# EXECUTIVE SUMMARY

**Uniform Formulary Beneficiary Advisory Panel (BAP)**
April 5, 2018

## I. UNIFORM FORMULLARY DRUG CLASS REVIEWS

### A. NON-INSULIN DIABETES DRUGS: GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS (GLP1RA) SUBCLASS

#### 1. GLP1RA Subclass—UF Recommendation

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

- UF and step-preferred
  - exenatide once weekly (Bydureon and Bydureon BCise)
  - dulaglutide (Trulicity)
- NF and non step-preferred
  - albiglutide (Tanzeum)
  - exenatide twice daily (Byetta)
  - liraglutide (Victoza)
  - lixisenatide (Adlyxin)
  - semaglutide (Ozempic)
- This recommendation includes step therapy which requires a trial of exenatide once weekly (Bydureon or Bydureon BCise) and dulaglutide (Trulicity) prior to use of the NF, non step-preferred GLP1RA drugs in all new and current users.

#### 2. GLP1RA Subclass—Manual Prior Authorization (PA) Criteria

PA criteria currently apply to the GLP1RAs subclass. Currently, a trial of metformin or a sulfonylurea is required prior to use of a GLP1RA, and use of the step-preferred GLP1RAs are also required prior to the non step-preferred products. The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) removing the requirement for a trial of a sulfonylurea, and maintaining the metformin step, based on the treatment guidelines from several diabetes associations where metformin is preferred due to its positive effects on glycemic control, safe adverse effect profile, and minimal cost. Additionally sulfonylureas are no longer considered first line therapy for diabetes.

The Committee also recommended updating the existing manual PA criteria so that new and current GLP1RA users must try the step-preferred products, Bydureon or Bydureon BCise and Trulicity, prior to using Tanzeum, Byetta, Victoza, Adlyxin, or Ozempic. Use of the non step-preferred products is allowed if the patient has had an inadequate response to the step-preferred GLP1RAs.

PA Criteria:

All new users of a GLP1RA are required to try metformin before receiving a GLP1RA. Patients currently taking a GLP1RA must have had a trial of metformin first.

Bydureon/Bydureon BCise, Trulicity, Tanzeum, Byetta, Victoza, Adlyxin, or Ozempic is approved (i.e., a trial of metformin is NOT required) if:

- The patient has a confirmed diagnosis of Type 2 diabetes mellitus.
- The patient has experienced any of the following issues on metformin:
  - impaired renal function precluding treatment with metformin
  - history of lactic acidosis
- The patient has had inadequate response to metformin
- The patient has a contraindication to metformin

In addition to the above criteria regarding metformin the following PA criteria would apply specifically to new and current users of Tanzeum, Byetta, Victoza, Adlyxin, and Ozempic:

- The patient has had an inadequate response to Bydureon/Bydureon BCise and Trulicity.

Off-label uses are not approved.

Prior Authorization does not expire.

**3. GLP1RA Subclass—PA Criteria UF and PA Implementation Plan**

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

1) An effective date of the first Wednesday after a 90-day implementation period in all points of service and, 2) DHA send letters to beneficiaries who are affected by the UF decision.

***Summary of Physician's Perspective:***

The rationale for reviewing this drug class again is due to the market withdrawal of Tanzeum, plus the new entrants. The utilization of the GLP1 class is growing, so we will continue to monitor the usage and cost.

The Committee re-affirmed that a minimally clinically important difference in A1c lowering is a change of at least 0.5%. For the GLP1s, there is a high degree of therapeutic interchangeability in terms of effects on hemoglobin A1c.

The Committee did review the cardiovascular outcomes trial data. For the GLP1s, the hazard ratios and confidence intervals did overlap between the studies. Other drug classes have a higher quality and body of evidence for lowering cardiovascular risk in diabetics than the GLP1s, including ACE inhibitors, statins and aspirin.

For the Prior Authorization requirements, the Committee wanted to maintain the requirement to try metformin first, which is consistent with all the diabetic treatment guidelines. The previous requirement to also try a sulfonylurea has been removed, due to the recognized risk of hypoglycemia with this class of drugs, and the guidelines. The goal of the step therapy is to promote use of the preferred GLP1Rs – the Bydureon products and now Trulicity, instead of Tanzeum. The Committee again recommended "no grandfathering", which means that all new and current patients with a prescription for the non preferred products must try Bydureon or Trulicity, unless they have had an inadequate response to the preferred products.

We will mail letters to patients, informing them of the new PA criteria. We will also mail letters to the patients who are currently on Tanzeum, notifying them of the impending market discontinuation and upcoming non formulary status.

***Summary of Panel Questions and Comments:***

Mr. Hostettler asked about the difference in the sizes of the needles for Victoza and Bydureon.

Dr. Allerman stated that they are 25-27 gage for Bydureon. The others are 27-29 gauge.

Mr. Hostettler replied that is not a huge difference. Is there any compliance data that supports the benefits of taking the injections once a day, twice a day or once weekly?

CAPT VonBerg stated there is a not a direct comparison trial.

Mr. Hostettler asked is there any data that states taking the injections once weekly has better compliance than taking it once daily or twice daily?

Dr. Allerman replied there is no published data. For convenience, we feel once a week has some advantages.

Mr. Hostettler replied it may be difficult for the patient to remember to take medications on a weekly basis.

Dr. Allerman replied that if it's an injection, it would be easier to do on a weekly basis vs. daily.

Mr. Hostettler asked why the recommendation didn't include grandfathering patients. As a result, 32,000 patients have to see their provider to get new prescriptions and be re-evaluated, which changes their therapy. This recommendation forces a change into the system of a diabetic patient population, where providers and patients are trying to maintain consistency.

Dr. VonBerg stated the review was prompted by the market discontinuation of Tanzeum. We knew there was going to be a large set of population that needed to transfer to a different medication.

Mr. Hostettler asked of the 32,000, how many were taking Tanzeum?

CAPT VonBerg stated that 9,412 is the number of patients affected by the NF status. Because Tanzeum is no longer on the market, the patients must switch to another medication. The 32,000 are the patients on other medications.

There were two ways this could've been handled.

1. Review the entire class which would affect more patients than the 32,000,

   Or

2. Change the step condition sets for Tanzeum, alone, in the preferred step. There are less patients affected by changing the step conditions for Tanzeum rather than reviewing the entire class and moving all the Bydureon and Tanzeum patients. The P&T committee recommendation affects less patients because there are more patients taking Bydureon. The population affected could have been much, much larger if we opened up the entire class.

Mr. Hostettler asked if the co-pay will change to Tier 2 co-pay after the patient completes the process and go onto a non-formulary product.

CAPT VonBerg stated the patient must complete the medical necessity justification to change from Tier 3 to Tier 2.

Mr. Hostettler asked is this not the medical justification criteria? There is more criteria?

CAPT VonBerg stated that medical necessity recommendations are not under the purview of the BAP. The prior authorizations recommendations are under the purview of the BAP. The criteria for medical necessity is in the P&T committee minutes.

Mr. Hostettler said if a patient completes the process or steps A, B, C, and D, it would look as if that it is necessary by the time the patient reaches D. In his opinion, it is logical that it's the same.

CAPT VonBerg stated that the medical necessity criteria is not under the purview of the BAP.

Mr. Hostettler thanked CAPT VonBerg.

There were no more questions or comments for the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for the GLP1RA Subclass.

- **GLP1RA Subclass – UF Recommendation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **GLP1RA Subclass – Manual PA Criteria**

  Concur: 3 Non-Concur: 1 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **GLP1RA Subclass – UF and PA Implementation Plan**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

**4. Additional Questions and Comments from the Panel:**

Mr. Hostettler said he did not agree with the decision of no grandfathering patients. It is disruptive to their therapy and their therapy shouldn't be disrupted.

If the patient is stable on the medication, there should be no changed.

There was a discussion between Mr. Hostettler, CAPT VonBerg, CAPT Norton and Dr. Allerman. Initially, Mr. Hostettler did not concur with the implementation plan based on the number of patients affected by the recommendations. After the discussion and information provided about the discontinuation of Tanzeum in Aug 2018, Mr. Hostettler changed his vote, as the implementation would coincide with the market discontinuation of Tanzeum.

## B. ANTI-INFLAMMATORY IMMUNOMODULATORY OPHTHALMICS: OPHTHALMIC IMMUNOMODULATORY AGENTS SUBCLASS

### 1. Ophthalmic Immunomodulatory Agents Subclass—UF Recommendation

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) the following, based on clinical and cost effectiveness.

- UF:
  - cyclosporine 0.05% ophthalmic emulsion (Restasis)
  - lifitegrast 5% ophthalmic solution (Xiidra)
- NF: None

### 4. Ophthalmic Immunomodulatory Agents Subclass—Manual PA Criteria

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) revising the existing manual PA criteria for both Restasis and Xiidra. The drugs must be prescribed by an ophthalmologist or optometrist, the diagnosis of dry eye disease must be documented, and a trial of two OTC ocular lubricants is now required. The revised PA criteria will apply to new patients and existing users who have not filled a prescription for Restasis or Xiidra in the past 120 days.

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

- The drug is prescribed by an ophthalmologist or optometrist
- The patient is $\geq$ 18 years old
- A diagnosis of Moderate to Severe Dry Eye Disease is supported by both of the criteria below:
  - Positive symptomology screening for moderate to severe dry eye disease from an appropriate measure

    AND

- At least one positive diagnostic test (e.g., Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)

  AND

- Patient must have tried and failed the following:
  - At least 1 month of one ocular lubricant used at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol, etc.)
  - Followed by at least 1 month of a different ocular lubricant that is preservative-free at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol, etc.)

  AND

- Concomitant use of Restasis and Xiidra is NOT allowed.
- Restasis is also approved for the following conditions: graft rejection/graft versus host disease (GvHD), corneal transplant, atopic keratoconjunctivitis (AKC) / vernal keratoconjunctivitis (VKC), and LASIK associated dry eye (limited to 3 months of therapy)

Off-label uses for Xiidra are not approved.

Off-label uses for Restasis, other than those listed above, are not approved.

PA expires in 365 days.

Renewal PA Criteria: Coverage will be approved indefinitely if all criteria are met:

- The drug is prescribed by an ophthalmologist or optometrist.
- The patient must have documented improvement in ocular discomfort.
- The patient must have documented improvement in signs of dry eye disease.

**5. Ophthalmic Immunomodulatory Agents Subclass—UF and PA Implementation Plan**

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) an effective date of the first Wednesday after a 90-day implementation period in all points of service.

***Summary of Physician's Perspective:***

The recommendation is to have both products on the formulary, without step therapy, which avoids impacting a significant number of patients. The Committee did review dry eye disease treatment guidelines, which note that a significant number of patients won't respond to Restasis. Therefore, having Xiidra also on the formulary allows for more options for patients.

There were some changes made to the manual PA criteria that will apply to both drugs. The updates include that both drugs have to be prescribed by an optometrist or ophthalmologist, and patients must have tried and had an inadequate response to two different classes of OTC artificial tears products. This requirement comes from feedback when we surveyed our providers. The providers felt that a trial of artificial tears first was appropriate.

Our own MHS data shows that only around half of patients remain on therapy for more than 3 months. So the Committee wanted to have the PA apply to current users who have had a gap in therapy for 3 months, and then also new patients. We are estimating that about 3,000 patients will be subject to the new PA, out of the total of about 45,000 patients on these two drugs. The PA does not allow for patients to be on both Restasis and Xiidra at the same time, since there are no studies evaluating this combination.

***Summary of Panel Questions and Comments:***

Mr. Hostettler asked if there was a typo on page 33. Is it 120 days versus 180 days.

Dr. Allerman stated there is a typo and a 120 days is correct.

Mr. Hostettler asked about the process to differentiate between a patients who had prescriptions filled last week from those patients needing an annual review for a PA. If they are grandfathered, what is the process?

Dr. Allerman stated that it is addressed when the prescription is presented and based on the information found in the look-back period. For every new patient, their 365 day period starts when their prescription is submitted. We will work with ESI on identifying patients who must complete the PA process, again.

Mr. Hostettler asked for clarification. If a patient had a prescription filled in the last 120 days, the patient is not required to complete the PA process, initially. Is the patient required to complete the PA process a year from now?

Dr. Allerman stated that if the PA process was completed in the last 120 days, they don't, but they will need an annual review. That is consistent with the guidelines for efficacy and therapy.

Mr. Hostettler thanked her.

There were no more questions or comments for the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for the Ophthalmic Immunomodulatory Agents Subclass.

- **Ophthalmic Immunomodulatory Agents Subclass – UF Recommendation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **Ophthalmic Immunomodulatory Agents Subclass – Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **Ophthalmic Immunomodulatory Agents Subclass – UF and PA Implementation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

## C. OSTEOPOROSIS DRUGS: PARATHYROID HORMONE (PTH) ANALOGS

1. **Osteoporosis Drugs: Parathyroid Hormone (PTH) Analogs—UF Recommendation**

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

- UF and step-preferred: teriparatide (Forteo)
- NF and non step-preferred: abaloparatide (Tymlos)
- This recommendation includes step therapy, which requires a trial of teriparatide in new patients, prior to use of abaloparatide.

2. **Osteoporosis Drugs: Parathyroid Hormone (PTH) Analogs— Manual PA Criteria**

The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) manual PA criteria for new users of Forteo and Tymlos, consistent with the package labeling for indications and safety. Additionally, the step therapy requirements will be included in the manual PA.

Manual PA criteria

1. **teriparatide (Forteo)**

Forteo is approved if ALL of the following criteria are met:

- The patient is ≥ 18 years old
- The drug is prescribed for treatment of osteoporosis, and not for prevention of osteoporosis.
- The patient has one of the following diagnoses:
  - Patient is a postmenopausal female with osteoporosis,

    OR

  - The patient is male with primary or hypogonadal osteoporosis,

    OR

  - The patient has osteoporosis associated with sustained systemic glucocorticoid therapy (e.g., > 6 months use of >7.5mg/day prednisone or equivalent)

    AND

- Patient has one of the following:
  - The patient is at high risk for fracture, defined as one of the following:
    - history of osteoporotic fracture

- multiple risk factors for fracture (e.g., a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)
- documented bone mineral density (BMD) T-score of -2.5 or worse
- has one of the following: has tried and experienced an inadequate response to, therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (e.g., alendronate, ibandronate)

AND

- The patient will continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate

AND

- Cumulative treatment with Forteo will not exceed 24 months during the patient's lifetime

AND

- Patient is not at increased risk for osteosarcoma (e.g., Paget's disease, unexplained elevations of alkaline phosphatase, patients with open epiphyses, prior external beam or implant radiation therapy involving the skeleton)

Off-label uses are not approved unless supporting documentation is provided.

Prior Authorization expires in 24 months.

Prior Authorization may not be renewed.

2. **Abaloparatide (Tymlos)**

   The PA criteria for Tymlos are similar to that of Forteo, with the exception that Tymlos is only approved for postmenopausal females with osteoporosis at high risk for fracture, and the patient cannot comply with the refrigeration requirements for Forteo

3. **Osteoporosis Drugs: Parathyroid Hormone (PTH) Analogs—UF and PA Implementation Plan**

   The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) an effective date of the first Wednesday after a 60-day implementation period in all points of service.

***Summary of Physician's Perspective:***

The major difference between Tymlos and Forteo is the lack of refrigeration required with Tymlos, so that was included as the primary factor in the step therapy criteria to receive Tymlos.

If a patient has not responded to Forteo, it is unlikely that they would receive additional benefit by changing to Tymlos; instead a different osteoporosis drug should be used. A survey of MHS providers felt that the products were highly therapeutically interchangeable. Forteo does have a larger number of FDA approved indications, and this is allowed for in the PA.

The Committee did recommend manual PA criteria for both drugs, since the place in therapy for the PTH analogs is very specific – they are for patients who have already experienced a fracture or for those at high risk for fracture. Also, the safety profile of the drug is another reason for the PA, since they are limited to a treatment duration of 2 years.

We didn't recommend mailing letters, since Tymlos is currently designated as non formulary (from the new drug review in August 2017). The step therapy and the PA will only apply to new patients; so patients currently on Tymlos can remain on therapy until the 2-years treatment course is completed. Likewise, patients currently on Forteo can also complete their 2 years of therapy without having to go to through the PA.

***Summary of Panel Questions and Comments:***

Mr. Du Teil asked about the study on Forteo and the risk for osteosarcoma mentioned in the study. Was the committee convinced there was an equal risk for both medications? Forteo is the approved drug and there is a study that warns about the risk of osteosarcoma.

CAPT VonBerg replied it is unknown.

Mr. Hostettler asked if the study for Tymlos was conducted on rats.

CAPT VonBerg stated that he will have to verify.

Mr. Hostettler said it's a good question. The P&T committee recommends a medication that has some documentation on significant risks. The other medication had no documentation but, I understand, is doesn't necessarily mean there is no risk.

CAPT VonBerg said he didn't remember, exactly, the committee discussions. The topic was discussed extensively and the committee did not think there was a

significant difference. That's why the information was provided. Although there was a concern in rats, there was none shown in humans?

Mr. Hostettler said that he knows physicians are polled for input. He asked if the committee would provide the number of responses received from the poll. Not who responded, but the number of responses and possibly a break down by specialties.

CAPT VonBerg replied that we do have that information, but he doesn't have it with him.

Mr. Hostettler replied that he's talking more general now, but in the future, as we get the number, he'd like to see the physician, especially what specialists that is giving input.

CAPT VonBerg said we can give you examples. It depends, in general, how specialized the therapy and the size of the group. With diabetes, sometimes we receive 400 responses. Many are endocrinologists. We poll them, as experts, for any of the conditions the committee reviews. For more defined therapies, that affect less of the population, the number as smaller. However, we do get a cross section of Army, Navy, Air Force and civilian providers, in the network, that respond.

Mr. Hostettler replied excellent and thinks we'll come back to this on the next topic.

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

- **PTH Analogs – UF Recommendation**

Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

***Director, DHA:***

These comments were taken under consideration prior to my final decision

- **PTH Analogs – Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **PTH Analogs – UF and PA Implementation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

8. **Additional Questions and Comments from the Panel.**

   Mr. Hostettler said according to the data presented, no unique utilizers are affected because the PA applies to new users. How many new users do you anticipate in the next 12 months?

   CAPT VonBerg asked how many new users in total?

   Mr. Hostettler replied yes. Is it a large or small number?

   CAPT VonBerg asked Mr. Hostettler for clarification regarding "a large number".

   Mr. Hostettler replied thousands.

   CAPT VonBerg said no, it is not in the thousands.

   Dr. Allerman stated there are only approximately 1,400 users in the whole class.

   Mr. Hostettler asked is it worth all this effort, patient disruption, and time to get to 14-15 patients. I'm looking from a patient standpoint. PAs are not simple processes. They take time. Is it really worth it for that number of patients?

   CAPT VonBerg replied with absolutely yes it is.

## D. CORTICOSTEROIDS-IMMUNE MODULATORS: ADRENOCORTICOTROPIC HORMONES (ACTH)

### 1. Adrenocorticotropic Hormones (ACTH)—UF Recommendation

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) the following, based on clinical and cost effectiveness:

- UF: injectable corticotropin (H.P. Acthar Gel)
- NF: None

*Dr. Allerman noted that there was a typo in the table on page 34 of the Background document – **Acthar gel is recommended for UF status.***

### 2. Adrenocorticotropic Hormones (ACTH)—Manual PA Criteria

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) manual PA criteria for new and current users of H.P. Acthar Gel for treatment of infantile spasms (West Syndrome) in infants less than 24 months of age who are unresponsive to high-dose steroids. Manual PA criteria are also recommended for new and current users of H.P. Acthar Gel with MS exacerbation who have failed or who are intolerant to an adequate trial of IV or oral corticosteroids. PA renewal will be allowed for infantile spasms; however, PA review will be required for each occurrence of MS exacerbation.

