DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS
FROM THE MAY 2024 MEETING

INFORMATION FOR THE UNIFORM FORMULARY
BENEFICIARY ADVISORY PANEL MEETING JUNE 26, 2024

I. UNIFORM FORMULARY REVIEW PROCESS

In accordance with 10 United States Code § 1074g, as implemented by 32 Code of Federal Regulations 199.21, the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee is responsible for developing the Uniform Formulary (UF). Recommendations to the Director, Defense Health Agency (DHA) or their designee, on formulary or complete exclusion status, prior authorizations (PAs), pre-authorizations, and the effective date for a pharmaceutical agent's change from formulary to nonformulary (NF) or to complete exclusion status are received from the Uniform Formulary Beneficiary Advisory Panel (UF BAP), which must be reviewed by the Director or their designee before making a final decision.

II. UF DRUG CLASS REVIEW–INSULINS: BASAL INSULIN ANALOGS

P&T Comments

A. Insulins: Basal Insulin Analogs—Relative Clinical Effectiveness Conclusion

The Basal Insulin subclass was last reviewed at the August 2017 DoD P&T Committee meeting, and branded insulin glargine (Lantus) was designated as step-preferred. Since the last review, several biosimilars and unbranded biologics are now marketed.

There is significant biosimilar presence for the Basal Insulins. A biosimilar is defined by the Food and Drug Administration (FDA) as a biological product that is approved based on data demonstrating it is highly similar to an FDA-approved biological product, known as a reference product, and that there are no clinically meaningful differences between the biosimilar product and the reference product. The DoD P&T Committee at the November 2022 meeting concluded that by FDA approval and definition, biosimilars are equally safe and efficacious which provides strong competition within products for drug classes with biosimilars. Not all biosimilars are cost effective when compared to their reference product. Unbranded biologics are marketed under the same 351(a) Biologic License Application (BLA) as the reference product. These unbranded biologics can have differing formulary status compared to their reference product.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

Products

- The branded products in the Basal Insulins subclass include insulin glargine (Lantus), insulin detemir (Levemir), insulin glargine U-300 (Toujeo), insulin degludec (Tresiba U-100, Tresiba U-200), and three other branded insulin glargine products, Basaglar, Semglee, and

Rezvoglar. Several biosimilars and unbranded biologics for glargine and degludec are available.

- The products are all supplied as prefilled disposable pens. In addition, vials are available for all the products with the exception of Toujeo, Basaglar, and Rezvoglar.
- Market discontinuation will occur this year for insulin detemir (Levemir) and insulin glargine (Semglee). Market supply disruptions have also affected the subclass.

Clinical Practice Guidelines

- Professional treatment guidelines for both Type 1 diabetes mellitus (T1DM) and Type 2 diabetes mellitus (T2DM) from the American Diabetes Association (ADA) do not state a preference for one basal insulin analog over another. Similar recommendations are made by the American Association of Clinical Endocrinology (ACCE) and by the United Kingdom National Institute for Health and Care Excellence (NICE).
- For pregnancy and gestational diabetes, the ADA and American College of Obstetrics and Gynecology prefer insulin glargine, detemir, and neutral protamine Hagedorn (NPH) insulin over other basal insulins, based on long marketing history and not due to efficacy or safety concerns.
- For children, the ADA and the International Society for Pediatric and Adolescent Diabetes recommend basal insulins over other insulins, but no preference is stated for a particular product.

Efficacy

- There was no new compelling data to change the 2017 efficacy conclusion that while basal insulins differ in pharmacokinetic properties such as duration of action and dosing frequency, this variance does not translate into improved glycemic control or hemoglobin A1C improvements compared to one another.

Safety

- For T1DM, systematic reviews and meta-analyses in pediatric and nonpregnant adult patients comparing insulin detemir to insulin glargine, insulin degludec to insulin detemir, or insulin degludec to insulin glargine did not find clinically relevant differences for outcomes, including rates of hypoglycemia
- Similar results were found for systematic reviews and meta-analyses in nonpregnant adult patients with T2DM when comparing insulin glargine or insulin detemir to NPH insulin.

Individual Product Characteristics

- **insulin glargine (Lantus)** is the reference biologic for insulin glargine. Advantages include availability in a prefilled pen, cartridge and vial, and approval for both adult and pediatric administration without a lower age limit. Lantus is well-accepted for use in pregnant patients. It is available in 100 units per milliliter (mL) which provides 80 units as the maximum dose. Lantus has a long history as the preferred MHS basal insulin dating back to 2010.
    - Unbranded insulin glargine U-100 is available.
- **insulin glargine U-300 (Toujeo)** is a concentrated insulin glargine product containing 300 units per mL in two prefilled reusable pen options. It is approved for pediatric patients down to age six. Compared to Lantus, Toujeo offers a longer half-life (19 hours vs. 12 hours) and longer duration of action (24-36 hours vs. 24 hours). Toujeo is available in a SoloStar pen which administers up to 80 units per dose, and a Max SoloStar pen which administers up to 160 units per dose.
    - Unbranded insulin glargine U-300 SoloStar and Max SoloStar are available.
- **insulin glargine (Basaglar)** is considered a "follow-on" insulin (originally approved by the 505(b)(2) pathway but through FDA administrative action is deemed a Biologic License Application (BLA) as of March 23, 2020) and is not a true biosimilar to Lantus, although the data to support approval included a series of clinical studies to demonstrate similarity to Lantus. Basaglar has the same amino acid and pH as Lantus.
    - Basaglar is also available as a TempoPen. The TempoSystem consists of a phone app, glucometer, Tempo Smart Button, and Tempo Insulin Pen. The TempoPen provides no additional benefit as compared to KwikPen formulations. The TempoSystem is not a TRICARE pharmacy benefit and is not currently covered under the TRICARE medical benefit.
- **insulin glargine (Semglee), insulin glargine-yfgn (Semglee), insulin glargine-aglr (Rezvoglar**) are biosimilars of Lantus. Semglee is available in both pens and vials and Semglee and Rezvoglar are interchangeable with Lantus. The branded insulin glargine (Semglee) formulation will be discontinued.
    - Unbranded insulin glargine-yfgn is available.
- **insulin degludec (Tresiba)** is the reference product for insulin degludec and offers a long duration of action up to 42 hours which allows for flexibility with regard to time of administration. Tresiba is available in both a U-100 and U-200 concentration. The U-100 pen administers up to 80 units per single injection and the U-200 pen administers up to 160 units per single injection.

    - Both concentrations are available as unbranded biologic products
- **insulin detemir (Levemir)** is the reference insulin detemir product. Detemir requires twice daily dosing. Market discontinuation will occur in 2024. There are no biosimilar nor unbranded products available.

Other Factors

- The basal insulins are rated as pregnancy category C, with the exception of detemir which is rated as pregnancy category B.
- There is no compelling evidence to support use of one basal product over another in either pregnancy or pediatric patients per current guidelines.

Overall Clinical Conclusion

- There is no new meaningful clinical evidence to change the previous conclusions from 2017 formulary review.
- Per the definition of a biosimilar product, there are no clinically meaningful differences between the reference drug product and the biosimilar, allowing for a high degree of therapeutic interchangeability.
- Clinical practice guidelines do not prefer one basal product over another for safety or efficacy. Basal insulin analogs are considered equally safe and efficacious when compared to one another.
- Differences between basal products are largely based on provider experience or patient preferences.
- MHS provider feedback was overwhelmingly positive for Lantus remaining on the formulary.
- In order to meet the needs of MHS patients, one basal insulin product is needed, but additional options should be considered to protect against shortage situations.

B. Insulins: Basal Insulin Analogs—Relative Cost Effectiveness Analysis and Conclusion

The P&T Committee reviewed the solicited bids from manufacturers and conducted a cost minimization analysis (CMA), budget impact analysis (BIA) and sensitivity analysis. The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results showed that insulin glargine-yfgn (unbranded), Lantus, insulin glargine (unbranded) and Rezvoglar were the most cost effective basal insulins, followed by Toujeo. Levemir, Basaglar, and Tresiba were the least cost effective.

- A BIA and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary, NF, or completely excluded on the UF. BIA results showed that designating the basal insulin agents in accordance with the formulary recommendation below demonstrated significant cost avoidance for the MHS.

C. Insulins: Basal Insulin Analogs—UF Recommendation

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) the following.

- UF step-preferred
  - insulin glargine (Lantus)
- UF non-step-preferred
  - insulin glargine U-300 (Toujeo SoloStar, Toujeo Max SoloStar)
  - insulin glargine U-300 (unbranded)
  - insulin glargine (Rezvoglar) (*moves from NF to UF non-step-preferred*)
  - insulin glargine-yfgn (unbranded) (*moves from NF to UF non-step-preferred*)
  - insulin glargine U-100 (unbranded by Winthrop) (*vials move from NF to UF non-step-preferred, pens remain UF non-step-preferred*)
- NF non-step-preferred
  - insulin detemir (Levemir), pens and vials *(pens move from UF to NF non-step-preferred, vials remain NF non-step-preferred); note market removal in 2024)*
  - insulin degludec (Tresiba)
  - insulin degludec (unbranded)
  - insulin glargine (Basaglar)
  - insulin glargine (Semglee); *note market removal in 2024*
  - insulin glargine-yfgn (Semglee)
- Completely Excluded
  - None
- Note that as part of this recommendation, a trial of Lantus is required for all non-step-preferred products. (See the PA criteria section for additional details.)
- Note that Lantus will remain on the Basic Core Formulary (BCF)

D. Insulins: Basal Insulin Analogs—Manual PA Criteria

PA is not required for Lantus; however, PA criteria have applied to the non-step-preferred products since the 2017 class review.

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) changes to the PA criteria for the non-step-preferred products in all new users as outlined below.

- For new users of Basaglar, Semglee, Semglee-yfgn, Rezvoglar, insulin glargine-yfgn (unbranded), insulin glargine (unbranded), or insulin detemir (Levemir), a trial of Lantus is required first, unless the patient has had an inadequate response to Lantus.
- New users of insulin glargine U-300 (Toujeo, unbranded) must be currently using greater than 80 units of basal insulin per day and have experienced clinically significant hypoglycemia; or they must be using greater than 100 units of basal insulin per day (regardless of whether they have experienced hypoglycemia).
- Providers ordering insulin degludec (unbranded) for new users must explain why the patient cannot use Lantus and Toujeo.
- For insulin degludec (Tresiba) in new users, the provider must indicate why the patient cannot use Lantus, Toujeo, and insulin degludec (unbranded).

The Manual PA criteria is as follows. Changes are noted in bold and strikethrough.

