P&T Committee Meeting Minutes
Commercial/Exchange/CHIP
December 2023 e-Vote

DRUG REVIEWS

ELEVIDYS (delandistrogene moxeparvovec-rokl)

Review: Elevidys is an adeno-associated virus (AAV)-based gene therapy that is administered as a one-time, single intravenous (IV) dose. It is approved for the treatment of ambulatory pediatric patients 4 through 5 years of age with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the *DMD* gene. It utilizes an adeno-associated virus (AAVrh74) to introduce a shortened version of the *DMD* gene (encoding Elevidys micro-dystrophin) into muscle tissue, partially compensating for the lack of a functional *DMD* gene and targeting the underlying genetic defect that causes DMD. This indication is approved under accelerated approval based on expression of Elevidys micro-dystrophin in skeletal muscle observed in patients treated with Elevidys. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Elevidys dosing is a single dose intravenous infusion only. Patients selected for treatment with Elevidys with anti-AAVrh74 total binding antibody titers <1:400. An FDA authorized test for the detection of AAVrh74 total binding antibodies is not currently available. Currently available tests may vary in accuracy and design. The recommended dosage: 1.33 × 1014 vector genomes (vg) per kg of body weight. In order to calculate the number of the dose as well as the number of vials required, an example at the end of this drug review has been added. * Prior to administration, patients should have their liver function, platelet counts, and troponin-I assessed. Elevidys intravenous infusion will last over 1−2 hours. The infusion rate is less than 10 mL/kg/hour. After the infusion, the patient should be initiated on a corticosteroid regimen for a minimum of 60 days. It is recommended that patients with liver function abnormalities should have a modified corticosteroid dose. Elevidys administration should be postponed in patients with concurrent infections until the infection has resolved.

There are no other FDA-approved gene therapies for DMD; however, prior to the availability of Elevidys, patients may have been receiving treatment with corticosteroids, including Emflaza, or other FDA-approved DMD therapies, such as Exondys 51, Vyondys 53, Amondys 45, or Viltepso.

Some ongoing trials to further investigate Elevidys safety and efficacy approval in the usage of DMD are Study 102 and Study 103, also known as Endeavor. Both studies focused on Elevidys efficacy as well as the safety of Elevidys in the indication of DMD.

The safety data that supported the accelerated approval of Elevidys were from three ongoing studies: Study 101, Study 102, and Study 103. The serious adverse reactions observed in the clinical studies were acute serious liver injury, immune-mediated myositis, and myocarditis. Notably, patients with deletions in the *DMD* gene in exons 1 to 17 and/or exons 59 to 71 may be at risk for severe immune mediated myositis reactions. Elevidys is contraindicated in patients with any deletion in exon 8 and/or exon 9 in the *DMD* gene, due to the potential increased risk for immune-mediated myositis. The most common adverse reactions (incidence ≥5%) in clinical studies (N = 85) were vomiting (61%), nausea (40%), liver function test increase (37%), pyrexia (24%), and thrombocytopenia (12%). At this point, Elevidys is approved for use in pediatric patients 4–5 years of age. Although Study 102 and Cohort 1 of Study 103 included male participants 4–7 years of age, only the male participants 4–5 years of age showed a numerical advantage in NSAA score with Elevidys.

There has been no study on effectiveness or safety in patients younger than 3 years of age nor older than 6 years of age. There have been no studies on the safety and efficacy of geriatric patients with DMD.

Elevidys is not intended for use in pregnant women with estimated background risk of 2-4% major birth defects and 15-20% miscarriages clinically recognized in pregnancies in the US general population.

There has been no information available on the presence of Elevidys in human milk or the effect of milk production and on breastfed infants. There have been no studies on the safety and efficacy of Elevidys in patients with hepatic impairment of elevated GGT. Careful consideration of Elevidys therapy should be made for patients with pre-existing liver impairment or chronic hepatic viral infection in which patients may be at increased risk of acute serious liver injury.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Elevidys will be a medical benefit. It is recommended to add Elevidys to the medical benefit cost share list. Elevidys will require prior authorization with the following criteria:

- Medical record documentation of a diagnosis of Duchenne Muscular Dystrophy confirmed by a genetic mutation in the Duchenne Muscular Dystrophy gene **AND**
- Medical record documentation that the patient does NOT have a deletion in exon 8 and/or exon 9 in the Duchenne Muscular Dystrophy gene **AND**
- Medical record documentation that the member is a male based on assigned sex at birth and is at least 4, but no older than 5 years of age **AND**
- Medical record documentation that Elevidys is prescribed by a neurologist or pediatric neurologist **AND**
- Medical record documentation that patient has been initiated on corticosteroids* for Duchenne muscular dystrophy one day prior to Elevidys infusion and medical documentation that patient will continue the regimen after for 60 days **AND**
- Medical record documentation that the patient is on the appropriate weight-based dose** **AND**
- Medical record documentation that the patient has never received Elevidys treatment in their lifetime **AND**
- Medical record documentation that the member has not received any previous gene therapy for Duchenne muscular dystrophy **AND**
- Medical record documentation that the patient will not receive exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly with Elevidys treatment. (Note: Any current authorizations for exon-skipping therapy will be terminated upon Elevidys approval.)

NOTES:

*Corticosteroid should be administered for at least 60 days after Elevidys infusion. Below is a table provided by Elevidys PI for corticosteroid dosing pre and post-infusion. Emflaza is not recommended as a corticosteroid in combinate usage with Elevidys. In Study 103 (ENDEVOR), the corticosteroid dose used was 1 mg/kg/day.

Baseline corticosteroid dosing [a]	Peri-ELEVIDYS infusion corticosteroid dose (prednisone equivalent) [b]	Recommended maximum total daily dose (prednisone equivalent)[b]
Daily or intermittent dose 60 mg/day	Start 1 day prior to infusion: 1 mg/kg/day (and continue baseline dose)	60 mg/day
High dose for 2 days per week	Start 1 day prior to infusion: 1 mg/kg/day taken on days without	60 mg/day

	high-dose corticosteroid treatment (and continue baseline dose)	
Not on corticosteroids	Start 1 week prior to infusion: 1.5 mg/kg/day	60 mg/day

[a] Patient continues to receive this dose
[b] Deflazacort is not recommended for use as a peri-ELEVIDYS infusion corticosteroid

** Elevidys is administered as a single dose intravenous infusion only. The recommended dose of ELEVIDYS is 1.33 × 10^14 vector genomes per kilogram (vg/kg) of body weight (or 10 mL/kg body weight). In order to calculate the dose is shown as:

ELEVIDYS dose (in mL) = patient body weight (in kilogram) x 10
The multiplication factor 10 represents the per kilogram dose (1.33 × 10^14 vg/kg) divided by the amount of vector genome copies per mL of the ELEVIDYS suspension (1.33 × 10^13 vg/mL).
Number of ELEVIDYS vials needed = ELEVIDYS dose (in mL) divided by 10 (round to the nearest number of vials).

Example:
Calculation of volume needed for a 19.6 kg patient.
19.6 kg × 10 = 196 mL
Number of ELEVIDYS vials needed = 196 divided by 10, rounded to the nearest number of vials = 20 vials

Note to Reviewer: Based on the Elevidys PI, patients with deletions in the DMD gene in exons 1 to 17 and /or exons 59 to 71 may be at risk for severe immune-mediated myositis reaction.

Note to Reviewer: Based on the Elevidys PI patient selection. Selective patients for treatment were to have labs results indicating that their anti-AAVrh74 total binding antibody titers are <1:400. In AAV-vector based gene therapies, preexisting anti-AAV antibodies may impede transgene expression at desired therapeutic levels. An FDA authorized test for the detection of AAVrh74 total binding antibodies is not currently available. Currently available tests may vary in accuracy and design. Although there are no FDA-approved AAVrh74 total binding antibodies detection test, Sarepta is pleased to expand its collaboration with Quest beyond our investigational therapies and to partner to develop essential diagnostic tools for our approved gene therapies that help streamline/match gene therapy treatment to eligible patients.

AUTHORIZATION DURATION: one (1) time approval per lifetime

RE-AUTHORIZATION CRITERIA: Requests for authorizations exceeding these limits will require the following medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration.

RPH SIGNOFF REQUIRED: Yes

ADDITIONAL RECOMMENDATIONS: Due to lack of evidence for combined use, it is recommended to add criterion to the exon-skipping therapies to confirm gene therapy has not previously been given.

It is recommended to add the following criterion to the following policies: MBP 241 Amondys 45, MBP 148 Exondys 51, MBP 226 Viltepso, MBP 214 Vynodys 53,:

- Medical record documentation that the patient has not received prior treatment with gene therapy (e.g. Elevidys)*

*Note: Requests for members that show decline in clinical status following treatment with Elevidys will be reviewed on a case by case basis.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ROCTAVIAN (valoctogene roxaparvovec)

Review: Roctavian is an adeno-associated virus serotype 5 (AAV5) based gene therapy vector indicated for the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity <1 IU/dL) without antibodies to AAV5 detected by an FDA-approved testa. It is designed to introduce a functional copy of a transgene encoding the B-domain deleted SQ form of human coagulation factor VIII. This gene is then created within the liver resulting in the replacement of the missing coagulation factor VIII needed for effective hemostasis. Roctavian is approved for a one-time single intravenous dose only.

Roctavian is given intravenously with a recommended dose of 6x1013 vector genomes per kilogram (vg/kg) of body weight administered as a single infusion. The infusion pump should be set at a rate of 1 mL/min, which can be increased every 30 minutes by up to 1 mL/min up to a maximum rate of 4 mL/min.

Roctavian's efficacy was evaluated in a prospective, phase 3, open-label, single dose, single arm, multinational study consisting of 134 adult males (Age ≥ 18) with severe Hemophilia A and entered a five-year follow-up period. The primary efficacy outcome included a non-inferiority test representing the difference in annualized bleeding rate (ABR) between the efficacy evaluation period (EEP) after receiving Roctavian and the baseline period in the rollover population. The EEP started on week 5 after the end of factor VIII prophylaxis and included a washout period after Roctavian treatment. The rollover population was a sub population of the modified intention to treat group that had been followed for at least 6 months in a previous study for results without a related intervention for Hemophilia A. All patients were followed for at least 3 years. The non-inferiority margin was 3.5 bleeds per year.

The results of this study determined that the mean ABR EEP was 2.6 bleeds/year, compared to a mean baseline ABR of 5.4 bleeds/year in the rollover population. This resulted in a mean difference of -2.8 bleeds/year (95% confidence interval: -4.3, -1.2). As the ABR EEP was less than 3.5 bleeds per year this shows the effectiveness of Roctavian. In addition, it is important to note the Median bleeds per year as this data more accurately portrays the effectiveness of Roctavian. Half of the patients who received Roctavian were having less than 0.3 bleeds per year, demonstrating the effectiveness of the medication.