H.P. Acthar Gel is not approved for use of any other condition outside of infantile spasms or MS exacerbation. H.P. Acthar Gel's efficacy for the other indications listed above in the clinical effectiveness conclusion has not been established and/or remains unproven. Experimental and investigational use of H.P. Acthar Gel for these other conditions is not medically necessary and is therefore excluded from TRICARE coverage.

<u>Manual PA criteria</u>

Manual PA criteria apply to all new and current users of H.P. Acthar Gel.
H.P. Acthar Gel PA will be approved if <u>all</u> of the following criteria are met for either treatment of infantile spasms or treatment of exacerbation in patients with multiple sclerosis.

a. Infantile Spasms (West Syndrome):

- The patient is < 24 months old
- The patient is diagnosed with infantile spasms with electroencephalogram-confirmed hypsarrhythmia
- The patient has tried a 2-week course of high-dose (40-60 mg/day) prednisone/prednisolone for any episode of infantile spasms and has

failed therapy as evidenced by continued signs/symptoms of either spasms or hypsarrhythmia on EEG

- H.P. Acthar Gel is prescribed by or in consultation with a pediatric neurologist with expertise in the management of infantile spasm.

Prior Authorization expires in 30 days.

Renewal Criteria for infantile spasms: Coverage will be approved for an additional 365 days for infantile spasms if all criteria are met:

- The patient is < 24 months old
- The patient has demonstrated a clinical response to H.P. Acthar Gel as defined by cessation of both previous characteristic spasms AND hypsarrhythmia on EEG within 2 weeks of starting H.P. Acthar Gel
- The patient has not previously demonstrated intolerance to H.P. Acthar Gel, defined as the patient requiring discontinuation of H.P. Acthar Gel therapy.

b. Multiple Sclerosis Exacerbation:

- The patient is an adult diagnosed with multiple sclerosis
- The patient is diagnosed with an exacerbation of multiple sclerosis OR optic neuritis as a specific exacerbation of multiple sclerosis
- The patient has failed or is intolerant to an adequate trial of IV/PO corticosteroids (e.g., 1000 mg methylprednisolone IV x 5-14 days OR oral equivalent) for the present exacerbation.
    - Note that anticipated hypercortisolism and other non-emergent side effects (e.g., non-emergent hyperglycemia, weight gain, non-urgent/emergent hypertension, edema, paresthesias, insomnia, constipation, diarrhea, hyperphagia, anorexia, nasal/sinus congestion, acne, and menstrual irregularities, etc.) do not meet the threshold for authorization of this PA. Similarly, if the patient has had emergent or life-threatening adverse effects to high-dose corticosteroids, H.P. Acthar gel is contraindicated.
    - H.P. Acthar Gel is prescribed by or in consultation with a neurologist.

Prior Authorization expires in 30 days.

PA Renewal is not authorized for multiple sclerosis exacerbation.

c. Other uses: PA will be not be approved for any condition other than infantile spasms in infants less than 24 months of age or MS exacerbation, including, but not limited to the following: optic neuritis not related to MS exacerbation, Rheumatoid Arthritis, Systemic Lupus Erythematosus, Psoriatic Arthritis, Ankylosing Spondylitis, Dermatomyositis, Polymyositis,

Juvenile Idiopathic Arthritis, Erythema Multiforme (any severity), Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis Syndrome, Serum Sickness, Keratitis, Iritis, Iridocyclitis, Uveitis, Choroiditis, Birdshot choroiditis, Chorioretinitis, anterior segment inflammation, Nephrotic Syndrome including focal segmental glomerulosclerosis (FSGS), idiopathic membranous nephropathy, IgA nephropathy, membranoproliferative glomerulonephritis (MPGN), and monoclonal diffuse proliferative glomerulonephritis, non-nephrotic edematous states, sarcoidosis, gout, scleritis, or conjunctivitis.

**3. Adrenocorticotropic Hormones (ACTH)—UF and PA Implementation Period**

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) an effective date of the first Wednesday after a 60-day implementation period in all points of service and that DHA send letters to beneficiaries who are affected by the UF decision

***Summary of Physician's Perspective:***

Acthar is an older drug that came to our attention when the manufacturer did a trial and received an orphan drug indication for infantile spasms in 2010. Prior to 2008, Acthar gel had received approval for treatment of MS exacerbations in the 1970s.

We did a survey of providers who prescribe Acthar. Overall the survey results found that Acthar was considered as 3rd line therapy or a drug of last resort, after other treatments had failed.

Based on the review of the literature and the feedback from providers, the PA only allows for treatment for infantile spasms or MS exacerbation. Limiting the PA to these 2 indications also follows what several civilian health plans are doing.

***Summary of Panel Questions and Comments:***

Mr. Ostrowski referred to the Manual PA criteria for Multiple Sclerosis Exacerbation. He asked Dr. Allerman to define of the word "adult".

Dr. Allerman replied 18 and older. We can indicate that in the criteria.

Mr. Ostrowski stated that it would be best to change the criteria to 18 and older.

Mr. Hostettler asked about the unique utilizers affected by the decision. Does the number 86 include patients for the 2 indications or the other utilization prior to this recommendation?

Dr. Allerman replied the 86 patients included every indication.

Mr. Hostettler said there is a long standing practice, maybe not directly indicated in this literature, but there is a long standing practice for some of these indications. According to the data in the presentation, the PA will not be approved for any condition other than infantile spasms? Is there an appeal process?

Dr. Allerman replied people can go through the appeal process. In fact, right now the appeal process is the only mechanism to get an indication outside infantile spasms. Our recommendations for the indications not covered is due to extensive review of literature and discussion with providers who prescribe Acthar.

Mr. Hostettler asked if there were any providers in support of any of those areas that are not covered.

Dr. Allerman replied the providers surveyed stated they used the medication as a 3rd line therapy or last resort.

Mr. Hostettler replied that if the providers surveyed stated that it was used for 3rd line therapy or a last resort, there is a place in the algorithm for this product. It might be last, it might be a year to get there, but there is a place for it somewhere as third line therapy. Saying that you can't have it, doesn't sound like the right answer. It sounds as if there should be a process (complete steps A, B, C, D) to get to it. But there should be a way to get to it even if it's last resort.

Dr. Allerman replied that they did review the evidence as well as published manual PA criteria for other health plans. The P&T Committee's recommendation is consistent with several major plans.

Mr. Hostettler said he doesn't mean to beat a dead horse. When you look at other package insert, there is no clear indication for infantile spasms.

CAPT VonBerg said there is an appeal process.

Mr. Hostettler replied okay.

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

- **ACTH – UF Recommendation**

  Concur: 1 Non-Concur: 3 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **ACTH – Manual PA Criteria**

  Concur: 1 Non-Concur: 3 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **ACTH – UF and PA Implementation Period**

  Concur: 1 Non-Concur: 3 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

## E. NEWLY-APPROVED DRUGS PER 32 CFR 199.21(G)(5)

### 1. Newly-Approved Drugs per CFR 199.21(g)(5)—UF Recommendation

The P&T Committee recommended (Part 1: 15 for, 0 opposed, 1 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) the following:

- UF:
  - acalabrutinib (Calquence) – Oral Oncologic Agent for Mantle Cell Lymphoma
  - benznidazole – Miscellaneous Anti-Infective for Chagas Disease
  - dolutegravir/rilpivirine (Juluca) – Antiretrovirals for Human Immunodeficiency Virus (HIV)

- emicizumab-kxwh (Hemlibra) – Antihemophilic Factors
- letermovir (Prevymis) Antivirals

- NF:

  - coagulation factor IX, recombinant (Rebinyn) – Antihemophilic Factors
  - dapagliflozin/saxagliptin (Qtern) – Non-Insulin Diabetes Drugs – Sodium Glucose Co-Transporter-2 (SGLT2) Inhibitor
  - fluticasone propionate 93 mcg nasal spray (Xhance) – Nasal Allergy Drugs – Corticosteroids
  - house dust mite allergen extract (Odactra) – Immunological Agents Miscellaneous: Oral Agents
  - latanoprostene bunod ophthalmic solution (Vyzulta) – Glaucoma Drugs
  - minocycline ER (Ximino) – Antibiotics: Tetracyclines
  - sodium picosulfate/magnesium oxide/anhydrous citric acid (Clenpiq) – Laxatives-Cathartics-Stool Softeners
  - spironolactone 25 mg/5 mL oral suspension (CaroSpir) – Diuretics

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

The P&T Committee recommended (Part 1: 15 for, 0 opposed, 1 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) the following:

- Applying the same manual PA criteria for dapagliflozin/saxagliptin (Qtern) in new and current users, as is currently in place for the other non step-preferred SGLT2 inhibitors and dipeptidyl peptidase-4 (DPP-4) inhibitors. Patients must first try the step-preferred SGLT2 inhibitor empagliflozin (Jardiance).

- Applying the same manual PA criteria for minocycline ER (Ximino) in new and current users, as is currently in place for the other non step-preferred tetracyclines. Patients must first try formulary step-preferred agents.

- Applying manual PA criteria to new users of Odactra, Hemlibra, and Calquence, and for new users of CaroSpir who are over 12 years old.

- Applying manual PA criteria to new and current users of Xhance and Vyzulta.

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

**b. acalabrutinib (Calquence)**

Manual PA criteria apply to all new users of Calquence. Coverage will be approved if all criteria are met:

- The patient is ≥ 18 years
- The patient has pathologically confirmed mantle cell lymphoma, with documentation of monoclonal B cells that have a chromosome translocation t(11;14)(q13;q32) and/or overexpress cyclin D1
- The patient must not have significant cardiovascular disease such as uncontrolled or symptomatic arrhythmias, congestive heart failure, or myocardial infarction within 6 months of screening, or any Class 3 or 4 cardiac disease as defined by the New York Heart Association Functional Classification, or corrected QT interval (QTc) > 480 msec

Off-label uses are not approved.

Prior authorization does not expire.

**c. dapagliflozin/saxagliptin (Qtern)**

Manual PA criteria apply to all new and current users of Qtern. Coverage will be approved if all criteria are met:

- The patient must have had an inadequate response or experienced significant ADRs, or have a contraindication to metformin

  AND

- The patient must have tried one of the preferred SGLT2 inhibitors (Jardiance, Glyxambi, Synjardy, and Synjardy XR) and had an inadequate response or experienced significant ADRs, or have a contraindication to empagliflozin

  AND

- The patient must have tried one of the preferred DPP-4 inhibitors (Januvia, Janumet, and Janumet XR) and had inadequate response or experienced significant ADRs, or have a contraindication to sitagliptin.

Off-label uses are not approved.

Prior authorization does not expire.

**d. emicizumab-kxwh (Hemlibra)**

Manual PA criteria apply to all new users of Hemlibra. Coverage will be approved if all criteria are met:

- The patient must have a documented diagnosis of Hemophilia A

  AND

- The patient must have a history of a high titer of factor VIII inhibitor (greater than or equal to 5 Bethesda units per mL)

  AND

- The patient must NOT have been treated within the last 12 months for thromboembolic disease, or have current signs of, thromboembolic disease

  AND

- Hemlibra must be prescribed by or in consultation with a hematologist.

Off-label uses are not approved.

Prior authorization does not expire.

**e. fluticasone propionate 93 mcg nasal spray (Xhance)**

Manual PA criteria apply to all new users and current users of Xhance. Coverage will be approved if all criteria are met:

- Patient has nasal polyps

  AND

- Patient must have tried and failed at least two of the following: azelastine 137 mcg nasal spray (generic Astelin), flunisolide nasal spray, fluticasone propionate 50 mcg nasal spray (generic Flonase), or ipratropium nasal spray (Atrovent nasal spray)

  AND

- Patient has tried and failed mometasone (Nasonex) OR beclomethasone (Beconase)

Off-label uses are not approved.

Prior authorization does not expire.

**f. house dust mite allergen extract (Odactra)**

Manual PA criteria apply to all new users of Odactra. Coverage will be approved if all criteria are met:

- Odactra is prescribed by an allergist/immunologist

  AND

- The patient is between the ages of 18 and 65 years

  AND

- The patient has a diagnosis of house dust mite (HDM) allergic rhinitis confirmed with either a positive skin test or an in vitro testing pollen-specific for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

  AND

  - The patient's symptoms of allergic rhinitis have not been controlled with a nasal corticosteroid (e.g., fluticasone) AND at least one of the following: oral antihistamine, nasal antihistamines, or a leukotriene receptor antagonist (montelukast)

    OR

  - The patient has a diagnosis of HDM-related allergic rhinitis and allergic asthma that has not responded to an adequate trial of inhaled steroids, and the patient's FEV >70%

    AND

- The patient has received the first dose in the office setting and was observed for 30 minutes with no allergic reactions noted

  AND

- The patient has a prescription for self-administered SC epinephrine

  AND

- The patient does not have a history of severe local allergic reaction to sublingual immunotherapy

AND

- Patient is not receiving co-administered SC immunotherapy

AND

- Patient does not have severe, uncontrolled, unstable asthma

Other off-label uses other than allergic asthma are not approved

PA expires in 6 months.

Renewal Criteria: Coverage will be approved indefinitely if the patient has responded positively to treatment and is not receiving co-administered SC immunotherapy and does not have severe, uncontrolled, unstable asthma.

**g. latanoprostene bunod ophthalmic solution (Vyzulta)**

Manual PA criteria apply to all new and current users of Vyzulta. Coverage will be approved if all criteria are met:

- Patient must have a diagnosis of open angle glaucoma OR ocular hypertension
- Patient is ≥16 years old
- Patient has tried and failed at least two ophthalmic prostaglandin glaucoma agents (e.g., latanoprost, bimatoprost)

Off-label uses are not approved.

Prior authorization does not expire.

**h. minocycline ER (Ximino)**

PA criteria apply to all new and current users of Ximino.

Automated PA Criteria:

- Patient has filled a prescription for one generic IR doxycycline (either hyclate or monohydrate salt; does not include doxycycline monohydrate 40 mg IR/DR) AND one generic minocycline IR product at any Military Treatment Facility (MTF), retail network pharmacy, or the mail order pharmacy in the previous 180 days

Manual PA Criteria—if automated PA criteria are not met, Ximino is allowed if:

- The patient has acne with inflammatory lesions

AND

- The patient cannot tolerate generic minocycline IR due to gastrointestinal adverse events

Off-label uses are not approved.

Prior authorization expires in 365 days.

Renewal criteria: Ximino will be approved for an additional 365 days, if:

- The patient's therapy has been re-evaluated within the last 12 months
- The patient is tolerating treatment and there continues to be a medical need for the medication
- The patient has disease stabilization or improvement in disease while on therapy

**i. spironolactone 25 mg/5 mL oral suspension (CaroSpir)**

Manual PA criteria apply to all new users of CaroSpir who are over 12 years old. Coverage will be approved if all criteria are met.

- The patient has heart failure, hypertension or edema from cirrhosis

AND

- The provider must write in why the patient requires CaroSpir and cannot take an aldosterone blocker / potassium-sparing diuretic in a tablet formulation
  - Acceptable responses: patient cannot swallow tablets due to some documented medical condition – dysphagia, etc., and not due to convenience

Off-label uses are not approved.

Prior authorization does not expire.

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

The P&T Committee recommended (Part 1: 15 for, 0 opposed, 1 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) an effective date upon the first Wednesday two weeks after the signing of the minutes in all points of service.

***Summary of Physician's Perspective:***

We reviewed 13 new drugs at this meeting; with 5 recommended for UF status, and 8 recommended for nonformulary placement. Ozempic is also a new drug, but was previously mentioned in the GLP1 review. For the drugs recommended for non formulary status, several of them fall into classes that have already been reviewed by the P&T Committee, and there are cost effective products already available in the class.

Since the start of the new drug program in August 2015 a total of 113 new drugs have been reviewed, with 57 designated as UF and 57 designated as nonformulary. PA has applied to 65 of the drugs, which includes a mix of new manual PAs or in cases where there is already a PA for the class.

For this review, for the 8 drugs where a PA was recommended, 3 of them fall into classes where there are already PA requirements (the diabetes drug Qtern, the acne drug Ximino, and the steroid inhaler Xhance).

For 3 of the drugs with PA, grandfathering was recommended, so the PA will only apply to new users (the oncology drug Calquence for mantle cell lymphoma, the new hemophilia drug Hemlibra, and the new allergy drug Odactra). "No grandfathering", where the PA will apply to both new and current users, was recommended for the new glaucoma drug Vyzulta and the Xhance inhaler.

Carospir is a new oral liquid formulation of spironolactone. The P&T Committee recognized that there is the potential for use of this drug in the pediatric population, so the recommendation here was that the PA only apply to patients older than 12 years.

***Summary of Panel Questions and Comments:***

Mr. Hostettler said he's looking at the coagulation factor 9. I am curious why there is a non-formulary recommendation for this product? There is no PA or other criteria. It obviously is a product that when it is needed it is needed.

CAPT VonBerg replied something changed about the market in that now there are a lot of similar products available.

Mr. Hostettler thanked him.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, PA Criteria, and UF and PA Implementation plan for the Newly-Approved Drugs.

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

## F. UTILIZATION MANAGEMENT CORTICOSTEROIDS-IMMUNE MODULATOR AGENTS – CORTICOSTEROID SUBCLASS

**(CAPT VONBERG)**

### 1. Corticosteroids-Immune Modulator Agents—Corticosteroid Subclass: Prednisone Delayed Release (Rayos)—New Manual PA Criteria

Rayos is a branded formulation of delayed release (DR) prednisone that has the same indications as immediate release (IR) prednisone, which was approved in 1955. It is dosed once daily, similar to IR prednisone, and has the same safety profile. Cost-

effective generic formulations of prednisone and other glucocorticoids are available on the UF without PA required.

The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) manual PA criteria for Rayos due to the significant cost differences and lack of clinically compelling benefits between Rayos and generic prednisone. New and current users of Rayos are required to try generic prednisone IR and a second corticosteroid first.

Full PA Criteria:

Manual PA criteria apply to all new and current users of Rayos. Note that PA is not required for generic prednisone; providers are encouraged to consider changing the prescription to generic prednisone. Coverage for Rayos will be approved if:

- The provider writes in why the patient requires delayed release prednisone and why patient cannot take immediate release prednisone
- Acceptable responses are approved if ALL of the criteria are met:
  - The patient has a diagnosis of rheumatoid arthritis

    AND

  - The patient medical history includes trial and failure of both:
    - generic prednisone

      AND

    - at least one generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, etc.

Off-label uses are not approved.

Prior Authorization does not expire.

2. **Corticosteroids-Immune Modulator Agents—Corticosteroid Subclass: Prednisone Delayed Release (Rayos)—New Manual PA Implementation Date**

The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) new manual PA for Rayos become effective on the first Wednesday after a 90-day implementation period in all points of service. Additionally, the P&T Committee recommended DHA send letters to the beneficiaries affected by this decision.

***Summary of Physician's Perspective:***

This formulation of prednisone theoretically was developed to be taken at night by patients with rheumatoid arthritis, so that upon awakening, the full effect of the dose will be seen, especially for the symptoms of joint stiffness. Immediate release prednisone is very effective for treating rheumatoid arthritis and has this FDA indication. Improvement in morning stiffness would not be unique to a delayed release formulation of prednisone. Additionally, the differences in the kinetic profile between the two products do not provide any unique efficacy advantages for Rayos. The P&T Committee felt that generic immediate release prednisone was much more cost effective, by two orders of magnitude, and clinically equivalent to Rayos.

There are a total of 245 patients in DoD who are currently taking Rayos; all new and current users will be required to go through the PA. We will be sending letters to the patients informing them of the new PA.

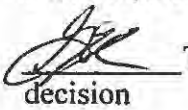
***Summary of Panel Questions and Comments:***

There were no more questions or comment from the Panel. The Chair called for a vote on the Prednisone Delayed Release (Rayos).