1. **insulin glargine U-300 (Toujeo SoloStar, Toujeo Max SoloStar, unbranded U-300)**

   Manual PA criteria apply to all new users of insulin glargine U-300 (Toujeo SoloStar, Toujeo Max SoloStar, unbranded insulin glargine U-300)

   Manual PA Criteria: Coverage is approved if:

   - **The provider acknowledges that insulin glargine (Lantus) is DoD's preferred basal insulin and is available without a PA at the lowest Tier 1 copay**
   - The patient is 6 years of age or older
   - The patient has a diagnosis of diabetes and is using a minimum of 100 units of **basal** insulin ~~glargine (Lantus)~~ per day **(i.e., insulin glargine, insulin degludec)** OR
   - The patient **has diagnosis of diabetes and is using a minimum of 80 units of basal insulin** ~~requires a dosage increase with Lantus~~ and has experienced a clinically significant, severe hypoglycemia episode~~, despite splitting the Lantus dose~~

- The patient, parent, or caregiver has been counseled regarding the risk of dosing errors

  The following are not acceptable reasons for receiving Toujeo:

  - Nonadherence to previous insulin treatment OR
  - Patient or prescriber preference for the use of Toujeo OR
  - Patient or prescriber preference for a smaller injection volume

- For patients older than 18 years of age, the prescription is written by or in consultation with an appropriate specialist (endocrinologist, infectious disease specialist, general surgeon, or gastroenterologist)

Non-FDA-approved uses are not approved

Prior authorization does not expire

2. insulin glargine (Rezvoglar), insulin glargine-yfgn (unbranded), insulin glargine U-100 (unbranded by Winthrop), insulin glargine (Basaglar), insulin glargine (Semglee), insulin glargine-yfgn (Semglee)

Manual PA criteria apply to all new users of Basaglar, Semglee, Semglee-yfgn, Rezvoglar, insulin glargine-yfgn (unbranded), or insulin glargine (unbranded Winthrop)

Manual PA Criteria: Coverage is approved if:

- **The provider acknowledges that insulin glargine (Lantus) is DoD's preferred basal insulin and is available without a PA at the lowest Tier 1 copay**
- The patient has tried and ~~**failed**~~ **had an inadequate response** to insulin glargine (Lantus)

Non-FDA-approved uses are not approved

Prior authorization does not expire

3. insulin detemir (Levemir)

Manual PA criteria apply to all new users of Levemir

Manual PA Criteria: Coverage for Levemir is approved if:

- **The provider acknowledges that insulin glargine (Lantus) is the preferred basal insulin and is available without a PA at the lowest Tier 1 copay**
- **The provider acknowledges that branded Levemir will be discontinued from the market in 2024**
- The patient has tried and ~~**failed**~~ **had an inadequate response** to insulin glargine (Lantus)

- ~~The patient is pregnant and cannot use insulin glargine~~

Non-FDA-approved uses are not approved

Prior authorization does not expire

4. insulin degludec (unbranded)

Manual PA criteria apply to all new users of insulin degludec (unbranded)

Manual PA Criteria: Coverage for insulin degludec (unbranded) is approved if:

- **The provider acknowledges that insulin glargine (Lantus) is DoD's preferred basal insulin and is available without a PA at the lowest Tier 1 copay**
- The patient has tried and ~~**failed**~~ **had an inadequate response** to insulin glargine (Lantus)
- The patient is one year of age or older
- The provider must explain why the patient cannot use Lantus (fill in the blank) AND
- The provider must explain why the patient cannot use Toujeo (fill in the blank)
  - **Acceptable responses include the following:**
    - **The patient has experienced clinically significant hypoglycemia with insulin glargine (Lantus) and insulin glargine U-300 (Toujeo) that is not expected to occur with insulin degludec OR**
    - **The patient works an alternating or inconsistent work shift schedule resulting in substantially varied meal times on a day-to-day bases resulting in an increased risk for level 2 or 3 hypoglycemia**
      - **Level 2 (moderate) hypoglycemia defined as glucose level less than 54 mg/dL**
      - **Level 3 (severe) hypoglycemia define a person is unable to function due to mental/physical changes from a low glucose level and requires assistance**
  - **Note the following are not acceptable reasons for receiving insulin degludec**
    - **Non-adherence to previous insulin treatment OR**
    - **Patient or prescriber preference for the use of insulin degludec**

Non-FDA-approved uses are not approved

Prior authorization does not expire

5. **insulin degludec (Tresiba)**

   Manual PA criteria apply to all new users of insulin degludec (Tresiba)

   Manual PA Criteria: Coverage for insulin degludec (Tresiba) is approved if:

   - **The provider acknowledges that insulin glargine (Lantus) is DoD's preferred basal insulin and is available without a PA at the lowest Tier 1 copay**
   - The patient has tried and ~~failed~~ **had an inadequate response** to insulin glargine (Lantus)
   - The patient is one year of age or older
   - The provider must explain why the patient cannot use Lantus (fill in the blank)
   - The provider must explain why the patient cannot use Toujeo (fill in the blank)
   - **The provider must explain why the patient cannot use unbranded insulin degludec (fill in the blank)**
     - **Acceptable responses include the following:**
       - **The patient has experienced clinically significant hypoglycemia with insulin glargine (Lantus), insulin glargine U-300 (Toujeo) and insulin degludec (unbranded) that is not expected to occur with insulin degludec**
     - **Note the following are not acceptable reasons for receiving insulin degludec (Tresiba)**
       - **Non-adherence to previous insulin treatment**
       - **Patient or prescriber preference for the use of insulin degludec (Tresiba)**

   Non-FDA-approved uses are not approved

   Prior authorization does not expire

E. Insulins: Basal Insulin Analogs—Tier 1 Copay for Lantus

Lantus currently has a Tier 1 copay, implemented in 2017. The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) maintaining the Tier 1 copay for Lantus.

F. Insulins: Basal Insulin Analogs— UF, PA, Tier 1 Copay, and Implementation Period

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday 90 days after signing of the minutes in all points of service, and 2) that DHA will send letters to beneficiaries receiving Levemir who will be affected by the NF recommendation and market removal.

III. UF DRUG CLASS REVIEW—INSULINS: BASAL INSULIN ANALOGS

UF BAP Comments

A. Insulins: Basal Insulin Analogs—UF Recommendation

The P&T Committee recommended formulary status as discussed above.

- UF step-preferred
  - Lantus
- UF non-step-preferred
  - Toujeo SoloStar, Toujeo Max SoloStar
  - insulin glargine U-300 (unbranded)
  - Rezvoglar
  - insulin glargine-yfgn (unbranded)
  - insulin glargine U-100 (unbranded by Winthrop)
- NF non-step-preferred
  - Levemir, pens and vials
  - Tresiba
  - insulin degludec (unbranded)
  - Basaglar
  - insulin glargine (Semglee)
  - insulin glargine-yfgn (Semglee)
- Completely Excluded
  - None

Note that as part of this recommendation, a trial of Lantus is required in new users for all non-step-preferred products

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Insulins: Basal Insulin Analogs—Manual PA Criteria

The P&T Committee recommended manual PA criteria in new users as outlined above, in new users.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Insulins: Basal Insulin Analogs—Tier 1 Copay for Lantus

The P&T Committee recommended maintaining the Tier 1 copay for Lantus as discussed above.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

D. Insulins: Basal Insulin Analogs—UF, PA, Tier 1 Copay, and Implementation Period

The P&T Committee recommended 1) an effective date of the first Wednesday 90 days after signing of the minutes in all points of service, and 2) that DHA will send letters to beneficiaries receiving Levemir who will be affected by the NF recommendation and market removal.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

IV. UF DRUG CLASS REVIEW–WEIGHT LOSS AGENTS

P&T Comments

A. Weight Loss Agents—Relative Clinical Effectiveness Conclusion

Section 729 of the National Defense Authorization Act of 2017 authorized coverage under TRICARE Prime and TRICARE Select for medically necessary treatment of obesity even if it is the sole or major condition treated. The DoD P&T Committee initially reviewed the weight loss agents for formulary status in 2017.

The drugs in the class are comprised of older amphetamine derivatives (e.g., phentermine, benzphetamine), and branded products including fixed dose combinations of phentermine/topiramate (Qsymia), bupropion/naltrexone (Contrave), a proprietary phentermine 8 mg formulation (Lomaira), the fat absorption inhibitor orlistat (Xenical) and the injectable glucagon-like peptide-1 receptor agonists (GLP1-RAs) liraglutide (Saxenda), semaglutide (Wegovy), and tirzepatide (Zepbound). Semaglutide, tirzepatide and liraglutide are also FDA-approved under distinct brand names for diabetes (Ozempic, Mounjaro, and Victoza, respectively). Notable changes since the last formulary review include clinical practice guideline updates and market removal of locaserin (Belviq) in 2020.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

Clinical Practice Guidelines

- In overweight and obese individuals, particularly those with comorbidities, long-term weight loss greater than or equal to 5 percent of baseline body weight following diet, exercise, or drug treatment is associated with improvement in metabolic and cardiovascular risk factors.
- Although professional treatment guidelines differ with respect to weight loss recommendations, there is universal agreement that comprehensive lifestyle intervention is the foundation for obesity management. Pharmacotherapy may be considered for patients with a body mass index (BMI) greater than 30 and for those with a BMI greater than or equal to 27 with additional obesity-associated comorbidities (e.g., diabetes, impaired glucose tolerance, hypertension, dyslipidemia, sleep apnea).
- The 2024 ADA Standards of Care in Diabetes state obesity management can delay the development of T2DM. There is additional strong evidence that maintaining a 10% weight loss can lead to disease modifying effects and possible remission of T2DM. The guideline specifies that semaglutide and tirzepatide are very highly effective for weight loss compared to other available therapies, with dulaglutide (Trulicity) and liraglutide (Victoza), which are GLP-1RAs approved for diabetic patients listed as highly effective.
- The 2023 AACE consensus statement recommends the GLP-1RA agents (semaglutide, liraglutide, tirzepatide) or Qsymia for overweight or obese patients who are at risk of developing T2DM and who have failed lifestyle modification. Contrave, short-term phentermine, or orlistat can be used if the above medications are not tolerated or are inaccessible to patients.
- The 2022 American Gastroenterological Association (AGA) guideline recommends semaglutide over other approved anti-obesity medications for long term treatment in most patients with an inadequate response to lifestyle interventions. The AGA recommends against the use of orlistat

(Xenical) for weight loss. Tirzepatide was not yet approved for weight loss at the time of the guideline publication.