Roctavian is contraindicated in patients with active infections (either acute or uncontrolled chronic), patients with known hepatic fibrosis or cirrhosis, and patients with known hypersensitivity to mannitol. Roctavian has warnings/precautions for infusion related reactions, hepatotoxicity, thromboembolic events, monitoring laboratory tests, and malignancy.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Roctavian will be a medical Benefit. It is recommended to add Roctavian to the medical benefit cost share list. Roctavian will require a prior authorization with the following criteria:

- Medical record documentation that the patient is a male based on assigned sex at birth and age greater than or equal to 18 years **AND**

- Medical record documentation that the patient is diagnosed with severe hemophilia Aa **AND**
- Medical record documentation that Roctavian is being dosed according to the Food and Drug Administration approved labeling for hemophilia Ab A**ND**
- Medical record documentation that the member has not received any previous gene therapy for hemophilia A **AND**
- The prescription must be written with consultation from or by a Hematologist **AND**
- Medical record documentation showing lack of pre-existing antibodies to AAV5 using the FDA approved companion diagnostic **AND**
- Medical record documentation of factor VIII inhibitor titer testing showing lack of factor VIII inhibitor **AND**
- Medical record documentation whether a patient can receive corticosteroids and/or other immunosuppressive therapy that may be required for an extended period **AND**
- Medical record documentation that the patient DOES NOT have active acute or uncontrolled chronic infections, known significant hepatic fibrosis (stage 3 or 4 on the Batts-Ludwig scale or equivalent) or cirrhosis, or mannitol hypersensitivity

NOTES:

a. *Severe hemophilia A: Factor VIII activity <1% (<0.01 units/mL) with spontaneous bleeding into joints or muscles*

b. *Dose Calculation:*
   i. *To determine a patient's dose in milliliters, multiply the patient's body weight in kilograms by 3 = dose in milliliters.*
   ii. *To determine the number of Roctavian vials to be thawed divide the patient dose volume (in milliliters) by 8 = number of vials to be thawed (always round up to the next whole number).*

Table 1: Example of Dose Volume and Number of Vials to be Thawed[3]

Patient Weight	***Patient Dose by Volume (mL) (body weight multiplied by 3)***	***Number of Vials to be Thawed (dose volume divided by 8, then rounded up)***
70 kg	***210 mL***	***27 vials (rounded up from 26.25)***

c. *The FDA companion diagnostic for Hemophilia A is the AAV5 DetectCDx produced by ARUP Laboratories. This diagnostic detects antibodies to the adeno-associated virus serotype 5 (AAV5) viral vector.*

AUTHORIZATION DURATION: Patient should be approved for a one-time dose of this medication along with other agents of the same class. Requests for authorizations exceeding these limits will require further medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration.

RPH SIGNOFF REQUIRED: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

FAST FACTS

BOSULIF (bosutinib)

Clinical Summary: Bosulif is now indicated for the treatment of pediatric patients 1 year of age and older with chronic phase Ph+ chronic myelogenous leukemia (CML), new diagnosed or resistant or intolerant to prior therapy and for the treatment of pediatric patients 1 year of age and older with accelerated or blast phase Ph+ CML with resistance or intolerance to prior therapy. Previously, this was only indicated in adult patients for these indications.

The updated dosage for the pediatric population is 300 mg/m2 orally once daily with food for newly-diagnosed chronic phase Ph+ CML, and is 400 mg/m2 orally once daily with food for chronic phase Ph+ with resistance or intolerance to prior therapy.

The safety and efficacy of Bosulif in pediatric patients with newly diagnosed chronic phase Ph+ CML or with chronic phase Ph+ CML with resistance or intolerance to prior therapy were assessed in BCHILD (NCT 04258943), a multicenter, non-randomized, open label study to identify a dose to recommend for pediatric patients with these conditions. There were 28 patients with chronic phase Ph+ CML resistant or intolerance to one prior TKI therapy at 300 mg/m2 to 400 mg/m2 once daily, and 21 patients with newly diagnosed chronic phase Ph+ CML treated at 300 mg/m2 once daily. The efficacy outcomes studied included complete cytogenic response (CCyR), major cytogenic response (MCyR), and major molecular response (MMR). In patients with newly diagnosed chronic phase Ph+ CML, the MCyR was 76.2%, the CCyR was 71.4%, and the MMR was 28.6%. In patients with chronic phase Ph+ CML resistant or intolerance to prior therapy, the MCyR was 82.1%, the CCyR was 78.6%, and the MMR was 50%.

The most common adverse reactions occurring in ≥20% of patients for this patient population included constipation, decreased appetite, respiratory tract infection, and the known adverse reactions in adults. No new warnings, contraindications, or black box warnings were identified.

Current Formulary Status: Pharmacy Benefit on the Oral Oncology Brand NP tier, requires a prior authorization.

Recommendation: No changes are recommended to the formulary placement of Bosulif. No changes are recommended to the current policies as they do not currently have any age requirement and all of the alternatives that need to be tried are also indicated in the same patient population.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

DENGVAXIA (dengue tetravalent vaccine, live)

Clinical Summary: Dengvaxia® (Dengue Tetravalent Vaccine, Live) is a vaccine indicated for the prevention of dengue disease caused by dengue virus serotypes 1, 2, 3, and 4. Dengvaxia is now approved for use in individuals 6 through 16 years of age with laboratory-confirmed previous dengue infection and living in endemic areas. Dengvaxia is not approved for use in individuals younger than 6 years of age or in individuals not previously infected by any dengue virus serotype or for whom this information is unknown. These individuals are at increased risk of severe and hospitalized dengue disease following vaccination with Dengvaxia and subsequent infection with any dengue virus serotype. Previous dengue infection can be assessed through a medical record of a previous laboratory-confirmed dengue infection or through serological testing prior to vaccination. Additionally, the safety and

effectiveness of Dengvaxia have not been established in individuals living in dengue nonendemic areas who travel to dengue endemic areas.

The efficacy of Dengvaxia was evaluated in two randomized, observer-blind, placebo controlled, multi-center studies. Study 1 (N=20,869) was conducted in individuals 9 through 16 years of age in four Latin American countries and Puerto Rico; and Study 2 (N=10,275) was conducted in individuals 2 through 14 years of age in five Asia-Pacific countries. A subset of subjects in each study (10% in Study 1; 20% in Study 2) was evaluated for antibodies to dengue virus at the time of enrollment and at later time points. Both studies enrolled subjects irrespective of evidence of previous dengue infection. Subjects were randomized 2:1 to receive either Dengvaxia or saline placebo and were monitored for symptomatic virologically confirmed dengue (VCD) starting at Day 0. Per protocol vaccine efficacy was assessed beginning 28 days after the third vaccination for 12 months. VCD was defined as an acute febrile illness (temperature ≥38°C on at least 2 consecutive days) virologically confirmed by dengue RT-PCR and/or dengue non-structural protein 1 (NS1) ELISA Antigen Test. For each study, the pre-specified criterion for demonstrating efficacy of Dengvaxia against VCD due to any dengue virus serotype and irrespective of previous dengue virus infection, was met (lower bound of 95% CI for vaccine efficacy >25%). These studies were not designed to demonstrate efficacy of Dengvaxia against individual dengue serotypes.

Given the identification of the increased risk for severe dengue following vaccination with Dengvaxia and subsequent infection with dengue virus in persons not previously infected with dengue virus, Table 4 presents analyses of vaccine efficacy against VCD due to any dengue virus serotype, limited to subjects who had baseline sera evaluated and who were dengue seropositive at baseline. These analyses include subjects 9 through 16 years of age from Study 1 and subjects 6 through 14 years of age from Study 2.

The recommended dose remains the same: Three doses (0.5 mL each) 6 months apart (at month 0, 6, and 12).

Current Formulary Status: Dengavxia is currently covered with no prior authorization required on both pharmacy and medical benefit for $0 cost sharing as required by the Affordable Care Act (ACA).

Recommendation: No changes recommended. Dengvaxia will remain covered with no prior authorization required on both pharmacy and medical benefit for $0 cost sharing as required by the Affordable Care Act (ACA).

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

EZALLOR SPRINKLE (rosuvastatin)

Clinical Summary: Ezallor Sprinkle is now indicated to reduce the risk of stroke, myocardial infarction, and arterial revascularization procedures in adults without established coronary heart disease who are at increased risk of cardiovascular (CV) disease based on age, hsCRP ≥2 mg/L, and at least one additional CV risk factor. It is also indicated as an adjunct to diet to reduce LDL-C in adults with primary hyperlipidemia, reduce low-density lipoprotein cholesterol (LDL-C) and slow the progression of atherosclerosis in adults, reduce LDL-C in adults and pediatric patients aged 8 years and older with heterozygous familial hypercholesterolemia (HeFH). Ezallor Sprinkle is also indicated as an adjunct to other LDL-C-lowering therapies, or alone if such treatments are unavailable, to reduce LDL-C in adults and pediatric patients aged 7 years and older with homozygous familial hypercholesterolemia (HoFH).

No new studies have been completed for the updated indications of Ezallor. The safety and efficacy of Ezallor has been established in clinical trials of Crestor. Previously bioequivalent studies were completed

at time of original approval which showed that Ezallor Sprinkle capsules were bioequivalent to Crestor tablets in both fasting and fed conditions. No new safety updates.

Current Formulary Status: Pharmacy benefit, non-formulary requiring prior authorization

Recommendation: There are no changes recommended to the formulary placement or prior authorization criteria at this time.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ILARIS (canakinumab)

Clinical Summary: Ilaris is now indicated for gout flares in adults in whom non-steroidal anti-inflammatory drugs (NSAIDs) and colchicine are contraindicated, are not tolerated, or do not provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate.

Recommended dosage is 150 mg subcutaneously. In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose of Ilaris may be administered. Ilaris injection is supplied as a 150 mg/mL solution in single-dose vials.

The efficacy of Ilaris was demonstrated in two 12-week, randomized, double-blind, active-controlled studies in patients with gout flares for whom NSAIDs and/or colchicine were contraindicated, not tolerated or ineffective, and who had experienced at least three gout flares in the previous year (Studies 1 and 2). The studies continued in 1) two 12-week, double-blind, active-controlled extensions, followed by 2) two open-label extensions and continued 3) in a third open-label extension (combined for both studies) up to a maximum of 36 months where all patients were treated with Ilaris upon a new flare.

In Study 1 (NCT01029652), patients were randomized to receive Ilaris 150 mg subcutaneous (N = 115) or triamcinolone acetonide 40 mg intramuscular (N = 115) at baseline and thereafter treated upon a new flare. Two patients randomized to canakinumab were not included in the analysis as they did not receive any study medication. In Study 2 (NCT01080131), patients were randomized to receive Ilaris 150 mg subcutaneous (N =112) or triamcinolone acetonide 40 mg intramuscular (N =114) at baseline and thereafter treated upon a new flare.

In Studies 1 and 2, over 85% of patients had at least one co-morbidity, including hypertension (60%), obesity (53%), diabetes (15%), and ischemic heart disease (12%). Twenty-five percent of patients had chronic kidney disease (stage ≥3), based on eGFR. Concomitant treatment with allopurinol or other uric acid lowering therapies was reported by 42% of patients at entry.

The majority of patients (73%) reported between 3-6 flares in the year prior to study entry and the remainder reported seven or more flares. Approximately one-third of the patients enrolled [76 in the Ilaris group (33.5%) and 84 in the triamcinolone acetonide (36.7%) group] had documented inability (intolerance, contraindication or lack of response) to use both, NSAIDs and colchicine. The remainder had intolerance, contraindication or lack of response to either NSAIDs or colchicine.

In both studies, the co-primary endpoints were: (i) patient's assessment of gout flare pain intensity at the most affected joint at 72 hours post-dose measured on a 0-100 mm visual analogue scale (VAS) and (ii) the time to first new gout flare. The studies aimed to determine whether Ilaris 150 mg would be superior to triamcinolone acetonide 40 mg.

Study 3 (NCT01356602), an additional 12-week, randomized, double-blind, active-controlled study, enrolled 397 patients with Ilaris 150 mg subcutaneous (Pre-Filled Syringe (PFS), N=133, Lyophilizate (LYO), N=132) or triamcinolone acetonide 40 mg intramuscular (N=132). Eight patients (2 Ilaris PFS, 3 Ilaris LYO, 3 triamcinolone) were not included for efficacy assessment as they did not receive study medication. Pain intensity at the most affected joint, assessed on a 0-100 mm VAS at 72-hours post-dose was the primary endpoint, and time to first new gout flare was a secondary endpoint. Approximately 44% of patients (45.9% Ilaris PFS group, 47.4%, Ilaris LYO group and 40.6% in the triamcinolone acetonide group) were unable to use NSAIDs and colchicine (due to contraindications, intolerance, or inadequate response) in this study.