- **Prednisone Delayed Release (Rayos) – New Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

   These comments were taken under consideration prior to my final decision

- **Prednisone Delayed Release (Rayos) – New Manual PA Implementation Plan**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

   These comments were taken under consideration prior to my final decision

## G. UTILIZATION MANAGEMENT ANTIVIRALS

### 1. Antivirals: Acyclovir/Hydrocortisone 5%/1% Cream (Xerese), Penciclovir 1% Cream (Denavir), and Acyclovir 50 mg buccal tablet (Sitavig)—New Manual PA Criteria

The committee reviewed three treatments for herpes labialis (cold sores). Xerese is a branded combination of acyclovir/hydrocortisone cream that has an equivalent efficacy and safety profile as the separate ingredients applied individually. Denavir is a branded penciclovir 1% cream that is indicated for treatment of recurrent cold sores, while Sitavig is a buccal tablet formulation of acyclovir. Cost-effective generic formulations of acyclovir cream and the oral antiviral agents (e.g., acyclovir, valacyclovir) used for treating herpes labialis are available on the UF without PA required.

The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) manual PA criteria for Xerese, Denavir, and Sitavig due to the significant cost differences and lack of clinically compelling benefits compared with generic topical and oral antivirals. New and current users of these products are required to try generic acyclovir cream and oral antiviral agents first.

Full PA Criteria

**a. acyclovir 5%/hydrocortisone 1% cream (Xerese)**

Note: DoD Formulary products include topical or oral antiviral agents. Consider alternate agents first, such as acyclovir oral/topical or valacyclovir oral tablets. This PA is only approved for treatment of immunocompetent patients 6 years and older with recurrent herpes labialis (not approved for prophylaxis).

Manual PA criteria apply to all new and current users of Xerese. Coverage for Xerese is approved if:

- The provider writes in why the patient requires Xerese and why they cannot take oral antivirals or cannot use acyclovir 5% cream and hydrocortisone 1% cream separately.
- Acceptable responses are approved if ALL of the criteria are met:
  - Tried and failed topical acyclovir 5% cream and hydrocortisone 1% cream separately

    AND

- Treatment failure of one of the following: oral acyclovir, valacyclovir, or famciclovir

Off-label uses are not approved.

Prior authorization does not expire.

**b. Penciclovir1% cream (Denavir) and acyclovir 50 mg buccal tablet (Sitavig)**

Note: DoD Formulary products include topical or oral antiviral agents. Consider alternate agents first, such as acyclovir oral/topical or valacyclovir oral tablets. This PA is only approved for treatment of immunocompetent patients 12 years and older with recurrent herpes labialis (not approved for prophylaxis).

Manual PA criteria apply to all new and current users of Denavir or Sitavig. Coverage is approved if:

- The provider writes in why the patient requires Denavir or Sitavig and why they cannot take oral antivirals or cannot use acyclovir 5% cream.
- Acceptable responses are approved if ALL of the criteria are met:
  - Tried and failed topical acyclovir 5% cream

    AND

  - Treatment failure of one of the following: oral acyclovir, valacyclovir, or famciclovir

Off-label uses are not approved.

Prior authorization does not expire.

**2. Antivirals: Acyclovir/Hydrocortisone 5%/1% Cream (Xerese), Penciclovir 1% Cream (Denavir), and Acyclovir 50 mg buccal tablet (Sitavig)—New Manual PA Implementation Plan**

The P&T Committee recommended the new manual PA for Xerese, Denavir and Sitavig become effective on the first Wednesday after a 90-day implementation period, and that DHA send letters to the beneficiaries affected by this decision.

***Summary of Physician's Perspective:***

These three products are essentially slight variations of currently available drugs. The Committee felt that the theoretical benefits of these new products did not warrant the increased cost over the traditional therapies for cold sores.

The PA criteria will may potentially affect 1,000 patients, based on patients who have recently received prescriptions for these three drugs. Even though the disease state is short and patients may not receive a repeat course of therapy, we will mail letters to the patients affected by the new PA criteria.

***Summary of Panel Questions and Comments:***

There were no more questions or comment from the Panel. The Chair called for a vote on the New Manual PA Criteria and New Manual PA Implementation Plan for the Antivirals: Xerese, Denavir, and Sitavig.

- **Antivirals: Xerese, Denavir and Sitavig – New Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

   These comments were taken under consideration prior to my final decision

- **Antivirals: Xerese, Denavir and Sitavig – New Manual PA Implemenation Plan**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

   These comments were taken under consideration prior to my final decision

## H. UTILIZATION MANAGEMENT – UPDATED MANUAL PA CRITERIA AND STEP THERAPY

### 1. Updated Manual PA Criteria and PA Renewal Criteria

Updates to the step therapy and manual PA criteria for several drugs were recommended by the P&T Committee due to a variety of reasons, including expanded FDA indications and safety. The updated manual PAs outlined below will apply to new users.

The P&T Committee recommended (12 for, 0 opposed, 0 abstained, 4 absent) updates to the manual PA criteria for Xeljanz, Xeljanz XR, Taltz, Trulance, Addyi, and Lyrica; and updated PA renewal criteria for the tetracyclines.

a. **Targeted Immunomodulatory Biologics (TIBs): Tofacitinib (Xeljanz/Xeljanz XR) and Ixekizumab Injection (Taltz)**—The TIBs were most recently reviewed in August 2014, with step therapy requiring a trial of adalimumab (Humira) first. Xeljanz was originally approved for treating rheumatoid arthritis, while Taltz was originally approved for plaque psoriasis and was reviewed as a new drug in May 2016. PA criteria were updated to add the additional indication for active psoriatic arthritis in adults for Xeljanz, Xeljanz XR, and Taltz.

b. **GI-2 Miscellaneous Agents: Plecanatide (Trulance)**—Trulance was reviewed as a new drug in May 2017 and indicated for chronic idiopathic constipation, with manual PA criteria recommended. The PA criteria were updated to add the additional FDA indication for treatment of irritable bowel syndrome with constipation (IBS-C), with the requirement for a trial of linaclotide (Linzess) before approval of plecanatide for IBS-C.

c. **Female Hypoactive Sexual Desire Disorder Agents: Flibanserin (Addyi)**—Addyi was reviewed in November 2015 with manual PA criteria recommended. The PA criteria were updated to add an expiration date of three months, with renewal PA criteria ensuring efficacy and safety.

d. **Antidepressants and Non-Opioid Pain Syndrome Agents: Pregabalin (Lyrica) PA and MN Criteria**—Step therapy and manual PA criteria have applied to Lyrica since it was originally reviewed for formulary placement in November 2011, with the most recent update occurring in May 2017. The additional indication for treatment of neuropathic pain associated with spinal cord injury after a trial of gabapentin and duloxetine was added to the PA criteria.

e. **Antibiotics: Tetracyclines**—The PA criteria for the tetracyclines, which were originally reviewed in February 2017, was updated to include renewal criteria, that ensure the patient has been re-evaluated within the past 12 months, that the patient is tolerating therapy, and continues to need the medication and that the disease has stabilized or improved while on therapy. The PA renewal will expire in 365 days.

**2. Updated Manual PA Criteria and PA Renewal Criteria—PA Implementation Plan**

The P&T Committee recommended the following updates to the current PAs for Taltz, Xeljanz/Xeljanz XR, Addyi, Trulance, and Lyrica, and the renewal criteria for the tetracyclines become effective on the first Wednesday two weeks after the signing of the minutes in all points of service.

***Summary of Physician's Perspective:***

The P&T Committee does keep up with new indications for drugs that have prior authorization, new safety data, and also reviews requests from providers regarding specific PA criteria. The majority of the updates here are for new FDA-approved

indications. You will see these types of recommendations made at every BAP meeting.

***Summary of Panel Questions and Comments:***

There were no more questions or comment from the Panel. The Chair called for a vote on the Prednisone Delayed Release (Rayos).

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

## I. BRAND OVER GENERIC AUTHORIZATION FOR SILDENAFIL TABLETS (VIAGRA)

### 1. Viagra—Brand over Generic Requirement and Manual PA Criteria

TRICARE Policy requires dispensing of generic products at the Retail Network and Mail Order Pharmacy. However, pricing for the branded Viagra product is more cost effective than the AB-rated generic formulations for sildenafil, which were launched in December 2017. The manufacturer of Viagra has offered a Distribution and Pricing Agreement (DAPA). Therefore, the branded Viagra product will continue to be dispensed, and the generic will only be available with prior authorization (i.e., the reverse of the current brand to generic policy). The Tier 1 (generic) copayment will apply to Viagra. The "brand over generic" requirement for Viagra will be removed administratively when it is no longer cost effective compared to the AB-rated generics.

The P&T Committee recommended (12 for, 0 opposed, 0 abstained, 4 absent) implementing the requirement to prefer the branded Viagra product over generic formulations. Manual PA criteria are required for generic sildenafil in the Retail

Network and Mail Order Pharmacy. The prescriber will provide patient-specific justification as to why the branded Viagra product cannot be used.
PA Criteria

Manual PA criteria apply to all new users of generic Viagra. Note that brand Viagra is the preferred PDE-5 inhibitor product in DoD.

Manual PA Criteria: Coverage for generic sildenafil is approved if the following criteria is met:

- The provider has provided patient-specific justification as to why the brand Viagra product cannot be used.
- Acceptable reasons include the following, which have occurred or are likely to occur with the branded Viagra product: allergy to the branded Viagra; contraindication; sub-therapeutic response; physical restriction (e.g., swallowing issues); and brand availability issues.

**2. Viagra—Brand Copayment Change**

The P&T Committee recommended (12 for, 0 opposed, 0 abstained, 4 absent) that the brand (Tier 2) formulary cost share for Viagra in the TRICARE Mail Order Pharmacy and the TRICARE Retail Network Pharmacy be lowered to the generic (Tier 1) formulary cost share.

***Summary of Physician's Perspective:***

TRICARE requires mandatory use of generics. Generic formulations of Viagra became available in December of last year. However, the price of the generics are significantly more expensive than the government pricing for brand Viagra, so P&T waived the generic use requirement and made the brand name product preferred.

The reason for having the copay decrease to tier 1 (or generic copay) is an incentive for the brand name Viagra to be dispensed. The price of the generics will be monitored, so when it is no longer cost effective to continue dispensing brand Viagra, we will administratively remove this requirement, and go back to our usual process of preferring the generic.

***Summary of Panel Questions and Comments:***

There were no more questions or comment from the Panel. The Chair called for a vote on the Viagra – Brand over Generic Requirement and Manual PA Criteria.

- **Viagra – Brand over Generic Requirement and Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

- **Viagra – Brand Copayment Change**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

  ***Director, DHA:***

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

CAPT Norton started to thank and conclude the meeting.

Mr. Hostettler asked to provide more comments regarding the GLP1RA. The recommendations stated that letters will be mailed to the affected patients. Would it be possible to include network providers? There are a lot of patients to get back through the system.

CAPT VonBerg said they will work with managed support contractors.

Mr. Hostettler said it would make sense include the network providers so they know why all the patients are coming back in to get new prescriptions.

CAPT Norton addressed his comments by saying P&T minutes are signed and shared with the STRACTOM within DHA. They communicate with the various stakeholders which would include the managed support contractors who communicate changes to their network providers. There are several avenues that the decisions of the P&T Committee meetings are made available to the public as well as affected providers and patients.

Mr. Hostettler said he understands how administrative contractors are made aware, but not sure if routinely send that kind of information out to their network providers.

CAPT Norton thanked everyone for their attendance. Thanked the Panel. Concluded the meeting.

Mr. Ostrowski thanked CAPT VonBerg for his service to the Panel and appreciated all that he's done and wished him well in his new endeavors.

**(Meeting Concludes)**

**Appendix A – Private Citizen Comments – Radius Health**
**Appendix B – Private Citizen Comments – Mallinckrodt Pharmaceuticals**
**Appendix C – Brief Listing of Acronyms Used in this Summary**

Dear Uniform Beneficiary Advisory Panel,

We appreciate the recent review you conducted of TYMLOS in consideration for formulary addition. Radius Health is disappointed by the outcome, and respectfully accepts the offer to submit this letter in response.

Listening to our patients, payers and government agencies, we learned prior to launching TYMLOS that patient affordability was a significant factor in the historically low and declining utilization rates of anabolic therapy. In response, Radius priced TYMLOS significantly below that of the only other anabolic on the market. Please consider the following:

- Today, the WAC price of TYMLOS is $1,720.88 vs. $3,294.70 per pen for Forteo, a 48% difference
- Over the course of a 12-month period, TYMLOS WAC is $20,260.56 compared to Forteo's WAC of $42,831.10.
- The TYMLOS pen contains 30 days of therapy whereas the Forteo pen contains 28 days of therapy, resulting in one less pen needed to complete a year of therapy (assuming full compliance)

- NOTE: Price comparisons do not imply comparable efficacy, safety or indications

Further, 93% of Commercially insured lives in the nation currently have coverage for TYMLOS.

Considering the clinical profile of TYMLOS and the significant difference in net cost between TYMLOS and teriparatide, plus the additional information outlined below, we respectfully ask that you re-evaluate the non formulary P&T recommendation, and allow physicians and patients to have a choice in the anabolic therapy class by adding TYMLOS to your Tier 2 Formulary.

We observed in the meeting minutes that the P&T committee concluded there is a high degree of interchangeability between Forteo and Tymlos. Radius Health respectfully disagrees, and ask that you consider the following additional clinical points:

Additional points for consideration:

- Clinical
  - TYMLOS achieved **the** primary and secondary endpoints of ***significant fracture risk reduction at both*** **vertebral and nonvertebral sites** ***and increases in BMD*** **at the lumbar spine, total hip and femoral neck** in the 18-month efficacy trial; Tymlos achieved a 86% relative risk reduction (3.6%

ARR) in new vertebral fractures **(p <0.0001)** and 43% relative risk reduction (2.0% ARR) in non-vertebral fractures **(p=0.049)** at 18 months **compared to placebo**

- For vertebral, non-vertebral, and major osteoporotic fractures, TYMLOS **time to fracture events began to** separate from placebo at **approximately month 3**; Forteo separated from placebo at **approximately** 12 months
- There were significant increases in BMD at the lumbar spine, total hip, and femoral neck vs. placebo at 18 months**, additionally data demonstrated TYMLOS had significant increases in BMD at both the total hip and femoral neck at month 6**
    - Fracture risk reductions and BMD increases were continued at 25 and 43 months (18 months of treatment with TYMLOS and 1 month without treatment, followed by 24 months of alendronate)
    - In an open label, active comparator arm of the study, the percentage of patients with new vertebral fractures at 18 months taking Forteo was 4.2% vs. 0.8% with placebo; the percentage of nonvertebral fracture was 3.3% for Forteo and 4.7% for placebo
- NOTE: This study was not designed to provide head-to-head comparative efficacy data and cannot be interpreted as evidence of superiority or noninferiority to teriparatide

- Other
    - Radius submitted a bid to Tricare requesting a parity position
    - Tymlos offered a rebate above the FFS standard rate required
    - Radius has aligned with the FDA on a study for male osteoporosis
    - Radius request the opportunity to match the current rebate offered by Eli Lilly for Forteo
    - A one-year course of TYMLOS is $22,180.54 less than FORTEO

Thank you for your consideration,

Amanda G. Mott, JD
Sr. Vice President, Market Access Radius Health
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**Mallinckrodt Pharmaceuticals**
**Comments on DoD P&T Committee Proposal**

## I. INTRODUCTION

- My name is Sean Griffin, and I am an attorney with the law firm Sidley Austin LLP.
- I am here today on behalf of Mallinckrodt Pharmaceuticals.
- Mallinckrodt has asked me to address a mix of clinical and legal concerns regarding the P&T Committee's recent recommendations regarding the class of drugs known as Adrenocorticotropic Hormones or ACTH.
- Mallinckrodt manufacturers Acthar Gel, which is the only ACTH product currently approved for therapeutic use in the United States.
- Acthar Gel is widely recognized as a medically necessary product and has the distinction of being FDA approved for 19 different indications.
- We have not had much time to review the Committee's recommendations, so my comments today are necessarily at a high-level.
- Mallinckrodt is concerned, however, that certain of the PA criteria recommended for the Infantile Spasm (IS) and Multiple Sclerosis (MS) indications are inappropriate and will harm patients by delaying access to an important and effective therapy.
- Mallinckrodt also is concerned about the omission of any prior authorization criteria for the other FDA-approved indications. That omission appears to be based on a false premise-namely, that those indications have not been evaluated or approved by FDA for effectiveness. That is false. Each of the current labeled uses was approved for effectiveness in 1977 and again in 2010.

- These clinical and factual issues also raise serious legal issues. Under the Administrative Procedures Act (or APA), agency decisions must be evidence-based and supported by a reasoned explanation. [1] Those requirements take on special force when, as now, an agency proposes to substantially revise a policy that has been in place for several years.[2] At a minimum, the Committee should have acknowledged that it was changing the coverage policy for IS and other uses, explained why the change is justified based on specific, reliable evidence, and addressed the legitimate reliance that patients, providers, and Mallinckrodt have placed

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1 *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 43 (1983) ("[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.").

2 *FCC v. Fox Television Stations, Inc.*, 129 S. Ct. 1800, 1811 (2009) (An agency must "provide a more detailed justification ... when, for example, its new policy rests upon factual findings that contradict those which underlay its prior policy.").

- on the prior policies.[3] The Committee appears not to have followed these important APA requirements.

- In light of these concerns, we request that the Panel modify the Committee's recommendations in three ways.

  - First, we believe that the PA criteria for the IS indication should not include a requirement that patients first receive a 2-week course of high-dose prednisone/prednisolone. This will harm patients and is inconsistent with nationally-accepted clinical practice guidelines.

  - Second, we believe that the PA criteria for the MS indication should be edited to remove the words "for the present exacerbation." It is plainly inappropriate to require a failed steroid treatment for each individual exacerbation as it occurs. Forcing patients to endure multiple, repeated treatment failures would be an entirely unreasonable barrier to access to an established second line therapy.

  - Finally, we believe that the Panel should strike the Committee's language describing other FDA-approved uses of Acthar Gel as "unsupported" or "unproven" and adopt appropriate PA criteria for at least those uses that previously have been covered "on appeal." The Committee failed to explain in any manner how new evidence justified the departure from its prior coverage policies, which did cover these uses in appropriate circumstances. A policy of no coverage under any circumstances, no matter how severe the patient need and no matter how extensively other therapies have been tried and failed, is plainly arbitrary and capricious.

- I will now address our three concerns in greater detail.

## II. Infantile Spasms

- We have several concerns regarding the Committee's proposal that patients be required to receive 2 weeks of steroids before receiving Acthar Gel. First and foremost, we are concerned that a two-week course of steroids will harm patients by delaying the onset of treatment with Acthar Gel.

  - Infantile Spasms is a rare but catastrophic syndrome that typically onsets within the first year of life and is characterized by both spasms and hypsarrhythmic EEG patterns.
  - The condition very frequently results in neurological delay or impairment.

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3 *Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015) ("It would be arbitrary and capricious to ignore" "serious reliance interests that must be taken into account."); *accord Smiley v. Citibank (South Dakota), N.A.*, 517 U.S. 735, 742 (1996).

- Delayed treatment that exposes infants to three or more weeks of hypsarrhythmia has been shown to cause increased impairment.[4]

- We are concerned that a two-week delay before commencing treatment with Acthar Gel could result in unnecessary, permanent disability.

- Our concerns are underscored by the fact that neither prednisone nor prednisolone has been approved by FDA for the treatment of IS.

  - We think it is plainly inappropriate to rely on unapproved uses of these steroids *as a* first-line treatment for such a serious and time-sensitive condition.

  - Indeed, we are not aware of any government payor or major commercial payor that currently requires patients suffering from Infantile Spasms to receive steroid treatment prior to receiving Acthar Gel

- To the contrary, Acthar Gel is widely recognized as the standard of care for IS.