Efficacy

- There are limited head-to-head comparative data for the weight loss drugs. Individual clinical trial data, package labeling and meta-analyses show greater weight loss with semaglutide and tirzepatide compared to phentermine, liraglutide, phentermine/topiramate and bupropion/naltrexone.
- A 2023 network meta-analysis comparing the efficacy of the GLP-1RAs for obesity management concluded the GLP-1RAs produce significant reductions in weight. Tirzepatide resulted in greater weight loss than semaglutide or liraglutide.
- A comparison of semaglutide with dulaglutide in the SUSTAIN-7 trial in diabetic patients showed the magnitude of weight loss achieved with semaglutide was double the amount achieved with dulaglutide.
- The SELECT trial evaluated major adverse cardiovascular events (MACE) between placebo and semaglutide in obese patients with pre-existing cardiovascular disease with no history of diabetes. After a mean follow-up of 40 months, semaglutide resulted in a 20% reduction in the risk of MACE (a composite of cardiovascular (CV) death, nonfatal myocardial infarction or non-fatal stroke), compared with placebo. The Wegovy package labeling was updated for this indication in March 2024.
    - The ongoing SURMOUNT-MMO trial is investigating cardiovascular outcomes with tirzepatide in obese patients without diabetes, with results expected in 2027.

Safety

- The products differ in their individual safety profiles, but common adverse reactions for most agents include increased heart rate, nausea, and diarrhea.
- Phentermine and the other amphetamine products are contraindicated in patients with a history of cardiovascular disease including coronary artery disease, stroke, arrhythmias, congestive heart failure, and uncontrolled hypertension.
- The GLP-1RAs share the same precautions, warnings, and adverse events. Gastrointestinal (GI) adverse events are most commonly reported and include nausea and vomiting. Patients receiving a GLP-1RA require counseling regarding potential mental health side effects, need for contraception, and risk of GI paralysis.
- Contrave labeling includes a black box warning against use in major depression or psychiatric disorders and should be avoided in patients that

have a history of seizures, uncontrolled hypertension, and in patients taking opioids.

- Qsymia requires a Risk Evaluation and Mitigation Strategy (REMS) program due to safety concerns in pregnant women and risk of congenital malformations, due to the topiramate component. Patients with hypertension, elevated heart rate, or renal dysfunction should use Qsymia with caution.
- Xenical should be avoided in patients with gallbladder disease or malabsorption syndromes.

Individual Product Characteristics

- **phentermine, phendimetrazine, benzphetamine, and diethylpropion** have been approved for decades for short-term weight management. MHS provider feedback support phentermine as a first step for treating obese patients who do not have contraindications.
- **phentermine 8 mg (Lomaira)** is a low-dose phentermine formulation approved for short-term use that can be administered up to three times daily before meals. Package labeling contains the same cardiovascular warning as the other amphetamine products.
- **phentermine/topiramate (Qsymia)** is mentioned in the 2023 AACE guidelines and can produce weight loss ranging from 5% to 11% from baseline. Disadvantages include the REMS program requirement for teratogenicity due to the topiramate component, its controlled substance status (CIV), and unavailability from the national mail order pharmacy (due to the REMS program). Qsymia generic formulations are expected in late 2024. MHS providers mentioned they prescribe the individual generic components separately.
- **naltrexone SR/bupropion SR (Contrave)** treatment results in a weight loss average of 5% from baseline. Contrave is relegated to second-line status due to the black box warning for suicidal thoughts and reduced efficacy relative to the other members of the class.
- **orlistat (Xenical)** is approved for children however it results in minimal weight loss, causes significant adverse GI effects, and is no longer recommended in clinical practice guidelines.
- **liraglutide (Saxenda)** advantages include evidence for reduced major adverse cardiovascular outcomes with the Victoza branded product. It is the least effective of the injectable weight loss GLP-1RAs, resulting in an average 8% weight loss.
- **semaglutide (Wegovy)** treatment results in an average 15% weight loss from baseline. Semaglutide is mentioned in several guidelines as being highly effective for weight loss. It is the only GLP-1RA labeled to reduce the risk of adverse CV outcomes, based on the SELECT trial.

- **tirzepatide (Zepbound)** treatment can reduce baseline weight on average of 15% to 20%. MHS providers mentioned a potentially better tolerated GI side effect profile of tirzepatide over semaglutide.

Other Factors

- For adolescent patients, Wegovy, Qsymia and Xenical are approved for patients as young as 12 years, while phentermine is not recommended for those under 16 years of age.
- A comparison of DoD with other health care plans showed several commercial plans do not cover weight loss medications due to cost considerations.
- Shortages have notably affected this class as demand increases nationally and globally. Prescribers are encouraged to reserve use of GLP1-RAs specifically approved for diabetes [e.g., dulaglutide (Trulicity), liraglutide (Victoza), semaglutide (Ozempic) and tirzepatide (Mounjaro)], solely for patients with diabetes and not for treating non-diabetic obese patients.

Overall Clinical Conclusion

- There is a moderate degree of interchangeability within the weight loss agents class as a whole due to differences in efficacy and safety profiles. However, there is a high degree of interchangeability between Wegovy and Zepbound.
- Provider feedback showed support for a shared decision-making model for pharmacotherapy for weight management. There was strong agreement for formulary inclusion of at least one GLP-1RA.

B. Weight Loss Agents—Relative Cost Effectiveness Analysis and Conclusion

The Committee reviewed the solicited bids from manufacturers and conducted a cost minimization analysis (CMA), budget impact analysis (BIA), and sensitivity analysis.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

- The committee reviewed the CMA results for benzphetamine, diethylpropion IR and ER, liraglutide (Saxenda), naltrexone SR/bupropion SR (Contrave), orlistat (Xenical, generics), phendimetrazine, phentermine, phentermine 8 mg (Lomaira, generics), phentermine/topiramate (Qsymia), semaglutide (Wegovy), and tirzepatide (Zepbound).
- A BIA and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary, NF, or completely excluded on the UF. BIA results showed that

designating the weight loss agents in accordance with the formulary recommendation below demonstrated significant cost avoidance for the MHS.

C. Weight Loss Agents—UF Recommendation

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) the following.

- UF generics
  - phentermine (Adipex-P, generics)
  - benzphetamine (Didrex, generics)
  - diethylpropion immediate release (IR) and sustained release (SR) (Tenuate, Tandil, generics)
  - phendimetrazine IR and SR (Bontril, generics)
- UF step-preferred brands
  - naltrexone SR/bupropion SR (Contrave) – *moves from NF to UF step-preferred*
  - phentermine/topiramate (Qsymia) – *moves from NF to UF step-preferred*
  - phentermine 8mg (Lomaira, generics) – *moves from NF to UF step-preferred*
  - semaglutide (Wegovy) – *moves from UF to UF step-preferred*
  - tirzepatide (Zepbound) – *moves from UF to UF step-preferred*
- NF non-step-preferred brands
  - liraglutide (Saxenda)
  - orlistat (Xenical, generics)
- Completely Excluded
  - None
- Note that as part of this recommendation, a trial of generic phentermine or one of the older generic amphetamine products in addition to all of the step-preferred branded drugs is required first for the NF, non-step-preferred products in all new users, unless the patient has a contraindication, inadequate response, or has experienced adverse effects with the step-preferred products.

D. Weight Loss Agents—Manual PA Criteria

PA has been in place since the original class review in 2017.

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) updates to the PA criteria as discussed below. PA is required to ensure appropriate use of the weight loss drugs and due to national supply shortages. Currently a sequential trial of phentermine, Qsymia, and Contrave is required before a GLP1-RA. The PA changes will apply to new patients, due to the varying mechanisms of action for the products and national supply shortages.

- Lifestyle modification remains a requirement prior to use of pharmacotherapy, based on clinical practice guidelines.
- PA is removed for phentermine, benzphetamine, diethylpropion IR/SR, phendimetrazine IR/and Lomaira.
- For Contrave, Qsymia, Wegovy and Zepbound, only a trial of generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR is required, rather than sequential use of all the products, unless the patient has a contraindication, inadequate response, or has experienced adverse effects to the step-preferred products.
- For Wegovy and Zepbound, the requirement for a trial of dulaglutide (Trulicity) and metformin first in patients with diabetes is removed, as Trulicity is not as effective at weight loss compared to semaglutide and tirzepatide.
- For new adult users of Saxenda and Xenical, a trial of phentermine plus all the step-preferred branded drugs (Contrave, Qsymia, Wegovy, and Zepbound) is required first, unless the patient has a contraindication, inadequate response, or has experienced adverse effects to the step-preferred products.
- The initial four- or six- month renewal period was removed, and the PAs will now expire annually (yearly renewal required).
- FDA-approved ages for pediatric patients were considered in the step-therapy requirements for adolescents.

The Manual PA criteria is as follows. Changes are noted in bold and strikethrough.

1. bupropion/naltrexone (Contrave)

Manual PA criteria apply to all new users of Contrave, and coverage is approved if:

- The patient is 18 years of age or older
- The patient has a BMI greater than or equal to 30, or a BMI greater than or equal to **27 in the presence of at least one weight-related comorbidity** ~~for those with risk factors in addition to obesity~~ (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)

- Patient has engaged in a trial of behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy
- The patient must have tried and failed to achieve a 5 percent reduction in baseline weight after 12-week course of phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR OR
- The patient has a contraindication to generic phentermine (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, hyperthyroidism) OR
- **The patient has experienced an adverse reaction to phentermine that is not expected to occur with Contrave**
- The patient is not receiving concurrent opioid therapy, and does not have a seizure disorder
- The patient is not currently on a monoamine oxidase inhibitor (e.g., Emsam, Marplan, Nardil), or another formulation of bupropion or naltrexone
- Patient is not pregnant
- ~~If patient has impaired glucose tolerance or diabetes, must have tried metformin first, or is concurrently taking metformin~~

Non-FDA-approved uses are not approved

PA expires **in 12 months** ~~after 4 months~~ for initial therapy,~~ renewal therapy approves for 12 months~~; **annual renewal required**

Renewal PA Criteria: Contrave will be approved for an additional 12 months if the following are met:

- The patient is currently engaged in behavioral modification and on a reduced calorie diet
- The patient lost greater than or equal to 5 percent of baseline body weight since starting medication
- The patient is not pregnant

2. phentermine/topiramate (Qsymia)

Manual PA criteria apply to all new users of Qsymia and coverage is approved if:

- Patient is 12 years of age or older and younger than 18 years of age with BMI greater than or equal to 95th percentile standardized for age and sex OR
- Patient is 18 years of age or older with a BMI greater than or equal to 30, or a BMI greater than or equal to 27 **in the presence of at least one weight-related comorbidity** ~~for those with risk factors in~~

~~addition to obesity~~ (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)

