Migraine Awareness, Inc.
The Coalition For Headache And Migraine Patients (CHAMP)
The Danielle Byron Henry Migraine Foundation
Golden Graine
Health Union / Migraine.com
HealthyWomen
Hope for Migraine / Migraine Meanderings
Migraine Again
The Migraine Diva
Migraine Pal
Migraine World Summit
Miles for Migraine
National Headache Foundation
SoldierStrong ACCESS
World Health Education Foundation

Uniform Formulary Beneficiary Advisory Panel (BAP)

Meeting Summary
June 24, 2020
Washington, D.C.

Present Panel Members

- Mr. Jon Ostrowski, Non Commissioned Officers Association, Chairperson
- Dr. Richard Bertin, Commissioned Officers Association of the US Public Health Service
- Dr. Karen Dager, Health Net Federal Services
- Mr. John Du Teil, US Army Warrant Officers Association
- Mr. Charles Hostettler, AMSUS, The Society of Federal Health Professionals
- Dr. Joseph McKeon, Humana
- Dr. Jay Peloquin, Express Scripts, Inc.

Absent Panel Members

- None

Agenda

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

- Welcome and Opening Remarks
- Public Citizen Comments
- Therapeutic Class Reviews

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

    a. *antihemophilic factor (recombinant) glycoPEGylated-exei (Esperoct) — Antihemophilic Factor; new recombinant pegylated formulation of factor VIII*

    b. *avapritinib (Ayvakit) — Oncological agent for gastrointestinal stromal tumors (GIST)*

    c. *cenobamate (Xcopri) — Anticonvulsants-Antimania Agents; for partial-onset seizures*

    d. *diazepam nasal spray (Valtoco) — Anticonvulsants-Antimania Agents; new nasal spray formulation of diazepam for seizures*

    e. *metformin ER suspension (Riomet ER) — Diabetes Non-Insulin Drugs, Biguanides; new extended-release oral suspension formulation of metformin*

f. *peanut (Arachis hypogaea) Allergen Powder-dnfp (Palforzia) — Miscellaneous Immunologic Agent for peanut allergy*

g. *rimegepant orally disintegrating tablet (Nurtec ODT) — Migraine agent for acute treatment of migraine*

h. *tazemetostat (Tazverik) — Oncological agent for epithelioid sarcoma*

i. *bempedoic acid (Nexletol) — Antilipidemic I (LIP-1) approved as an adjunct to a statin to reduce low density lipoprotein (LDL) cholesterol*

j. *cetirizine 0.24% ophthalmic solution (Zerviate) — Ophthalmic Allergy Drugs; new ophthalmic formulation of cetirizine*

k. *lasmiditan (Reyvow) — Migraine Agent for acute treatment of migraine*

l. *lumateperone (Caplyta) — Atypical Antipsychotic for schizophrenia*

m. *teriparatide (Bonsity) — Osteoporosis Agents: Parathyroid Hormone, a biosimilar of Forteo for osteoporosis*

n. *ubrogepant (Ubrelvy) — Migraine Agent for acute treatment of migraine*

- Panel Discussion

  The Uniform Formulary Beneficiary Advisory Panel 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 recommendation and vote to accept or reject the recommendations. 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 May 6, 2020.

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 subsequent recommended changes. Comments to the Director, 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 of or with the advance approval of the DFO in consultation with the Chairperson of the Panel.

- To prepare minutes of the proceedings and prepare comments for 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, DHA.

The DFO provided guidance regarding this meeting:

- 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 may be interested in the drug classes selected for review, drugs recommended for the basic core formulary (BCF) or specific pricing data, these topics do not fall under the purview of the BAP.

- The P&T Committee met for approximately 5 hours conducting its reviews of the drug class recommendations presented today. Since this meeting is considerably shorter, the Panel will not receive the same extensive information that is 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 meeting minutes and the Director's decisions will be available on the TRICARE website in approximately four to six weeks.

The DFO provided a few ground rules for conduct during this virtual meeting:

- Due to travel restrictions and guidance provided due to COVID-19, this meeting will be conducted in a remote access format.

- Audience participation is limited to private citizen comments received in writing prior to the meeting.

- Participants will be joined in listen-mode only.

- To ensure there are no disruptions to discussions and as precaution, please mute your phones.

- Panel and presenter guidance: presenters or anyone responding to questions are asked to state their name prior to asking your question or responding.

- The meeting is being recorded. Please speak clearly.

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

- Members of the FMB and P&T are available to answer questions related to the BAPs deliberations. Should a misstatement be made, these individuals may interrupt to ensure that the minutes accurately reflect relevant facts, regulations, or policy.