Analyses of both endpoints were conducted for Studies 1, 2, and 3 for the subpopulation of patients unable to use NSAIDs and colchicine (due to contraindications, intolerance, or inadequate response) and overall population of patients unable to use NSAIDs and/or colchicine.

In all studies (Study 1, 2, and 3), pain intensity of the most affected joint (0-100 mm VAS) at 72 hours post-dose was consistently lower for patients treated with Ilaris compared with triamcinolone acetonide in the subpopulation of patients unable to use NSAIDs and colchicine as shown in Table 9, and Figure 3 (Study 3). This benefit of Ilaris on pain intensity was comparable to the overall patient populations i.e., patients unable to use NSAIDs and/or colchicine in all three studies.

In the subpopulation of patients in Studies 1, 2 and 3 unable to use NSAIDs and colchicine, time to new flare over 12 weeks from randomization showed a reduction in the risk of a new flare when treated with Ilaris compared with triamcinolone acetonide 40 mg. This risk reduction for a new flare after Ilaris treatment versus triamcinolone acetonide was comparable to the overall patient population over 12 weeks in all 3 studies.

The safety of Ilaris compared to triamcinolone acetonide in patients with gout flares was assessed in four 12-week randomized, double-blind, active-controlled Phase 3 studies [see Clinical Studies (14.4) for details of the studies supporting efficacy] and in two 12-week double-blind active-controlled extension studies. In the Ilaris treatment groups 512 patients were treated up to 12 weeks and 165 of these patients up to 24 weeks. In the triamcinolone acetonide groups, 381 patients were treated up to 12 weeks and 152 of these patients up to 24 weeks. Patients received a single dose of Ilaris 150 mg (n = 467) via subcutaneous injection or triamcinolone acetonide 40 mg (n = 279) via intramuscular injection. Upon a new flare, 85 and 152 patients received at least one additional dose of Ilaris and triamcinolone acetonide, respectively.

The most commonly reported adverse drug reactions were infections and infestations (see Table 3). The most common infections reported in more than 2% of patients in the Ilaris treatment groups were nasopharyngitis, upper respiratory tract infections, and urinary tract infections. The trends observed in all infections are aligned with the overall known safety profile of canakinumab. Serious adverse events were reported in 1.4% of the Ilaris-treated patients, all of which were single events. No serious adverse events were reported in the triamcinolone acetonide-treated group.

Of the Ilaris-treated patients, 17% were 65 years of age and older, including 3% who were 75 years of age and older. No new safety findings were observed between these patients compared to patients under 65 years of age.

Current Formulary Status: Ilaris is a medical benefit medication requiring prior authorization under MBP 77.0 and is a specialty medication.

Recommendation: Recommend the following additional prior authorization criteria be added to the Ilaris MBP 77.0 for the new indication of acute gout flares:

- Medical record documentation of a diagnosis of acute gout flare **AND**
- Medical record documentation that the member is age 18 or older **AND**
- Medical record documentation that Ilaris is being prescribed by a rheumatologist **AND**

- Medical record documentation of therapeutic failure on, intolerance to or contraindication to 2 formulary NSAID's and colchicine **AND**
- Medical record documentation of therapeutic failure on, intolerance to or contraindication to 1 formulary corticosteroid.

AUTHORIZATION DURATION: One-Time Authorization of one (1) Ilaris dose (Facets RX count: 150 (J0638) units) over a duration of 3 months.

QUANTITY LIMIT: 1 vial (150mg) per 12 weeks (Darwin RX Count: 1).

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

INGREZZA (valbenazine)

Clinical Summary: The new indication for Ingrezza is for the treatment of adults with chorea associated with Huntington's Disease. Previously approved indication is for tardive dyskinesia.

The recommended dosing for the treatment of chorea associated with Huntington's disease is 40 mg once daily initially. The dose can be increased in 20 mg increments every two weeks to the recommended dosage of 80 mg once daily. Depending on response and tolerability, a dosage of 40 mg or 60 mg once daily may be considered. Ingrezza 40 mg once daily is recommended for the following: patients with moderate or severe hepatic impairment, known CYP2D6 poor metabolizers, patients receiving strong CYP3A4 inhibitors and patients receiving strong CYP2D6 inhibitors. Coadministration with strong CYP3A4 inducers is not recommended.

The safety and efficacy of Ingrezza was evaluated in a 14-week randomized, double-blind, placebo-controlled study which included 128 patients with chorea associated with Huntington's disease. The mean age was 54 years (range 25 to 74 years), 46% were male and 96% were White. Treatment duration was 12 weeks followed by a 2-week period off the drug. Initial dose was 40 mg per day and the dose could be increased every 2 weeks in 20 mg increments up to a maximum dosage of 80 mg per day. Greater than 80% of patients were taking the 80 mg daily dosage at the end of the 12-week treatment period. The primary efficacy endpoint was the change from baseline to the end of the treatment period (average of Week 10 and Week 12) in the Total Maximal Chorea score of the Unified Huntington's Disease Rating Scale (UHDRS). The Total Maximal Chorea score is rated from 0 to 4 (with 0 representing no chorea) for 7 different parts of the body, with a total score ranging from 0 to 28. The mean change in Total Maximal Chorea scores for patients receiving Ingrezza improved by 4.6 units (LS mean) from baseline to the end of the treatment period (average of Week 10 and Week 12), compared to 1.4 units in the placebo group. The treatment effect of -3.2 units was statistically significant ($p<0.0001$). At the Week 14 follow-up visit (2 weeks after discontinuation of the study medication), the Total Maximal Chorea scores of patients who had received Ingrezza returned to baseline. In a clinician-rated global impression of change (CGI-C), clinicians rated 43% of patients treated with Ingrezza as "Much Improved" or "Very Much Improved" at the end of treatment, compared to 13% of patients who received placebo ($p < 0.001$).

A patient-rated global impression of change (PGI-C) assessed how patients rated their overall chorea symptoms. Of the patients treated with Ingrezza, 53% rated their symptoms as "Much Improved" or "Very Much Improved" at the end of treatment, compared to 26% of patients who received placebo ($p<0.01$). Common adverse reactions include somnolence, lethargy, sedation, urticaria, rash, and insomnia. Ingrezza has warnings/precautions for increased risk of depression and suicidal thoughts and behavior in patients with Huntington's disease, increased QT interval, Neuroleptic Malignant Syndrome (NMS), and Parkinson-like symptoms.

Current Formulary Status: Ingrezza is a non-formulary pharmacy benefit requiring prior authorization

Recommendation: Recommend adding the following highlighted indication and bullets to Policy 465.0:

Tardive Dyskinesia:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Ingrezza is prescribed by, or in consultation with, a psychiatrist or neurologist **AND**
- Medical record documentation of a diagnosis of tardive dyskinesia (TD) as evidenced by one of the following:
    - Moderate to severe abnormal body movement (AIMS score 3 or 4) in greater than or equal to 1 body area **OR**
    - Mild abnormal body movements (AIMS score 1 or 2) in greater than or equal to 2 body areas **AND**
- Medical record documentation that the member was assessed for and determined to have no other causes of involuntary movements **AND**
- Medical record documentation of the member's baseline AIMS score prior to initiating therapy **AND**
- If member's symptoms are related to use of a first-generation antipsychotic, medical record documentation that a switch to a second-generation antipsychotic has been attempted and did not resolve tardive dyskinesia symptoms **OR** provider rationale as to why a switch to a second-generation antipsychotic would not be appropriate for the member **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to amantadine

Huntington's Disease:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Ingrezza is prescribed by, or in consultation with, a neurologist or psychiatrist **AND**
- Medical record documentation of a diagnosis of Huntington's Disease **AND**
- Medical record documentation of symptoms of chorea **AND**
- Medical record documentation of patient's baseline Total Maximal Chorea Score prior to initiating therapy **AND**
- One of the following:
    - If patient has a history of prior suicide attempt, bipolar disorder, or major depressive disorder: Medical record documentation that patient was evaluated and treated by a psychiatrist **OR**
    - For all others: Medical record documentation of a mental health evaluation performed by the prescriber **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to tetrabenazine

MEDISPAN AUTHORIZATION LEVEL: GPI-10

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- QL FOR LETTER ONLY: 1 capsule per day, 30-day supply per fill

AUTHORIZATION DURATION: Initial approval will be for a period of one (1) year.
Reevaluation of coverage will require documentation of:

For Tardive Dyskinesia: Medical record documentation of an improvement in tardive dyskinesia (TD) as evidenced by a reduction from baseline AIMS score.

For Huntington's Disease: Medical record documentation of an improvement in chorea associated with Huntington's Disease as evidenced by a reduction in the Total Maximal Chorea Score from baseline.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

KEYTRUDA (pembrolizumab)

Clinical Summary: Keytruda is now indicated for the treatment of resectable (tumors ≥4 cm or node positive) NSCLC in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery.

The dosage for the new NSCLC indication is 200 mg every 3 weeks or 400 mg every 6 weeks. Keytruda is administered prior to chemotherapy when given on the same day. Neoadjuvant treatment with Keytruda + chemotherapy is given for 12 weeks or until disease progression that precludes definitive surgery or unacceptable toxicity followed by adjuvant treatment as a single agent after surgery for 39 weeks or until disease progression or unacceptable toxicity.

The efficacy of Keytruda in the new NSCLC indication was evaluated in KEYNOTE-671, a randomized, double-blind, placebo-controlled trial in 797 patients with previously untreated resectable Stage II, IIIA, or IIIB NSCLC, regardless of PD-L1 expression. Patients were randomized 1:1 to one of the following:

- Treatment Arm A: neoadjuvant KEYTRUDA 200 mg on Day 1 in combination with cisplatin 75 mg/m2 and either pemetrexed 500 mg/m2 on Day 1 or gemcitabine 1000 mg/m2 on Days 1 and 8 of each 21-day cycle for up to 4 cycles. Within 4-12 weeks following surgery, KEYTRUDA 200 mg was administered every 3 weeks for up to 13 cycles.
- Treatment Arm B: neoadjuvant placebo on Day 1 in combination with cisplatin 75 mg/m2 and either pemetrexed 500 mg/m2 on Day 1 or gemcitabine 1000 mg/m2 on Days 1 and 8 of each 21-day cycle for up to 4 cycles. Within 4-12 weeks following surgery, placebo was administered every 3 weeks for up to 13 cycles.

Treatment with Keytruda or placebo continued until completion of the treatment (17 cycles), disease progression the precluded definitive surgery, disease recurrence in the adjuvant phase, disease progression for those who did not undergo surgery or had incomplete resection and entered the adjuvant phase, or unacceptable toxicity.

The major efficacy outcome was overall survival and investigator-assessed event-free survival. Additional efficacy outcomes measures include pathological complete response rate and major pathological response rate. Eighty-one percent of patients treated with Keytruda in combination with platinum-containing chemotherapy received definitive surgery compared to 76% in the placebo treatment arm. The trial demonstrated statistically significant improvements in OS and EFS for the Keytruda treatment arm compared to the placebo treatment arm.

The safety profile of the combined regimen of pembrolizumab plus chemotherapy followed by surgery and adjuvant pembrolizumab was consistent with safety profiles of the individual medications. No new safety signals have been identified.

Keytruda is now indicated in combination with gemcitabine and cisplatin, for the treatment of patients with locally advanced unresectable or metastatic biliary tract cancer. The recommended dosage for the treatment of biliary tract cancer is 200 mg every 3 weeks or 400 mg every 6 weeks administered until disease progression, unacceptable toxicity, or up to 24 months.