- Patient has engaged in a trial of behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss and will remain engaged throughout course of therapy
- The patient must have tried and failed to achieve a 5 percent reduction in baseline weight after 12-week course of phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR OR
- The patient has a contraindication to generic phentermine (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, hyperthyroidism) OR
- **The patient has experienced an adverse reaction to phentermine that is not expected to occur with the requested agent**
- ~~Patient does not have a history of cardiovascular disease (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, hyperthyroidism)~~
- ~~Patient has tried generic phentermine for 3 months and had an inadequate response if they are older than 18 years OR~~
- Patient is not pregnant.
- Provider agrees to monitor the rate of weight loss in pediatric patients. If weight loss exceeds 2 pounds (0.9 kg)/week, consider dosage reduction
- Prescriber will abide by and the patient has been informed of the Risk Evaluation and Mitigation Strategy (REMS) program and safety concerns associated with this agent:
  - Use in combination with other products intended for weight loss has not been established
  - Use in patients with increased cardiovascular risk has not been established
  - Qsymia is pregnancy category X and is associated with increased risk of teratogenicity
- ~~If patient has impaired glucose tolerance or diabetes, must have tried metformin first or is concurrently taking metformin.~~

Non-FDA approved uses are not approved

PA expires after ~~four~~ in **12 months** for initial therapy, ~~renewal therapy approves for 12 months~~, **annual renewal required**

Renewal PA Criteria: Qsymia will be approved for an additional 12 months if the following are met:

- The patient is currently engaged in behavioral modification and on a reduced calorie diet
- The patient has lost greater than or equal to 5 percent of baseline body weight since starting medication
- For patients initially receiving Qsymia 7.5 mg/46 mg: discontinue Qsymia or escalate to 15 mg/92 mg if a percent reduction in baseline body weight is not achieved **or a pediatric patient has not experienced a reduction of at least 3% of baseline BMI** at 12 weeks
- For patients receiving Qsymia 15 mg/92 mg: discontinue if a 5 percent reduction in baseline body weight is not achieved **or a pediatric patient has not experienced a reduction of at least 5% of baseline BMI** at 12 weeks
- The patient is not pregnant

3. semaglutide (Wegovy) and tirzepatide (Zepbound)

Manual PA criteria apply to all new users of Wegovy and Zepbound and coverage is approved if:

For Wegovy and Zepbound for adults

- Patient is 18 years of age or older
- Patient has a BMI greater than or equal to 30, or a BMI greater than or equal to 27 i**n the presence of at least one weight-related comorbidity** ~~for those with risk factors in addition to obesity~~ (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)
- Patient has engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy
- ~~•~~ Patient has tried **3 months of generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR and had an inadequate response** ~~all of the following (generic phentermine, and Qsymia, and Contrave)~~

  Phentermine: Date_____ Duration of therapy _____ OR
- ~~•~~ The patient has a contraindication to **generic phentermine (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension) OR** ~~to all of the following weight loss medications (Note: provider must include the date of use and duration of therapy or contraindication to the drug)~~
- ~~• Qsymia: Date_____ Duration of therapy_____~~

- ~~Contrave: Date _____ Duration of therapy_____~~
- ~~If the patient is diabetic, must have tried and failed metformin and the DoD's preferred GLP1RAs (Trulicity)~~
- **The patient has experienced an adverse reaction to phentermine that is not expected to occur with Wegovy or Zepbound**

For Wegovy for adolescents (note that Zepbound is not currently FDA-approved for adolescents)

- Patient is 12 years of age or older and younger than 18 years of age
- Patient has a BMI greater than or equal to 95th percentile standardized for age
- Patient has engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy

For all patients

- Concomitant use of this medication with another GLP1RA is not allowed (e.g., Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)
- The patient does not have a history of or family history of medullary thyroid cancer or multiple endocrine neoplasia syndrome type 2
- Patient is not pregnant

Non-FDA approved uses are not approved including diabetes mellitus

~~Initial prior authorization expires after 4 months and then annually.~~

PA expires in 12 months for initial therapy; annual renewal required

<u>Renewal PA Criteria</u>: Wegovy and Zepbound will be approved for an additional 12 months if the following are met:

- The patient is currently engaged in behavioral modification and on a reduced calorie diet
- For Wegovy: for patients older than 12 years of age and younger than 18 years of age, the patient has lost greater than or equal to 4% of baseline body weight since starting medication ~~despite 16 weeks of therapy~~ **with full dosage titration**
- For Wegovy and Zepbound: for patients older than 18 years of age, the patient has lost greater than or equal to 5% of baseline body weight since starting medication
- The patient is not pregnant

4. liraglutide (Saxenda)

Manual PA criteria apply to all new users of Saxenda and coverage is approved if:

Adults

- Patient is 18 years of age or older
- Patient has a BMI greater than or equal to 30, or a BMI greater than or equal to 27 i**n the presence of at least one weight-related comorbidity** ~~for those with risk factors in addition to obesity~~ (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)
- Patient has engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy
- Patient has tried and failed all of the following (generic phentermine, or benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR, Qsymia, and Contrave) or has experienced an adverse reaction or has a contraindication to all of the following weight loss medications (Note: provider must include the date of use and duration of therapy or contraindication to the drug)
  - Phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR:
    Date _____ Duration of therapy_____
  - Qsymia (or one of its individual generic components phentermine or topiramate):
    Date _____Duration of therapy _____
  - Contrave (or one of its individual generic components bupropion or naltrexone):
    Date _____Duration of therapy _____
  - **Wegovy:**
    Date _____Duration of therapy _____
  - **Zepbound:**
    Date _____Duration of therapy _____
- ~~If the patient is diabetic, must have tried and failed metformin and the DoD's preferred GLP1RAs (Trulicity)~~

Adolescents

- Patient is 12 years of age or older and younger than 18 years of age with BMI greater than or equal to 95th percentile standardized for age

- Patient has engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy
- Patient has tried and failed Qsymia or its individual generic components OR
- Patient has a contraindication or has had an adverse reaction to Qsymia or its individual generic components (Note: provider must include the date of use and duration of therapy or contraindication to the drug) and Wegovy
  - Qsymia (or one of its individual generic components, phentermine or topiramate):
    Date_____ Duration of therapy _____
  - **Wegovy**:
    Date_____ Duration of therapy _____

For all patients

- Concomitant use of Wegovy with another GLP1RA is not allowed (e.g., Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)
- The patient does not have a history of or family history of medullary thyroid cancer or multiple endocrine neoplasia syndrome type 2
- Patient is not pregnant

Non-FDA approved uses are not approved including diabetes mellitus

~~Initial prior authorization expires after 4 months and then annually.~~

PA expires in 12 months for initial therapy, annual renewal required

Renewal PA Criteria: Saxenda will be approved for an additional 12 months if the following are met:

- The patient is currently engaged in behavioral modification and on a reduced calorie diet
- **Patient is older than 12 years of age and younger than 18 years of age: the patient has lost greater than or equal to 4% of baseline body weight since starting medication despite 16 weeks of therapy with full dosage titration**
- **Patient is older than 18 years of age: the patient has lost greater than or equal to 5% of baseline body weight since starting medication**
- The patient is not pregnant

5. orlistat (Xenical)

Manual PA criteria apply to all new users of Xenical and coverage is approved if:

For adults:

- The patient is 18 years of age or older
- Patient has a BMI greater than or equal to 30, or a BMI greater than or equal to 27 **in the presence of at least one weight-related comorbidity** ~~for those with risk factors in addition to obesity~~ (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)
- Patient has engaged in a trial of behavioral modification and dietary restriction for at least 6 months and will remain engaged throughout course of therapy.
- **Patient has tried and failed all of the following (generic phentermine [or benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR], Qsymia, Contrave, Wegovy, and Zepbound) or has experienced an adverse reaction or has a contraindication to all of the following weight loss medications (Note: provider must include the date of use and duration of therapy or contraindication to the drug)**
  - **Phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR:**
    Date _____ Duration of therapy_____
  - **Qsymia** (or one of its individual generic components phentermine or topiramate):
    Date _____Duration of therapy _____
  - **Contrave** (or one of its individual generic components bupropion or naltrexone):
    Date _____Duration of therapy _____
  - **Wegovy:**
    Date _____Duration of therapy _____
  - **Zepbound:**
    Date _____ Duration of therapy _____
- Patient does not have chronic malabsorption syndrome, or cholestasis
- Patient is not pregnant
- ~~If patient has impaired glucose tolerance or diabetes, must have tried metformin first, or is concurrently taking metformin~~

Non-FDA-approved uses are not approved

PA expires after 12 months ~~4 months~~ for initial therapy, ~~renewal therapy approves for 12 months~~ **annual renewal required**

Renewal Criteria

- Patient is currently engaged in behavioral modification and on a reduced calorie diet
- The patient has lost greater than or equal to 5% of baseline body weight since starting medication
- The patient is not pregnant

For adolescents:

- The patient is 12 years if age or older and younger than 18 years of age
- Patient currently has a BMI greater than or equal to 95th percentile for age and sex, or in greater than or equal to 85th percentile but less than 95th percentile for age and sex and has at least one severe co-morbidity (type 2 diabetes mellitus, premature cardiovascular disease) or has a strong family history of diabetes or premature cardiovascular disease (CVD)
- Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months and has failed to achieve the desired weight loss and will remain engaged throughout course of therapy
- Must have tried and failed or have adverse reaction or have a contraindication to ~~generic phentermine~~ **Qsymia and Wegovy** (Note: provider must include the date of use and duration of therapy or contraindication to the drug)
  - **Qsymia** (or one of its individual generic components, phentermine or topiramate):
    Date_____ **Duration of therapy** _____
  - **Wegovy**:
    Date_____ **Duration of therapy** _____
- Patient does not have chronic malabsorption syndrome, or cholestasis
- Patient is not pregnant

Non-FDA-approved uses are not approved

PA expires after **12 months** ~~4 months~~ for initial therapy, ~~renewal therapy approves for 12 months;~~ **annual renewal required**

Renewal Criteria

- Patient is currently engaged in behavioral modification and on a reduced calorie diet
- The patient current BMI percentile decreased for age and weight (considering the patient is increasing in height and will have a different normative BMI from when Xenical was started)
- The patient currently has a BMI greater than 85th percentile
- The patient is not pregnant

E. Weight Loss Agents—UF, PA, and Implementation Period

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) an effective date the first Wednesday 30 days after signing of the minutes in all points of service.

V. UF DRUG CLASS REVIEW—WEIGHT LOSS AGENTS

UF BAP Comments

A. Weight Loss Agents—UF Recommendation

The P&T Committee recommended formulary status as discussed above.