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

Written statements from were received from the Headache and Migraine Policy Forum and Alliance for Patient Access. The statements forwarded to the Panel for their review and consideration.

Chairman's Opening Remarks

Mr. Ostrowski thanks everyone for being a part of the virtual meeting.

DRUG CLASS REVIEW PRESENTATION

(LT COL KHOURY)

GOOD MORNING. I am Lieutenant Colonel Ronald Khoury, Chief of the Formulary Management Branch (FMB) of the DHA Pharmacy Operations Division. Doctor and retired Army Colonel John Kugler, the Chairman of the Pharmacy and Therapeutics Committee is also here "virtually". Joining us virtually is one clinical pharmacist from the Formulary Management Branch, CDR Scott Raisor. 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:

1) 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.

2) 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: The P&T Committee evaluated 16 newly approved drugs per 32 CFR 199.2(g)(5), which are currently in pending status and available under terms comparable to Nonformulary drugs. Associated prior authorizations (PAs) were also discussed.

The DoD P&T Committee will make a recommendation as to the effective date of the agents being changed from the Uniform Formulary (UF) tier to Nonformulary (NF) 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.

Before we start, I'd like to mention that we held a virtual P&T Committee meeting, due to the COVID-19 pandemic. We shifted the drug classes planned for May to August, and completed the newly approved drugs as required by statute. We'd like to thank the BAP for their flexibility

in adjusting to this situation, as the committee has had to similarly modify their activity in response to this event.

UNIFORM FORMULARY REVIEW PROCESS

I. NEWLY APPROVED DRUGS PER 32 CFR 199.29(g)(5) PRESENTATION

(CDR RAISOR)

A. Newly Approved Drugs per 32 CFR 199.21(g)(5)—Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions

The P&T Committee agreed (16 for, 0 opposed, 0 abstained, 0 absent) with the relative clinical and cost-effectiveness analyses presented for the newly approved drugs reviewed according to 32 CFR 199.21(g)(5).

B. Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF Recommendation

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

- UF:

  a. antihemophilic factor (recombinant) glycoPEGylated-exei (Esperoct) injection – Antihemophilic Factor; new recombinant pegylated formulation of factor VIII

  b. avapritinib (Ayvakit) – Oncological agent for gastrointestinal stromal tumors (GIST)

  c. cenobamate (Xcopri) – Anticonvulsants-Antimania Agents; for partial-onset seizures

  d. diazepam nasal spray (Valtoco) – Anticonvulsants-Antimania Agents; new nasal spray formulation of diazepam for seizures

  e. metformin ER suspension (Riomet ER) – Diabetes Non-Insulin Drugs, Biguanides; new extended-release oral suspension formulation of metformin

  f. peanut (Arachis hypogaea) Allergen Powder-dnfp (Palforzia) – Miscellaneous Immunologic Agent for peanut allergy

  g. rimegepant orally disintegrating tablet (Nurtec ODT) – Migraine agent for acute treatment of migraine

  h. tazemetostat (Tazverik) – Oncological agent for epithelioid sarcoma

- NF:

    a. bempedoic acid (Nexletol) – Antilipidemic I (LIP-1) approved as an adjunct to a statin to reduce low density lipoprotein (LDL) cholesterol

    b. cetirizine 0.24% ophthalmic solution (Zerviate) – Ophthalmic Allergy Drugs; new ophthalmic formulation of cetirizine

    c. lasmiditan (Reyvow) – Migraine Agent for acute treatment of migraine

    d. teriparatide (Bonsity) injection – Osteoporosis Agents: Parathyroid Hormone, a biosimilar of Forteo for osteoporosis

    e. ubrogepant (Ubrelvy) – Migraine Agent for acute treatment of migraine

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

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

a. Applying the same manual PA criteria to new and current users of Bonsity that currently applies to Forteo and Tymlos.

b. Applying manual PA criteria to new and current users of Reyvow and Zerviate.

c. Applying manual PA criteria to new users of Ayvakit, Caplyta, Nexletol, Nurtec ODT, Palforzia, Tazverik, and Ubrelvy.

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

1. teriparatide injection (Bonsity)

Manual PA criteria applies to all new and current users of Bonsity.

Bonsity is approved if all criteria are met:

- The provider acknowledges that Forteo is the Department of Defense's preferred osteoporosis parathyroid hormone (PTH) analog; the patient must try and fail Forteo prior to use of Bonsity

- Patient is ≥ 18 years old

- The drug is prescribed for treatment of osteoporosis and not for prevention of osteoporosis.