- Mallinckrodt previously submitted a comprehensive set of articles and studies related to the use of Acthar Gel as a treatment for IS. We would particularly like to draw the Panel's attention to:

  - The current evidence-based clinical guidelines from the American Academy of Neurology/ Child Neurology Society, which not only endorse Acthar Gel as a first line therapy but also conclude that there is insufficient evidence to recommend the use of prednisolone or other therapies. [5]
  - A 2010 meeting of knowledge leaders, which concluded that a high-dose regimen of Acthar Gel "continues to be the clinical standard of treatment of infantile spasms in the United States and several other countries."[6]
  - A study published in 2016 by the National Infantile Spasms Consortium, which found that ACTH appeared to be a more effective treatment for Infantile Spasms than other standard therapies.[7]
  - A randomized trial published in 1996, which found that a 2-week course of high- dose ACTH (86.6% efficacy) was superior to 2 weeks of what would now be

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4 Mackay MT, et al. Neurology. 2004;62(10):1668-1681; Goh S, et al. Neurology. 2005;65(2)235-238

5 Go C.Y. et al. Evidence-based guideline update: Medical treatment of infantile spasms: Report of the Guideline Development Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society Neurology, 2012:78:1974-1980

6 Stafstrom CE et al. Treatment of IS insights from clinical & basic science perspectives- J Child Neurol 2011 26(11) 1411-1421.

7 Knupp K.G. et al. Response to Treatment in a Prospective National Infantile Spasms Cohort Ann Neurol 2016:79:475-484.

considered low-dose prednisone (28.6%) for treatment of infantile spasms as assessed by both clinical and EEG criteria.[8]

- We believe that the Committee's recommendation would not survive judicial review under the APA.
    - The Committee's recommendation does not appear to be evidence based. Although there are oblique statements regarding a review of the evidence, the Committee does not cite any particular source that supports its position.
    - The Committee also appears to have ignored the materials I've mentioned, none of which are acknowledged in the decision, and all of which contradict the recommendation.
    - The Committee's recommendation does not acknowledge that the 2 weeks of steroids requirement is a substantial change in policy. The PA criteria that have been in place since 2013 do not require prior steroid treatment. No new evidence is presented, and we are not aware of new evidence that would be sufficient to outweigh or contradict the settled view that Acthar Gel is the standard of care for this condition.
    - Last, the Committee did not consider the reliance interests of patients, providers, and Mallinckrodt surrounding the prior policy.
    - Each of these issues is independently a basis to conclude that the Committee's recommendation is arbitrary and capricious under the APA.
- Accordingly, we ask the Panel to remove the PA criteria that all patients with IS first try a 2 week course of steroids.

## III. Multiple Sclerosis

- With respect to the MS indication, we agree that prior authorization is appropriate and that patients should try and fail treatment with steroids prior to receiving Acthar Gel for MS exacerbations.

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8 Barram TZ et al. High dose Corticotropin (ACTH) Versus Prednisone for Infantile Spasms: A Prospective, Randomized, Blinded Study - Pediatrics 1996;97(3):375-379.

Our objection is only to the requirement that patients must have failed steroid treatment in connection with "the present exacerbation," which seems plainly unreasonable.

- MS patients often experience multiple exacerbations or relapses, with many experiencing more than one exacerbation a year.
- If steroids failed in a prior exacerbation, there should be no reason to force the patient to repeat the failed therapy again.
- If the committee's recommendation is adopted, veterans theoretically could be forced to try steroid treatments 5, 6, 7 or more times beyond the first failure, with each exacerbation forcing a new trial and failure.
- We cannot believe that was the Committee's intent.

- Repeated steroid treatments also pose quality of life problems for MS patients:
  - During an exacerbation without appropriate treatment, patients can experience a range of harms, from difficulty walking to optic neuritis, a painful vision issue, and cognitive delays.
  - A steroidal treatment also typically requires the patient to visit a clinic every day to receive the infusion, as opposed to Acthar Gel, which can be administered by the patient in the home. For a patient in an exacerbation, with limited or no mobility, that is a very real and very serious barrier to care.
- Accordingly, we ask the Committee to remove the requirement that steroids must be used first in the "present exacerbation."

## IV. All Other Uses

- For all remaining indications of Acthar Gel, the P&T Committee recommends that all other uses "are unsupported and excluded from TRICARE coverage."
- We have several concerns about this recommendation.
- First, the recommendation is based on a plain misunderstanding of the facts and the law.
  - The Committee document (at page 13) asserts that all indications other than IS and MS have not been approved by FDA for clinical effectiveness because the drug was originally approved prior to the 1962 Amendments to the FDCA.
  - That is false
  - ACTH was considered through the Drug Efficacy Study Implementation Program. Through that program, Acthar Gel was reviewed and approved as effective in 1977 for a large number of indications and in 1978 for MS.
  - FDA then re-reviewed the drug in 2010 as part of a supplemental NDA filing, and reaffirmed 19 approved indications. Each of those indications have been approved by FDA for both safety and effectiveness.
  - The APA does not permit an agency to base a decision on a false premise.

- Second, the recommendation is a break from existing coverage policy.
    - Previously, the program provided coverage for indications like lupus and protein-wasting nephropathies on "appeal only."
    - While we have many concerns about the legality of "appeal only" coverage, that policy did enable at least some patients to receive coverage.
    - For instance, between January 2014 and March 2018, at least 113 naive patients received coverage for Acthar Gel for protein-wasting nephropathies on appeal.
    - By statute, this means that the Department has recognized that these uses were medically necessary in those particular cases. [9]
- Thus, the Committee articulated a change of position, but without any explanation, such as new evidence that could support the decision to cut off coverage for uses that were previously covered. The change therefore is subject to challenge under the APA.
- Finally, we are very concerned that the recommendation does not address the legal concerns that we have raised over the past several months.
    - Previously, we raised a serious of concerns in which some patients who had been prescribed Acthar Gel for these uses were not given initial determinations that they are entitled to receive under applicable law.
    - They were instead given appeal rights, but were falsely told by DoD's contractor that the appeal would necessarily fail. Not only did this result in delay, it strongly disincented patients from pursuing their appeal rights.
    - We were told that the P&T Committee review would address these serious issues, but the current recommendation makes the problem worse.
    - There is no mechanism to correct for past patients to receive the initial coverage determination that they were deprived. Nor is there a process to correct the false statements made to patients regarding their appeals.

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9 TRICARE's coverage is limited to services and supplies that "are medically or psychologically necessary for the diagnosis or treatment of a covered illness ... or injury...." 32 CFR 199.4(g)(1).

- And, for future patients, there is no indications that they will even receive appeal rights, let alone an initial determination.

- Accordingly, we believe the Panel should establish PA criteria for the uses previously covered on appeal.

- Thank you for your time. The company will be following up with an additional letter and we can address the questions in that letter.

## Brief Listing of Acronyms Used in this Summary

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

- A1c – hemoglobin A1c
- ACTH – Adrenocorticotropic Hormones
- AKC - Atopic Keratoconjunctivitis
- ALS - Amyotrohic Lateral Sclerosis
- BIA – Budget Impact Analysis
- BMD – Bone
- CFR – Code of Federal Regulations
- CMA – Cost-Minimization Analysis
- CV - Cardiovascular
- CVOT – Cardiovascular Outcome Trials
- DAPA – Distribution and Pricing Agreement
- DHA – Defense Health Agency
- DoD – Department of Defense
- DPP-4 – Dipeptidyl Peptidase 4
- DR – Delayed Release
- EEG - Electroencephalogram-Confirmed
- ER - Extended Release
- FDA - Food & Drug Administration
- FEV1 – forced expiratory volume in one second
- FSGS - Focal Segmental Glomerulosclerosis
- GI - Gastrointestinal
- GLP1RA - Glucogon-Like Peptide-1 Receptor Agonists
- GvHD – Graft Versus Host Disease
- HDM - House Dust Mite
- HIV - Human Immunodeficiency Virus
- IBS-C – Irritable Bowel Syndrome with Constipation
- IR – Immediate Release
- IR/DR – Immediate Release/Delayed Release
- IV – Intravenous
- IV/PO – Intravenous/Oral Equivalent
- MHS – Military Health System
- MPGN – Membranoproliferative Glomerulonephritis
- MS – Multiple Sclerosis
- MTF – Military Treatment Facility
- NF – Non Formulary

- NNT – Number Need to Treat
- OTC – Over the Counter
- P&T – Pharmacy and Therapeutics Committee
- PA – Prior Authorization
- PDE-5 – phosphodiesterase type -5 inhibitor
- PTH – Parathyroid Hormone Analogs
- QTc - corrected QT
- SGLT2 – Sodium Glucose Co-Transporter-2 Inhibitor
- T2DM – Type 2 Diabetes Mellitus
- TEN – Toxic Epidermal Necrolysis
- TIB – Targeted Immunomodulatory Biologics
- UF – Uniform Formulary
- VCK – Vernal Keratoconjunctivitis
- XR – Extended release

**Uniform Formulary Beneficiary Advisory Panel (BAP)**

Meeting Summary
April 5, 2018
Washington, D.C.

## Present Panel Members

- Mr. Jon Ostrowski, Non Commissioned Officers Association, Chairperson
- Dr. Sarika Joshi, HealthNet Federal Services
- Mr. Charles Hostettler, AMSUS, The Society of Federal Health Professionals
- Mr. John Du Teil, US Army Warrant Officers Association

## Absent Panel Members

- Mrs. Theresa Buchanan, National Military Family Association
- Dr. Richard Bertin, Commissioned Officers Association of the USPHS
- Mrs. Suzanne Walker, Military Officers Association of America

The meeting was held at Naval Center Theater, 701 Pennsylvania, N.W., Washington D.C., and CAPT Edward Norton called the meeting to order at 9:00 A.M.

## Agenda

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

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

    1. Drug Class Reviews

        a. Non-Insulin Diabetes Drugs: Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs) Subclass
        b. Anti-Inflammatory Immunomodulatory Ophthalmics: Ophthalmic Immunomodulatory Agents Subclass
        c. Osteoporosis Drugs: Parathyroid Hormone (PTH) Analogs Subclass
        d. Corticosteroids-Immune Modulators: Adrenocorticotropic Hormones (ACTH)

    2. Newly-Approved Drug per CFR 199.21(g)(5)

        a. acalabrutinib (Calquence)—Oncological Agents for Mantle Cell Lymphoma
        b. benznidazole—Miscellaneous Anti-Infective for Chagas Disease
        c. coagulation factor IX, recombinant (Rebinyn)—Antihemophilic Factors
        d. dolutegravir/rilpivirine (Juluca)—Antiretrovirals
        e. emicizumab-kxwh (Hemlibra)—Antihemophilic Factors

f. fluticasone propionate 93 mcg nasal spray (Xhance)—Nasal Allergy Drugs: Corticosteroids
g. house dust mite (HDM) allergen extract (Odactra)—Immunological Agents — Miscellaneous: Oral Agents
h. latanoprostene bunod ophthalmic solution (Vyzulta)—Glaucoma Agents
i. letermovir (Prevymis)—Antivirals
j. minocycline ER capsules (Ximino)—Antibiotics: Tetracyclines
k. dapagliflozin/saxagliptin (Qtern)—Non-Insulin Diabetes Drugs: Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors
l. semaglutide (Ozempic)—Non-Insulin Diabetes Drugs: GLP1RAs
m. sodium picosulfate/magnesium oxide/anhydrous citric acid (Clenpiq)—Laxatives-Cathartics-Stool Softeners
n. spironolactone 25 mg/5 mL oral suspension (CaroSpir)—Diuretics

3. Utilization Management Issues

   a. Prior Authorization Criteria – New Criteria

      - Corticosteroids-Immune Modulator Agents: Corticosteroids Subclass prednisone delayed release (Rayos)
      - Antivirals: acyclovir 5%/hydrocortisone 1% cream (Xerese); penciclovir 1% cream (Denavir); acyclovir 50 mg buccal tablet (Sitavig)

   b. Prior Authorization Criteria – Updated Criteria

      - Acne Agents—Topical Acne and Rosacea Agents: dapsone gel 5% and 7.5% (Aczone)
      - TIBs: tocilizumab (Actemra)
      - Ophthalmic Immunomodulatory Agents: lifitegrast (Xiidra)
      - Corticosteroids – Immune Modulators: crisaborole (Eucrisa)
      - Proton Pump Inhibitors (PPIs): esomeprazole delayed release packets for suspension (Nexium Packets)
      - Non-Insulin Diabetes Drugs: Sodium Glucose Co-Transporter 2
      - (SGLT2) Inhibitors

4. Brand Over Generic Authorization for Sildenafil (Viagra): Prior Authorization and Co-pay Change

5. Panel Discussions

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

**Opening Remarks**

CAPT Edward Norton introduced himself as the Designated Federal Officer (DFO) for the Uniform Formulary (UF) Beneficiary Advisory Panel (BAP). The Panel has convened to comment on the recommendations of the DoD Pharmacy and Therapeutics (P&T) Committee meeting, which occurred on February 8 – 9, 2018.

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

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

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

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

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

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

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

- The P&T Committee met for approximately 15 hours conducting this review of the drug class recommendation presented today. Since this meeting is considerably shorter, the Panel

will not receive the same extensive information as presented to the P&T Committee members. However, the BAP will receive an abbreviated version of each presentation and its discussion. The materials provided to the Panel are available on the TRICARE website. Detailed minutes of this meeting are being prepared. The BAP minutes, the DoD P&T Committee minutes, and the Director's decisions will be available on the TRICARE website in approximately four to six weeks.

The DFO provided ground rules for conducting the meeting:

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

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

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

CAPT Norton introduced the individual Panel members (see list above) and noted housekeeping considerations.

Private citizen comments were received by Mallinckrodt Pharmaceuticals and Radius Health. Comments were forwarded to Uniform Formulary Beneficiary Advisory Panel for review.

**(SEE APPENDICIES A and B)**

**Chairman's Opening Remarks**

Mr. Ostrowski welcomes everyone and thanks the Panel and Staff for being here today.

## UNIFORM FORMULARY REVIEW PROCESS

**(CAPT VONBERG)**

GOOD MORNING. I am CAPT Edward VonBerg, Chief of the Formulary Management Branch. Joining me is doctor and retired Army Colonel John Kugler, the Chairman of the Pharmacy & Therapeutics Committee, who will provide the physician perspective and comments on the recommendations made by the P&T Committee. Also joining us from the Formulary Management Branch today is Angela Allerman, a clinical pharmacist. I would also like to recognize Bryan Wheeler, Deputy Assistant General Counsel.

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

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

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

- A brief overview of the relative clinical effectiveness analyses considered by the DoD P & T Committee. All reviews include but are not limited to the sources of information listed in 32 CFR 199.21 (e)(1) and (g)(5). Also note that non formulary medications are generally restricted to the mail order program according to amended section 199.21, revised paragraphs (h)(3)(i) and (ii), effective August 26, 2015.

- A brief general overview of the relative cost effectiveness analyses. This overview will be general in nature since we are unable to disclose the actual costs used in the economic models. This overview will include the factors used to evaluate the costs of the agents in relation to the safety, effectiveness, and clinical outcomes.

- The DoD P&T Committee's Uniform Formulary recommendation is based upon its collective professional judgment when considering the analyses from both the relative clinical- and relative cost-effectiveness evaluations.

  The Committee reviewed the following:

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

     a) the Non-Insulin Diabetes Drugs: Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs) Subclass;

b) the Anti-Inflammatory Immunomodulatory Ophthalmics: Ophthalmic Immunomodulatory Agents Subclass;
c) the Osteoporosis Drugs: Parathyroid Hormone (PTH) Analogs Subclass; and
d) the Corticosteroids-Immune Modulators: Adrenocorticotropic Hormones (ACTH)

A summary table of the UF drug class recommendations and the numbers of affected utilizers is found on page 27 & 28 of the background document. It also contains the numbers of the unique utilizers affected by the recommendations.

2. The P&T Committee also evaluated 14 Newly Approved Drug per CFR 199.21 (g)(5), which are currently in pending status and available under terms comparable to non-formulary drugs.

3. We will also discuss Prior Authorizations (PAs) for **10** drugs in **7** drug classes, plus one drug class with a step therapy modification.

a) Corticosteroids – Immune Modulators – Corticosteroids Subclass
b) Antivirals
c) Targeted Immunomodulatory Biologics
d) Gastrointestinal-2 Miscellaneous Agents
e) Female Hypoactive Sexual Desire Disorder Agents
f) Antidepressants and Non-Opioid Pain Syndrome Agents
g) Antibiotics

and

h) We discussed one product for brand over generic authorization.

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

## UNIFORM FORMULARY DRUG CLASS REVIEWS

# I. UF CLASS REVIEWS

## A. NON-INSULIN DIABETES DRUGS: GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS (GLP1RA) SUBCLASS

**(CAPT VONBERG)**

### 1. Non-Insulin Diabetes Drugs: Glucagon-Like Peptide-1 Receptor Agonists (GLP1RA) Subclass—Relative Clinical Effectiveness Analysis and Conclusion

*Background*— The GLP1RAs were most recently reviewed in August 2015, with exenatide once weekly (Bydureon) and albiglutide (Tanzeum) selected as Uniform Formulary (UF) and step-preferred status, with all the other GLP1RAs designated as non formulary (NF) and non step-preferred. Since the last review, two new products have been approved, an exenatide once weekly autoinjector (Bydureon BCise), and semaglutide (Ozempic). The GLP1RA combinations with insulin were not included in this review.

Voluntary market discontinuation of Tanzeum is expected in August 2018.

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

- Metformin remains the first-line treatment in all patients with type 2 diabetes mellitus (T2DM) unless there are contraindications.

- The new Bydureon BCise autoinjector formulation is easier to self-administer than the Bydureon pen. It is comparable to Bydureon in lowering A1c.

- When used as monotherapy or in combination with other oral agents, the GLP1RAs decrease hemoglobin A1c (A1c) on average approximately 1% to 2% from baseline. Overall, differences in A1c between the GLP1RAs are not clinically relevant.

    - However, in one study (SUSTAIN-3), semaglutide (Ozempic) was statistically and clinically superior to exenatide once weekly (Bydureon) in glycemic control, as semaglutide lowered A1c by 1.5% from baseline compared to 0.9% with exenatide. Limitations to the SUSTAIN-3 study include its open label, active comparator design; it was not designed to show superiority.

    - In the open-label, active comparator SUSTAIN-7 study, semaglutide was statistically superior to dulaglutide (Trulicity) in glycemic control, as it reduced A1c by 1.5-1.8% from baseline compared to 1.1-1.4% with dulaglutide. However, the differences in change in A1c between semaglutide and

dulaglutide were not considered clinically relevant, as the change in A1c between the two drugs was less than 0.5%.

- Patients are likely to experience weight loss with use of any GLP1RA.

- Cardiovascular outcomes trials (CVOTs) evaluating the effects on endpoints, including CV mortality, non-fatal myocardial infarction, and stroke, have been completed with four of the products: liraglutide (Victoza) in the LEADER trial, Ozempic in SUSTAIN-6, Bydureon in the EXSCEL trial, and lixisenatide (Adlyxin) in the ELIXA trial. Trials are currently ongoing with dulaglutide (Trulicity) in the REWIND trial and Tanzeum in the HARMONY-OUTCOME trial.

- Liraglutide (Victoza) is the only GLP1RA that has an additional indication to reduce CV risk in patients with established CV disease, based on the LEADER trial. However, given the differences in patient populations in the CVOTs, it is difficult to directly compare one GLP1RA to another in terms of CV benefit.

- In the four CVOTs the association of GLP1RAs with retinopathy has been a concern, however this was a secondary outcome, and the trials were underpowered to adequately assess worsening retinopathy. Additional studies are needed to definitively determine the long-term effects of GLP1RAs on diabetic retinopathy.

- Gastrointestinal (GI) effects of nausea, vomiting, and diarrhea are the most commonly reported adverse effects with the class. The incidence of nausea varies based on dosing, with higher doses resulting in more nausea. Bydureon has the lowest incidence of nausea at 14%, compared to Ozempic (16-20%), Trulicity (12-21%), Victoza (23%), Adlyxin (29%), and exenatide twice daily (Byetta) (35%).