- UF generics
  - Adipex-P, generics
  - Didrex, generics
  - Tenuate, Tandil, generics
  - Bontril, generics
- UF step-preferred brands
  - Contrave
  - Qsymia
  - Lomaira, generics
  - Wegovy
  - Zepbound
- NF non-step-preferred brands
  - Saxenda
  - Xenical, generics
- Completely Excluded
  - None

- Note that as part of this recommendation, a trial of generic phentermine or one of the older generic amphetamine products in addition to all of the step-preferred branded drugs is required first for the NF, non-step-preferred products in all users, unless the patient has a contraindication, inadequate response, or has experienced adverse effects with the step-preferred products.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Weight Loss Agents—Manual PA Criteria

The P&T Committee recommended manual PA criteria in new users as outlined above.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Weight Loss Agents—UF, PA, and Implementation Period

The P&T Committee recommended an effective date the first Wednesday 30 days after signing of the minutes in all points of service.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

VI. CLASS REVIEW– PULMONARY II AGENTS: INHALED CORTICOSTEROIDS (ICS) SUBCLASS

P&T Comments

Pulmonary II Agents: Inhaled Corticosteroids (ICS) Subclass—Relative Clinical Effectiveness Conclusion

The P&T Committee evaluated the relative clinical effectiveness of the Inhaled Corticosteroids (ICS) subclass. The class includes a variety of dry powder inhalers and hydrofluoroalkane (HFA) oral inhalers. This class was last reviewed for formulary

status in May 2014, when fluticasone propionate (Flovent Diskus and Flovent HFA) was designated as the UF step-preferred products, and all other products were non-step-preferred.

The branded Flovent HFA and Diskus agents were discontinued from the market in late 2023 (see November 2023 DoD P&T Committee meeting minutes). Language in the PA criteria for the non-step-preferred inhaled corticosteroids was updated to require a trial of fluticasone propionate first, rather than Flovent HFA or Flovent Diskus. Additionally, the previous Tier 1 copay for brand Flovent HFA and Flovent Diskus were removed in November 2023.

Note that budesonide nebulized solution (Pulmicort Respule) remains UF but is not subject to the step-therapy structure for this subclass. All agents are FDA-approved for asthma management. The clinical review focused on available published trials, clinical practice guidelines, meta-analyses, and systematic reviews.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

Clinical Practice Guidelines

- *Asthma*: Guidelines support monotherapy with ICS as part of a treatment plan for children and as an alternative treatment option for adolescents and adults. Preferred asthma treatment continues to support use of Maintenance and Reliever Therapy (MART) with combination formoterol and ICS. Society guidelines do not prefer one specific ICS product over another.
- *Off-label uses*:
    - *Eosinophilic Esophagitis (EoE)*: Topical corticosteroids may be used to treat EoE; however no single product is favored in guidelines.
    - *Chronic Obstructive Pulmonary Disease (COPD)*: Professional guidelines state monotherapy with ICS is not recommended.

Efficacy

- *Asthma*: There is limited head-to-head data between agents within the subclass. A network meta-analysis was reviewed for asthma treatment in children and concludes an improvement in asthma symptoms and exacerbations with ciclesonide versus budesonide and fluticasone could be neither demonstrated nor refuted. An additional network meta-analysis was reviewed which supported comparable treatment effect between fluticasone furoate (Arnuity Ellipta) and fluticasone propionate (Flovent) in adolescents and adults with persistent asthma.

Safety

- In terms of safety, all agents carry similar warnings. Milk allergen concerns are unique to dry powder inhaler formulations. Budesonide remains the preferred ICS for use in pregnancy. MHS providers mentioned ciclesonide (Alvesco) may be preferred for use in rare cases of concern for patients with adrenal suppression.

Other Factors and Individual Product Characteristics

- Budesonide is the only drug in this subclass which is available in a nebulized solution (Pulmicort Respules) and dry powder inhaler (Pulmicort Flexhaler). Mometasone is available in a dry powder inhaler (Asmanex Twisthaler) and HFA (Asmanex HFA).
- Fluticasone propionate is available in multiple formulations, including dry powder inhaler (diskus) and HFA. The branded Flovent products were removed from the market by the manufacturer in late 2023, but authorized generic formulations are available for both the diskus and HFA. The completely excluded agent, fluticasone propionate digihaler (ArmonAir Digihaler), continues to offer no significant clinical benefit relative to other ICS agents and the needs of TRICARE beneficiaries are met by numerous alternative agents.
- Fluticasone furoate (Arnuity Ellipta) is available as a single product (dry powder inhaler) and offers no compelling clinical advantages compared to using fluticasone propionate.
- Beclomethasone (Qvar Redihaler) and ciclesonide (Alvesco) are only available in HFA formulations.

Overall Clinical Conclusion

- In order to meet the needs of MHS patients, at least two ICS products are required on the formulary.

B. Pulmonary II Agents: Inhaled Corticosteroids (ICS) Subclass—Relative Cost Effectiveness Analysis and Conclusion

The Committee reviewed the solicited bids from manufacturers and conducted a cost minimization analysis (CMA), budget impact analysis (BIA), and sensitivity analysis.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results of the ICSs showed the following, ranked from most cost effective to least cost effective: ciclesonide (Alvesco HFA), mometasone furoate (Asmanex Twisthaler), fluticasone propionate diskus authorized generic, mometasone furoate (Asmanex HFA), fluticasone propionate HFA authorized generic, fluticasone propionate (Flovent Diskus brand - discontinued), fluticasone furoate (Arnuity Ellipta), budesonide (Pulmicort Flexhaler), beclomethasone (Qvar Redihaler), fluticasone propionate (Flovent HFA brand - discontinued), budesonide (Pulmicort Respule) and fluticasone propionate digihaler (Armonair Digihaler).
- A BIA and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary, NF, or completely excluded on the UF. BIA results showed that designating the ICS agents in

accordance with the formulary recommendation below demonstrated significant cost avoidance for the MHS.

C. Pulmonary II Agents: Inhaled Corticosteroids (ICS) Subclass—UF Recommendation

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) the following.

- UF
  - ciclesonide (Alvesco) – *moves from NF to UF status*
  - fluticasone propionate diskus authorized generic
  - fluticasone propionate HFA authorized generic
  - mometasone (Asmanex Twisthaler) – *moves from NF to UF status*
  - mometasone (Asmanex HFA)
- NF
  - beclomethasone (QVAR Redihaler)
  - budesonide (Pulmicort Flexhaler)
  - fluticasone furoate (Arnuity Ellipta) – *moves from UF to NF status*
- Completely Excluded
  - fluticasone propionate digihaler (Armonair Digihaler)
- Note that budesonide nebulized solution (Pulmicort Respules) remains UF
- Note the brand fluticasone diskus and HFA (Flovent Diskus, Flovent HFA) are no longer marketed

D. Pulmonary II Agents: Inhaled Corticosteroids (ICS) Subclass—Manual PA Criteria Removal

PA and step therapy have been required since the original class review in 2014. The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) removing the PA criteria and step therapy for all the products in the class.

E. Pulmonary II Agents: Inhaled Corticosteroids (ICS) Subclass—UF, PA Removal, and Implementation Period

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday 90 days after signing of the minutes in all points of service, and 2) that DHA mail letters to patients affected by the copay change for Arnuity Ellipta.

VII. UF DRUG CLASS REVIEW—PULMONARY II AGENTS: INHALED CORTICOSTEROIDS

UF BAP Comments

A. Pulmonary II Agents: Inhaled Corticosteroids (ICS)—UF Recommendation

The P&T Committee recommended formulary the following.

- UF
  - Alvesco
  - fluticasone propionate diskus authorized generic
  - fluticasone propionate HFA authorized generic
  - Asmanex Twisthaler
  - Asmanex HFA
- NF
  - QVAR Redihaler
  - Pulmicort Flexhaler
  - Arnuity Ellipta
- Completely Excluded
  - Armonair Digihaler
- Note that Pulmicort Respules remains UF
- Note that Flovent Diskus, Flovent HFA are no longer marketed

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Pulmonary II Agents: Inhaled Corticosteroids (ICS)—Manual PA Criteria Removal

The P&T Committee recommended removing the current manual PA, as outlined above.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Pulmonary II Agents: Inhaled Corticosteroids (ICS)—UF, PA Removal, and Implementation Period

The P&T Committee recommended 1) an effective date of the first Wednesday 90 days after signing of the minutes in all points of service, and 2) that DHA mail letters to patients affected by the copay change for Arnuity Ellipta.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

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

P&T Comments

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

The P&T Committee agreed (17 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).

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

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) the following:

- UF
  - birch triterpenes 10% (w/w) topical gel (Filsuvez) – Skin Preps for epidermolysis bullosa
  - budesonide 2 mg/10 mL oral suspension (Eohilia) – Gastrointestinal-1 Agent for eosinophilic esophagitis (EoE)
  - eflornithine tablets (Iwilfin) – Oncological Agent for neuroblastoma
  - eltrombopag 9 mg, 18 mg, 35 mg, 54 mg tablets (Alvaiz) – Hematological Agents: platelets, for chronic immune thrombocytopenia (ITP)
  - eplontersen injection (Wainua) – Miscellaneous Neurological Agent for hereditary transthyretin-mediated amyloidosis
  - infliximab-dyyb injection (Zymfentra) – Targeted Immunomodulatory Biologics (TIBs): tumor necrosis factor (TNF) inhibitor for ulcerative colitis and Crohn's disease.
  - nedosiran injection (Rivfloza) – Nephrology Agent for hyperoxaluria type 1 (PH1)

        - omalizumab autoinjector (Xolair) – Atopy Agents; new formulation and indication for reduction of allergic reactions (Type I) in patients with IgE-mediated food allergy
        - vamorolone oral suspension (Agamree) – Corticosteroids – Immune Modulator for Duchenne Muscular Dystrophy
        - zilucoplan injection (Zilbrysq) – Miscellaneous Neurological Agent for myasthenia gravis
    - NF
        - bosutinib capsules (Bosulif) – Oncological Agents for chronic myelogenous leukemia (CML)
        - cyclosporine 0.1% ophthalmic solution (Vevye) – Ophthalmic agent for dry eye disease
        - iptacopan (Fabhalta) – Hematological Agent for paroxysmal nocturnal hemoglobinuria (PNH)
        - roflumilast 0.3% topical foam (Zoryve) – Psoriasis Agent
        - sitagliptin free base (Zituvio) – Diabetes Non-Insulin: Dipeptidyl Peptidase 4 (DPP-4) Inhibitor for diabetes
        - sitagliptin free base (Zituvio authorized generic) – Diabetes Non-Insulin: (DPP-4) Inhibitor for diabetes
    - Completely Excluded
        - None

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

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) the following PA criteria.

- Applying manual PA criteria to new users of the oncology drugs Bosulif capsules and Iwilfin; and for new users of Filsuvez, Eohilia, Wainua, Fabhalta, Rivfloza, Agamree, Xolair and Zilbrysq.
- Applying manual PA criteria to new users of Zymfentra requiring a trial of Humira or intravenous infliximab, similar to what is in place for the other non-step-preferred TIBs approved for treating ulcerative colitis.
- Applying manual PA criteria to new users of Vevye, requiring a three-month trial of generic Restasis unit dose, Cequa, and Xiidra first, similar to the requirements for the other NF ophthalmic cyclosporine products.
- Applying manual PA criteria to new users of Zituvio and Zituvio authorized generic, requiring a trial of Januvia, similar to other NF, non-step-preferred DPP-4 inhibitor in the class.