- Patient has one of the following diagnoses:

    - Patient is a postmenopausal female with osteoporosis; OR
    - Patient is a male with primary or hypogonadal osteoporosis; OR
    - Patient is a male or female with osteoporosis associated with sustained systemic glucocorticoid therapy (e.g., more than 6 months use of greater than 7.5 mg/day of prednisone or equivalent) AND

- The patient has one of the following:

    - A high risk for fracture due to history of osteoporotic fracture, OR
    - Has multiple risk factors for fracture (e.g., a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)

- Patient has a documented bone mineral density (BMD) with T-score of -2.5 or worse

- Patient is able to take calcium and vitamin D supplements and will continue throughout therapy

- Patient has tried and experienced an inadequate response to, has had therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (e.g., alendronate (Fosamax), ibandronate (Boniva))

- Patient does not have an increased risk for osteosarcoma

- Cumulative treatment with Bonsity, Tymlos, and/or Forteo must not exceed 24 months during the patient's lifetime

Non-FDA approved uses are not approved.

PA expires in 24 months.

2. lumateperone (Caplyta)

Manual PA is required for all new users of Caplyta.

Caplyta is approved if <u>all</u> criteria are met:

- Age ≥ 18 years

- Patient has a diagnosis of schizophrenia

- Patient has tried and failed at least TWO formulary atypical antipsychotics (e.g. risperidone (Risperdal), aripiprazole (Ability), lurasidone (Latuda), quetiapine (Seroquel))

- Drug is prescribed by or in consultation with a psychiatrist

Non-FDA-approved uses are not approved including disorders, depression, and other neuropsychiatric and neurological disorders.

PA does not expire.

3. bempedoic acid (Nexletol)

Manual PA is required for all new users of Nexletol.

Nexletol is approved if all criteria are met:

- The drug is prescribed by a cardiologist, endocrinologist or lipidologist (e.g., provider is certified through the National Lipid Association or similar organization) AND

- The patient has tried a Department of Defense preferred statin with similar LDL lowering (moderate or low intensity; including atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin or simvastatin) at maximal doses and has not reached LDL goal OR

- The patient has tried a Department of Defense preferred statin with similar LDL lowering (moderate or low intensity; including atorvastatin (Lipitor), fluvastatin (Lescol), lovastatin (Mevacor), pravastatin (Pravacol), rosuvastatin (Crestor) or simvastatin (Zocor)) at maximal doses and has been unable to tolerate it due to adverse effects AND

- The patient will continue on statin therapy, consistent with the package labeling.

Non-FDA-approved uses are not approved.

PA does not expire.

4. cetirizine 0.24% ophthalmic solution (Zerviate)

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

Zerviate is approved if <u>all</u> criteria are met:

- The patient has ocular symptoms of allergic conjunctivitis AND

- The patient has tried and failed TWO of the following formulary alternatives in the last 90 days, olopatadine 0.1%(generic Patanol), olopatadine 0.7% (Pazeo), azelastine (generic Optivar), or epinastine (generic Elestat) OR
- The patient has experienced intolerable adverse effects to at least TWO of the following formulary alternatives, olopatadine 0.1%, olopatadine 0.7% (Pazeo), azelastine, or epinastine

Non-FDA-approved uses are not approved.

PA does not expire.

5. peanut (Arachis Hypogaea) Allergen Powder-dnfp (Palforzia)

Manual PA is required for all new users of Palforzia.

Palforzia is approved if all criteria are met:

- Palforzia is prescribed by an allergist or immunologist , or in consultation with an allergist or immunologist, and the provider has satisfied the requirements of the REMS program
- The patient is between the ages of 4 to 17 years
- The patient has a documented history of peanut allergy
- The patient has a history of diagnostic evidence of peanut allergy, including either serum IgE to peanut of ≥0.35 kUA/L (serum testing) and/or positive skin prick test (SPT) for peanut ≥ 3 mm greater than negative control
- The patient does not have uncontrolled asthma; eosinophilic esophagitis or other eosinophilic gastrointestinal diseases
- The patient has not had severe or life-threatening anaphylaxis within the previous 60 days prior to starting therapy
- Provider acknowledges that the patient will be counseled on the following:
  - Avoiding peanut ingestion
  - The need for access to an epinephrine injector
  - Palforzia is not intended to treat emergencies

Non-FDA-approved uses are not approved.

PA does not expire.

6. lasmiditan (Reyvow)

Manual PA is required for all new and current users of Reyvow.