- Victoza, Adlyxin, and Ozempic have an advantage in offering a smaller needle size for patient convenience. One disadvantage of Bydureon and Bydureon BCise is the larger needle size.

- Bydureon, Bydureon BCise, Trulicity, and Ozempic, have the advantage of once weekly dosing, while Victoza and Adlyxin are dosed once daily, and Byetta is dosed twice daily. Potential advantages of Bydureon and Bydureon BCise include that they are the only GLP1RAs that do not require dosage titration.

- Trulicity, Victoza, and Ozempic require no dose adjustment in renal insufficiency.

**2. GLP1RA Subclass—Relative Cost-Effectiveness Analysis and Conclusion**

Cost-minimization analysis (CMA) and budget impact analysis (BIA) were performed to evaluate the GLP1RAs. The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results showed that exenatide once weekly (Bydureon and Bydureon BCise) were the most cost-effective agents, followed by dulaglutide (Trulicity), exenatide twice daily (Byetta), semaglutide (Ozempic), liraglutide (Victoza), and lixisenatide (Adlyxin).

- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating exenatide (Bydureon and Bydureon BCise) and dulaglutide (Trulicity) as formulary and step-preferred, with exenatide twice daily (Byetta), semaglutide (Ozempic), liraglutide (Victoza), and lixisenatide (Adlyxin) as NF and non step-preferred demonstrated the largest estimated cost avoidance for the Military Health System (MHS).

**3. GLP1RA Subclass—UF Recommendation**

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

- UF and step-preferred
  - exenatide once weekly (Bydureon and Bydureon BCise)
  - dulaglutide (Trulicity)

- NF and non step-preferred

  - albiglutide (Tanzeum)
  - exenatide twice daily (Byetta)
  - liraglutide (Victoza)
  - lixisenatide (Adlyxin)
  - semaglutide (Ozempic)

- This recommendation includes step therapy which requires a trial of exenatide once weekly (Bydureon or Bydureon BCise) and dulaglutide (Trulicity) prior to use of the NF, non step-preferred GLP1RA drugs in all new and current users.

**4. GLP1RA Subclass—Manual Prior Authorization (PA) Criteria**

PA criteria currently apply to the GLP1RAs subclass. Currently, a trial of metformin or a sulfonylurea is required prior to use of a GLP1RA, and use of the step-preferred GLP1RAs are also required prior to the non step-preferred products. The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) removing the requirement for a trial of a sulfonylurea, and maintaining the metformin step, based on the treatment guidelines from several diabetes associations where metformin is preferred due to its positive effects on glycemic control, safe adverse effect profile, and minimal cost. Additionally sulfonylureas are no longer considered first line therapy for diabetes.

The Committee also recommended updating the existing manual PA criteria so that new and current GLP1RA users must try the step-preferred products, Bydureon or Bydureon BCise and Trulicity, prior to using Tanzeum, Byetta, Victoza, Adlyxin, or Ozempic. Use of the non step-preferred products is allowed if the patient has had an inadequate response to the step-preferred GLP1RAs.

PA Criteria:

All new users of a GLP1RA are required to try metformin before receiving a GLP1RA. Patients currently taking a GLP1RA must have had a trial of metformin first.

Bydureon/Bydureon BCise, Trulicity, Tanzeum, Byetta, Victoza, Adlyxin, or Ozempic is approved (i.e., a trial of metformin is NOT required) if:

- The patient has a confirmed diagnosis of Type 2 diabetes mellitus.
- The patient has experienced any of the following issues on metformin:
  - impaired renal function precluding treatment with metformin
  - history of lactic acidosis
- The patient has had inadequate response to metformin
- The patient has a contraindication to metformin

In addition to the above criteria regarding metformin the following PA criteria would apply specifically to new and current users of Tanzeum, Byetta, Victoza, Adlyxin, and Ozempic:

- The patient has had an inadequate response to Bydureon/Bydureon BCise and Trulicity.

Off-label uses are not approved.

Prior Authorization does not expire.

**5. GLP1RA Subclass—PA Criteria UF and PA Implementation Plan**

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

1) An effective date of the first Wednesday after a 90-day implementation period in all points of service an

2) DHA send letters to beneficiaries who are affected by the UF decision.

**6. Physician's Perspective**

The rationale for reviewing this drug class again is due to the market withdrawal of Tanzeum, plus the new entrants. The utilization of the GLP1 class is growing, so we will continue to monitor the usage and cost.

The Committee re-affirmed that a minimally clinically important difference in A1c lowering is a change of at least 0.5%. For the GLP1s, there is a high degree of therapeutic interchangeability in terms of effects on hemoglobin A1c.

The Committee did review the cardiovascular outcomes trial data. For the GLP1s, the hazard ratios and confidence intervals did overlap between the studies. Other drug classes have a higher quality and body of evidence for lowering cardiovascular risk in diabetics than the GLP1s, including ACE inhibitors, statins and aspirin.

For the Prior Authorization requirements, the Committee wanted to maintain the requirement to try metformin first, which is consistent with all the diabetic treatment guidelines. The previous requirement to also try a sulfonylurea has been removed, due to the recognized risk of hypoglycemia with this class of drugs, and the guidelines.

The goal of the step therapy is to promote use of the preferred GLP1Rs – the Bydureon products and now Trulicity, instead of Tanzeum. The Committee again recommended "no grandfathering", which means that all new and current patients with a prescription for the non preferred products must try Bydureon or Trulicity, unless they have had an inadequate response to the preferred products.

We will mail letters to patients, informing them of the new PA criteria. We will also mail letters to the patients who are currently on Tanzeum, notifying them of the impending market discontinuation and upcoming non formulary status.

**7. Panel Questions and Comments**

Mr. Hostettler asked about the difference in the sizes of the needles for Victoza and Bydureon.

Dr. Allerman stated that they are 25-27 gage for Bydureon. The others are 27-29 gauge.

Mr. Hostettler replied that is not a huge difference. Is there any compliance data that supports the benefits of taking the injections once a day, twice a day or once weekly?
CAPT VonBerg stated there is a not a direct comparison trial.

Mr. Hostettler asked is there any data that states taking the injections once weekly has better compliance than taking it once daily or twice daily?

Dr. Allerman replied there is no published data. For convenience, we feel once a week has some advantages.

Mr. Hostettler replied it may be difficult for the patient to remember to take medications on a weekly basis.

Dr. Allerman replied that if it's an injection, it would be easier to do on a weekly basis vs. daily.

Mr. Hostettler asked why the recommendation didn't include grandfathering patients. As a result, 32,000 patients have to see their provider to get new prescriptions and be re-evaluated, which changes their therapy. This recommendation forces a change into the system of a diabetic patient population, where providers and patients are trying to maintain consistency.

Dr. VonBerg stated the review was prompted by the market discontinuation of Tanzeum. We knew there was going to be a large set of population that needed to transfer to a different medication.

Mr. Hostettler asked of the 32,000, how many were taking Tanzeum?

CAPT VonBerg stated that 9,412 is the number of patients affected by the NF status. Because Tanzeum is no longer on the market, the patients must switch to another medication. The 32,000 are the patients on other medications.

There were two ways this could've been handled.

1. Review the entire class which would affect more patients than the 32,000,

   or

2. Change the step condition sets for Tanzeum, alone, in the preferred step. There are less patients affected by changing the step conditions for Tanzeum rather than reviewing the entire class and moving all the Bydureon and Tanzeum patients. The P&T committee recommendation affects less patients because there are more patients taking Bydureon. The population affected could have been much, much larger if we opened up the entire class.

Mr. Hostettler asked if the co-pay will change to Tier 2 co-pay after the patient completes the process and go onto a non-formulary product.

CAPT VonBerg stated the patient must complete the medical necessity justification to change from Tier 3 to Tier 2.

Mr. Hostettler asked is this not the medical justification criteria? There is more criteria?

CAPT VonBerg stated that medical necessity recommendations are not under the purview of the BAP. The prior authorizations recommendations are under the purview of the BAP. The criteria for medical necessity is in the P&T committee minutes.

Mr. Hostettler said if a patient completes the process or steps A, B, C, and D, it would look as if that it is necessary by the time the patient reaches D. In his opinion, it is logical that it's the same.

CAPT VonBerg stated that the medical necessity criteria is not under the purview of the BAP.

Mr. Hostettler thanked CAPT VonBerg.

There were no more questions or comments for the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for the GLP1RA Subclass.

- **GLP1RA Subclass – UF Recommendation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **GLP1RA Subclass – Manual PA Criteria**

  Concur: 3 Non-Concur: 1 Abstain: 0 Absent: 3

- **GLP1RA Subclass – UF and PA Implementation Plan**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

## 8. ADDITIONAL QUESTIONS AND COMMENTS FROM THE PANEL:

Mr. Hostettler said he did not agree with the decision of no grandfathering patients. It is disruptive to their therapy and their therapy shouldn't be disrupted. If the patient is stable on the medication, there should be no changed.

There was a discussion between Mr. Hostettler, CAPT VonBerg, CAPT Norton and Dr. Allerman. Initially, Mr. Hostettler did not concur with the implementation plan based on the number of patients affected by the recommendations. After the discussion and information provided about the discontinuation of Tanzeum in Aug 2018, Mr. Hostettler changed his vote, as the implementation would coincide with the market discontinuation of Tanzeum.

## B. ANTI-INFLAMMATORY IMMUNOMODULATORY OPHTHALMICS: OPHTHALMIC IMMUNOMODULATORY AGENTS SUBCLASS

**(CAPT VONBERG)**

### 1. Anti-Inflammatory Immunomodulatory Opthalmics: Opthalmic Immunomodulatory Agents Subclass – Relative Effectiveness Analysis and Conclusion

Cyclosporine ophthalmic emulsion (Restasis) and lifitegrast 5% ophthalmic solution (Xiidra) are the two products in this subclass, which are both approved to treat dry eye disease. Prior authorization criteria currently apply to both drugs. *Relative Clinical Effectiveness Conclusion*—The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 1 absent) the following for the ophthalmic immunomodulatory drugs:

- Ocular surface inflammation and damage are characteristic of moderate to severe dry eye disease. Restasis and Xiidra are both approved for dry eye disease, but their mechanisms of action differ.

- Both drugs are dosed twice daily. Xiidra's onset of action can occur as soon as two weeks following initiation of therapy, however peak effect will not likely occur until after 12 weeks of therapy. In contrast, Restasis' onset of action may take up to six months. Over-the-counter (OTC) ocular lubricants can be used concomitantly with both Restasis and Xiidra.

- Both Xiidra and Restasis in individual placebo-vehicle controlled trials have shown reductions in signs and symptoms of dry eye disease using different endpoints. There are no head-to-head trials between Restasis and Xiidra. It is difficult to determine the clinical relevance of these changes, and dry eye disease is a progressive condition that waxes and wanes. Recent treatment guidelines for dry eye disease do not favor one product over another (American Academy of Ophthalmology 2017; Dry Eye Workshop II 2017).

- There are no published studies evaluating efficacy when patients are switched from one product to another.

- While the clinical studies that led to FDA approval had low patient dropout rates, most trials were of short duration. An analysis of MHS prescription claims showed that approximately 70% of patients fill prescriptions for less than six months of therapy.

- The safety profiles of Restasis and Xiidra are most commonly associated with ocular burning and stinging. Lifitegrast causes dysgeusia in 16% of patients. There are no apparent serious concerns.

- There is a moderate degree of therapeutic interchangeability with Restasis and Xiidra, as there is a variable response to these drugs in practice. To meet the needs of DoD beneficiaries, at least one ophthalmic immunomodulatory agent is needed to treat the majority of patients with dry eye syndrome.

**2. Ophthalmic Immunomodulatory Agents Subclass—Relative Cost-Effectiveness Analysis and Conclusion**

CMA, and BIA were performed. The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA showed that Restasis and Xiidra were cost effective in the various formulary scenarios.

- BIAs with corresponding sensitivity analyses were performed on all formulary scenarios.

**3. Ophthalmic Immunomodulatory Agents Subclass—UF Recommendation**

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) the following, based on clinical and cost effectiveness.

- UF:

  - cyclosporine 0.05% ophthalmic emulsion (Restasis)
  - lifitegrast 5% ophthalmic solution (Xiidra)

- NF: None

**4. Ophthalmic Immunomodulatory Agents Subclass—Manual PA Criteria**

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) revising the existing manual PA criteria for both Restasis and Xiidra. The drugs must be prescribed by an ophthalmologist or optometrist, the diagnosis of dry eye disease must be documented, and a trial of two OTC ocular lubricants is now required. The revised PA criteria will apply to new patients and existing users who have not filled a prescription for Restasis or Xiidra in the past 120 days.

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

- The drug is prescribed by an ophthalmologist or optometrist
- The patient is $\geq$ 18 years old
- A diagnosis of Moderate to Severe Dry Eye Disease is supported by both of the criteria below:

- Positive symptomology screening for moderate to severe dry eye disease from an appropriate measure AND
- At least one positive diagnostic test (e.g., Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)

AND

- Patient must have tried and failed the following:
  - At least 1 month of one ocular lubricant used at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol, etc.)
  - Followed by at least 1 month of a different ocular lubricant that is preservative-free at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol, etc.)

AND

- Concomitant use of Restasis and Xiidra is NOT allowed.

- Restasis is also approved for the following conditions: graft rejection/graft versus host disease (GvHD), corneal transplant, atopic keratoconjunctivitis (AKC) / vernal keratoconjunctivitis (VKC), and LASIK associated dry eye (limited to 3 months of therapy)

Off-label uses for Xiidra are not approved.

Off-label uses for Restasis, other than those listed above, are not approved.

PA expires in 365 days.

Renewal PA Criteria: Coverage will be approved indefinitely if all criteria are met:

- The drug is prescribed by an ophthalmologist or optometrist.

- The patient must have documented improvement in ocular discomfort.

- The patient must have documented improvement in signs of dry eye disease.

**5. Ophthalmic Immunomodulatory Agents Subclass—UF and PA Implementation Plan**

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) an effective date of the first Wednesday after a 90-day implementation period in all points of service.

**6. Physician's Perspective**

The recommendation is to have both products on the formulary, without step therapy, which avoids impacting a significant number of patients. The Committee did review dry eye disease treatment guidelines, which note that a significant number of patients won't respond to Restasis. Therefore, having Xiidra also on the formulary allows for more options for patients.

There were some changes made to the manual PA criteria that will apply to both drugs. The updates include that both drugs have to be prescribed by an optometrist or ophthalmologist, and patients must have tried and had an inadequate response to two different classes of OTC artificial tears products. This requirement comes from feedback when we surveyed our providers. The providers felt that a trial of artificial tears first was appropriate.

Our own MHS data shows that only around half of patients remain on therapy for more than 3 months. So the Committee wanted to have the PA apply to current users who have had a gap in therapy for 3 months, and then also new patients. We are estimating that about 3,000 patients will be subject to the new PA, out of the total of about 45,000 patients on these two drugs. The PA does not allow for patients to be on both Restasis and Xiidra at the same time, since there are no studies evaluating this combination.

**7. Panel Questions and Comments**

Mr. Hostettler asked if there was a typo on page 33. Is it 120 days versus 180 days.

Dr. Allerman stated there is a typo and a 120 days is correct.

Mr. Hostettler asked about the process to differentiate between a patients who had prescriptions filled last week from those patients needing an annual review for a PA. If they are grandfathered, what is the process?

Dr. Allerman stated that it is addressed when the prescription is presented and based on the information found in the look-back period. For every new patient, their 365 day period starts when their prescription is submitted. We will work with ESI on identifying patients who must complete the PA process, again.

Mr. Hostettler asked for clarification. If a patient had a prescription filled in the last 120 days, the patient is not required to complete the PA process, initially. Is the patient required to complete the PA process a year from now?

Dr. Allerman stated that if the PA process was completed in the last 120 days, they don't, but they will need an annual review. That is consistent with the guidelines for efficacy and therapy.
Mr. Hostettler thanked her.

There were no more questions or comments for the Panel. The Chair called for a vote on the UF Recommendation, Manual PA Criteria, and UF and PA Implementation Plan for the Ophthalmic Immunomodulatory Agents Subclass.

- **Ophthalmic Immunomodulatory Agents Subclass – UF Recommendation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **Ophthalmic Immunomodulatory Agents Subclass – Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **Ophthalmic Immunomodulatory Agents Subclass – UF and PA Implementation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

## C. OSTEOPOROSIS DRUGS: PARATHYROID HORMONE (PTH) ANALOGS

**(CAPT VONBERG)**

### 1. Osteoporosis Drugs*:* Parathyroid Hormone (PTH) Analogs—Relative Clinical Effectiveness Analysis and Conclusion

The P&T Committee evaluated the PTH analogs for treatment of osteoporosis; this subclass has not previously been reviewed for formulary status, although the full class was reviewed in 2008. The subclass consists of two injectable products, teriparatide (Forteo) and abaloparatide (Tymlos), which are both approved for the treatment (and not for the prevention) of osteoporosis in postmenopausal women at high risk for fracture.

*Relative Clinical Effectiveness Analysis and Conclusion*—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- Both abaloparatide (Tymlos) and teriparatide (Forteo) have potential benefit in reducing fracture risk in high-risk patients or those with a history of fragility fractures, regardless of whether they were treated with bisphosphonates or not.

- With regard to fracture risk reduction, both Tymlos and Forteo have comparable efficacy for vertebral and non-vertebral fracture risk reduction in patients at high risk for fractures, compared to placebo. A 2016 trial (ACTIVE) reported the risk difference of new vertebral fractures with abaloparatide versus placebo was 3.6%, with a number needed to treat (NNT) of 28, compared to a risk difference of 3.4% with teriparatide versus placebo (NNT 29).

- In terms of changes in bone mineral density, both Tymlos and Forteo produced a statistically significant increase in bone mineral density at 18 months compared to placebo at the hip, femoral neck, and lumbar spine (ACTIVE trial).

- Both PTH analogs have similar adverse drug reaction profiles. Both drugs are limited to cumulative lifetime use of two years based on findings of osteosarcoma associated with use of teriparatide in rodent studies. However, a 2017 meta-analysis from the Institute for Clinical and Economic Review reported extensive real world clinical experience with teriparatide (Forteo) in postmenopausal women without identification of any new adverse events.

- In terms of other factors, Tymlos does not require refrigeration, while Forteo must be kept refrigerated. Forteo has additional indications for men with high fracture risk and for treatment of glucocorticoid-induced osteoporosis in patients at high risk for fracture.

- There is a high degree of interchangeability between Forteo and Tymlos.

**2. Osteoporosis Drugs*:* Parathyroid Hormone (PTH) Analogs—Relative Cost Effectiveness Analysis and Conclusion**

CMA and BIA were performed. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that Forteo was the more cost-effective PTH analog, followed by Tymlos.

- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating Forteo as formulary and step-preferred, with Tymlos as NF and non step-preferred demonstrated the largest estimated cost avoidance for the MHS.

**3. Osteoporosis Drugs*:* Parathyroid Hormone (PTH) Analogs—UF Recommendation**

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

- UF and step-preferred: teriparatide (Forteo)
- NF and non step-preferred: abaloparatide (Tymlos)
- This recommendation includes step therapy, which requires a trial of teriparatide in new patients, prior to use of abaloparatide.

**4. Osteoporosis Drugs*:* Parathyroid Hormone (PTH) Analogs— Manual PA Criteria**

The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) manual PA criteria for new users of Forteo and Tymlos, consistent with the package labeling for indications and safety. Additionally, the step therapy requirements will be included in the manual PA.

Manual PA criteria

**1. teriparatide (Forteo)**

Forteo is approved if ALL of the following criteria are met:

- The patient is ≥ 18 years old
- The drug is prescribed for treatment of osteoporosis, and not for prevention of osteoporosis.
- The patient has one of the following diagnoses:
  - Patient is a postmenopausal female with osteoporosis,

    OR

  - The patient is male with primary or hypogonadal osteoporosis,

    OR

  - The patient has osteoporosis associated with sustained systemic glucocorticoid therapy (e.g., > 6 months use of >7.5mg/day prednisone or equivalent)

    AND

- Patient has one of the following:

- The patient is at high risk for fracture, defined as one of the following:
  - history of osteoporotic fracture
  - multiple risk factors for fracture (e.g., a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)
  - documented bone mineral density (BMD) T-score of -2.5 or worse
  - has one of the following: has tried and experienced an inadequate response to, therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (e.g., alendronate, ibandronate)

    AND

- The patient will continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate

  AND

- Cumulative treatment with Forteo will not exceed 24 months during the patient's lifetime

  AND

- Patient is not at increased risk for osteosarcoma (e.g., Paget's disease, unexplained elevations of alkaline phosphatase, patients with open epiphyses, prior external beam or implant radiation therapy involving the skeleton)

Off-label uses are not approved unless supporting documentation is provided.

Prior Authorization expires in 24 months.

Prior Authorization may not be renewed.

**2. Abaloparatide (Tymlos)**

The PA criteria for Tymlos are similar to that of Forteo, with the exception that Tymlos is only approved for postmenopausal females with osteoporosis at high risk for fracture, and the patient cannot comply with the refrigeration requirements for Forteo

**5. Osteoporosis Drugs*:* Parathyroid Hormone (PTH) Analogs—UF and PA Implementation Plan**

The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) an effective date of the first Wednesday after a 60-day implementation period in all points of service.

**6. Physician's Perspective**

The major difference between Tymlos and Forteo is the lack of refrigeration required with Tymlos, so that was included as the primary factor in the step therapy criteria to receive Tymlos.

If a patient has not responded to Forteo, it is unlikely that they would receive additional benefit by changing to Tymlos; instead a different osteoporosis drug should be used. A survey of MHS providers felt that the products were highly therapeutically interchangeable. Forteo does have a larger number of FDA approved indications, and this is allowed for in the PA.

The Committee did recommend manual PA criteria for both drugs, since the place in therapy for the PTH analogs is very specific – they are for patients who have already experienced a fracture or for those at high risk for fracture. Also, the safety profile of the drug is another reason for the PA, since they are limited to a treatment duration of 2 years.

We didn't recommend mailing letters, since Tymlos is currently designated as non formulary (from the new drug review in August 2017). The step therapy and the PA will only apply to new patients; so patients currently on Tymlos can remain on therapy until the 2-years treatment course is completed. Likewise, patients currently on Forteo can also complete their 2 years of therapy without having to go to through the PA.

**7. Panel Questions and Comments**

Mr. Du Teil asked about the study on Forteo and the risk for osteosarcoma mentioned in the study. Was the committee convinced there was an equal risk for both medications? Forteo is the approved drug and there is a study that warns about the risk of osteosarcoma.

CAPT VonBerg replied it is unknown.

Mr. Hostettler asked if the study for Tymlos was conducted on rats.

CAPT VonBerg stated that he will have to verify.

Mr. Hostettler said it's a good question. The P&T committee recommends a medication that has some documentation on significant risks. The other medication had no documentation but, I understand, is doesn't necessarily mean there is no risk.

CAPT VonBerg said he didn't remember, exactly, the committee discussions. The topic was discussed extensively and the committee did not think there was a

significant difference. That's why the information was provided. Although there was a concern in rats, there was none shown in humans?

Mr. Hostettler said that he knows physicians are polled for input. He asked if the committee would provide the number of responses received from the poll. Not who responded, but the number of responses and possibly a break down by specialties.

CAPT VonBerg replied that we do have that information, but he doesn't have it with him.

Mr. Hostettler replied that he's talking more general now, but in the future, as we get the number, he'd like to see the physician, especially what specialists that is giving input.

CAPT VonBerg said we can give you examples. It depends, in general, how specialized the therapy and the size of the group. With diabetes, sometimes we receive 400 responses. Many are endocrinologists. We poll them, as experts, for any of the conditions the committee reviews. For more defined therapies, that affect less of the population, the number as smaller. However, we do get a cross section of Army, Navy, Air Force and civilian providers, in the network, that respond.

Mr. Hostettler replied excellent and thinks we'll come back to this on the next topic.

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

- **PTH Analogs – UF Recommendation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **PTH Analogs – Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **PTH Analogs – UF and PA Implementation**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

**8. Additional Questions and Comments from the Panel.**

Mr. Hostettler said according to the data presented, no unique utilizers are affected because the PA applies to new users. How many new users do you anticipate in the next 12 months?

CAPT VonBerg asked how many new users in total?

Mr. Hostettler replied yes. Is it a large or small number?

CAPT VonBerg asked Mr. Hostettler for clarification regarding "a large number".

Mr. Hostettler replied thousands.

CAPT VonBerg said no, it is not in the thousands.

Dr. Allerman stated there are only approximately 1,400 users in the whole class.

Mr. Hostettler asked is it worth all this effort, patient disruption, and time to get to 14-15 patients. I'm looking from a patient standpoint. PAs are not simple processes. They take time. Is it really worth it for that number of patients?

CAPT VonBerg replied with absolutely yes it is.

## D. CORTICOSTEROIDS-IMMUNE MODULATORS: ADRENOCORTICOTROPIC HORMONES (ACTH)

**(DR. ALLERMAN)**

**1. Adrenocorticotropic Hormones (ACTH)—Relative Clinical Effectiveness Analysis and Conclusion**

The P&T Committee evaluated the ACTH subclass, which is comprised of injectable corticotropin. Injectable corticotropin has been commercially available since 1952, but now is only marketed as a proprietary product, H.P. Acthar Gel. This is the first formulary review of the subclass, but manual PA criteria have applied to H.P. Acthar Gel since December 2013.

H.P. Acthar Gel is a highly purified natural product of adrenocorticotropin derived from porcine pituitary gland. H. P. Acthar gel carries FDA indications for treatment of infantile spasms (West Syndrome) and treatment of exacerbations of multiple sclerosis (MS). The label also states that H.P. Acthar Gel "may" be used for a wide variety of other disorders, but does not explicitly state that it is indicated for those disorders. This language is in the context of the drug's initial approval in 1952, prior to the higher

standards demonstrating clinical effectiveness mandated by the Kefauver-Harris Amendment in 1962.

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

- Infantile Spasms
    - Optimal treatment of infantile spasms involves early hormonal therapy.
    - Evidence supports both glucocorticoid-dependent as well as glucocorticoid-independent pathways in the treatment of infantile spasms.
    - A comprehensive review of the evidence in infantile spasms suggests that the clinical effectiveness of high-dose oral corticosteroids (e.g., prednisone) is non-inferior to that of ACTH. Evidence also supports that some patients refractory to high-dose oral corticosteroids will respond to ACTH.
    - Trial evidence is supported by numerous Level 1 systematic reviews and meta-analyses with low to moderate quality evidence.
    - The most common adverse effects of ACTH in infantile spasms leading to intervention, dose-reduction, or discontinuation include infection and irritability. The adverse effects are typically transitory in relation to treatment duration.
- MS Exacerbation
    - Professional treatment guidelines clearly and unanimously define the standard of care for treating MS exacerbations with intravenous (IV) methylprednisolone.
    - A comprehensive review of the evidence in MS suggests that the clinical effectiveness of high-dose oral corticosteroids is equivalent to or superior to that of ACTH.
    - A 2013 Cochrane review concluded that onset of treatment in an MS exacerbation is irrelevant to the exacerbation outcome. The evidence is insufficient to determine the impact of hormonal therapies on future exacerbation prevention and is also insufficient to determine the impact of hormonal therapies on long-term disability.
    - There is limited evidence to delineate adverse event profiles between ACTH and methylprednisolone. Head-to-head clinical trials have shown that the adverse reactions with ACTH and methylprednisolone are equivalent. Methylprednisolone is associated with a higher propensity for GI and

psychiatric effects, while ACTH has a higher propensity for causing weight gain and edema.

- Clinical trial evidence is supported by numerous Level 1 systematic reviews and meta-analyses with low to moderate quality evidence.

- Other Uses

  A comprehensive review of the evidence for all of the disease states where H.P. Acthar Gel "may" be used failed to identify well-controlled studies of clinically meaningful endpoints that substantively determined H.P. Acthar Gel's efficacy, maximum-tolerated dose, toxicity, and safety as compared with standard means of treatment. Therefore, the evidence for H.P. Acthar Gel failed to establish clinical effectiveness for those conditions. H.P. Acthar Gel is unsupported by the literature in the following conditions:

  - Rheumatologic disorders: systemic lupus erythematosus, inflammatory myopathies (including dermatomyositis and polymyositis), psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, and ankylosing spondylitis

  - Dermatologic diseases: erythema multiforme (of any severity), Stevens-Johnson syndrome, and Toxic Epidermal Necrolysis (TEN) syndrome

  - Allergic states: serum sickness

  - Ophthalmic diseases: severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, birdshot choroiditis, chorioretinitis, anterior segment inflammation, scleritis, conjunctivitis, and Opsoclonus Myoclonus syndrome

  - Respiratory diseases: sarcoidosis

  - Nephrotic syndromes, including focal segmental glomerulosclerosis (FSGS), idiopathic membranous nephropathy, IgA nephropathy, membranoproliferative glomerulonephritis (MPGN), and monoclonal diffuse proliferative glomerulonephritis, and any other non-nephrotic edematous state

  - Other neurologic disease: amyotrophic lateral sclerosis (ALS), MS (not related to exacerbation of MS), optic neuritis (not related to exacerbation of MS), and neurosarcoidosis

  - Any other indication outside of the medically necessary indications of infantile spasms and MS exacerbation

**2. Adrenocorticotropic Hormones (ACTH)—Relative Clinical Effectiveness Analysis and Conclusion**

CMA was performed. The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 2 absent) that H.P. Acthar Gel was significantly more costly than its clinical comparators.

**3. Adrenocorticotropic Hormones (ACTH)—UF Recommendation**

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) the following, based on clinical and cost effectiveness:

- UF: injectable corticotropin (H.P. Acthar Gel)
- NF: None

*Dr. Allerman noted that there was a typo in the table on page 34 of the Background document –* ***Acthar gel is recommended for UF status.***

**4. Adrenocorticotropic Hormones (ACTH)—Manual PA Criteria**

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) manual PA criteria for new and current users of H.P. Acthar Gel for treatment of infantile spasms (West Syndrome) in infants less than 24 months of age who are unresponsive to high-dose steroids. Manual PA criteria are also recommended for new and current users of H.P. Acthar Gel with MS exacerbation who have failed or who are intolerant to an adequate trial of IV or oral corticosteroids. PA renewal will be allowed for infantile spasms; however, PA review will be required for each occurrence of MS exacerbation.

H.P. Acthar Gel is not approved for use of any other condition outside of infantile spasms or MS exacerbation. H.P. Acthar Gel's efficacy for the other indications listed above in the clinical effectiveness conclusion has not been established and/or remains unproven. Experimental and investigational use of H.P. Acthar Gel for these other conditions is not medically necessary and is therefore excluded from TRICARE coverage.

<u>Manual PA criteria</u>

Manual PA criteria apply to all new and current users of H.P. Acthar Gel.

H.P. Acthar Gel PA will be approved if <u>all</u> of the following criteria are met for either treatment of infantile spasms or treatment of exacerbation in patients with multiple sclerosis.

a. Infantile Spasms (West Syndrome):

- The patient is < 24 months old
- The patient is diagnosed with infantile spasms with electroencephalogram-confirmed hypsarrhythmia
- The patient has tried a 2-week course of high-dose (40-60 mg/day) prednisone/prednisolone for any episode of infantile spasms and has failed therapy as evidenced by continued signs/symptoms of either spasms or hypsarrhythmia on EEG
- H.P. Acthar Gel is prescribed by or in consultation with a pediatric neurologist with expertise in the management of infantile spasm.

Prior Authorization expires in 30 days.

Renewal Criteria for infantile spasms: Coverage will be approved for an additional 365 days for infantile spasms if all criteria are met:

- The patient is < 24 months old
- The patient has demonstrated a clinical response to H.P. Acthar Gel as defined by cessation of both previous characteristic spasms AND hypsarrhythmia on EEG within 2 weeks of starting H.P. Acthar Gel
- The patient has not previously demonstrated intolerance to H.P. Acthar Gel, defined as the patient requiring discontinuation of H.P. Acthar Gel therapy.

b. Multiple Sclerosis Exacerbation:

- The patient is an adult diagnosed with multiple sclerosis
- The patient is diagnosed with an exacerbation of multiple sclerosis OR optic neuritis as a specific exacerbation of multiple sclerosis
- The patient has failed or is intolerant to an adequate trial of IV/PO corticosteroids (e.g., 1000 mg methylprednisolone IV x 5-14 days OR oral equivalent) for the present exacerbation.
    - Note that anticipated hypercortisolism and other non-emergent side effects (e.g., non-emergent hyperglycemia, weight gain, non-urgent/emergent hypertension, edema, paresthesias, insomnia, constipation, diarrhea, hyperphagia, anorexia, nasal/sinus congestion, acne, and menstrual irregularities, etc.) do not meet the threshold for authorization of this PA. Similarly, if the patient has had emergent or life-threatening adverse effects to high-dose corticosteroids, H.P. Acthar gel is contraindicated.
- H.P. Acthar Gel is prescribed by or in consultation with a neurologist.

Prior Authorization expires in 30 days.

PA Renewal is not authorized for multiple sclerosis exacerbation.

c. Other uses: PA will be not be approved for any condition other than infantile spasms in infants less than 24 months of age or MS exacerbation, including, but not limited to the following: optic neuritis not related to MS exacerbation, Rheumatoid Arthritis, Systemic Lupus Erythematosus, Psoriatic Arthritis, Ankylosing Spondylitis, Dermatomyositis, Polymyositis, Juvenile Idiopathic Arthritis, Erythema Multiforme (any severity), Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis Syndrome, Serum Sickness, Keratitis, Iritis, Iridocyclitis, Uveitis, Choroiditis, Birdshot choroiditis, Chorioretinitis, anterior segment inflammation, Nephrotic Syndrome including focal segmental glomerulosclerosis (FSGS), idiopathic membranous nephropathy, IgA nephropathy, membranoproliferative glomerulonephritis (MPGN), and monoclonal diffuse proliferative glomerulonephritis, non-nephrotic edematous states, sarcoidosis, gout, scleritis, or conjunctivitis.

**5. Adrenocorticotropic Hormones (ACTH)—UF and PA Implementation Period**

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) an effective date of the first Wednesday after a 60-day implementation period in all points of service and that DHA send letters to beneficiaries who are affected by the UF decision

**6. Physician's Perspective**

Acthar is an older drug that came to our attention when the manufacturer did a trial and received an orphan drug indication for infantile spasms in 2010. Prior to 2008, Acthar gel had received approval for treatment of MS exacerbations in the 1970s.

We did a survey of providers who prescribe Acthar. Overall the survey results found that Acthar was considered as 3rd line therapy or a drug of last resort, after other treatments had failed.

Based on the review of the literature and the feedback from providers, the PA only allows for treatment for infantile spasms or MS exacerbation. Limiting the PA to these 2 indications also follows what several civilian health plans are doing.

**7. Panel Question and Comments**

Mr. Ostrowski referred to the Manual PA criteria for Multiple Sclerosis Exacerbation. He asked Dr. Allerman to define of the word "adult".

Dr. Allerman replied 18 and older. We can indicate that in the criteria.

Mr. Ostrowski stated that it would be best to change the criteria to 18 and older.

Mr. Hostettler asked about the unique utilizers affected by the decision.
Does the number 86 include patients for the 2 indications or the other utilization prior to this recommendation?

Dr. Allerman replied the 86 patients included every indication.

Mr. Hostettler said there is a long standing practice, maybe not directly indicated in this literature, but there is a long standing practice for some of these indications. According to the data in the presentation, the PA will not be approved for any condition other than infantile spasms? Is there an appeal process?

Dr. Allerman replied people can go through the appeal process. In fact, right now the appeal process is the only mechanism to get an indication outside infantile spasms. Our recommendations for the indications not covered is due to extensive review of literature and discussion with providers who prescribe Acthar.

Mr. Hostettler asked if there were any providers in support of any of those areas that are not covered.

Dr. Allerman replied the providers surveyed stated they used the medication as a 3rd line therapy or last resort.

Mr. Hostettler replied that if the providers surveyed stated that it was used for 3rd line therapy or a last resort, there is a place in the algorithm for this product. It might be last, it might be a year to get there, but there is a place for it somewhere as third line therapy. Saying that you can't have it, doesn't sound like the right answer. It sounds as if there should be a process (complete steps A, B, C, D) to get to it. But there should be a way to get to it even if it's last resort.

Dr. Allerman replied that they did review the evidence as well as published manual PA criteria for other health plans. The P&T Committee's recommendation is consistent with several major plans.

Mr. Hostettler said he doesn't mean to beat a dead horse. When you look at other package insert, there is no clear indication for infantile spasms.

CAPT VonBerg said there is an appeal process.

Mr. Hostettler replied okay.

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

- **ACTH – UF Recommendation**

  Concur: 1 Non-Concur: 3 Abstain: 0 Absent: 3

- **ACTH – Manual PA Criteria**

  Concur: 1 Non-Concur: 3 Abstain: 0 Absent: 3

- **ACTH – UF and PA Implementation Period**

  Concur: 1 Non-Concur: 3 Abstain: 0 Absent: 3

## E. NEWLY-APPROVED DRUGS PER 32 CFR 199.21(G)(5)

**(DR. ALLERMAN)**

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

The P&T Committee agreed (Part 1: 16 for, 0 opposed, 0 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) with the relative clinical and cost-effectiveness analyses presented for the newly-approved drugs reviewed according to 32 CFR 199.21(g)(5).

### 2. Newly-Approved Drugs per CFR 199.21(g)(5)—UF Recommendation

The P&T Committee recommended (Part 1: 15 for, 0 opposed, 1 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) the following:

- UF:
  - acalabrutinib (Calquence) – Oral Oncologic Agent for Mantle Cell Lymphoma
  - benznidazole – Miscellaneous Anti-Infective for Chagas Disease
  - dolutegravir/rilpivirine (Juluca) – Antiretrovirals for Human Immunodeficiency Virus (HIV)
  - emicizumab-kxwh (Hemlibra) – Antihemophilic Factors
  - letermovir (Prevymis) Antivirals
- NF:
  - coagulation factor IX, recombinant (Rebinyn) – Antihemophilic Factors
  - dapagliflozin/saxagliptin (Qtern) – Non-Insulin Diabetes Drugs – Sodium Glucose Co-Transporter-2 (SGLT2) Inhibitor
  - fluticasone propionate 93 mcg nasal spray (Xhance) – Nasal Allergy Drugs – Corticosteroids

- house dust mite allergen extract (Odactra) – Immunological Agents Miscellaneous: Oral Agents
- latanoprostene bunod ophthalmic solution (Vyzulta) – Glaucoma Drugs
- minocycline ER (Ximino) – Antibiotics: Tetracyclines
- sodium picosulfate/magnesium oxide/anhydrous citric acid (Clenpiq) – Laxatives-Cathartics-Stool Softeners
- spironolactone 25 mg/5 mL oral suspension (CaroSpir) – Diuretics

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

The P&T Committee recommended (Part 1: 15 for, 0 opposed, 1 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) the following:

- Applying the same manual PA criteria for dapagliflozin/saxagliptin (Qtern) in new and current users, as is currently in place for the other non step-preferred SGLT2 inhibitors and dipeptidyl peptidase-4 (DPP-4) inhibitors. Patients must first try the step-preferred SGLT2 inhibitor empagliflozin (Jardiance).

- Applying the same manual PA criteria for minocycline ER (Ximino) in new and current users, as is currently in place for the other non step-preferred tetracyclines. Patients must first try formulary step-preferred agents.

- Applying manual PA criteria to new users of Odactra, Hemlibra, and Calquence, and for new users of CaroSpir who are over 12 years old.

- Applying manual PA criteria to new and current users of Xhance and Vyzulta.

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

**a. acalabrutinib (Calquence)**

Manual PA criteria apply to all new users of Calquence. Coverage will be approved if all criteria are met:

- The patient is ≥ 18 years
- The patient has pathologically confirmed mantle cell lymphoma, with documentation of monoclonal B cells that have a chromosome translocation t(11;14)(q13;q32) and/or overexpress cyclin D1
- The patient must not have significant cardiovascular disease such as uncontrolled or symptomatic arrhythmias, congestive heart failure, or myocardial infarction within 6 months of screening, or any Class 3 or 4 cardiac disease as defined by the New York Heart Association Functional Classification, or corrected QT interval (QTc) > 480 msec

Off-label uses are not approved.

Prior authorization does not expire.

**b. dapagliflozin/saxagliptin (Qtern)**

Manual PA criteria apply to all new and current users of Qtern. Coverage will be approved if all criteria are met:

- The patient must have had an inadequate response or experienced significant ADRs, or have a contraindication to metformin

  AND

- The patient must have tried one of the preferred SGLT2 inhibitors (Jardiance, Glyxambi, Synjardy, and Synjardy XR) and had an inadequate response or experienced significant ADRs, or have a contraindication to empagliflozin

  AND

- The patient must have tried one of the preferred DPP-4 inhibitors (Januvia, Janumet, and Janumet XR) and had inadequate response or experienced significant ADRs, or have a contraindication to sitagliptin.

Off-label uses are not approved.

Prior authorization does not expire.

**c. emicizumab-kxwh (Hemlibra)**

Manual PA criteria apply to all new users of Hemlibra. Coverage will be approved if all criteria are met:

- The patient must have a documented diagnosis of Hemophilia A

  AND

- The patient must have a history of a high titer of factor VIII inhibitor (greater than or equal to 5 Bethesda units per mL)

  AND

- The patient must NOT have been treated within the last 12 months for thromboembolic disease, or have current signs of, thromboembolic disease

AND

- Hemlibra must be prescribed by or in consultation with a hematologist.

Off-label uses are not approved.

Prior authorization does not expire.

**d. fluticasone propionate 93 mcg nasal spray (Xhance)**

Manual PA criteria apply to all new users and current users of Xhance. Coverage will be approved if all criteria are met:

- Patient has nasal polyps

  AND

- Patient must have tried and failed at least two of the following: azelastine 137 mcg nasal spray (generic Astelin), flunisolide nasal spray, fluticasone propionate 50 mcg nasal spray (generic Flonase), or ipratropium nasal spray (Atrovent nasal spray)

  AND

- Patient has tried and failed mometasone (Nasonex) OR beclomethasone (Beconase)

Off-label uses are not approved.

Prior authorization does not expire.

**e. house dust mite allergen extract (Odactra)**

Manual PA criteria apply to all new users of Odactra. Coverage will be approved if all criteria are met:

- Odactra is prescribed by an allergist/immunologist

  AND

- The patient is between the ages of 18 and 65 years

  AND

- The patient has a diagnosis of house dust mite (HDM) allergic rhinitis confirmed with either a positive skin test or an in vitro testing pollen-specific for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

  AND

  - The patient's symptoms of allergic rhinitis have not been controlled with a nasal corticosteroid (e.g., fluticasone) AND at least one of the following: oral antihistamine, nasal antihistamines, or a leukotriene receptor antagonist (montelukast)

    OR

  - The patient has a diagnosis of HDM-related allergic rhinitis and allergic asthma that has not responded to an adequate trial of inhaled steroids, and the patient's FEV >70%

    AND

- The patient has received the first dose in the office setting and was observed for 30 minutes with no allergic reactions noted

  AND

- The patient has a prescription for self-administered SC epinephrine

  AND

- The patient does not have a history of severe local allergic reaction to sublingual immunotherapy

  AND

- Patient is not receiving co-administered SC immunotherapy

  AND

- Patient does not have severe, uncontrolled, unstable asthma

Other off-label uses other than allergic asthma are not approved

PA expires in 6 months.

Renewal Criteria: Coverage will be approved indefinitely if the patient has responded positively to treatment and is not receiving co-administered SC immunotherapy and does not have severe, uncontrolled, unstable asthma.

**f. latanoprostene bunod ophthalmic solution (Vyzulta)**

Manual PA criteria apply to all new and current users of Vyzulta. Coverage will be approved if all criteria are met:

- Patient must have a diagnosis of open angle glaucoma OR ocular hypertension
- Patient is ≥16 years old
- Patient has tried and failed at least two ophthalmic prostaglandin glaucoma agents (e.g., latanoprost, bimatoprost)

Off-label uses are not approved.

Prior authorization does not expire.

**g. minocycline ER (Ximino)**

PA criteria apply to all new and current users of Ximino.

Automated PA Criteria:

- Patient has filled a prescription for one generic IR doxycycline (either hyclate or monohydrate salt; does not include doxycycline monohydrate 40 mg IR/DR) AND one generic minocycline IR product at any Military Treatment Facility (MTF), retail network pharmacy, or the mail order pharmacy in the previous 180 days

Manual PA Criteria—if automated PA criteria are not met, Ximino is allowed if:

- The patient has acne with inflammatory lesions

  AND

- The patient cannot tolerate generic minocycline IR due to gastrointestinal adverse events

Off-label uses are not approved.

Prior authorization expires in 365 days.

Renewal criteria: Ximino will be approved for an additional 365 days, if:

- The patient's therapy has been re-evaluated within the last 12 months

- The patient is tolerating treatment and there continues to be a medical need for the medication
- The patient has disease stabilization or improvement in disease while on therapy

**h. spironolactone 25 mg/5 mL oral suspension (CaroSpir)**

Manual PA criteria apply to all new users of CaroSpir who are over 12 years old. Coverage will be approved if all criteria are met.

- The patient has heart failure, hypertension or edema from cirrhosis

  AND

- The provider must write in why the patient requires CaroSpir and cannot take an aldosterone blocker / potassium-sparing diuretic in a tablet formulation
  - Acceptable responses: patient cannot swallow tablets due to some documented medical condition – dysphagia, etc., and not due to convenience

Off-label uses are not approved.

Prior authorization does not expire.

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

The P&T Committee recommended (Part 1: 15 for, 0 opposed, 1 abstained, 0 absent; Part 2: 15 for, 0 opposed, 0 abstained, 1 absent) an effective date upon the first Wednesday two weeks after the signing of the minutes in all points of service.

**5. Physician's Perspective**

We reviewed 13 new drugs at this meeting; with 5 recommended for UF status, and 8 recommended for nonformulary placement. Ozempic is also a new drug, but was previously mentioned in the GLP1 review. For the drugs recommended for non formulary status, several of them fall into classes that have already been reviewed by the P&T Committee, and there are cost effective products already available in the class.

Since the start of the new drug program in August 2015 a total of 113 new drugs have been reviewed, with 57 designated as UF and 57 designated as nonformulary. PA has applied to 65 of the drugs, which includes a mix of new manual PAs or in cases where there is already a PA for the class.

For this review, for the 8 drugs where a PA was recommended, 3 of them fall into classes where there are already PA requirements (the diabetes drug Qtern, the acne drug Ximino, and the steroid inhaler Xhance).

For 3 of the drugs with PA, grandfathering was recommended, so the PA will only apply to new users (the oncology drug Calquence for mantle cell lymphoma, the new hemophilia drug Hemlibra, and the new allergy drug Odactra). "No grandfathering", where the PA will apply to both new and current users, was recommended for the new glaucoma drug Vyzulta and the Xhance inhaler.

Carospir is a new oral liquid formulation of spironolactone. The P&T Committee recognized that there is the potential for use of this drug in the pediatric population, so the recommendation here was that the PA only apply to patients older than 12 years.

**6. Panel Questions and Comments**

Mr. Hostettler said he's looking at the coagulation factor 9. I am curious why there is a non-formulary recommendation for this product? There is no PA or other criteria. It obviously is a product that when it is needed it is needed.

CAPT VonBerg replied something changed about the market in that now there are a lot of similar products available.

Mr. Hostettler thanked him.

There were no more questions or comments from the Panel. The Chair called for a vote on the UF Recommendation, PA Criteria, and UF and PA Implementation plan for the Newly-Approved Drugs.

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

## F. UTILIZATION MANAGEMENT CORTICOSTEROIDS-IMMUNE MODULATOR AGENTS – CORTICOSTEROID SUBCLASS

**(CAPT VONBERG)**

### 1. Corticosteroids-Immune Modulator Agents—Corticosteroid Subclass: Prednisone Delayed Release (Rayos)—New Manual PA Criteria

Rayos is a branded formulation of delayed release (DR) prednisone that has the same indications as immediate release (IR) prednisone, which was approved in 1955. It is dosed once daily, similar to IR prednisone, and has the same safety profile. Cost-effective generic formulations of prednisone and other glucocorticoids are available on the UF without PA required.

The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) manual PA criteria for Rayos due to the significant cost differences and lack of clinically compelling benefits between Rayos and generic prednisone. New and current users of Rayos are required to try generic prednisone IR and a second corticosteroid first.

Full PA Criteria:

Manual PA criteria apply to all new and current users of Rayos. Note that PA is not required for generic prednisone; providers are encouraged to consider changing the prescription to generic prednisone. Coverage for Rayos will be approved if:

- The provider writes in why the patient requires delayed release prednisone and why patient cannot take immediate release prednisone
- Acceptable responses are approved if ALL of the criteria are met:
  - The patient has a diagnosis of rheumatoid arthritis

    AND
  - The patient medical history includes trial and failure of both:
    - generic prednisone

      AND
    - at least one generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, etc.

Off-label uses are not approved.

Prior Authorization does not expire.

**2. Corticosteroids-Immune Modulator Agents—Corticosteroid Subclass: Prednisone Delayed Release (Rayos)—New Manual PA Implementation Date**

The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) new manual PA for Rayos become effective on the first Wednesday after a 90-day implementation period in all points of service. Additionally, the P&T Committee recommended DHA send letters to the beneficiaries affected by this decision.

**3. Physician's Perspective**

This formulation of prednisone theoretically was developed to be taken at night by patients with rheumatoid arthritis, so that upon awakening, the full effect of the dose will be seen, especially for the symptoms of joint stiffness. Immediate release prednisone is very effective for treating rheumatoid arthritis and has this FDA indication. Improvement in morning stiffness would not be unique to a delayed release formulation of prednisone. Additionally, the differences in the kinetic profile between the two products do not provide any unique efficacy advantages for Rayos. The P&T Committee felt that generic immediate release prednisone was much more cost effective, by two orders of magnitude, and clinically equivalent to Rayos.

There are a total of 245 patients in DoD who are currently taking Rayos; all new and current users will be required to go through the PA. We will be sending letters to the patients informing them of the new PA.

**4. Panel Questions and Comments**

There were no more questions or comment from the Panel. The Chair called for a vote on the Prednisone Delayed Release (Rayos).

- **Prednisone Delayed Release (Rayos) – New Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **Prednisone Delayed Release (Rayos) – New Manual PA Implementation Plan**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

## G. UTILIZATION MANAGEMENT ANTIVIRALS

**(CAPT VONBERG)**

1. **Antivirals: Acyclovir/Hydrocortisone 5%/1% Cream (Xerese), Penciclovir 1% Cream (Denavir), and Acyclovir 50 mg buccal tablet (Sitavig)—New Manual PA Criteria**

   The committee reviewed three treatments for herpes labialis (cold sores). Xerese is a branded combination of acyclovir/hydrocortisone cream that has an equivalent efficacy and safety profile as the separate ingredients applied individually. Denavir is a branded penciclovir 1% cream that is indicated for treatment of recurrent cold sores, while Sitavig is a buccal tablet formulation of acyclovir. Cost-effective generic formulations of acyclovir cream and the oral antiviral agents (e.g., acyclovir, valacyclovir) used for treating herpes labialis are available on the UF without PA required.

   The P&T Committee recommended (11 for, 0 opposed, 0 abstained, 5 absent) manual PA criteria for Xerese, Denavir, and Sitavig due to the significant cost differences and lack of clinically compelling benefits compared with generic topical and oral antivirals. New and current users of these products are required to try generic acyclovir cream and oral antiviral agents first.

   Full PA Criteria

   a. **acyclovir 5%/hydrocortisone 1% cream (Xerese)**

      Note: DoD Formulary products include topical or oral antiviral agents. Consider alternate agents first, such as acyclovir oral/topical or valacyclovir oral tablets. This PA is only approved for treatment of immunocompetent patients 6 years and older with recurrent herpes labialis (not approved for prophylaxis).

      Manual PA criteria apply to all new and current users of Xerese. Coverage for Xerese is approved if:

      - The provider writes in why the patient requires Xerese and why they cannot take oral antivirals or cannot use acyclovir 5% cream and hydrocortisone 1% cream separately.

- Acceptable responses are approved if ALL of the criteria are met:
  - Tried and failed topical acyclovir 5% cream and hydrocortisone 1% cream separately

    AND

  - Treatment failure of one of the following: oral acyclovir, valacyclovir, or famciclovir

Off-label uses are not approved.

Prior authorization does not expire.

**b. Penciclovir1% cream (Denavir) and acyclovir 50 mg buccal tablet (Sitavig)**

Note: DoD Formulary products include topical or oral antiviral agents. Consider alternate agents first, such as acyclovir oral/topical or valacyclovir oral tablets. This PA is only approved for treatment of immunocompetent patients 12 years and older with recurrent herpes labialis (not approved for prophylaxis).

Manual PA criteria apply to all new and current users of Denavir or Sitavig. Coverage is approved if:

- The provider writes in why the patient requires Denavir or Sitavig and why they cannot take oral antivirals or cannot use acyclovir 5% cream.
- Acceptable responses are approved if ALL of the criteria are met:
  - Tried and failed topical acyclovir 5% cream

    AND

  - Treatment failure of one of the following: oral acyclovir, valacyclovir, or famciclovir

Off-label uses are not approved.

Prior authorization does not expire.

2. **Antivirals: Acyclovir/Hydrocortisone 5%/1% Cream (Xerese), Penciclovir 1% Cream (Denavir), and Acyclovir 50 mg buccal tablet (Sitavig)—New Manual PA Implementation Plan**

   The P&T Committee recommended the new manual PA for Xerese, Denavir and Sitavig become effective on the first Wednesday after a 90-day implementation period, and that DHA send letters to the beneficiaries affected by this decision.

3. **Physician's Perspective**

   These three products are essentially slight variations of currently available drugs. The Committee felt that the theoretical benefits of these new products did not warrant the increased cost over the traditional therapies for cold sores.

   The PA criteria will may potentially affect 1,000 patients, based on patients who have recently received prescriptions for these three drugs. Even though the disease state is short and patients may not receive a repeat course of therapy, we will mail letters to the patients affected by the new PA criteria.

4. **Panel Questions and Comments**

   There were no more questions or comment from the Panel. The Chair called for a vote on the New Manual PA Criteria and New Manual PA Implementation Plan for the Antivirals: Xerese, Denavir, and Sitavig.

   - **Antivirals: Xerese, Denavir and Sitavig – New Manual PA Criteria**

     Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

   - **Antivirals: Xerese, Denavir and Sitavig – New Manual PA Implemenation Plan**

     Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

## H. UTILIZATION MANAGEMENT – UPDATED MANUAL PA CRITERIA AND STEP THERAPY

**(DR ALLERMAN)**

1. **Updated Manual PA Criteria and PA Renewal Criteria**

   Updates to the step therapy and manual PA criteria for several drugs were recommended by the P&T Committee due to a variety of reasons, including expanded FDA indications and safety. The updated manual PAs outlined below will apply to new users.

The P&T Committee recommended (12 for, 0 opposed, 0 abstained, 4 absent) updates to the manual PA criteria for Xeljanz, Xeljanz XR, Taltz, Trulance, Addyi, and Lyrica; and updated PA renewal criteria for the tetracyclines.

a. **Targeted Immunomodulatory Biologics (TIBs): Tofacitinib (Xeljanz/Xeljanz XR) and Ixekizumab Injection (Taltz)—**The TIBs were most recently reviewed in August 2014, with step therapy requiring a trial of adalimumab (Humira) first. Xeljanz was originally approved for treating rheumatoid arthritis, while Taltz was originally approved for plaque psoriasis and was reviewed as a new drug in May 2016. PA criteria were updated to add the additional indication for active psoriatic arthritis in adults for Xeljanz, Xeljanz XR, and Taltz.

b. **GI-2 Miscellaneous Agents: Plecanatide (Trulance)**—Trulance was reviewed as a new drug in May 2017 and indicated for chronic idiopathic constipation, with manual PA criteria recommended. The PA criteria were updated to add the additional FDA indication for treatment of irritable bowel syndrome with constipation (IBS-C), with the requirement for a trial of linaclotide (Linzess) before approval of plecanatide for IBS-C.

c. **Female Hypoactive Sexual Desire Disorder Agents: Flibanserin (Addyi)**—Addyi was reviewed in November 2015 with manual PA criteria recommended. The PA criteria were updated to add an expiration date of three months, with renewal PA criteria ensuring efficacy and safety.

d. **Antidepressants and Non-Opioid Pain Syndrome Agents: Pregabalin (Lyrica) PA and MN Criteria**—Step therapy and manual PA criteria have applied to Lyrica since it was originally reviewed for formulary placement in November 2011, with the most recent update occurring in May 2017. The additional indication for treatment of neuropathic pain associated with spinal cord injury after a trial of gabapentin and duloxetine was added to the PA criteria.

e. **Antibiotics: Tetracyclines—**The PA criteria for the tetracyclines, which were originally reviewed in February 2017, was updated to include renewal criteria, that ensure the patient has been re-evaluated within the past 12 months, that the patient is tolerating therapy, and continues to need the medication and that the disease has stabilized or improved while on therapy. The PA renewal will expire in 365 days.

**2. Updated Manual PA Criteria and PA Renewal Criteria—PA Implementation Plan**

The P&T Committee recommended the following updates to the current PAs for Taltz, Xeljanz/Xeljanz XR, Addyi, Trulance, and Lyrica, and the renewal criteria for the tetracyclines become effective on the first Wednesday two weeks after the signing of the minutes in all points of service.

### 3. Physician's Perspective

The P&T Committee does keep up with new indications for drugs that have prior authorization, new safety data, and also reviews requests from providers regarding specific PA criteria. The majority of the updates here are for new FDA-approved indications. You will see these types of recommendations made at every BAP meeting.

### 4. Panel Questions and Comments

There were no more questions or comment from the Panel. The Chair called for a vote on the Prednisone Delayed Release (Rayos).

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

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

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

## I. BRAND OVER GENERIC AUTHORIZATION FOR SILDENAFIL TABLETS (VIAGRA)

**(DR ALLERMAN)**

### 1. Viagra—Brand over Generic Requirement and Manual PA Criteria

TRICARE Policy requires dispensing of generic products at the Retail Network and Mail Order Pharmacy. However, pricing for the branded Viagra product is more cost effective than the AB-rated generic formulations for sildenafil, which were launched in December 2017. The manufacturer of Viagra has offered a Distribution and Pricing Agreement (DAPA). Therefore, the branded Viagra product will continue to be dispensed, and the generic will only be available with prior authorization (i.e., the reverse of the current brand to generic policy). The Tier 1 (generic) copayment will apply to Viagra. The "brand over generic" requirement for Viagra will be removed administratively when it is no longer cost effective compared to the AB-rated generics.

The P&T Committee recommended (12 for, 0 opposed, 0 abstained, 4 absent) implementing the requirement to prefer the branded Viagra product over generic formulations. Manual PA criteria are required for generic sildenafil in the Retail Network and Mail Order Pharmacy. The prescriber will provide patient-specific justification as to why the branded Viagra product cannot be used.

PA Criteria

Manual PA criteria apply to all new users of generic Viagra. Note that brand Viagra is the preferred PDE-5 inhibitor product in DoD.

Manual PA Criteria: Coverage for generic sildenafil is approved if the following criteria is met:

- The provider has provided patient-specific justification as to why the brand Viagra product cannot be used.
- Acceptable reasons include the following, which have occurred or are likely to occur with the branded Viagra product: allergy to the branded Viagra; contraindication; sub-therapeutic response; physical restriction (e.g., swallowing issues); and brand availability issues.

**2. Viagra—Brand Copayment Change**

The P&T Committee recommended (12 for, 0 opposed, 0 abstained, 4 absent) that the brand (Tier 2) formulary cost share for Viagra in the TRICARE Mail Order Pharmacy and the TRICARE Retail Network Pharmacy be lowered to the generic (Tier 1) formulary cost share.

**3. Physician's Perspective**

TRICARE requires mandatory use of generics. Generic formulations of Viagra became available in December of last year. However, the price of the generics are significantly more expensive than the government pricing for brand Viagra, so P&T waived the generic use requirement and made the brand name product preferred.

The reason for having the copay decrease to tier 1 (or generic copay) is an incentive for the brand name Viagra to be dispensed. The price of the generics will be monitored, so when it is no longer cost effective to continue dispensing brand Viagra, we will administratively remove this requirement, and go back to our usual process of preferring the generic.

4. **Panel Questions and Comments**

There were no more questions or comment from the Panel. The Chair called for a vote on the Viagra – Brand over Generic Requirement and Manual PA Criteria.

- **Viagra – Brand over Generic Requirement and Manual PA Criteria**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

- **Viagra – Brand Copayment Change**

  Concur: 4 Non-Concur: 0 Abstain: 0 Absent: 3

CAPT Norton started to thank and conclude the meeting.

Mr. Hostettler asked to provide more comments regarding the GLP1RA. The recommendations stated that letters will be mailed to the affected patients. Would it be possible to include network providers? There are a lot of patients to get back through the system.

CAPT VonBerg said they will work with managed support contractors.

Mr. Hostettler said it would make sense include the network providers so they know why all the patients are coming back in to get new prescriptions.

CAPT Norton addressed his comments by saying P&T minutes are signed and shared with the STRACTOM within DHA. They communicate with the various stakeholders which would include the managed support contractors who communicate changes to their network providers. There are several avenues that the decisions of the P&T Committee meetings are made available to the public as well as affected providers and patients.

Mr. Hostettler said he understands how administrative contractors are made aware, but not sure if routinely send that kind of information out to their network providers.
CAPT Norton thanked everyone for their attendance. Thanked the Panel. Concluded the meeting.

Mr. Ostrowski thanked CAPT VonBerg for his service to the Panel and appreciated all that he's done and wished him well in his new endeavors.

**(Meeting Concludes)**

**Appendix A – Private Citizen Comments – Radius Health**
**Appendix B – Private Citizen Comments – Mallinckrodt Pharmaceuticals**
**Appendix C – Brief Listing of Acronyms Used in this Summary**

Mr. Jon Ostrowski,
UF BAP Chair

Appendix A 04/05/2018 BAP Meeting

Dear Uniform Beneficiary Advisory Panel,

We appreciate the recent review you conducted of TYMLOS in consideration for formulary addition. Radius Health is disappointed by the outcome, and respectfully accepts the offer to submit this letter in response.

Listening to our patients, payers and government agencies, we learned prior to launching TYMLOS that patient affordability was a significant factor in the historically low and declining utilization rates of anabolic therapy. In response, Radius priced TYMLOS significantly below that of the only other anabolic on the market. Please consider the following:

- Today, the WAC price of TYMLOS is $1,720.88 vs. $3,294.70 per pen for Forteo, a 48% difference
- Over the course of a 12-month period, TYMLOS WAC is $20,260.56 compared to Forteo's WAC of $42,831.10.
- The TYMLOS pen contains 30 days of therapy whereas the Forteo pen contains 28 days of therapy, resulting in one less pen needed to complete a year of therapy (assuming full compliance)

NOTE: Price comparisons do not imply comparable efficacy, safety or indications

Further, 93% of Commercially insured lives in the nation currently have coverage for TYMLOS.

Considering the clinical profile of TYMLOS and the significant difference in net cost between TYMLOS and teriparatide, plus the additional information outlined below, we respectfully ask that you re-evaluate the non formulary P&T recommendation, and allow physicians and patients to have a choice in the anabolic therapy class by adding TYMLOS to your Tier 2 Formulary.

We observed in the meeting minutes that the P&T committee concluded there is a high degree of interchangeability between Forteo and Tymlos. Radius Health respectfully disagrees, and ask that you consider the following additional clinical points:

Additional points for consideration:

- Clinical
  - TYMLOS achieved **the** primary and secondary endpoints of ***significant fracture risk reduction at both*** **vertebral and nonvertebral sites** ***and increases in BMD*** **at the lumbar spine, total hip and femoral neck** in the 18-month efficacy trial; Tymlos achieved a 86% relative risk reduction (3.6%

ARR) in new vertebral fractures **(p <0.0001)** and 43% relative risk reduction (2.0% ARR) in non-vertebral fractures **(p=0.049)** at 18 months **compared to placebo**

- For vertebral, non-vertebral, and major osteoporotic fractures, TYMLOS **time to fracture events began to** separate from placebo at **approximately month 3**; Forteo separated from placebo at **approximately** 12 months
- There were significant increases in BMD at the lumbar spine, total hip, and femoral neck vs. placebo at 18 months**, additionally data demonstrated TYMLOS had significant increases in BMD at both the total hip and femoral neck at month 6**
    - Fracture risk reductions and BMD increases were continued at 25 and 43 months (18 months of treatment with TYMLOS and 1 month without treatment, followed by 24 months of alendronate)
    - In an open label, active comparator arm of the study, the percentage of patients with new vertebral fractures at 18 months taking Forteo was 4.2% vs. 0.8% with placebo; the percentage of nonvertebral fracture was 3.3% for Forteo and 4.7% for placebo
- NOTE: This study was not designed to provide head-to-head comparative efficacy data and cannot be interpreted as evidence of superiority or noninferiority to teriparatide

- Other
    - Radius submitted a bid to Tricare requesting a parity position
    - Tymlos offered a rebate above the FFS standard rate required
    - Radius has aligned with the FDA on a study for male osteoporosis
    - Radius request the opportunity to match the current rebate offered by Eli Lilly for Forteo
    - A one-year course of TYMLOS is $22,180.54 less than FORTEO

Thank you for your consideration,

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**04/04/18**

**Mallinckrodt Pharmaceuticals**
**Comments on DoD P&T Committee Proposal**

## I. INTRODUCTION

- My name is Sean Griffin, and I am an attorney with the law firm Sidley Austin LLP.
- I am here today on behalf of Mallinckrodt Pharmaceuticals.
- Mallinckrodt has asked me to address a mix of clinical and legal concerns regarding the P&T Committee's recent recommendations regarding the class of drugs known as Adrenocorticotropic Hormones or ACTH.
- Mallinckrodt manufacturers Acthar Gel, which is the only ACTH product currently approved for therapeutic use in the United States.
- Acthar Gel is widely recognized as a medically necessary product and has the distinction of being FDA approved for 19 different indications.
- We have not had much time to review the Committee's recommendations, so my comments today are necessarily at a high-level.
- Mallinckrodt is concerned, however, that certain of the PA criteria recommended for the Infantile Spasm (IS) and Multiple Sclerosis (MS) indications are inappropriate and will harm patients by delaying access to an important and effective therapy.
- Mallinckrodt also is concerned about the omission of any prior authorization criteria for the other FDA-approved indications. That omission appears to be based on a false premise-namely, that those indications have not been evaluated or approved by FDA for effectiveness. That is false. Each of the current labeled uses was approved for effectiveness in 1977 and again in 2010.

- These clinical and factual issues also raise serious legal issues. Under the Administrative Procedures Act (or APA), agency decisions must be evidence-based and supported by a reasoned explanation. [1] Those requirements take on special force when, as now, an agency proposes to substantially revise a policy that has been in place for several years.[2] At a minimum, the Committee should have acknowledged that it was changing the coverage policy for IS and other uses, explained why the change is justified based on specific, reliable evidence, and addressed the legitimate reliance that patients, providers, and Mallinckrodt have placed

1 *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mui. Automobile Ins. Co.,* 463 U.S. 29, 43 (1983) ("[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.").

2 *FCC v. Fox Television Stations, Inc.,* 129 S. Ct. 1800, 1811 (2009) (An agency must "provide a more detailed justification ... when, for example, its new policy rests upon factual findings that contradict those which underlay its prior policy.").

- on the prior policies.[3] The Committee appears not to have followed these important APA requirements.

- In light of these concerns, we request that the Panel modify the Committee's recommendations in three ways.

    - First, we believe that the PA criteria for the IS indication should not include a requirement that patients first receive a 2-week course of high-dose prednisone/prednisolone. This will harm patients and is inconsistent with nationally-accepted clinical practice guidelines.

    - Second, we believe that the PA criteria for the MS indication should be edited to remove the words "for the present exacerbation." It is plainly inappropriate to require a failed steroid treatment for each individual exacerbation as it occurs. Forcing patients to endure multiple, repeated treatment failures would be an entirely unreasonable barrier to access to an established second line therapy.

    - Finally, we believe that the Panel should strike the Committee's language describing other FDA-approved uses of Acthar Gel as "unsupported" or "unproven" and adopt appropriate PA criteria for at least those uses that previously have been covered "on appeal." The Committee failed to explain in any manner how new evidence justified the departure from its prior coverage policies, which did cover these uses in appropriate circumstances. A policy of no coverage under any circumstances, no matter how severe the patient need and no matter how extensively other therapies have been tried and failed, is plainly arbitrary and capricious.

- I will now address our three concerns in greater detail.

## II. Infantile Spasms

- We have several concerns regarding the Committee's proposal that patients be required to receive 2 weeks of steroids before receiving Acthar Gel. First and foremost, we are concerned that a two-week course of steroids will harm patients by delaying the onset of treatment with Acthar Gel.

    - Infantile Spasms is a rare but catastrophic syndrome that typically onsets within the first year of life and is characterized by both spasms and hypsarrhythmic EEG patterns.
    - The condition very frequently results in neurological delay or impairment.

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3 *Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015)("1t would be arbitrary and capricious to ignore" "serious reliance interests that must be taken into account."); *accord Smiley v. Citibank (South Dakota}, N.A.*, 517 U.S. 735, 742 (1996).

- Delayed treatment that exposes infants to three or more weeks of hypsarrhythmia has been shown to cause increased impairment.[4]

- We are concerned that a two-week delay before commencing treatment with Acthar Gel could result in unnecessary, permanent disability.

- Our concerns are underscored by the fact that neither prednisone nor prednisolone has been approved by FDA for the treatment of IS.

  - We think it is plainly inappropriate to rely on unapproved uses of these steroids *as a* first-line treatment for such a serious and time-sensitive condition.

  - Indeed, we are not aware of any government payor or major commercial payor that currently requires patients suffering from Infantile Spasms to receive steroid treatment prior to receiving Acthar Gel

- To the contrary, Acthar Gel is widely recognized as the standard of care for IS.

- Mallinckrodt previously submitted a comprehensive set of articles and studies related to the use of Acthar Gel as a treatment for IS. We would particularly like to draw the Panel's attention to:

  - The current evidence-based clinical guidelines from the American Academy of Neurology/ Child Neurology Society, which not only endorse Acthar Gel as a first line therapy but also conclude that there is insufficient evidence to recommend the use of prednisolone or other therapies. [5]
  - A 2010 meeting of knowledge leaders, which concluded that a high-dose regimen of Acthar Gel "continues to be the clinical standard of treatment of infantile spasms in the United States and several other countries."[6]
  - A study published in 2016 by the National Infantile Spasms Consortium, which found that ACTH appeared to be a more effective treatment for Infantile Spasms than other standard therapies.[7]
  - A randomized trial published in 1996, which found that a 2-week course of high- dose ACTH (86.6% efficacy) was superior to 2 weeks of what would now be

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4 Mackay MT, et al. Neurology. 2004;62(10):1668-1681; Goh S, et al. Neurology. 2005;65(2)235-238

5 Go C.Y. et al. Evidence-based guideline update: Medical treatment of infantile spasms: Report of the Guideline Development Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society - Neurology, 2012;78:1974·1980

6 Stafstrom CE et al. Treatment of IS insights from clinical & basic science perspectives- J Child Neurol 2011 26(11) 1411·1421.

7 Knupp K.G. et al. Response to Treatment in a Prospective National Infantile Spasms Cohort - Ann Neurol 2016;79:475-484.

considered low-dose prednisone (28.6%) for treatment of infantile spasms as assessed by both clinical and EEG criteria.[8]

- We believe that the Committee's recommendation would not survive judicial review under the APA.
    - The Committee's recommendation does not appear to be evidence based. Although there are oblique statements regarding a review of the evidence, the Committee does not cite any particular source that supports its position.
    - The Committee also appears to have ignored the materials I've mentioned, none of which are acknowledged in the decision, and all of which contradict the recommendation.
    - The Committee's recommendation does not acknowledge that the 2 weeks of steroids requirement is a substantial change in policy. The PA criteria that have been in place since 2013 do not require prior steroid treatment. No new evidence is presented, and we are not aware of new evidence that would be sufficient to outweigh or contradict the settled view that Acthar Gel is the standard of care for this condition.
    - Last, the Committee did not consider the reliance interests of patients, providers, and Mallinckrodt surrounding the prior policy.
    - Each of these issues is independently a basis to conclude that the Committee's recommendation is arbitrary and capricious under the APA.
- Accordingly, we ask the Panel to remove the PA criteria that all patients with IS first try a 2 week course of steroids.

## III. Multiple Sclerosis

- With respect to the MS indication, we agree that prior authorization is appropriate and that patients should try and fail treatment with steroids prior to receiving Acthar Gel for MS exacerbations.

8 Barram TZ et al. High dose Corticotropin (ACTH) Versus Prednisone for Infantile Spasms: A Prospective, Randomized, Blinded Study - Pediatrics 1996;97(3):375-379.

Our objection is only to the requirement that patients must have failed steroid treatment in connection with "the present exacerbation," which seems plainly unreasonable.

- MS patients often experience multiple exacerbations or relapses, with many experiencing more than one exacerbation a year.

- If steroids failed in a prior exacerbation, there should be no reason to force the patient to repeat the failed therapy again.

- If the committee's recommendation is adopted, veterans theoretically could be forced to try steroid treatments 5, 6, 7 or more times beyond the first failure, with each exacerbation forcing a new trial and failure.

- We cannot believe that was the Committee's intent.

- Repeated steroid treatments also pose quality of life problems for MS patients:

  - During an exacerbation without appropriate treatment, patients can experience a range of harms, from difficulty walking to optic neuritis, a painful vision issue, and cognitive delays.

  - A steroidal treatment also typically requires the patient to visit a clinic every day to receive the infusion, as opposed to Acthar Gel, which can be administered by the patient in the home. For a patient in an exacerbation, with limited or no mobility, that is a very real and very serious barrier to care.

- Accordingly, we ask the Committee to remove the requirement that steroids must be used first in the "present exacerbation."

## IV. All Other Uses

- For all remaining indications of Acthar Gel, the P&T Committee recommends that all other uses "are unsupported and excluded from TRICARE coverage."
- We have several concerns about this recommendation.
- First, the recommendation is based on a plain misunderstanding of the facts and the law.

  - The Committee document (at page 13) asserts that all indications other than IS and MS have not been approved by FDA for clinical effectiveness because the drug was originally approved prior to the 1962 Amendments to the FDCA.

  - That is false

  - ACTH was considered through the Drug Efficacy Study Implementation Program. Through that program, Acthar Gel was reviewed and approved as effective in 1977 for a large number of indications and in 1978 for MS.

  - FDA then re-reviewed the drug in 20lO as part of a supplemental NOA filing, and reaffirmed 19 approved indications. Each of those indications have been approved by FDA for both safety and effectiveness.

  - The APA does not permit an agency to base a decision on a false premise.

- Second, the recommendation is a break from existing coverage policy.
    - Previously, the program provided coverage for indications like lupus and protein-wasting nephropathies on "appeal only."
    - While we have many concerns about the legality of "appeal only" coverage, that policy did enable at least some patients to receive coverage.
    - For instance, between January 2014 and March 2018, at least 113 naive patients received coverage for Acthar Gel for protein-wasting nephropathies on appeal.
    - By statute, this means that the Department has recognized that these uses were medically necessary in those particular cases. [9]
- Thus, the Committee articulated a change of position, but without any explanation, such as new evidence that could support the decision to cut off coverage for uses that were previously covered. The change therefore is subject to challenge under the APA.
- Finally, we are very concerned that the recommendation does not address the legal concerns that we have raised over the past several months.
    - Previously, we raised a serious of concerns in which some patients who had been prescribed Acthar Gel for these uses were not given initial determinations that they are entitled to receive under applicable law.
    - They were instead given appeal rights, but were falsely told by DoD's contractor that the appeal would necessarily fail. Not only did this result in delay, it strongly disincented patients from pursuing their appeal rights.
    - We were told that the P&T Committee review would address these serious issues, but the current recommendation makes the problem worse.
    - There is no mechanism to correct for past patients to receive the initial coverage determination that they were deprived. Nor is there a process to correct the false statements made to patients regarding their appeals.

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9 TRICARE's coverage is limited to services and supplies that "are medically or psychologically necessary for the diagnosis or treatment of a covered illness ... or injury...." 32 CFR 199.4(g)(l).

    - And, for future patients, there is no indications that they will even receive appeal rights, let alone an initial determination.

- Accordingly, we believe the Panel should establish PA criteria for the uses previously covered on appeal.

- Thank you for your time. The company will be following up with an additional letter and we can address the questions in that letter.

## Brief Listing of Acronyms Used in this Summary

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

- A1c – hemoglobin A1c
- ACTH – Adrenocorticotropic Hormones
- AKC - Atopic Keratoconjunctivitis
- ALS - Amyotrohic Lateral Sclerosis
- BIA – Budget Impact Analysis
- BMD – Bone
- CFR – Code of Federal Regulations
- CMA – Cost-Minimization Analysis
- CV - Cardiovascular
- CVOT – Cardiovascular Outcome Trials
- DAPA – Distribution and Pricing Agreement
- DHA – Defense Health Agency
- DoD – Department of Defense
- DPP-4 – Dipeptidyl Peptidase 4
- DR – Delayed Release
- EEG - Electroencephalogram-Confirmed
- ER - Extended Release
- FDA - Food & Drug Administration
- FEV1 – forced expiratory volume in one second
- FSGS - Focal Segmental Glomerulosclerosis
- GI - Gastrointestinal
- GLP1RA - Glucogon-Like Peptide-1 Receptor Agonists
- GvHD – Graft Versus Host Disease
- HDM - House Dust Mite
- HIV - Human Immunodeficiency Virus
- IBS-C – Irritable Bowel Syndrome with Constipation
- IR – Immediate Release
- IR/DR – Immediate Release/Delayed Release
- IV – Intravenous
- IV/PO – Intravenous/Oral Equivalent
- MHS – Military Health System
- MPGN – Membranoproliferative Glomerulonephritis
- MS – Multiple Sclerosis
- MTF – Military Treatment Facility
- NF – Non Formulary

- NNT – Number Need to Treat
- OTC – Over the Counter
- P&T – Pharmacy and Therapeutics Committee
- PA – Prior Authorization
- PDE-5 – phosphodiesterase type -5 inhibitor
- PTH – Parathyroid Hormone Analogs
- QTc - corrected QT
- SGLT2 – Sodium Glucose Co-Transporter-2 Inhibitor
- T2DM – Type 2 Diabetes Mellitus
- TEN – Toxic Epidermal Necrolysis
- TIB – Targeted Immunomodulatory Biologics
- UF – Uniform Formulary
- VCK – Vernal Keratoconjunctivitis
- XR – Extended release