The Manual PA criteria is as follows:

1. birch triterpenes 10% topical gel (Filsuvez)

Manual PA criteria apply to all new users of Filsuvez and coverage is approved if all criteria are met:

- Patient is 6 months of age or older
- Prescribed by a dermatologist or wound care specialist
- Patient has a diagnosis of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB)
- Patient has one or more open wounds that will be treated
- Patient's wound is clean in appearance and does not appear to be infected

Non-FDA approved uses are NOT approved

PA expires in **6** months

Renewal criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved annually for continuation of therapy if all the criteria are met:

- The patient has had disease stabilization or improvement in disease on therapy
- Renewal prescription is written by a dermatologist or wound care specialist

2. bosutinib capsules (Bosulif)

Manual PA criteria apply to all new users of Bosulif capsules and coverage is approved if all criteria are met:

- Bosulif capsules are prescribed by or in consultation with a hematologist/oncologist
- Patient is 1 years of age or older with chronic phase Ph+ chronic myelogenous leukemia, that is either newly diagnosed or resistant or intolerant to prior therapy OR
- Patient is 18 years of age or older with accelerated or blast phase Ph+ chronic myeloid leukemia with resistance or intolerance to prior therapy
- Patient cannot swallow tablets due to a documented medical condition (e.g., dysphagia)
- The provider is aware of all warnings, screening, and monitoring precautions for Bosulif

- 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

Other non-FDA approved uses are NOT approved except as noted above

PA does not expire

3. budesonide 2 mg/10 mL oral suspension (Eohilia)

Manual PA criteria apply to all new users of Eohilia and coverage is approved if all criteria are met:

- Prescribed by a gastroenterologist or allergy/immunology specialist
- Patient has a documented diagnosis of eosinophilic esophagitis (EoE) by endoscopic biopsy
- Patient has tried and had an inadequate response, intolerance, or contraindication to a Proton Pump Inhibitor

Non-FDA approved uses are NOT approved

PA does not expire

4. cyclosporine 0.1% ophthalmic solution (Vevye)

Manual PA criteria apply to all new users of Vevye and coverage is approved if all criteria are met:

- Patient is 18 years of age or older
- Medication is prescribed by an ophthalmologist or optometrist
- Patient has a diagnosis of moderate to severe dry eye disease
- Patient had positive symptomology screening for dry eye disease from an appropriate measure
- Patient has at least one positive diagnostic test (e.g., Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)
- Patient has had at least 1 month of one ocular lubricant used at optimal dosing and frequency (e.g., carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc.], polyvinyl alcohol [Liquitears, Refresh Classic, etc.], or wetting agents [Systane, Lacrilube])
- Patient has had at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol)
- Patient has had at least a 3-month trial of cyclosporine (Restasis) cyclosporine 0.09% (Cequa) or lifitegrast (Xiidra)

Non-FDA approved uses are not approved

PA does not expire

5. eflornithine tablets (Iwilfin)

Manual PA criteria apply to all new users of Iwilfin

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

- Prescribed by or in consultation with an oncologist
- Patient has high-risk neuroblastoma
- Medication is being used to reduce the risk of relapse
- Patient has had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy
- The provider is aware of all warnings, screening, and monitoring precautions for Iwilfin
- 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

Other non-FDA approved uses are not approved except as noted above

PA does not expire

6. eplontersen injection (Wainua)

Manual PA criteria apply to all new users of Wainua and coverage is approved if all criteria are met:

- The patient is 18 years of age or older
- Drug is prescribed by or in consultation with a specialist who manages hereditary transthyretin amyloidosis (such as neurologist, cardiologist, and/or medical geneticist)
- The patient has documented evidence of hATTR polyneuropathy as confirmed by the following:
  - Genetically confirmed transthyretin mutation resulting in Coutinho stage 1 or 2 hereditary transthyretin-mediated amyloidosis (hATTR)
  - The patient has polyneuropathy secondary to hereditary transthyretin-mediated amyloidosis
  - The patient has a Neuropathy Impairment Score between 10-130

- The patient is not receiving concurrent treatment with Tegsedi (inotersen), Onpattro (patisiran), Amvuttra (vutrisiran) or Vyndaqel/Vyndamax (tafamidis)
- The provider acknowledges that the patient will receive an oral Vitamin A supplement at the recommended daily allowance while receiving the requested medication

Non-FDA approved uses are not approved including hATTR cardiomyopathy

PA expires in one year

Renewal Criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if all the criteria are met:

- Patient has demonstrated improvement in neuropathy

7. infliximab-dyyb injection (Zymfentra)

Manual PA criteria apply to all new users of Zymfentra and coverage is approved if all criteria are met:

- Patient is 18 years of age or older
- Patient has moderate to severely active ulcerative colitis or moderate to severe Crohn's disease
- The provider acknowledges Humira is the Department of Defense's preferred targeted biologic agent for ulcerative colitis and Crohn's disease
- Patient has experienced one of the following:
  - Patient has had an inadequate response to Humira
  - Patient has had an adverse reaction to Humira that is not expected to occur with the requested agent
  - Patient has a contraindication to Humira
  - Patient is clinically stable on IV infliximab and changing to Humira would incur unacceptable risk
- Patient has received infliximab product administered intravenously as induction therapy and has demonstrated positive response
- Patient has had an inadequate response to nonbiologic systemic therapy (for example – methotrexate, aminosalicylates (e.g., sulfasalazine, mesalamine), corticosteroids, immunosuppressants (e.g., azathioprine), etc.
- Patient has negative TB test result in past 12 months (or TB is adequately managed)

- Patient will not be receiving any other targeted immunomodulatory biologics with infliximab-dyyb (Zymfentra) including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), upadacitinib (Rinvoq ER), or vedolizumab (Entyvio)

Non-FDA approved uses are not approved

PA does not expire

8. iptacopan (Fabhalta)

Manual PA criteria apply to all new users of Fabhalta and coverage is approved if all criteria are met:

- Patient is 18 years of age or older
- Prescribed by a hematologist or oncologist
- Patient has documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)
- Provider is aware of all monitoring requirements, screening precautions, importance of medication adherence, and REMS requirements
- Patient is not receiving C3 or C5 inhibitors with Fabhalta, including but not limited to the following: eculizumab (Soliris), ravulizumab (Ultomiris), danicopan (Voydeya), or pegcetacoplan (Empaveli)

Non-FDA approved uses are NOT approved

PA expires after 6 months

Renewal Criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if all the criteria are met:

- Patient meets initial criteria, has documentation of positive clinical response including increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, or reductions in hemolysis

9. nedosiran injection (Rivfloza)

Manual PA criteria apply to all new users of Rivfloza

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

- Patient has a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by genetic testing of the AGXT mutation
- The medication is prescribed by or in consultation with a nephrologist or urologist
- The medication is prescribed for an FDA-approved age
- Patient has an estimated glomerular filtration rate (eGFR) ≥30 mL/min/1.73 m2
- Patient has trialed pyridoxine and has experienced an inadequate response or intolerance OR patient has a contraindication to pyridoxine
- Rivfloza will not be used in combination with lumasiran (Oxlumo)

Non-FDA approved uses are NOT approved

PA expires after one year; annual renewal required

Renewal Criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved for continuation of therapy if all the criteria are met:

- The patient has had disease stabilization or improvement in disease on therapy

10. omalizumab autoinjector (Xolair)

Manual PA criteria apply to all new users of Xolair autoinjector

There were no changes to the PA criteria for Xolair indications other than the new indication for food allergy.

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

There were no changes to the PA criteria for Xolair indications other than the new indication for food allergy.

For food allergy:

- Xolair is prescribed by an allergist or immunologist
- The patient has a documented history of food allergy
- Provider acknowledges clinical trials excluded those with a history of severe anaphylaxis, uncontrolled or severe asthma, uncontrolled atopic dermatitis, or eosinophilic gastrointestinal disease
- The patient is not currently receiving oral, intramuscular (IM), or intravenous (IV) corticosteroids, tricyclic antidepressants, or beta-blockers (oral or topical)
- The patient is not currently receiving or has not received in the last 6 months any immunotherapy [e.g., oral immunotherapy (OIT),

sublingual immunotherapy (SLIT) or epicutaneous immunotherapy (EPIT)] to the food allergen being treated

- The patient is not currently receiving or has not received in the last 6 months other immunomodulatory therapy
- Provider acknowledges that the patient will be counseled on the following:
  - Xolair does NOT eliminate food allergy and the patient must continue to avoid food allergen
  - The need for access to an epinephrine injector
  - Xolair is not intended to treat emergencies

For all indications:

- Provider acknowledges Xolair carries a black box warning for anaphylaxis, should be initiated in a healthcare setting, and self-administration of Xolair should be based on criteria to mitigate risk from anaphylaxis.
- Patient has received or will receive at least 3 doses of Xolair under the guidance of a healthcare provider without experiencing any hypersensitivity reactions
- Provider agrees to ensure that the patient or caregiver is able to recognize symptoms of anaphylaxis.
- Provider agrees to ensure that the patient or caregiver is able to treat anaphylaxis appropriately with co-prescribing epinephrine.
- Provider agrees to ensure that the patient or caregiver is able to perform subcutaneous injections with requested medication with proper technique according to the prescribed dosing regimen
- For all indications the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or dupilumab [Dupixent])
- For the Xolair prefilled syringe formulation, the provider acknowledges:
  - Patients 1 to 11 years of age: must be administered by a caregiver.
  - Patients older than 12 years: may be self-administered, or under adult supervision for pediatric patients
- For the Xolair autoinjector formulation the provider acknowledges:
  - Patients less than 12 years of age: not authorized
  - Patients older than 12 years: may be self-administered, or under adult supervision for pediatric patients

Non-FDA approves uses are not approved

PA expires in one year

Renewal criteria for food allergies

Note that initial TRICARE PA approval is required for renewal. Coverage will be approved annually for continuation of therapy if all the criteria are met:

- Food allergy: Provider acknowledges that the patient will continue to be counseled on the following:
  - Xolair does NOT eliminate food allergy and patient must continue to avoid food allergen
  - The need for access to an epinephrine injector
  - Xolair is not intended to treat emergencies

11. roflumilast 0.3% topical foam (Zoryve)

Manual PA criteria apply to all new users of Zoryve

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

- Patient is 9 years of age or older
- Prescribed by or in consultation with a dermatologist
- Patient has diagnosis of moderate to severe seborrheic dermatitis
- The patient must have tried for at least 2 weeks and failed, or have a contraindication to, or have had an adverse reaction to both of the following:
  - at least one topical corticosteroid (e.g., mometasone furoate 0.1% solution)
  - at least one topical antifungal (e.g., ketoconazole 2% shampoo)