Reyvow is approved if all criteria are met:

- Age ≥ 18
- Reyvow is prescribed by or in consultation with a neurologist
- Reyvow is not approved for patients who have history of hemorrhagic stroke
- Reyvow is not approved for patients with a history of epilepsy or any other condition with increased risk of seizure
- The patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications
    - sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), eletriptan (Relpax)
- The patient has had a contraindication to, intolerability to, or has failed a 2-month trial of Nurtec ODT
- If Reyvow is used with a triptan, provider acknowledges Reyvow and the triptan should not be used within 24 hours of each other
- Reyvow will be used with caution in patients with low heart rate and/or those using beta blockers, such as propranolol

Non-FDA-approved uses are not approved.

PA does not expire.

7. rimegepant orally disintegrating tablet (Nurtec ODT)

Manual PA criteria apply to all new users of Nurtec ODT.

Nurtec ODT is approved if all criteria are met:

- Age ≥ 18
- Nurtec ODT is prescribed by or in consultation with a neurologist

- Nurtec ODT is not approved for patients who have clinically significant or unstable cardiovascular disease

- The patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications

    - sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), eletriptan (Relpax)

- Concurrent use with any other small molecule CGRP targeted medication (i.e., including Ubrelvy or another "gepant") is not allowed

Non-FDA-approved uses are not approved.

PA does not expire.

8. ubrogepant (Ubrelvy)

Manual PA is required for all new users of Ubrelvy.

Ubrelvy is approved if all criteria are met:

- Age ≥ 18

- Ubrelvy is prescribed by or in consultation with a neurologist

- Ubrelvy is not approved for patients who have clinically significant or unstable cardiovascular disease

- The patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications

    - sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), eletriptan (Relpax)

- Patient has had a contraindication to, intolerability to, or has failed a 2-month trial of Nurtec ODT

- Concurrent use with any other small molecule CGRP targeted medication (i.e., including Nurtec ODT or another "gepant") is not allowed

Non-FDA-approved uses are not approved

PA does not expire.

9. avapritinib (Ayvakit)

Manual PA applies to new users of Ayvakit.

Ayvakit is approved if all criteria are met:

- Patient must be ≥ 18 years
- Ayvakit is prescribed by or in consultation with a hematologist/oncologist
- Patient has pathologically confirmed unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation with or without the D842V mutation
- Provider agrees to monitor for intracranial bleeding and other central nervous system adverse effects
- Female patients of childbearing age are not pregnant confirmed by (-) HCG
- Female patients will not breastfeed during treatment and for at least 2 weeks after the cessation of treatment
- Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 6 weeks after the cessation of therapy
- The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis: _____.

Non-FDA-approved uses are not approved except as noted above.

PA does not expire.

10. Tazemetostat (Tazverik)

Manual PA criteria apply to all new users of Tazverik.

Tazverik will be approved if all criteria are met:

- Patient must be ≥ 16 years
- Tazverik is prescribed by or in consultation with a hematologist/oncologist
- Patient has pathologically confirmed metastatic or locally advanced epithelioid sarcoma not eligible for complete resection

- Patient will be monitored for secondary malignancies (especially. T-cell lymphoblastic lymphoma, myelodysplastic syndrome, and acute myeloid leukemia)

- Female patients of childbearing age are not pregnant confirmed by (-) HCG.

- Female patients will not breastfeed during treatment and for at least 1 week after the cessation of treatment

- Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 3 months after cessation of therapy for males and 6 months for females

- The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis: _____.

Non-FDA approved uses are not approved except as noted above.

PA does not expire.

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

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

- **New Drugs Recommended for UF or NF Status:** An effective date upon the first Wednesday two weeks after signing of the minutes in all points of service.

E. Physician's Perspective

The Committee reviewed 14 new drugs, of which 8 were recommended for UF status, and 6 recommended for NF status. Note that there were no products recommended for Tier 4 status.

Prior authorization criteria will apply to 10 of the drugs. Several of the drugs are in classes where PAs are routine, including the 2 oncology drugs (Ayvakit, Tazverik), and the cholesterol drug (Nexletol).

"No grandfathering", where both new and current users must go through the PA was recommended for 2 products. For the osteoporosis drug Bonsity, the class has existing PA requirements, and this drug has the same active ingredient as Forteo, the preferred product. The ophthalmic allergy drug Zerviate also has no grandfathering, as it is no more effective than other products, and requires twice daily dosing.
For the peanut allergy drug (Palforzia), PA was recommended due to safety reasons, as the patient must have an EpiPen available and continue to avoid ingesting peanuts. We

did allow grandfathering here, because if there is an interruption of therapy, the patient must re-start the titration process. However, as of June 10th, there have not been any prescriptions yet for this product.