The efficacy of Keytruda in biliary tract cancer (BTC) was evaluated in KEYNOTE-966, a randomized, double-blind, placebo controlled trial in 1069 patients with locally advanced unresectable or metastatic BTC who had no received prior systemic therapy in the advanced disease setting. Patients were randomized 1:1 to Keytruda + gemcitabine + cisplatin or placebo + gemcitabine + cisplatin. Treatment continued until unacceptable toxicity or disease progression. For Keytruda, treatment continued for a maximum of 35 cycles, or approximately 24 months. For gemcitabine, treatment could be continued beyond 8 cycles while cisplatin was administered for a maximum of 8 cycles.

The major efficacy outcome was overall survival and additional efficacy outcome measures include progression free survival, overall response rate, and duration of response assessed by BICR according to RECIST v1.1. The adverse event profile was consistent with the known safety profiles of the individual treatment components and the incidence of adverse reactions was generally consistent between treatment groups.

Keytruda is now indicated in combination with fluoropyrimidine- and platinum-containing chemotherapy, for the first-line treatment of adults with locally advanced unresectable or metastatic HER2-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma. Previously Keytruda was approved for the treatment of adult patients with HER-2 positive gastric cancer in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy. Keytruda was also approved for a revision to the existing indication of pembrolizumab (Keytruda, Merck) with trastuzumab, fluoropyrimidine, and platinum-containing chemotherapy for the first-line treatment of patients with locally advanced unresectable or metastatic HER2-positive gastric or gastroesophageal junction (GEJ) adenocarcinoma. This indication, which is still under accelerated approval, has been updated to restrict its use to patients whose tumors express PD-L1 (CPS >1) as determined by an FDA approved test based on results from a recent prespecified interim analysis which showed a hazard ratio (HR) for OS and PFS in patients with PD-L1 <1 were 1.41 and 1.03, respectively.

The recommended dosage for the new gastric cancer indication is 200 mg every 3 weeks or 400 mg every 6 weeks administered until disease progression, unacceptable toxicity, or up to 24 months. Keytruda is administered prior to chemotherapy when given on the same day.

The efficacy of Keytruda in combination with fluoropyrimidine- and platinum-containing chemotherapy was evaluated in the KEYNOTE-859 trial, a randomized, double-blind, placebo-controlled trail in 1579 patients with HER2-negative advanced gastric or GEJ adenocarcinoma who had not previously received systemic therapy for metastatic disease. Patients were randomized 1:1 to one of the following treatment arms; treatments were administered prior to chemotherapy on Day 1 of each cycle:

- KEYTRUDA 200 mg, investigator's choice of combination chemotherapy of cisplatin 80 mg/m2 and 5- FU 800 mg/m2/day for 5 days (FP) or oxaliplatin 130 mg/m2 and capecitabine 1000 mg/m2 bid for 14 days (CAPOX).
- Placebo, investigator's choice of combination chemotherapy of cisplatin 80 mg/m2 and 5-FU 800 mg/m2/day for 5 days (FP) or oxaliplatin 130 mg/m2 and capecitabine 1000 mg/m2 bid for 14 days (CAPOX).

Treatment was continued until RECIST v1.1 defined progression of disease as determined by BICR, unacceptable toxicity, or a maximum of 24 months. The major efficacy outcome was overall survival. Secondary efficacy outcomes included progression-free survival, overall response rate, and duration of response. A statistically significant improvement in OS, PFS, and ORR was demonstrated in patients randomized to Keytruda + chemotherapy compared to placebo + chemotherapy at the pre-specified interim analysis of OS. The safety profile of Keytruda + chemotherapy was generally consistent with the known safety profiles of Keytruda monotherapy or chemotherapy alone.

Current Formulary Status: Medical Benefit, PA, When processed at a Specialty pharmacy, Specialty tier or Brand NP tier for members with a three tier benefit.

Recommendation: There are no changes recommended for the formulary placement Keytruda. It is recommended that Medical Benefit Policy 119.0 be updated as follows to incorporate the new indications:

Medical Benefit Policy 119.0

2. Neoadjuvant/Adjuvant Treatment of Resectable NSCLC

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of resectable (Tumors ≥ 4 cm or Node Positive) non-small cell lung cancer (NSCLC) **AND**
- Keytruda is being used in the neoadjuvant setting in combination with platinum containing chemotherapy then continued as a single agent in the adjuvant setting following resection

OR

- Medical record documentation of Stage IB (T2a ≥ 4 cm), II, or IIIa non-small cell lung cancer (NSCLC) **AND**
- Keytruda is being used as a single in the adjuvant setting following resection and platinum-based chemotherapy

8. Gastric Cancer

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that Keytruda will be used as first-line treatment **AND**
- Medical record documentation of one of the following:
    a. Medical record documentation of a diagnosis of locally advanced unresectable or metastatic HER-2 positive gastric or gastroesophageal junction adenocarcinoma **AND**
    b. Medical record documentation that tumors express PD-L1 (CPS≥1) as approved by an FDA approved test **AND**
    c. Medical record documentation that Keytruda will be used in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy **AND**

OR

    - Medical record documentation of locally advanced unresectable or metastatic HER-2 negative gastric or gastroesophageal junction (GEJ) adenocarcinoma AND
    - Medical record documentation that Keytruda will be used in combination with fluoropyrimidine- and platinum-containing chemotherapy

Biliary Tract Cancer

1. Prescription written by a hematologist/oncologist **AND**
2. Medical record documentation of locally advanced unresectable or metastatic biliary tract cancer **AND**
3. Medical record documentation that Keytruda will be used in combination with gemcitabine and cisplatin

For adjuvant treatment of metastatic melanoma (completely resected melanoma), neoadjuvant/adjuvant treatment of early-stage triple negative breast cancer, neoadjuvant/adjuvant treatment of non-small cell lung cancer, and adjuvant treatment of renal cell carcinoma:
Initial approval will be for 6 months. One subsequent approval will be for an additional 6 months and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Authorization of Keytruda for the adjuvant treatment of metastatic melanoma, of non-small cell lung cancer, and of renal cell carcinoma should not exceed the FDA-approved treatment duration of 1 year (12 months). Authorization for the treatment of neoadjuvant/adjuvant treatment of non-small cell lung cancer should not exceed the approved treatment duration of 12 weeks of neoadjuvant treatment and 39 weeks of adjuvant therapy. Authorization of Keytruda for the treatment of early-stage triple negative breast cancer should not exceed the approved treatment duration of 24 weeks for neoadjuvant therapy and 27 weeks for adjuvant therapy. For requests exceeding the above limit, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that

For all other indications: Initial approval will be for **6 months** or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional **12 months** or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

NUCYNTA (tapentadol)

Clinical Summary: Nucynta is an opioid analgesic indicated for the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate in adults and pediatric patients aged 6 years and older with a body weight of at least 40 kg. It was previously indicated in patients 18 years of age and older.

Pediatric patients who are at least 6 years old, weigh at least 40 kg, and are able to swallow oral tablets:

- **For patients weighing 40 to 59 kg**: administer 50 mg every 4 hours. Do not exceed a maximum single dose of 50 mg. If adequate analgesia is not achieved with a 50 mg tablet every 4 hours, do not increase to a 75 mg tablet. Instead consider use of another product that allows for more flexible dosing, such as Nucynta oral solution.
- **For patients weighing 60 to 79 kg**: initiate treatment with 50 mg every 4 hours. Increase the dose if needed to 75 mg every 4 hours to maintain adequate analgesia with acceptable tolerability. Do not exceed a maximum single dose of 75 mg. If adequate analgesia is not achieved with a 75 mg tablet every 4 hours, do not increase to a 100 mg tablet. Instead consider use of another product that allows for more flexible dosing, such as Nucynta oral solution.
- **For patients weighing greater than or equal to 80 kg**: initiate treatment with 50 mg every 4 hours. Increase the dose if needed to 75 mg every 4 hours to maintain adequate analgesia with acceptable tolerability. If adequate pain relief is not attained with a 75 mg tablet every 4 hours, increase the dose to 100 mg every 4 hours to maintain adequate analgesia with acceptable tolerability. Do not exceed a maximum single dose of 100 mg. The maximum daily dose is 7.5 mg/kg/day (i.e., six 1.25 mg/kg doses over 24 hours). Daily doses greater than 600 mg have not been studied in pediatric patients and are not recommended.
- In pediatric patients with high body mass index (BMI), the maximum daily dose must not exceed the calculated maximum dose for a body weight at the 97th percentile for a given age. The efficacy and safety of Nucynta tablets at doses higher than 1.25 mg/ kg body weight (maximum single dose of 100 mg) have not been studied; therefore, the use of tablets at doses higher than 1.25 mg/kg body weight is not recommended.
- Dose reductions may be considered over time as acute pain decreases.
- Not recommended for use in pediatric patients who weigh less than 40 kg as the recommended dose cannot be achieved with available tablet strengths. Consider use of another product, such as Nucynta oral solution, in patients who cannot swallow oral tablets or who weigh less than 40 kg
- In pediatric patients, the duration of treatment should not exceed 3 days as the safety and effectiveness of longer treatment have not been established.

The safety and effectiveness of Nucynta tablets in pediatric patients ages 6 years and older who weigh at least 40 kg have been established; based on one randomized, double-blind, placebo-controlled, multiple-

dose efficacy and safety study of Nucynta oral solution in 175 pediatric patients from birth to 17 years of age who had undergone surgery that would reliably produce moderate to severe pain and supported by pharmacokinetic and safety data from three open-label, single-dose studies of Nucynta oral solution in 129 patients from birth to 17 years of age with moderate to severe acute pain from a surgical procedure. The safety and effectiveness in pediatric patients less than 6 years of age have not been established. In pediatric patients less than 6 years of age, Nucynta oral solution did not demonstrate efficacy compared to placebo when evaluated in one randomized, double-blind, placebo-controlled, multiple dose study in 175 pediatric patients from birth to 17 years of age who had undergone surgery that would reliably produce moderate to severe pain. Nucynta tablets have not been studied in pediatric patients with hepatic or renal impairment; therefore, use in these populations is not recommended.

Current Formulary Status: Pharmacy Benefit; nonpreferred, Prior Authorization required

Recommendation: There are no recommended changes.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

OPDIVO (nivolumab)

Clinical Summary: Opdivo is now approved for the adjuvant treatment of adult and pediatric patients 12 years and older with completely resected Stage IIB, Stage IIC, Stage III, or Stage IV melanoma. Previously, Opdivo was approved for the adjuvant treatment of adult and pediatric patients 12 years and older with completely resected metastatic melanoma. Opdivo's new indication expands upon the existing indication to allow for treatment of completely resected stage IIB or IIC melanoma in addition to stages III and IV.

No changes to dosing for adjuvant treatment of completely resected melanoma. Opdivo is usually dosed 240 mg IV once every 2 weeks OR 480 mg IV once every 4 weeks; continue until disease recurrence or unacceptable toxicity for up to 1 year.

Current Formulary Status: Opdivo is currently a medical benefit requiring prior authorization.

Recommendation: No changes are recommended to the formulary placement of Opdivo. It is recommended to edit the melanoma criteria for Medical Benefit Policy 126.0 for Opdivo.

Medical Benefit Policy 126.0 (Opdivo)

Melanoma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 12 years of age **AND**
- Medical record documentation of one of the following:
    - A diagnosis of unresectable or metastatic melanoma **AND**
    - Opdivo is not being used in combination with any other agents for the treatment of unresectable or metastatic melanoma (with the exception of ipilimumab).