Non-FDA approves uses are not approved

PA expires in one year; new PA must be submitted

12. sitagliptin free base (Zituvio, Zituvio authorized generic)

Manual PA criteria apply to all new users of Zituvio and Zituvio authorized generic and coverage is approved if all criteria are met:

- Provider acknowledges that Januvia is TRICARE's preferred dipeptidyl peptidase-4 (DPP-4) inhibitor and are available to TRICARE beneficiaries without requiring prior authorization
- Provider must document why the patient cannot use the Zituvio. (blank write-in)

- Acceptable responses include that the patient has had an adverse reaction to an excipient in brand sitagliptin phosphate (Januvia) that would not be likely to occur with Zituvio

Non-FDA approved uses are NOT approved

PA does not expire

13. vamorolone oral suspension (Agamree)

Manual PA criteria apply to all new users of Agamree

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

- Patient is 2 years of age or older
- Prescribed by a neurologist
- Patient has a diagnosis of Duchenne Muscular Dystrophy (DMD) that has been confirmed by genetic testing or muscle biopsy
- Patient has a contraindication to, intolerability to, or has failed a trial for at least 3 months of at least one of the following:
  - prednisone or
  - deflazacort (Emflaza)
- Provider acknowledges the FDA safety alerts, warnings, precautions, drug interactions, and monitoring recommendations for the requested medication

Non-FDA approved uses are NOT approved

PA does not expire

14. zilucoplan injection (Zilbrysq)

Manual PA criteria apply to all new users of Zilbrysq

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

- Patient is 18 years of age or older
- Prescribed by a neurologist
- Patient has documented diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive
- Patient is not known to be muscle-specific tyrosine kinase antibody-positive
- Patient has had insufficient response or intolerance to pyridostigmine

- Patient has had insufficient response or intolerance to glucocorticoid sparing therapy such as azathioprine, mycophenolate, cyclosporine, or tacrolimus
- Patient has had insufficient response or intolerance to a neonatal Fc receptor antagonist such as efgartigimod alfa or rozanolixizumab (Rystiggo)
- Patient has been vaccinated against certain encapsulated bacteria (for example, Streptococcus pneumoniae, Neisseria meningitidis types A, C, W, Y, and B, and *Haemophilus influenzae* type B)
- Patient is not receiving neonatal Fc receptor antagonists or other C5 inhibitors with Zilbrysq, including but not limited to the following: eculizumab (Soliris), ravulizumab (Ultomiris), rozanolixizumab (Rystiggo), efgartigimod (Vyvgart), efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo)

Non-FDA approved uses are not approved

PA expires in 6 months

Renewal Criteria: Note that initial Tricare PA approval is required for renewal. Coverage will be approved annually for continuation of therapy if all the criteria are met:

- Patient is continuing to derive benefit from Zilbrysq, according to the prescriber (Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function)

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

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) an effective date of the following:

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

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

UF BAP Comments

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

The P&T Committee recommended the formulary status for the newly approved drugs as discussed above.

- UF

- Filsuvez
- Eohilia
- Iwilfin
- Alvaiz
- Wainua
- Zymfentra
- Rivfloza
- Xolair
- Agamree
- Zilbrysq

- NF
  - Bosulif
  - Vevye
  - Fabhalta
  - Zoryve
  - Zituvio
  - Zituvio authorized generic
- Completely Excluded
  - None

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

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

The P&T Committee recommended the PA criteria for the new drugs as stated previously.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent:

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

The P&T Committee recommended implementation period of two weeks as discussed above.

UF BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

X. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA AND IMPLEMENTATION PERIOD—ANTICONVULSANTS-ANTIMANIA AGENTS—BRIVARACETAM (BRIVIACT)

P&T Comments

A. New Manual PA Criteria

Anticonvulsants-Antimania Agents—brivaracetam (Briviact)

Briviact was reviewed as an innovator at the August 2016 P&T meeting and designated as NF. Briviact is an analog related to levetiracetam (Keppra). Indirect comparison suggests there are no statistically significant differences between Briviact and Keppra with regard to efficacy and adverse effects.

Specialist feedback supported use of other anticonvulsants, including levetiracetam, before prescribing Briviact. MHS utilization data showed 50% of Briviact prescriptions were initiated by a neurologist, and nearly 50% of patients did not have a trial of levetiracetam first. Many commercial health plans require PA criteria for Briviact. PA criteria were recommended for Briviact tablets and oral solution in new patients requiring neurologist prescribing, limiting use to FDA-approved indications, and requiring a trial of levetiracetam first. An automated look back will apply, allowing coverage if the patient has received any formulation of levetiracetam in the past 180 days.

The New Manual PA criteria is as follows:

1. **brivaracetam (Briviact)**

   PA criteria apply to all new users of Briviact tablets and oral solution.

   Automated PA Criteria: The patient has filled a prescription for any formulation of levetiracetam at any MHS pharmacy point of service (MTFs, retail network pharmacies, or national mail order pharmacy) during the previous 180 days. AND

   Manual PA criteria: If automated criteria are not met, coverage for Briviact is approved if all criteria are met:

   - The drug is prescribed by an adult or pediatric neurologist

- The patient has a diagnosis of partial onset seizures
- Patient has a contraindication to, intolerability to, or has had an inadequate response to a trial of levetiracetam

Non-FDA-approved uses are not approved

Prior authorization does not expire

B. Brivaracetam (Briviact) PA Criteria and Implementation Plan

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) PA criteria in new users of Briviact tablets and oral solution. The new PA will become effective the first Wednesday 60 days after the signing of the minutes.

XI. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA AND IMPLEMENTATION PERIOD—ANTICONVULSANTS – ANTIMANIA AGENTS—BRIVARACETAM (BRIVIACT)

UF BAP Comments

The P&T Committee recommended PA criteria in new users of Briviact tablets and oral solution. The new PA will become effective the first Wednesday 60 days after the signing of the minutes.

UF BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

XII. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA AND IMPLEMENTATION PERIOD FOR NEWLY APPROVED DRUGS NOT SUBJECT TO 32 CFR 199.21(g)(5)

P&T Comments

A. Manual PA Criteria for Newly Approved Drugs Not Subject to 32 CFR 199.21(g)(5)

Manual PA criteria was recommended for one recently marketed drug produced by a sole manufacturer which contains an active ingredient that is widely available in low-cost generic formulations. Due to the pathway used to gain FDA approval, the product does not meet the criteria for innovators and cannot be reviewed for formulary status. Numerous cost-effective formulary alternatives are available that do not require prior authorization.

Narcotic Analgesics and Combinations—tramadol 25 mg tablets—Numerous other tramadol formulations are available, including scored tramadol 50 mg tablets, that are more cost-effective than this 25 mg formulation made by a sole manufacturer.

The Manual PA criteria is as follows:

1. **tramadol 25 mg tablets**
   Manual PA criteria apply to all new and current users of tramadol 25 mg tablet, and coverage is approved if all criteria are met:

   - Provider is aware and acknowledges that tramadol 50 mg tablets are available to DoD beneficiaries without the need of prior authorization. Providers are encouraged to consider changing the prescription to the preferred tramadol 50 mg.
   - Provider must explain why the patient requires tramadol 25 mg and cannot take the cost-effective generic tramadol 50 mg formulations (fill-in the blank)
     - Acceptable responses include the patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to one or more inactive ingredients in currently available tramadol 50 mg tablets

   Non-FDA-approved uses are not approved

   Prior authorization does not expire

B. New PA Criteria for Drugs Not Subject to 32 CFR 199.21(G)(5) and Implementation Plan- tramadol 25 mg tablets

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) manual PA criteria for tramadol 25 mg tablets in new and current users, due to the significant cost differences compared with other available alternative agents. The new PAs will become effective the first Wednesday 60 days after the signing of the minutes, and DHA will send letters to affected patients.

XIII. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA AND IMPLEMENTATION PERIOD FOR NEWLY APPROVED DRUGS NOT SUBJECT TO 32 CFR 199.21(G)(5) – NARCOTIC ANALGESICS AND COMBINATIONS-TRAMADOL 25 MG TABLETS

UF BAP Comments

The P&T Committee recommended manual PA criteria for tramadol 25 mg tablets in new and current users, due to the significant cost differences compared with other available alternative agents. The new PAs will become effective the first Wednesday 60 days after the signing of the minutes, and DHA will send letters to affected patients.

UF BAP Comments

Concur:	***Non-Concur:***	***Abstain:***	***Absent:***

XIV. UTILIZATION MANAGEMENT—UPDATED PA CRITERIA FOR NEW FDA APPROVED INDICATIONS

P&T Comments

A. Updated PA Criteria for New FDA Approved Indications

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) updates to the PA criteria for several drugs, due to new FDA-approved indications and expanded age ranges. The updated PA criteria outlined below will apply to new users.

a) **Atopy—dupilumab (Dupixent)**—Dupixent was recently approved for use in younger patients with eosinophilic esophagitis. The manual PA criteria were updated to allow use in pediatric patients aged 1 year and older, weighing at least 15 kilograms.

b) **Oncological Agents: Breast Cancer—alpelisib (Piqray)**—The manual PA criteria for Piqray were updated to allow use in pre- and peri-menopausal women.

c) **Oncological Agents: Lung Cancer—alectinib (Alecensa)—**The manual PA criteria were updated to allow use in non-metastatic disease. Additionally, the FDA-approved age range was added to the PA, similar to what is in place for other oncology drugs.

d) **Oncological Agents—erdafitinib (Balversa)—**The manual PA criteria were updated due to two recent changes in the FDA labeling. The product labeling no longer requires a trial of platinum-containing chemotherapy, but rather requires only one line of prior systemic therapy. Additionally, the FDA indication was restricted and Balversa is no longer indicated for patients with FGFR2 generic alterations.

B. Updated Manual PA Criteria and Implementation Period for New Approved Indications

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for Dupixent, Piqray, Alecensa, and Balversa in new users. Implementation will be effective the first Wednesday 60 days after the signing of the minutes.

XV. UTILIZATION MANAGEMENT—UPDATED PA CRITERIA IMPLEMENTATION PERIOD FOR NEW FDA APPROVED INDICATIONS

UF BAP Comments

The P&T Committee recommended updates to the manual PA criteria for drugs listed above in new users and an implementation effective the first Wednesday 60 days after the signing of the minutes.