The antipsychotic drug, Caplyta, was recommended for NF status, but the PA will allow for grandfathering. The product has no compelling advantages over the formulary products, and was no more effective than risperidone. As of June 10th there are 6 patients on this drug.

There are 3 new oral drugs evaluated at this meeting that are approved to treat a migraine headache (Nurtec, Ubrelvy, and Reyvow). Other drug classes, including the triptans, are very effective and widely used for this same indication, at a much lower cost than these new products. Recall that all new drugs are placed in a nonformulary status, pending review by the Committee until otherwise placed on the formulary, by the Director, DHA. One of the drugs, Nurtec, was recommended to revert to formulary status, to allow use in patient who can't take triptans.

- The Committee recommended that all 3 new migraine drugs would require a PA, showing that the patient has tried 2 triptans, or has a contraindication to a triptan, such as cardiovascular disease. This is in line with other commercial health care plans that require use of the cost effective triptans before these new products are used. A review of PAs from several commercial plans, including United Healthcare and Medical Mutual, found that they were more restrictive than DoD, as a trial of three triptans is required. The Committee chose to have these products available as Formulary or Nonformulary, and did not elect to move any to Tier 4 status.

- No grandfathering, was recommended for Reyvow due to safety issues, including the fact that it can cause significant driving impairment up to 8 hours after administration; it is a controlled substance with a potential for dependence; and it can slow down the heart rate. Additionally, the potential impact on readiness for our active duty members is a concern with Reyvow.

- We did receive public comment from two organizations, the Headache and Migraine Policy Forum, and the Alliance for Patient Access. These letters were emailed to you. To summarize, the letters centered around ensuring patients having access to these 3 new migraine drugs.

    1) The DoD P&T Committee recognizes the importance of patient advocacy and ensures that the issue of patient access is discussed as part of the formulary and PA recommendations.

    2) All newly approved drugs are designated as nonformulary when they are launched, pending the decision of the Director. A review of prescription claims does show utilization for all three agents, therefore we have not prevented access to these drugs and in fact we are increasing access to these drugs with the formulary recommendation.

3) The P&T Committee's recommendations align with the overall mission of the MHS to ensure readiness, better health, better outcomes, and better spending.

F. Panel Questions and Comments

Mr. Hostettler asked about the mechanism of action for the new migraine products. What is the efficacy of the newer products in comparison to the triptans?

CDR Raisor responded there were no head-to-head trials between the new oral CGRP and triptans, but there was comparative analysis conducted by ICER that looked at their effectiveness. Their conclusion shows that triptans were more effective unless the patient had contraindications using the triptans. The new oral CGRP and lasmiditan were less effective than triptans.

Mr. Hostettler inquired about the adverse effects of the triptans in comparison to the newer products. The newer products appear to have less adverse effects than the triptans. There is a history of cardiovascular and other risks with the triptans.

CDR Raisor commented, I'd like to highlight there were no head-to-head trials comparing the triptans with the newer agents. Of the newer agents, Reyvow has more adverse events with blood pressure lowering and risk of driving impairment. It was noted that patients with driving impairment were unaware of their impairment. He argues that Reyvow has greater side effects. With the oral CGRPs, there were adverse drug events noted during the clinical trials. Granted, these trials were shorter term and we would have preferred longer term data to evaluate the full safety of the products. They did effectively eliminate the most severe cardiovascular patients within those trials with Ubrelvy and Nurtec ODT. Based on the limited trial population which excluded certain cardiovascular high risk patient, the newer agents do have fewer documented cardiovascular risks compared to the triptans.

Mr. Hostettler requested information regarding the utilization of the newer products and the number of patients are impacted by the decision. Especially Reyvow because the decision impacts new and current users? If I am not mistaken, the decision for Ubrelvy and Nurtec ODTNurtec only affects new users.

CDR Raisor responded there are 70 current users for Reyvow, 217 for Nurtec ODT, and 1206 for Ubrelvy.

Mr. Hostettler said it seems the providers have chosen Ubrelvy but the Committee chose the others for formulary rather than non-formulary. Other than cost, were there any clinical reason for placing Ubrelvy as NF and Nurtec ODT as formulary?

CDR Raisor responds that every drug that the Committee reviews there is a clinical and cost analysis. It's a composite of clinical and cost review that drives the decision.

Ubrelvy was the first to market and launch. Historically, often the first to launch has an advantage in the number of patients on the drug in the initial analysis.

Comments regarding the PA criteria:

Mr. Hostettler stated that he'd like to see what the possibility is that Ubrelvy - which seems to be, for whatever reason, maybe because it was the first to market, and if that is the reason, I don't know. I would hope doctors would make a better decision than ones based on first to market. Is there anyway Ubrelvy would not have to go through an extra step after failing two Triptans. Once the provider/patient makes a decision that the triptans have failed, moving on to the product with the highest utilization could be used and might make good clinical sense...maybe Ubrelvy would be in the non-formulary cost bucket (tier 3) but have the opportunity to be used behind the triptans. Just putting the question out there as a suggestion.

Dr. Khoury stated that the comment will be is taken for the record as he is unable to make a modification of that type at this point.

Comments regarding the Implementation Plan:

Mr. Hostettler states there were 200 patients on the migraine product that has new and current users. The implementation plan will go into effect 2 weeks after the signing of the minutes. Is this enough time to notify the affected population?

Dr. Khoury clarifies that the question is whether to grandfather patients and/or delay the implementation. As previously stated, there is no grandfathering for Reyvow. The total population affected by the Reyvow decision is 70 patients, new and current users, not 200. The recommendation impacts new and current users because there is a safety concern for this population from the Committee's judgement. Due to the safety concern, the Committee believes it is important to implement as soon as feasible.

Mr. Hostettler asked can we expedite the notification of the change to the affected population.

Dr. Khoury responded that there is no way to expedite the notification due to the short time frame of 2 weeks.

Mr. Hostettler stated that he is concerned that patients will show up at the Pharmacy for a refill and be turned away because they had no notification of the new PA. He is further concerned that the implementation plan does not allow the patient time to make an appointment with their provider to make the change before the treatment is needed.

Dr. Khoury responded the Committee considers how the implementation plan will impact patient's access as part of every decision. It is a balance of ensuring there is access to the medication from the cost perspective and trying to implement the decision as soon as feasible. In this case, the safety concern for Reyvow was pressing enough that the

committee was concerned about the safety over the delay. Keep in mind, the patient may not have followed the proper protocols to select this agents and there are readiness concerns for this population that is consistent with the data showing an adverse effect of driving impairment. I understand the concern about having somebody show up at the pharmacy for a refill, but the Committee is concerned with readiness of the active duty patients and readiness superseded ensuring rapid access to the product. The committee wants to make sure the patient is on an appropriate therapy that ensures readiness and safety in addition to all the other clinical and cost-effectiveness concerns that were part of the analysis.

Mr. Hostettler stated that it appears the 70 patients have been identified. You would know the active duty and could deal with those very easily since they're in your population and at hand.

There were no more Panel questions or comments. The Chair called for a vote on the UF Recommendation, PA Criteria and UF and PA implementation plan for the 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: 6 Non-Concur: 1 Abstain: 0 Absent: 0

  - *Mr. Hostettler asked is there anyway Ubrelvy would not have to go through an extra step after failing two Triptans.*

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

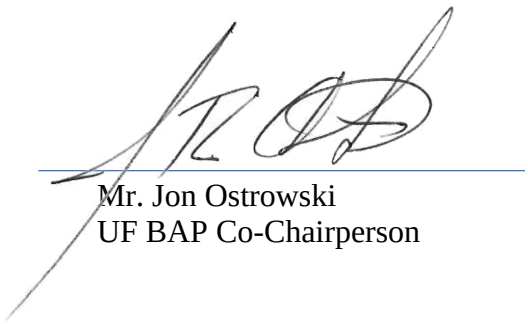
  Concur: 6 Non-Concur: 1 Abstain: 0 Absent: 0

  - *Mr. Hostettler non-concurs with Reyvow but has not issues or concerns with the Nurtec ODT and Ubrelvy. The implementation plan for Reyvow should be a longer time frame to make sure to notify patients that they may go without their medicine. That don't see their provider again.*

Mr. Ostrowski gives the floor back to Col Hoerner.

Col Hoerner thanks everyone for their attendance as well at the presenters the members of the FMB, and the participants.

(The meeting adjourns at 2:02 p.m.)



Mr. Jon Ostrowski
UF BAP Co-Chairperson

Appendices:

- Appendix 1 – Brief list of Acronyms used in this Summary
- Appendix 2: Public Comments: The Alliance for Patient Access.
- Appendix 3: Public Comments: The Headache and Migraine Policy Forum

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.

- BAP – Beneficiary Advisory Panel
- BCF – Basic Core Formulary
- BMD – Bone Mineral Density
- CDR – Commander
- CFR – Code Federal Regulations
- CGRP – Calcitonin Gene-Related Peptide
- COVID-19 – Corona Virus Disease 2019
- DFO – Designated Federal Officer
- DHA – Defense Health Agency
- DoD – Department of Defense
- FACA – Federal Advisory Committee Act
- FMB – Formulary Management Branch
- GIST – Gastrointestinal Stromal Tumors
- HCG – Human Chorionic Gonadotropin
- LDL – Low Density Lipoprotein
- LIP-1 – Antilipidemic I
- NCCN – National Comprehensive Cancer Network
- NF – Non-Formulary
- ODT – Orally Disintegrating Tablet
- P&T – Pharmacy and Therapeutics
- PA – Prior Authorization
- PDGFRA – Platelet-Driven Growth Factor Receptor Alpha
- PTH – Parathyroid Hormone
- SPT – Skin Prick Test
- UF – Uniform Formulary

Alliance for Patient Access

June 17, 2020

Colonel Paul J. Hoerner
Beneficiary Advisory Panel
Defense Health Agency (DHA)
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042

Re: Review of Acute Therapies for Migraine Disease

Dear Colonel Hoerner:

On behalf of the Alliance for Patient Access (AfPA) and our clinician members, I am writing regarding the DoD Pharmacy and Therapeutics (P&T) Committee coverage review for acute therapies for migraine disease. We appreciate the opportunity to provide comment in advance of the Beneficiary Advisory Panel meeting and respectfully urge the Committee to recommend including the full range of acute migraine therapies on the Uniform Formulary.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the physician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA's Headache and Migraine Disease Working Group, a unique network of clinicians treating headache and migraine disease, works to ensure that the clinician's perspective informs policy discussions around care for patients living with headache disorders or migraine disease.

As you know, headache and migraine disease is debilitating, negatively impacting patients' ability to live, work, and perform daily tasks. This disease robs patients of their quality of life and comes with significant co-morbidities, including anxiety and depression. Migraine disease also has a substantial negative impact on workplaces; United States workers with migraine that manifests more than 15 days a month lose approximately 14% of their annual productivity.[1] Research shows that direct and indirect migraine costs in the U.S. are estimated at $78 billion.[2] Therefore, innovative treatments such as the acute therapies under consideration hold immense promise for these patients.

It has come to our attention that the P&T Committee has recommended limited coverage for new acute migraine therapies, including – with step therapy requirements – only one acute therapy on its Uniform Formulary, while considering several others "non-formulary," only available after additional step therapy requirements. We are very concerned that these recommended restrictions will hinder access

[1] JOEM. 2010;52:8.

[2] Gooch C, Pracht E, Borenstein A. The burden of neurological disease in the United States: A summary report and call to action. Ann Neurol. 2017;81:479-484.

1275 Pennsylvania Avenue NW, Suite 1100A
Washington, DC 20004

to effective, FDA-approved and appropriate treatments for patients; as such, we urge you to reconsider this proposal. Limiting treatment options would place an undue burden on patients already managing a debilitating condition and, in many cases, lead to disease chronification and additional health care expenditures.

Allowing access to all treatment options will allow more opportunities for a patient-centered care approach, one that allows for tailored treatment of each patient and their individual needs. A patient-centered approach gives the ability to change course, as needed, and allows patients the opportunity to access innovative medications that could drastically improve their quality of life – but it is only possible by providing patients and clinicians with the full range of treatment options.

On behalf of the Alliance for Patient Access and our clinician members, I urge you to ensure that the full range of acute therapies for migraine disease are included on the Uniform Formulary. Doing so will support timely access to appropriate medical care for military personnel and their families and support a patient-centered system of care.

Thank you for the opportunity to provide comment and we appreciate your attention to this matter. If AfPA can provide further details or be of assistance in this matter, please contact us at 202-499-4114.

Sincerely,

Josie Cooper
Executive Director

June 17, 2020

Colonel Paul J. Hoerner
Beneficiary Advisory Panel
Defense Health Agency (DHA)
7700 Arlington Boulevard, Suite 5101
Falls Church, VA 22042

Via Email

Re: Beneficiary Advisory Panel Consideration of Acute Treatments for Migraine Disease

Dear Colonel Hoerner:

The Headache and Migraine Policy Forum (HMPF) is a national stakeholder coalition of more than two dozen patient, clinician, and research organizations that seek to advance public policies and practices that promote accelerated innovation and improved treatments for persons living with headache disorders and migraine disease. HMPF also works to ensure access to appropriate prevention and treatment options for all patients and has a practice of making comment on policy and coverage determinations that impact patient access and safety. On behalf of our stakeholder members, we appreciate the opportunity to comment on the findings of the DoD Pharmacy and Therapeutics ("P&T") Committee meeting on May 6th, specifically in regard to new acute therapies for the treatment of migraine disease. We are hopeful that the Beneficiary Advisory Panel will recognize the value in providing patients access to the full range of acute treatment options their physician may prescribe rather than forcing active duty military members and their beneficiaries to undergo onerous step therapy.

Migraine Disease is Disproportionately Burdensome to TriCare Recipients and Has a Substantial Impact on the Health and Readiness of Our Active Military.

Without question, migraine disease places a disproportionately high disease burden on the health of our servicemen and women and their families.[1] The prevalence of migraine attacks occur in roughly 1 out of every 7 Americans annually, approximately 1.5 million of the lives covered by active duty TriCare members and

[1] Concussion in the Military: an Evidence-Base Review of mTBI in US Military Personnel Focused on Posttraumatic Headache. Holtkamp MD, Grimes J, Ling G.Holtkamp MD, et al.Curr Pain Headache Rep. 2016 Jun;20(6):37. doi: 10.1007/s11916-016-0572-x.Curr Pain Headache Rep. 2016.PMID: 27084376Review.

their beneficiaries.[2] Moreover, the relationship of traumatic brain injury and concussion in the military is well-known; post-traumatic headache is the most common symptom after TBI in US service members, most often presenting as migraine-like headaches. For example, in a study of new patients seen between August 2008 and December 2009 assessed by a civilian headache specialist at the TBI Center at Womack Army Medical Center, Fort Bragg, NC, it was found that more than two-thirds of subjects recalled the onset of headache within 7 days of injury and the most commonly diagnosed headache was a continuous type with migraine features (n = 31 (18.7%)).[3]

Military personnel are also likely to encounter numerous physiological and psychological factors that are known to precipitate migraine attacks and exacerbate migraine disease. The factors include disrupted sleep and meal patterns, fatigue, psychological stress, emotional strain, heat, noise and other environmental exposures. The effects of migraine have specific consequences for military personnel in that migraine can impair their ability to function and may result in soldiers being non-deployable or discharged from military service.[4] Finally, the U.S. active-duty military population is composed chiefly of young adults, which is the age group at highest risk for migraine. Unsurprisingly, therefore, the reported rates are higher than those of similar age and gender in the general U.S. population.

The Beneficiary Advisory Panel Should Recommend the P&T Committee Provide Parity of Coverage for All New Acute Treatments for Migraine Disease Rather Than Force Patients to Undergo Burdensome Step Therapy.

We were therefore disappointed to learn that the P&T Committee recommended that migraine patients undergo a burdensome process by which they must first be failed by a two-step triptan therapy and then try one specific type of acute therapy before being able to access the therapy prescribed by the patient's physician. This decision runs contrary to the P&T Committee's mission to meet the clinical needs of DoD beneficiaries in an effective, efficient and fiscally responsible manner. HMPF therefore respectfully urges the Beneficiary Advisory Panel to recommend that the P&T Committee review its decision and instead provide full parity to the new class of medicines for these patients.

Thank you for your further consideration and we would welcome the opportunity to discuss the impact of these policies.

Sincerely,

Lindsay Videnieks, JD
Executive Director
The Headache and Migraine Policy Forum

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[2] The prevalence and burden of migraine and severe headache in the United States: updated statistics from government health surveillance studies, Burch RC, Loder S, Loder E, Smitherman TA.Burch RC, et al.Headache. 2015 Jan;55(1):21-34. doi: 10.1111/head.12482.Headache. 2015.PMID: 25600719Review.

[3] Headache in military service members with a history of mild traumatic brain injury: A cohort study of diagnosis and classification. Finkel AG, Yerry JA, Klaric JS, Ivins BJ, Scher A, Choi YS.Finkel AG, et al.Cephalalgia. 2017 May;37(6):548-559. doi: 10.1177/0333102416651285. Epub 2016 May 20.Cephalalgia. 2017.PMID: 27206963

[4] Wiley-Blackwell. "Army Personnel Show Increased Risk For Migraine; Condition Underdiagnosed, Mistreated." ScienceDaily. ScienceDaily, 28 August 2008. Available at: www.sciencedaily.com/releases/2008/08/080827164041.htm

On behalf of the following co-signers:
Alliance for Balanced Pain Management
Alliance for Patient Access
Association for Migraine Disorders
Chronic Migraine Awareness, Inc.
The Coalition For Headache And Migraine Patients (CHAMP)
The Danielle Byron Henry Migraine Foundation
Golden Graine
Health Union / Migraine.com
HealthyWomen
Hope for Migraine / Migraine Meanderings
Migraine Again
The Migraine Diva
Migraine Pal
Migraine World Summit
Miles for Migraine
National Headache Foundation
SoldierStrong ACCESS
World Health Education Foundation