    OR
    - A diagnosis of completely resected (no evidence of disease) ~~metastatic melanoma with distant metastases, which may include lymph nodes~~ Stage IIB, Stage IIC, Stage III, or Stage IV melanoma **AND**
    - ~~Medical record documentation of complete resection of distant metastases **AND**~~
    - Opdivo is being used in the adjuvant setting **AND**

- Opdivo is being used as a single agent
  **(*Note: The FDA-approved treatment duration for use of Opdivo in the adjuvant setting for completely resected ~~metastatic~~ stage IIB, stage IIC, stage III, and stage IV melanoma is for up to 1 year, see specific reauthorization criteria below.)*

AUTHORIZATION DURATION:

****For adjuvant treatment of ~~metastatic~~ melanoma *(completely resected melanoma*), adjuvant treatment of resected esophageal or gastroesophageal junction cancer, and adjuvant urothelial carcinoma:**
Initial approval will be for **6 months** or less if the reviewing provider feels it is medically appropriate. One subsequent approval will be for an additional **6 months** or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Authorization of Opdivo for the adjuvant treatment of ~~metastatic~~ melanoma, adjuvant treatment of resected esophageal or gastroesophageal junction cancer, or adjuvant treatment of urothelial carcinoma should not exceed the FDA-approved treatment duration of 1 year (12 months). For requests exceeding the above limit, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ROZLYTREK (entrectinib)

Clinical Summary: Rozlytrek is now approved for pediatric patients 1 month of age and older with unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation when patient has progressed following prior treatment or when no other satisfactory alternative therapies are available. It was previously approved for that same indication in patients 12 years of age and older. It is also approved for adult patients with ROS1-positive metastatic non-small cell lung cancer.

Rozlytrek is now available in 50mg pellets. 100mg and 200mg capsules are available as well. The pellets can be sprinkled on one or more spoonfuls of soft food for patients who have difficulty or are unable to swallow capsules but can swallow soft food and whose doses are multiples of 50mg. Pellets should not be used for preparation of a suspension or for enteral tube administration. Capsules can be swallowed whole or made into an oral suspension for patients who have difficulty or are unable to swallow capsules or who require enteral administration.

Efficacy was evaluated in 33 pediatric patients with unresectable or metastatic solid NTRK fusion-positive solid tumors. Patients were enrolled in one of two multicenter, open-label trials. Patients received Rozlytrek 20mg to 600mg based on BSA orally or via enteral feeding tube once daily in 4-week cycles until unacceptable toxicity or disease progression. The major efficacy outcome measure was overall response rate (ORR) as assessed by BICR according to RECIST v1.1 for extracranial tumors and according to Response Assessment in Neuro-Oncology (RANO) for primary central nervous system tumors.

Rozlytrek increases the risk of fractures. In clinical trials, 5% of adult patients and 25% of pediatric patients experienced fractures. Providers should evaluate for signs/symptoms of fractures, such as pain, changes in mobility, or deformity.

Current Formulary Status: Rozlytrek is a pharmacy benefit available at the Brand Non-Preferred Tier (Oral Oncology Tier) requiring prior authorization.

Recommendation: It is recommended to add the Rozlytrek Packets to formulary in parity with the capsules (i.e., Brand NP Tier). It is also recommended to update the prior authorization criteria:

NTRK-Fusion Positive Solid Tumors

- Medical record documentation that Rozlytrek is prescribed by an oncologist or hematologist **AND**
- ~~Medical record documentation of age greater than or equal to 12 years **AND**~~
- Medical record documentation of unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation **AND**
- One of the following:
    - Medical record documentation that the member must have progressed following treatment **OR**
    - Medical record documentation that no satisfactory alternative treatments are available

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for the remainder of the calendar year

QL FOR LETTER ONLY:

- 100 mg capsules: 1 capsule per day, 30 day supply per fill
- 200 mg capsules: 3 capsules per day, 30 day supply per fill
- 50mg packets: 12 packets per day, 30 day supply per fill

AUTHORIZATION DURATION: Rozlytrek is configured as a prior authorization for new starts only. Rozlytrek will no longer be covered if it is identified that the member is not receiving appropriate follow-up care from the prescribing specialist or if the member has greater than or equal to a 90 day break in therapy.

- Medical record documentation that the member is receiving appropriate follow-up care from the prescribing specialist

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

TIBSOVO (ivosidenib)

Clinical Summary: Tibsovo for the treatment of adult patients with relapsed or refractory myelodysplastic syndromes (MDS) with susceptible isocitrate dehydrogenase-1 (IDH-1) mutation as detected by and FDA-approved test.

The recommended dosage of Tibsovo is 500 mg taken orally once daily until disease progression or unacceptable toxicity. For patients with MDS without disease progression or unacceptable toxicity, Tibsovo should be continued for a minimum of 6 months to allow time for clinical response.

The efficacy of Tibsovo was evaluated in an open-label, single-arm trial in 18 adult patients with relapsed or refractory MDS with an IDH1 mutation. Patients received Tibsovo at the recommended dosage of 500 mg daily continuous for 28-day cycles until disease progression, unacceptable toxicity, or hematopoietic stem cell transplantation. Efficacy was based on rate of complete remission (CR) or partial remission according to 2006 International Working Group response criteria for MDS, duration of response, and rate of conversion from transfusion dependence to transfusion independence.

All observed responses were complete responses. Efficacy results are shown in Table 20. For patients achieving a complete response, the median time to CR was 1.9 months (range 1.0 to 5.6 months).

Among the 9 patients who were dependent on red blood cell (RBC) and/or platelet transfusions at baseline, 6 became independent of RBC and platelet transfusions during an 56-day pose-baseline period. Of the 9 patients who were independent of RBC and platelet transfusions at baseline, 7 remained transfusion independent during any 56-day post-baseline period.

The most common adverse reactions included arthralgia, fatigue, diarrhea, cough, mucositis, decreased appetite, myalgia, pruritis, and rash. The most common laboratory abnormalities were increased creatinine and aspartate aminotransferase, and decreased hemoglobin, albumin, sodium, and phosphate.

Current Formulary Status: Oral Oncology Brand Preferred tier, requires PA NSO

Recommendation: No changes are recommended to the formulary placement, quantity limits, or reauthorization criteria for Tibsovo. It is recommended that the following criteria be added to the Commercial Policy 528.0 to incorporate the new indication:

Relapsed or Refractory Myelodysplastic Syndrome (MDS)

- Medical record documentation of a diagnosis of relapsed or myelodysplastic syndromes (MDS) **AND**
- Medical record documentation that member is 18 years of age or older **AND**
- Medical record documentation that Tibsovo is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of an isocitrate dehydrogenase-1 (IDH1) mutation as detected by a Food and Drug Administration (FDA)-approved test

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

UPDATES

ADSTILADRIN (nadofaragene firadenovec-vncg) UPDATE

Background: The Adstiladrin drug review was presented at the November 2023 P&T. There was an error in the drug review that was discovered after the meeting. Adstiladrin was recommended to be a Medical benefit only for all lines of business, however specialty pharmacy language was included in the "Formulary Recommendations Based on Cost Analysis" and "Finalized Formulary Policy Recommendations" sections for Commercial/Exchange/CHIP.

Recommendation: This language should be removed from the drug review since specialty pharmacy will not be providing Adstiladrin.

Commercial/Exchange/CHIP:

- Adstiladrin will be a medical benefit and should be added to the medical benefit cost share list. ~~If processed at a specialty pharmacy, Adstiladrin should process at the Specialty tier or the Brand Non-preferred tier for members with a three-tier benefit.~~ No additional prior authorization criteria will apply.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

AKEEGA UPDATE

Background: Akeega was reviewed during the November 2023 P&T Meeting. After the meeting, it was determined that Akeega should be put at parity with other oral oncology products and the following corrections are recommended for the formulary placement and authorization duration/reauthorization criteria of Akeega for Commercial, Marketplace, and GHP Kids. No changes are needed for the prior authorization criteria, GPI, or Quantity Limits

Recommendation: Akeega should be added to the Oral Oncology Brand NP tier ($0 copay) and will require a prior authorization for new starts only.

Prior Authorization Criteria:

- Medical record documentation of a diagnosis of metastatic castration-resistant prostate cancer (mCRPC) **AND**
- Medical record documentation of deleterious or suspected deleterious BRCA-mutation (BRCAm) as detected by an FDA-approved test **AND**
- Medical record documentation that Akeega will be given in combination with prednisone **AND**
- Medical record documentation of one of the following:
    - Medical record documentation that Akeega will be given concurrently with a gonadotropin-releasing hormone (GnRH) **OR**
    - Medical record documentation that member has had bilateral orchiectomy

AND

- Medical record documentation that member is 18 years of age or older **AND**
- Medical record documentation that Akeega is prescribed by an oncologist or urologist.

GPI Level: GPI-12

Quantity Limits:

- 50 mg/500 mg Tablets: 60 tablets per 30 days
- 100 mg/500 mg Tablets: 60 tablets per 30 days

RE-AUTHORIZATION CRITERIA: Akeega will be configured as a prior authorization for new starts only. Akeega will no longer be covered if it is identified that the member is not receiving appropriate follow-up care from the prescribing specialist or if the member has greater than or equal to a 90 day break in therapy.

- Medical record documentation that the member is receiving appropriate follow-up care from the prescribing specialist

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

HUMIRA QUANTITY LIMIT UPDATES

Background: Humira starter packs are no longer available. The Humira CF starter packs are still available. It is recommended to update the quantity limits to allow loading doses.

Recommendation: There are no changes recommended to the quantity limits in the formulary.

GPI	Drug Name	Quantity Limit
6627001500F840	Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit 80 MG/0.8ML(CF)	3 per 28 days
6627001500F880	Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit 80 MG/0.8ML & 40MG/0.4ML(CF)	2 per 28 days
6627001500F430	Humira Pen Subcutaneous Pen-injector Kit 40 MG/0.4ML	2 per 28 days
6627001500F420	Humira Pen Subcutaneous Pen-injector Kit 40 MG/0.8ML	2 per 28 days
6627001500F440	Humira Pen Subcutaneous Pen-injector Kit 80 MG/0.8ML(CF)	3 per 28 days
6627001500F420	Humira Pen-CD/UC/HS Starter Subcutaneous Pen-injector Kit 40 MG/0.8ML (CF)	6 per 28 days
6627001500F440	Humira Pen-CD/UC/HS Starter Subcutaneous Pen-injector Kit 80 MG/0.8ML (CF)	3 per 28 days
6627001500F440	Humira Pen-Pediatric UC Start Subcutaneous Pen-injector Kit 80 MG/0.8ML (CF)	4 per 28 days
6627001500F420	Humira Pen-Ps/UV/Adol HS Start Subcutaneous Pen-injector Kit 40 MG/0.8ML (CF)	4 per 28 days
6627001500F450	Humira Pen-Psor/Uveit Starter Subcutaneous Pen-injector Kit 80 MG/0.8ML & 40MG/0.4ML	3 per 28 days

	(CF)	
6627001500F804	Humira Subcutaneous Prefilled Syringe Kit 10 MG/0.1ML	2 per 28 days
6627001500F809	Humira Subcutaneous Prefilled Syringe Kit 20 MG/0.2ML	2 per 28 days
6627001500F830	Humira Subcutaneous Prefilled Syringe Kit 40 MG/0.4ML	2 per 28 days
6627001500F820	Humira Subcutaneous Prefilled Syringe Kit 40 MG/0.8ML	2 per 28 days

Quantity Limits in the Commercial/Exchange/CHIP Policy: It is recommended to make the following updates to the quantity limits in the Commercial/Exchange/CHIP policy.

- For Rheumatoid Arthritis:
  - GPI-10
  - Bi-Weekly Dosing:
    - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
    - In PA Hub: Add OQL, ~~DS,~~ max quantity dispensed 2, ~~max day supply 28, min day supply 28,~~ with an end date of 12/31/2099
      - QL for letter: 2 per 28 days
  - Weekly Dosing:
    - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
    - In PA Hub: Add OQL, ~~DS,~~ max quantity dispensed 4, ~~max day supply 28, min day supply 28,~~ with an end date of 12/31/2099
      - QL for letter: 4 per 28 days
- For PJIA/JA:
  - GPI-10
  - Bi-Weekly Dosing:
    - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
    - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~max day supply 28, min day supply 28,~~ with an end date of 12/31/2099
      - QL for letter: 2 per 28 days
- For Psoriatic Arthritis:
  - GPI-10
  - Bi-Weekly Dosing:
    - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
    - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~max day supply 28, min day supply 28~~, with an end date of 12/31/2099
      - QL for letter: 2 per 28 days
- For AS:
  - GPI-10
  - Bi-Weekly Dosing:
    - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
    - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~max day supply 28, min day supply 28,~~ with an end date of 12/31/2099
      - QL for letter: 2 per 28 days
- For Crohn's:
  - GPI-10
  - Adults and pediatrics > 40 kg: 160 mg on Day 1, 80 mg 2 weeks later, then 40 mg biweekly
    - In NCRX: Add PA, OQL, max quantity 6, max day supply 28, max script 1 for a 3 week authorization duration

        - In PA Hub: Add OQL, ~~DS,~~ max quantity dispensed 2, ~~min day supply 28, max day supply 28,~~ with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for Letter: Loading dose: 160 mg on day 1, 80 mg 2 weeks later; Maintenance dose: 40 mg every other week (2 pens/syringes per 28 days)
    - Pediatrics < 40 kg: 80 mg on day 1, 40 mg 2 weeks later, then 20 mg biweekly
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~min day supply 28, max day supply 28,~~ with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for letter: Loading dose: 80 mg on day 1, 40 mg 2 weeks later; Maintenance dose: 20 mg every other week (2 pens/syringes per 28 days)
    - Weekly dosing:
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 4, ~~max day supply 28, min day supply 28~~, with an end date of 12/31/2099
            - QL for Letter: 4 per 28 days
- For PP:
    - GPI-10
    - 80 mg on day 1, then 40 mg biweekly
        - In NCRX: Add PA, OQL, max quantity 4, max day supply 28, max script 1 for a 3 week authorization duration
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~min day supply 28, max day supply 28,~~ with an end date of 12/31/2099. Start date of this authorization is 3 weeks after initial approval date.
            - QL for Letter: Loading dose: 80 mg on day 1; Maintenance dose: 40 mg every other week (2 pens/syringes per 28 days)
- For UC:
    - GPI-10
    - Adults: 160 mg on Day 1, 80 mg 2 weeks later, then 40 mg biweekly
        - In NCRX: Add PA, OQL, max quantity 6, max day supply 28, max script 1 for a 3 week authorization duration
        - In PA Hub: Add OQL, ~~DS,~~ max quantity dispensed 2, ~~min day supply 28, max day supply 28,~~ with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for Letter: Loading dose: 160 mg on day 1, 80 mg 2 weeks later; Maintenance dose: 40 mg every other week (2 pens/syringes per 28 days)
    - Adult Weekly dosing:
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 4, ~~max day supply 28, min day supply 28~~, with an end date of 12/31/2099
            - QL for Letter: 4 per 28 days
    - Pediatrics 20 to 40 kg: 80 mg on day 1, 40 mg on day 8 and day 15, then 20 mg every week
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA hub: Add OQL, ~~DS~~, max quantity dispensed 4, ~~min day supply 28, max day supply 28~~, with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for letter: Loading dose: 80 mg on day 1, 40 mg on day 8 and day 15; Maintenance dose: 20 mg every week (4 pens/syringes per 28 days)
    - Pediatrics greater than 40 kg: 160 mg on day 1, 80 mg on day 8 and day 15, then 40 mg every week

        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA hub: Add OQL, ~~DS~~, max quantity dispensed 4, ~~min day supply 28, max day supply 28~~, with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for letter: Loading dose: 160 mg on day 1, 80 mg on day 8 and day 15; Maintenance dose: 40 mg every week (4 pens/syringes per 28 days)
- For HS:
    - GPI-10
    - Adults and age 12-18 years weighing ≥ 60 kg: 160 mg on Day 1, 80 mg 2 weeks later, then 40 mg weekly
        - In NCRX: Add PA, OQL, max quantity 6, max day supply 28, max script 1 for a 3 week authorization duration
        - In PA Hub: Add OQL, ~~DS,~~ max quantity dispensed 4, ~~min day supply 28, max day supply 28,~~ with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for Letter: Loading dose: 160 mg on day 1, 80 mg 2 weeks later; Maintenance dose: 40 mg every week (4 pens/syringes per 28 days)

    - Adults and age 12-18 years weighing ≥ 60 kg: 160 mg on Day 1, 80 mg 2 weeks later, then 80 mg biweekly
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~min day supply 28, max day supply 28~~, with an end date of 12/31/2099. Start date of this authorization is 3 weeks after approval date.
            - QL for Letter: Loading dose: 160 mg on day 1, 80 mg 2 weeks later; Maintenance dose: 80 mg every other week (2 pens/syringes per 28 days)
    - Age 12-18 years weighing 30 to < 60 kg: 80 mg on day 1, then 40 mg biweekly
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~min day supply 28, max day supply 28~~, with an end date of 12/31/2099. Start date of this authorization is 3 weeks after initial approval date.
            - QL for Letter: Loading dose: 80 mg on day 1; Maintenance dose: 40 mg every other week (2 pens/syringes per 28 days)
- For Panuveitis:
    - GPI-10
    - Adult: 80 mg on day 1, then 40 mg biweekly
        - In NCRX: Add PA, OQL, max quantity 4, max day supply 28, max script 1 for a 3 week authorization duration
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~min day supply 28, max day supply 28,~~ with an end date of 12/31/2099. Start date of this authorization is 3 weeks after initial approval date.
            - QL for Letter: Loading dose: 80 mg on day 1; Maintenance dose: 40 mg every other week (2 pens/syringes per 28 days)
    - Pediatric:
        - In NCRX: Add PA, max script 1, enter for the remainder of the calendar year
        - In PA Hub: Add OQL, ~~DS~~, max quantity dispensed 2, ~~min day supply 28, max day supply 28~~, with an end date of 12/31/2099.
            - QL for letter: 2 per 28 days

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

MEDICAL BENEFIT POLICY UPDATES

ORENICA

Background: As part of the annual review process, carve outs for each line of business are being conducted when applicable. There are multiple changes to the Orencia policy that need to be made for the both of the carve outs.

Recommendation: It is recommended to update the prior authorization criteria for Orencia medical commercial/exchange/CHIP policy to align with alternatives listed in the commercial policy for the pharmacy benefit. In addition, it is recommended to update the prior authorization criteria for the Orencia medical Medicare policy to align with verbiage in the prescribing information and to comply with CMS regulations regarding alternatives.

MBP 40.0 Orencia IV (abatacept)

Orencia IV (abatacept) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the following criteria are met:

1. Rheumatoid arthritis (RA) that is refractory to DMARD therapy, including TNF (Tumor necrosis factor) antagonists:
    - Documentation of a diagnosis of moderate to severe RA in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis **AND**
    - Member must be at least 18 years old **AND**
    - Must be prescribed by a rheumatologist **AND**
    - Medical record documentation that Orencia is not being used concurrently with a TNF blocker or other biologic agent **AND**
    - Documentation of inadequate response to minimum 3 month trial of two of the following: Humira*, Rinvoq*, Enbrel* OR Xeljanz*

2. Polyarticular Juvenile Idiopathic Arthritis (PJIA)
    - Insured individual is 6 years of age or older **AND**
    - Medical record documentation of a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis or juvenile rheumatoid **AND**
    - Must be prescribed by a rheumatologist **AND**
    - Medical record documentation that Orencia is not being used concurrently with a TNF blocker or other biologic agent **AND**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to a minimum 4 month trial of two of the following: Humira*, Enbrel* OR Xeljanz*

3. Psoriatic Arthritis (PsA):
    - Prescription written by a rheumatologist **AND**
    - Medical record documentation of a diagnosis of moderate to severe active psoriatic arthritis which must include the following:
        - Documentation of either active psoriatic lesions OR a documented history of psoriasis **AND**
    - Medical record documentation of age ≥ 18 years of age **AND**
    - Medical record documentation that Orencia is not being used concurrently with a TNF blocker or other biologic agent **AND**
    - Medical record documentation of an inadequate response to a minimum 3 month trial of two of the following: Humira*, ~~**AND**~~ Cosentyx*, Enbrel*, Otezla*, Skyrizi*, Tremfya*, Rinvoq* OR Xeljanz/XR*

4. Prophylaxis of Acute Graft Versus Host Disease:
    - Prescription written by a hematologist, oncologist, or transplant specialist **AND**
    - Medical record documentation that the patient is 2 years of age and older **AND**
    - Medical record documentation that patient is undergoing hematopoietic stem cell

transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor **AND**

- Medical record documentation Orencia will be used in combination with a calcineurin inhibitor (i.e. cyclosporine, tacrolimus) and methotrexate **AND**
- Medical record documentation that the member is receiving a Food and Drug Administration (FDA) approved dose**

*Prior authorization required

**Note: The FDA approved dose for prophylaxis of acute graft versus host disease:

- For patients 2 years to less than 6 years old: 15 mg/kg IV on the day before transplantation (Day -1), followed by 12mg/kg IV on Days 5, 14, and 28 after transplantation
- For patients 6 years and older: 10 mg/kg (maximum of 1,000 mg) IV on the day before transplantation (Day -1), followed by administration on Days 5, 14, and 28 days after transplantation

PROLIA UPDATE

Background: As part of the annual review process, carve outs for the Medicare line of business specifically are being conducted when applicable. There are multiple changes to the Prolia policy that need to be made for the carve out.

Recommendation: It is recommended to update the prior authorization criteria for Prolia to resemble the verbiage more closely in the prescribing information and to comply with CMS regulations regarding alternatives.

Prolia (denosumab) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the following criteria are met:

1. **For post-menopausal women at high risk for fractures:**
   - Physician provided documentation of a diagnosis of post-menopausal osteoporosis; **AND**
   - One of the following:
     - Physician provided documentation of previous osteoporotic fracture*; **OR** ~~or~~
     - Physician provided documentation of high risk of fracture (defined as a spine or hip DXA T-score of less than or equal to -2.5, supporting clinical factors, and/or FRAX calculation showing a >3% probability of hip fracture OR >20% probability of major osteoporosis-related fracture); **OR**
     - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate

2. **For increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer:**
   - Physician provided documentation that patient is receiving adjuvant aromatase inhibitor therapy for breast cancer; **AND**
   - One of the following:
     - Physician provided documentation of previous osteoporotic fracture*; **OR**
     - Physician provided documentation of high risk of fracture (defined as a spine or hip DXA T-score of less than or equal to -2.5, supporting clinical factors, and/or FRAX calculation showing a >3% probability of hip fracture OR >20% probability of major osteoporosis-related fracture);

   AND
   - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate

3. **For increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer:**
   - Physician provided documentation that patient is receiving androgen deprivation therapy for non-metastatic prostate cancer; **AND**
   - One of the following:
     - Physician provided documentation of previous osteoporotic fracture*; **OR**
     - Physician provided documentation of high risk of fracture (defined as a spine or hip DXA T-score of less than or equal to -2.5, supporting clinical factors, and/or FRAX calculation showing a >3% probability of hip fracture OR >20% probability of major osteoporosis-related fracture);

   AND
   - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate

4. **For the treatment of men at high risk for fractures:**
   - Physician provided documentation of a diagnosis of osteoporosis; **AND**
   - One of the following:
     - Physician provided documentation of previous osteoporotic fracture*; **OR** ~~or~~
     - Physician provided documentation of high risk of fracture (defined as spine or hip DXA T-score of less than or equal to -2.0, supporting clinical factors, and/or FRAX calculation showing a >3% probability of hip fracture OR >20% probability of major osteoporosis-related fracture); **OR**
     - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate

5. **For the treatment of glucocorticoid-induced osteoporosis:**
   - Medical record documentation of a diagnosis of glucocorticoid-induced osteoporosis **AND**
   - Medical record documentation that the patient is initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone **AND**
   - Medical record documentation that the patient is going to remain on systemic glucocorticoid therapy for at least 6 months **AND**
   - One of the following:
     - Medical record documentation of previous osteoporotic fracture*; **OR** ~~or~~
     - Medical record documentation of high risk of fracture defined as DXA T-score of less than or equal to -2.0 at the lumbar spine, total hip, or femoral neck, supporting clinical factors and/or FRAX calculation showing a ≥3% probability of hip fracture OR ≥20% probability of major osteoporosis-related fracture **OR**
     - Medical record documentation of a failure on, intolerance to, or contraindication to one oral bisphosphonate

*Note:
Per the American Association of Clinical Endocrinologists/American College of Endocrinology
Osteoporotic fracture (low-trauma fracture, fragility fracture) - A fracture usually sustained from force similar to a fall from a standing position or less that would not have occurred in healthy bone, excepting fractures of the skull, face, fingers, and toes.

Per UpToDate
Osteoporotic fracture (fragility fracture) – Fracture at the spine, hip, wrist, humerus, and pelvis, without measurement of BMD. Fractures occurring from a fall from a standing height or less, without major trauma such as a motor vehicle accident. Fractures at some skeletal sites (including the skull, cervical spine, hands, and feet) are not considered fragility fractures. Stress fractures are also not considered fragility fractures as they are due to repetitive injury, often in individuals with otherwise healthy bones. Rib fractures may present as fragility fractures but more commonly result from trauma.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

MONOCLONCAL ANTIBODY UPDATE

Background: As part of the annual review process, carve outs for each line of business are being conducted. There are multiple changes to multiple policies within the monoclonal antibody space that need to be made.

Recommendation: It is recommended to update the prior authorization criteria for the monoclonal antibodies Xolair, Nucala, Cinqair, Fasenra, and Tezspire to resemble the verbiage more closely in the pharmacy benefit policies and to comply with CMS regulations regarding alternatives for the medical benefit specifically.

Commercial (Traditional)/ Exchange (Marketplace)/ CHIP (Kids)		
Medication	**Current Policy**	**Recommendations**
Xolair	**MBP 22.0 Xolair (Omalizumab)** Xolair (Omalizumab) will be considered medically necessary when all of the following criteria are met: Asthma: • Must be prescribed by an allergist or pulmonologist **AND** • Insured individual must be compliant with current therapeutic regimen **AND** • Insured individual is at least 6 years of age **AND** • Physician provided documentation of a diagnosis of moderate to severe persistent asthma* with evidence of reversible airway disease [i.e. greater than 12% improvement in forced expiratory volume in one second (FEV1) with at least 200 ml increase or at least a 20% or greater improvement in peak expiratory flow (PEF) after administration of albuterol] **AND** • Physician provided documentation of inadequate control or intolerance, despite a 3 month trial of: medium –high dose inhaled corticosteroids or systemic corticosteroids and long-acting beta agonists or leukotriene receptor antagonists **AND** • Physician provided documentation of an IgE level of greater than 30 IU/ml and less than 700 IU/ml for individuals age 12 and older OR IgE level of greater than 30 IU/ml and less than 1300 IU/ml for individuals age 6 through 11 **AND** • Physician provided documentation of evidence of a specific allergic reactivity to a perennial aeroallergen by positive skin or blood test for a specific IgE **AND** • Known environmental triggers within the member's control have	**MBP 22.0 Xolair (Omalizumab)** Xolair (Omalizumab) will be considered medically necessary for the Commercial, Exchange, and CHIP lines of business when all of the following criteria are met: Asthma: • Must be prescribed by an allergist or pulmonologist **AND** • Insured individual must be compliant with current therapeutic regimen **AND** • Insured individual is at least 6 years of age **AND** • Physician provided documentation of a diagnosis of moderate to severe persistent asthma* with evidence of reversible airway disease [i.e. greater than 12% improvement in forced expiratory volume in one second (FEV1) with at least 200 ml increase or at least a 20% or greater improvement in peak expiratory flow (PEF) after administration of albuterol] **AND** • Physician provided documentation of inadequate control or intolerance, despite a 3 month trial of: medium–high dose inhaled corticosteroids or systemic corticosteroids ~~and~~ AND long-acting beta agonists or leukotriene receptor antagonists **AND** • Physician provided documentation of an IgE level of greater than 30 IU/ml and less than 700 IU/ml for individuals age 12 and older OR IgE level of greater than 30 IU/ml and less than 1300 IU/ml for individuals age 6 through 11 **AND** • Physician provided documentation of evidence of a specific allergic reactivity to a perennial aeroallergen by positive skin or blood test for a specific IgE **AND**

	been eliminated. **AND** • Medical record documentation that Xolair will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Tezspire, Nucala, Fasenra, Dupixent, Cinqair) **The 12% improvement target value is calculated using the following methodology: The target value = baseline FEV1 x 1.12 The actual clinical calculation is: post-treatment FEV1 – baseline FEV1 = % improvement baseline FEV1 Xolair must be administered in a clinical setting equipped to manage life-threatening anaphylaxis. Patients should be observed for a minimum of two hours following administration of Xolair. It is also recommended by the FDA that patients on Xolair therapy should also carry and know how to initiate emergency self-treatment for anaphylaxis. **EXCLUSIONS:** Xolair has not been shown to be effective in patients age 12 and older with an IgE level less than 30 IU/ml or greater than 700 IU/ml, or in patients age 6 through 11 with an IgE level less than 30 IU/ml or greater than 1300 IU/ml Xolair® has not been shown to alleviate acute asthma exacerbations and should not be used for treatment of acute bronchospasm or status asthmaticus. Non-compliance with combination therapy including inhaled or systemic corticosteroids and a long acting beta-agonist or leukotriene receptor antagonist.	• Known environmental triggers within the member's control have been eliminated. **AND** • Medical record documentation that Xolair will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Tezspire, Nucala, Fasenra, Dupixent, Cinqair) **The 12% improvement target value is calculated using the following methodology: • The target value = baseline FEV1 x 1.12 • The actual clinical calculation is: (post-treatment FEV1 – baseline FEV1) / baseline FEV1 = % improvement baseline FEV1 ~~Xolair must be administered in a clinical setting equipped to manage life-threatening anaphylaxis. Patients should be observed for a minimum of two hours following administration of Xolair. It is also recommended by the FDA that patients on Xolair therapy should also carry and know how to initiate emergency self-treatment for anaphylaxis.~~ ~~**EXCLUSIONS:**~~ ~~Xolair has not been shown to be effective in patients age 12 and older with an IgE level less than 30 IU/ml or greater than 700 IU/ml, or in patients age 6 through 11 with an IgE level less than 30 IU/ml or greater than 1300 IU/ml~~ ~~Xolair® has not been shown to alleviate acute asthma exacerbations and should not be used for treatment of acute bronchospasm or status asthmaticus.~~ ~~Non-compliance with combination therapy including inhaled or systemic corticosteroids and a long acting beta-agonist or leukotriene receptor antagonist.~~ *Rationale: Per the 2014 PDF of MBP 22.0, the denominator for the*

		calculation of % improvement in baseline FEV1 is baseline FEV1. Exclusions are not clearly dictated within the FDA label and will be recommended to be taken out of the MBP
	For Chronic Idiopathic Urticaria: • Prescription is written by an allergist, immunologist, or dermatologist **AND** • Patient is at least 12 years of age **AND** • Diagnosis of moderate-to-severe chronic idiopathic urticaria **AND** • At least 6 week history of symptoms (e.g., hives associated with itching, angioedema) **AND** • Medical record documentation of a therapeutic failure on Xolair 150 mg dose, when Xolair 300mg dose is requested **AND** • Medical record documentation of contraindication to, therapeutic failure on, or intolerance to a four week trial of ALL of the following treatment alternatives: ○ At least two different high dose antihistamines ○ Maximum dose antihistamine(s) used in combination with a leukotriene receptor antagonist (e.g., montelukast) ○ High dose antihistamine used in combination with H2 receptor antagonist (e.g., ranitidine ○ Dose advancement of potent antihistamine (e.g., hydroxyzine or doxepin)	For Chronic Idiopathic Urticaria: • Prescription is written by an allergist, immunologist, or dermatologist **AND** • Patient is at least 12 years of age **AND** • Diagnosis of moderate-to-severe chronic idiopathic urticaria **AND** • At least 6 week history of symptoms (e.g., hives associated with itching, angioedema) **AND** • Medical record documentation of a therapeutic failure on Xolair 150 mg dose, when Xolair 300mg dose is requested **AND** • Medical record documentation of contraindication to, therapeutic failure on, or intolerance to a four week trial of ALL of the following treatment alternatives: ○ At least two different high dose antihistamines ○ Maximum dose antihistamine(s) used in combination with a leukotriene receptor antagonist (e.g., montelukast) ○ High dose antihistamine used in combination with H2 receptor antagonist (e.g., ranitidine) ○ Dose advancement of potent antihistamine (e.g., hydroxyzine or doxepin) *Rationale: Conservative measure are recommended per the stepwise approach outlined in 2014 national guidelines (p1277.e52).*
	For Nasal Polyps: • Medical record documentation that Nucala is prescribed by or in consultation with an allergist, pulmonologist, immunologist, or otolaryngologist (ENT provider) **AND** • Medical record documentation of age greater than or equal to 18 years **AND**	For Nasal Polyps: • Medical record documentation that Nucala is prescribed by or in consultation with an allergist, pulmonologist, immunologist, or otolaryngologist (ENT provider) **AND** • Medical record documentation of age greater than or equal to 18 years **AND**

	• Medical record documentation of a diagnosis of nasal polyps **AND** • Medical record documentation that Xolair will be used as add-on maintenance treatment **AND** • Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intranasal fluticasone and intranasal mometasone **LIMITATIONS:** The Plan considers the use of Xolair for conditions other than those listed under Indications to be experimental, investigational or unproven. There is insufficient peer-reviewed, published medical literature to support the use of Xolair for any of the following: • Other allergic conditions or other forms of urticarial besides chronic idiopathic urticaria. • Acute bronchospasm or status asthmaticus. • Pediatric patients less than 12 years of age. Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational, or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.	• Medical record documentation of a diagnosis of nasal polyps **AND** • Medical record documentation that Xolair will be used as add-on maintenance treatment **AND** • Medical record documentation of therapeutic failure on, intolerance to, or contraindication to ~~intranasal fluticasone and intranasal mometasone~~ three (3) intranasal corticosteroids (including but not limited to: beclomethasone, ciclesonide, fluticasone, mometasone, triamcinolone) **LIMITATIONS:** The Plan considers the use of Xolair for conditions other than those listed under Indications to be experimental, investigational or unproven. There is insufficient peer-reviewed, published medical literature to support the use of Xolair for any of the following: • Other allergic conditions or other forms of urticarial besides chronic idiopathic urticaria. • Acute bronchospasm or status asthmaticus. • Pediatric patients less than ~~12~~ 6 years of age. ~~Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational, or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.~~ *Rationale: The criteria point regarding alternatives will be updated to more closely resemble the FDA label which states Xolair is approved for patients with inadequate response to nasal corticosteroids. The criteria point will also more closely resemble the Xolair commercial pharmacy benefit policy. Pediatric patients 6 years and older can use Xolair for asthma specifically. Note concerning MP15 is not needed in the MBP at this time.*
Nucala	**MBP 141.0 Nucala vial (mepolizumab)** Nucala vial (mepolizumab) will be considered medically necessary when all of the following criteria are met:	**MBP 141.0 Nucala ~~vial~~ (mepolizumab)** Nucala vial (mepolizumab) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the

	Severe Eosinophilic Asthma
	• Documentation of patient age ≥ 6 years **AND**
	• Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Nucala is being used as add-on maintenance treatment **AND**
	• Prescription written by an allergist or pulmonologist **AND**
	• Medical record documentation of a blood eosinophil count of either ≥ 300 cells/mcL during the 12-month period before screening and/or ≥ 150 cells/mcL within 3 months of the start of therapy **AND**
	• Medical record documentation of:
	  ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3 month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
	  ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND**
	• Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
	• Known environmental triggers within the member's control have been eliminated **AND**
	• Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab))
	
	Eosinophilic Granulomatosis (EGPA)
	• Prescription written by an allergist/immunologist, pulmonologist, and/or rheumatologist **AND**
	• Medical record documentation that patient is ≥18 years of age **AND**
	• Medical record documentation of eosinophilic granulomatosis
		following criteria are met:
		
		Severe Eosinophilic Asthma
		• Documentation of patient age ≥ 6 years **AND**
		• Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Nucala is being used as add-on maintenance treatment **AND**
		• Prescription written by an allergist or pulmonologist **AND**
		• Medical record documentation of a blood eosinophil count of either ≥ 300 cells/mcL during the 12-month period before screening and/or ≥ 150 cells/mcL within 3 months of the start of therapy **AND**
		• Medical record documentation of:
		  ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3 month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
		  ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND**
		• Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
		• Known environmental triggers within the member's control have been eliminated **AND**
		• Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab), Tezspire (tezepelumab))
		
		Eosinophilic Granulomatosis (EGPA)
		• Prescription written by an allergist/immunologist, pulmonologist, and/or rheumatologist **AND**
		• Medical record documentation that patient is ≥18 years of age **AND**

	(EGPA) confirmed by biopsy evidence of vasculitis AND at least four (4) of the following criteria: ○ Asthma (a history of wheezing or the finding of diffuse high-pitched wheezes on expiration) ○ Eosinophilia (blood eosinophil level of ≥10% or ≥1500 cells/microL on differential white blood cell count) ○ Mononeuropathy (including multiplex) or polyneuropathy ○ Migratory or transient pulmonary opacities detected radiographically ○ Paranasal sinus abnormality ○ Biopsy containing a blood vessel showing the accumulation of eosinophils in extravascular areas **AND** • Medical record documentation of a therapeutic failure on, contraindication to, or intolerance to systemic glucocorticoid therapy AND at least one immunosuppressant therapy (cyclophosphamide, azathioprine, methotrexate) <u>Hypereosinophilic syndrome (HES)</u> • Medical record documentation of age greater than or equal to 12 years AND • Medical record documentation of a diagnosis of hypereosinophilic syndrome (HES) for greater than or equal to 6 months AND • Medical record documentation that member has been evaluated for and does NOT have an identifiable non-hematologic secondary cause* or FIP1 like 1-platelet derived growth factor receptor (FIP1L1-PDGFRα) kinase-positive hypereosinophilic syndrome (HES) AND • Medical record documentation of a blood eosinophil count of 1,000 cells/mcL or higher AND • Medical record documentation of at least two hypereosinophilic syndrome (HES) flares within the previous 12 months with a worsening of clinical symptoms of HES or increasing blood	• Medical record documentation of eosinophilic granulomatosis (EGPA) confirmed by biopsy evidence of vasculitis AND at least four (4) of the following criteria: ○ Asthma (a history of wheezing or the finding of diffuse high-pitched wheezes on expiration) ○ Eosinophilia (blood eosinophil level of ≥10% or ≥1500 cells/microL on differential white blood cell count) ○ Mononeuropathy (including multiplex) or polyneuropathy ○ Migratory or transient pulmonary opacities detected radiographically ○ Paranasal sinus abnormality ○ Biopsy containing a blood vessel showing the accumulation of eosinophils in extravascular areas **AND** • Medical record documentation of a therapeutic failure on, contraindication to, or intolerance to systemic glucocorticoid therapy AND at least one immunosuppressant therapy (cyclophosphamide, azathioprine, methotrexate) **AND** • Medical record documentation that the medication will not be used in combination with Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab), or Tezspire (tezepelumab) <u>Hypereosinophilic syndrome (HES)</u> • Medical record documentation of age greater than or equal to 12 years AND • Medical record documentation of a diagnosis of hypereosinophilic syndrome (HES) for greater than or equal to 6 months AND • Medical record documentation that member has been evaluated for and does NOT have an identifiable non-hematologic secondary cause* or FIP1 like 1-platelet derived growth factor receptor (FIP1L1-PDGFRα) kinase-positive hypereosinophilic syndrome (HES) AND • Medical record documentation of a blood eosinophil count of 1,000 cells/mcL or higher AND • Medical record documentation of at least two hypereosinophilic syndrome (HES) flares within the previous 12 months with a

	eosinophil level requiring an escalation in therapy AND • Medical record documentation that member is on stable hypereosinophilic syndrome (HES) therapy including, but not limited to oral corticosteroids, immunosuppressives, or cytotoxic therapy. *Note: Non-hematologic secondary causes can include but are not limited to drug hypersensitivity, parasitic helminth infection, HIV infection, and non-hematologic malignancy <u>Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)</u> • Medical record documentation that Nucala is prescribed by or in consultation with an allergist, pulmonologist, immunologist, or otolaryngologist (ENT provider) AND • Medical record documentation of age greater than or equal to 18 years AND • Medical record documentation of a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND • Medical record documentation that Nucala will be used as add-on maintenance treatment AND • Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to three (3) intranasal corticosteroids	worsening of clinical symptoms of HES or increasing blood eosinophil level requiring an escalation in therapy AND • Medical record documentation that member is on stable hypereosinophilic syndrome (HES) therapy including, but not limited to oral corticosteroids, immunosuppressives, or cytotoxic therapy **AND** • Medical record documentation that the medication will not be used in combination with Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab), or Tezspire (tezepelumab) *Note: Non-hematologic secondary causes can include but are not limited to drug hypersensitivity, parasitic helminth infection, HIV infection, and non-hematologic malignancy <u>Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)</u> • Medical record documentation that Nucala is prescribed by or in consultation with an allergist, pulmonologist, immunologist, or otolaryngologist (ENT provider) AND • Medical record documentation of age greater than or equal to 18 years AND • Medical record documentation of a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND • Medical record documentation that Nucala will be used as add-on maintenance treatment AND • Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to three (3) intranasal corticosteroids **AND** • Medical record documentation that the medication will not be used in combination with Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab), or Tezspire (tezepelumab) *Rationale: Nucala should not be used in combination with other biologic medication used for the treatment of the respective indications.*
Cinqair	**MBP 145.0 Cinqair (reslizumab)**	No changes recommended

	Cinqair (reslizumab) will be considered medically necessary when all of the following criteria are met:
	• Documentation of patient age ≥ 18 years **AND**
	• Patient must have severe persistent eosinophilic asthma **AND**
	• Cinqair is being used as add-on maintenance treatment **AND**
	• Prescription written by an allergist or pulmonologist **AND**
	• Medical record documentation of a blood eosinophil count of ≥ 400 cells/mcL since the time of asthma diagnosis **AND**
	• Medical record documentation of:
	  ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3 month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
	  ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND**
	• Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
	• Known environmental triggers within the member's control have been eliminated **AND**
	• Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Fasenra (benralizumab), Nucala (mepolizumab), Dupixent (dupilumab), Xolair (omalizumab), Tezspire (tezepelumab)) **AND**
	• Medical record documentation of therapeutic failure on, intolerance to, or contraindication to the use of two preferred biologic agents for severe asthma (Dupixent, Fasenra, Nucala, Tezspire, Xolair).	

Fasenra	**MBP 173.0 Fasenra Prefilled Syringes (benralizumab)** Fasenra Prefilled Syringes (benralizumab) will be considered medically necessary when ALL of the following criteria are met: • Prescribed by an allergist/immunologist or pulmonologist **AND** • Patient is 12 years of age or older **AND**	No changes recommended

	• Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Fasenra is being used as add-on maintenance treatment **AND**
	• Medical record documentation of blood eosinophil count ≥150 cells/microL (0.15 x 10E3/uL) within the past 3 months **AND**
	• Medical record documentation of:
	  ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3-month trial of high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
	  ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist
	AND
	• Medical record documentation that individual is adherent to current therapeutic regimen and has demonstrated appropriate inhaler technique **AND**
	• Medical record documentation that known environmental triggers within the member's control have been eliminated **AND**
	• Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Xolair (omalizumab), Nucala (mepolizumab), Dupixent (dupilumab), Cinqair (reslizumab), Tezspire (Tezepelumab))
	
	Limitations:
	• Fasenra is not indicated for treatment of other eosinophilic conditions.
	• Fasenra is not indicated for the relief of acute bronchospasm or status asthmaticus	

Tezspire	**MBP 259.0 Tezspire (tezepelumab-ekko)** Tezspire (tezepelumab-ekko) will be considered medically necessary when all of the following criteria are met: • Prescription written by or in consultation with an allergist, immunologist, or pulmonologist **AND** • Medical record documentation of age greater than or equal to	No changes recommended

	12 years **AND**
	• Medical record documentation of severe asthma **AND**
	• Medical record documentation that Tezspire will be used as an add-on maintenance treatment **AND**
	• Medical record documentation of one of the following:
	  ○ Poor control or intolerance, despite a 3 month trial of: medium –high dose inhaled corticosteroids and another controller medication (long-acting beta agonists, long-acting muscarinic antagonist, or leukotriene receptor antagonists) with or without oral corticosteroids **OR**
	  ○ Two or more asthma exacerbations requiring systemic corticosteroid treatment or one asthma exacerbation resulting in hospitalization in the past 12 months despite current therapy to medium- high inhaled corticosteroids and another controller medication (long-acting beta agonists, long-acting muscarinic antagonist, or leukotriene receptor antagonists)
	AND
	• Medical record documentation that Tezspire will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Xolair, Nucala, Fasenra, Dupixent, Cinqair)	

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ZAVZPRET (zavegepant)

Background: At the November 2023 P&T meeting, it was asked if we should require a step through Nurtec ODT and/or Ubrelvy prior to receiving Zavzpret. After the meeting, we confirmed with the rebating vendor that this approach is preferred. We also were asked to include criteria stopping members from using Zavzpret in combination with other acute CGRPs.

Recommendation: The following prior authorization changes are recommended for Zavzpret:

Commercial/Exchange/CHIP

- Medical record documentation of a diagnosis of migraine with or without aura **AND**
- Medical record documentation that member is 18 years of age or older **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Nurtec ODT and Ubrelvy **AND**
- Medical record documentation Zavzpret will not be used concomitantly with another calcitonin gene-related peptide (CGRP) receptor antagonist indicated for the acute treatment of migraine (e.g., Nurtec ODT or Ubrelvy).
- ~~Medical record documentation of one of the following:~~
  - ~~Medical record documentation that member is experiencing nausea and vomiting associated with migraine AND medical record documentation of therapeutic failure on intolerance to, or contraindication to one formulary intranasal triptan OR~~
  - ~~Medical record documentation of therapeutic failure on, intolerance to, or contraindication to three formulary triptans, one of which must be an intranasal formulation.~~

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Voting responses were received from 26 of 49 members. The vote was unanimously approved.

The next bi-monthly scheduled meeting will be held on January 16th, 2024 at 1:00 p.m.

Meeting will be held virtually via phone/Microsoft Teams.