UF BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

XVI. UTILIZATION MANAGEMENT—UPDATED PA CRITERIA AND IMPLEMENTATION PERIOD FOR REASONS OTHER THAN NEW INDICATIONS

P&T Comments

A. Updated PA Criteria for Reasons other than New Indications

a) **Oncological Agents: Lung Cancer—sotorasib (Lumakras)—**The manual PA criteria for Lumakras were updated to remove the preference for the 120 mg tablets over the 320 mg tablets as there is no longer a cost justification for the preference.

b) **Targeted Immunomodulatory Biologics (TIBs): Tumor Necrosis Factor Inhibitors (TNFs)—golimumab (Simponi)—**Based on MTF provider feedback and clinical trial data, Simponi will be allowed for use as monotherapy for rheumatoid arthritis. The requirement to use Simponi in conjunction with methotrexate will be removed.

c) **TIBs—adalimumab (Humira), etanercept (Enbrel), ixekizumab (Taltz), ustekinumab (Stelara), and secukinumab (Cosentyx)—**PA criteria for pediatric indications for several TIBs were evaluated. Opportunities to modify the PAs for Humira, Enbrel, Taltz, Stelara, and Cosentyx were identified to improve consistency, clarity, and intent. These changes include allowing Humira for additional ages (for children as young as 2 years of age for all uses), and indications (including psoriatic arthritis and plaque psoriasis) based on clinical evidence and practice guidelines; updating the other TIBs corresponding to the changes made to Humira; standardizing PA flow for pyoderma gangrenosum and hidradenitis suppurativa based on treatment guidelines; updating the criteria for ankylosing spondylitis and non-radiographic ankylosing spondyloarthritis (nr-axSpA) to follow similar NSAID treatment pathways based on guidelines; and removing research-based scoring systems for nr-axSpA. For Enbrel, Taltz and Stelara, a trial of Humira will be required for all appropriate indications regardless of age.

d) **Growth Hormone Stimulating Agents—**The growth hormone stimulating agents were last reviewed at the February 2024 P&T Committee meeting. Currently annual renewal is required for both adult and pediatric indications. Provider feedback relayed the adult indications for growth hormone agents are usually permanent and occur as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy. Clinical and utilization data were reviewed which supported removing the annual renewal criteria for adults. Annual renewal is still required for pediatric patients.

e) **Corticosteroid Immune Modulators—deflazacort (Emflaza)—**Emflaza was reviewed as a new drug at the February 2020 P&T Committee meeting and is approved for treating patients 2 years of age and older with Duchenne's Muscular Dystrophy (DMD), similar to the new drug Agamree. The Emflaza PA criteria were updated to reflect the criteria recommended for Agamree in the new drug section.

f) **Gastrointestinal-2 Agents—sacrosidase oral solution (Sucraid)—**At the May 2023 P&T meeting, PA criteria were originally added to Sucraid to ensure appropriate use of this specialty medication. Sucraid utilization and prescribing trends were reviewed. Based on MTF provider feedback, the following edits were recommended in new and current users: gastroenterologist specialist prescribing, diagnostic confirmation of congenital sucrase-isomaltase deficiency (CSID) by biopsy or genetic testing with documentation submitted, dietary restriction of sucrose, and annual PA expiration.

B. Updated PA Criteria and Implementation Period for Reasons other than New Indications

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for Lumakras, Simponi, Humira, Enbrel, Taltz, Stelara, Cosentyx, growth hormone stimulating agents and Emflaza in new users, and updates to the Sucraid PA in new and current users. Implementation will be effective the first Wednesday 60 days after signing of the minutes. Patients affected by the Sucraid updated PA criteria will receive letters.

XVII. UPDATED PA CRITERIA FOR REASONS OTHER THAN NEW INDICATIONS

UF BAP Comments

The P&T Committee recommended updates to the manual PA criteria for drugs listed above. Implementation will be effective the first Wednesday 60 days after signing of the minutes.

UF BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

XVIII. REMOVAL OF PA AND IMPLEMENTATION PLAN

P&T Comments

Diabetes Non-Insulin: Sodium-Glucose Co-Transporter 2 (SGLT-2) Inhibitors—empagliflozin/linagliptin (Glyxambi) and empagliflozin/ linagliptin/metformin XR (Trijardy XR)

Currently, both Glyxambi and Trijardy XR are designated as UF requiring PA. Empagliflozin (Jardiance) is the step-preferred SGLT-2 inhibitor. At the February 2021 P&T meeting, the PA was removed from empagliflozin and empagliflozin/metformin combinations. A cost analysis showed that Glyxambi and Trijardy XR are now more cost-effective than the individual component agents taken separately.

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) removing the PA criteria for Glyxambi and Trijardy XR. Implementation will be effective the first Wednesday 2 weeks after signing of the minutes.

XIX. REMOVAL OF PA AND IMPLEMENTATION PLAN

UF BAP Comments

The P&T Committee recommended removing the PA criteria for Glyxambi and Trijardy XR. Implementation will be effective the first Wednesday 2 weeks after signing of the minutes.

UF BAP Comments

Concur:	***Non-Concur:***	***Abstain:***	***Absent:***

XX. BRAND OVER GENERIC AUTHORIZATION AND TIER 1 COPAY FOR LISDEXAMFETAMINE (VYVANSE)

P&T Comments

A. Brand Over Generic Authorization and Tier 1 Copay for Lisdexamfetamine (Vyvanse)

Lisdexamfetamine (Vyvanse) capsules and chewable tablets are designated as UF and require a PA. AB-rated generic versions have entered the market; however, these generic products are less cost-effective compared to the branded agents. Therefore, the branded Vyvanse capsules and chewable tablets will continue to be dispensed at all three points of service, and the generic will only be available with prior authorization. The Tier 1 copay for brand Vyvanse is recommended.

B. Brand Over Generic Requirement, PA Criteria, Tier 1 Copay, and Implementation Period

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) requiring brand Vyvanse capsules and chewable tablets over the generics in all new users at all points of service, based on cost effectiveness. The prescriber will provide patient specific justification as to why the brand cannot be used. The Tier 1 (generic), copayment will apply to brand Vyvanse capsules and chewable tablets. The effective date will be no later than 60 days after the signing of the minutes. The "brand over

generic" requirement will be removed administratively when it is no longer cost-effective compared to the AB-rated generics.

XXI. BRAND OVER GENERIC AUTHORIZATION AND TIER 1 COPAY FOR LISDEXAMFETAMINE (VYVANSE)

UF BAP Comments

The P&T Committee recommended Brand Over Generic Authorization and Tier 1 Copay for Lisdexamfetamine (Vyvanse) as discussed above, with an implementation of the first Wednesday 60 days after signing of the minutes.

UF BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

XXII. RE-EVALUATION OF NF GENERICS: CALCIUM CHANNEL BLOCKERS, TOPICAL CORTICOSTEROIDS, PROTON PUMP INHIBITORS, AND SELECTIVE SEROTONIN REUPTAKE INHIBITORS

P&T Comments

A. Re-Evaluation of NF Generics: Calcium Channel Blockers, Topical Corticosteroids, Proton Pump Inhibitors, And Selective Serotonin Reuptake Inhibitors

The DHA Pharmacy Operations Division (POD) Formulary Management Branch (FMB) monitors changes in clinical information, current costs, and utilization trends to determine whether the formulary status of NF/Tier 3 drugs that are now available in generic formulations need to be readdressed. Refer to the May 2007, November 2012, and November 2022 P&T Committee minutes for additional information regarding established procedures for returning generic NF agents to formulary status.

The P&T Committee reviewed current utilization, formulary status, generic availability, and relative cost-effectiveness, including the weighted average cost per 30 days, for the current NF calcium channel blockers, topical corticosteroids, proton pump inhibitors, and selective serotonin reuptake inhibitors (SSRI).

B. Calcium Channel Blockers, Topical Corticosteroids, Proton Pump Inhibitors, and Selective Serotonin Reuptake Inhibitors Formulary Status and Implementation Period

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) making the following changes to formulary status, step therapy status, and prior authorization

criteria and medical necessity criteria, effective the first Wednesday 30 days after signing of the minutes.

a) Calcium Channel Blockers (CCBs)

- Return to UF status. The following CCBs are considerably more costly than the far more commonly used CCB amlodipine (Norvasc, generics), but are less costly than similar agents on the UF and utilization is very low
  - diltiazem 24h extended release (ER) tablets (Cardizem LA generics)
  - verapamil 24h sustained release pellet-filled capsules (Verelan generics)
  - nisoldipine 24h ER tablets, controlled release (Sular generics)
- Retain the following dihydropyridine CCBs as NF; even though both are available in generic formulations, they remain extremely costly
  - isradipine (Dynacirc generics)
  - nicardipine (Cardene generics)

b) High- and medium-potency "hair-friendly" topical corticosteroids (solutions, foams, shampoos)

- Return to UF status: betamethasone valerate 0.12% foam (Luxiq, generics; GCN 32052); generic formulations are now the least costly medium potency alternative
- Retain as NF with PA: clobetasol propionate/emollient 0.05% foam (Olux-E, generics); several alternatives (clobetasol propionate 0.05% solution, shampoo, and foam) are UF
- Retain as completely excluded
  - halobetasol propionate 0.05% foam (Lexette, generic)
  - clobetasol propionate 0.05% shampoo/cleanser kit (Clodan Kit)

c) High- and medium-potency topical corticosteroids (creams, gels)

- Return to UF status, based on comparable costs relative to other high-potency topical corticosteroids
  - fluocinonide 0.1% cream (Vanos, generics)
  - halobetasol propionate 0.05% cream (Ultravate, generics)

d) Proton Pump Inhibitors (PPIs)

- Move from UF, non-step-preferred to UF step-preferred status, to reduce administrative burden and due to relatively low use, as well as making necessary changes to PA requirements requiring the use of the step-preferred PPIs prior to non-preferred PPIs
  - rabeprazole tabs

- esomeprazole caps
- lansoprazole caps

- Making no changes to the status of the following:
  - omeprazole/bicarb caps (Zegerid, generics) [NF non-step-preferred]
  - lansoprazole rapidly dissolving tabs (Prevacid, generics) [NF non-step-preferred]
  - omeprazole/bicarb packets (Zegerid, generics) [NF non-step-preferred]
  - omeprazole/bicarb suspension (Konvomep) [UF with a PA]
  - vonoprazan (Voquezna) [NF with a PA]
  - dexlansoprazole caps (Dexilant, generics) [completely excluded]

e) SSRIs - fluoxetine

- Return to UF status: fluoxetine 10 and 20 mg tablets; while they remain more costly than the far more commonly used 10, 20, and 40 mg caps, costs have dropped substantially, and utilization is relatively low.
- Retain as NF: Generic fluoxetine 90 mg DR tabs (Prozac Weekly generics)

XXIII. RE-EVALUATION OF NF GENERICS: CALCIUM CHANNEL BLOCKERS, TOPICAL CORTICOSTEROIDS, PROTON PUMP INHIBITORS, AND SELECTIVE SEROTONIN REUPTAKE INHIBITORS

UF BAP Comments

The P&T Committee recommended making the changes discussed above to formulary status, step therapy status, and prior authorization criteria effective the first Wednesday 30 days after signing of the minutes.

UF BAP Comments

Concur: Non-Concur: Abstain: Absent: