STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Bureau for Medical Services
Pharmacy Services
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1542

Cynthia E. Beane
Commissioner

Pharmaceutical and Therapeutics Committee

October 25th, 2023

Time: Executive Session 2:30 PM – 3:30 PM
Time: Open Session 3:30 PM – 5:00 PM
Charleston, WV 25301
(304) 558-1700

MINUTES

Committee Members Present:
Scott Brown, RPh, Vice- Chairman
David Gloss, MD
John Bernabei, RPh (JJ)
Charles Rohrbaugh, RPh
Krista Capehart, PharmD
Toni DiChiacchio, DNP
Laura Davisson, MD
Mitzi Payne, RPh

Absent:
Chris Terpening, PharmD, PhD,
Philip Galapon, MD FAAFP, Chair

Division of Medicaid Staff Present:
Bill Hopkins, Operations Manager
Priya Shah, PharmD, DUR Coordinator
Doug Sorvig, Data Analyst
Lori Moles, RPH Appeals Pharmacist
Vicki Cunningham, RPH, Pharmacy Program Directyor
Gail Goodnight, RPH Rebate Pharmacist

Contract Staff Present:
Change Healthcare
Laureen Biczack, MD
Joseph Bergondo, PharmD
Paige Clayton, PharmD

Other Contract / State Staff Present:
Sherri A. Young, DO, MBA, FAAFP

I. Call to Order

Scott Brown, Vice Chairman, called the meeting to order at 9:10 AM.

II. Welcome and Introductions

Scott Brown welcomed all present to the committee meeting. Committee members, Bureau of Medical Services staff, and Change Healthcare staff introduced themselves.

III. Housekeeping Items / Updates

A. Approval of the August 23rd, Meeting Minutes

The Committee moved to approve the August 23rd, 2023 meeting minutes. All were in favor with no objections or revisions.

B. PDL Compliance / Generic Percent Report Updates

Joe Bergondo provided an explanation of the PDL Compliance and Generic Percent reports.

- Joe Bergondo reviewed the Generic Percent Report; overall generic utilization for Q3 2023 was 85.3%

- Joe Bergondo reviewed the PDL Compliance Report; overall compliance for Q3 2023 was 92.7%

IV. Drug Class Announcements

Change Healthcare recommended that the following classes be extracted:

- Acne Agents, Topical
- Analgesics, Narcotics – Short Acting (Non-Parental)
- Antibiotics, Inhaled
- Anticonvulsants
- Antiemetics
- Antihemophilia Factor Agents
- Antihyperuricemics
- Antipsychotics, Atypical
- Antiretrovirals
- Bronchodilators, Beta Agonists
- COPD Agents
- Cytokine and CAM Antagonists
- Epinephrine, Self-Injected
- Growth Hormones
- Heart Failure Treatments
- Hypoglycemics, Miscellaneous Agents
- Intranasal Rhinitis Agents

- Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents
- Laxatives and Cathartics
- Lipotropics, Other (Non-statins)
- MABs, Anti-IL/IgE
- Multiple Sclerosis Agents
- Ophthalmic Antibiotics
- Ophthalmic Antibiotic/Steroid Combinations
- Ophthalmics, Glaucoma Agents
- Opiate Dependence Treatments
- Proton Pump Inhibitors
- Stimulants & Related Agents
- VMAT Inhibitors

V. First Round of Extractions

Additional extractions presented by Committee members:

- PAH Agents – Prostacyclins

VI. Public Comments

Diane Ammerman – Xolair
John Roney – Tezspire
Nicole Abolins – Genotropin
Robert Jensen – Brixadi
Herbert Peeples – Briviact
David Humphreys – Vraylar
Jia Li – Qelbree
Kerry Francis – Repatha
Venessa Medona – Tyvaso
Janet Bekman – Vraylar
Timothy Birner – Lybalvi
Domenico Mantella – Leqvio
Nancy Njuguna – Biktarvi
Madeline Shurtleff – Abilify Asimtufii

VII. Second Round of Extractions

Additional extractions presented by Committee members:

- No additional rounds of extractions were recommended by committee members

VIII. Motion for All Non-Extracted Categories to be Approved as Proposed

- Alzheimer's Agents
- Analgesics, Narcotics – Long Acting (Non-Parental)

- Androgenic Agents
- Anesthetics, Topical
- Angiotensin Modulators
- Antianginal & Anti-Ischemic
- Antibiotics, Topical
- Antibiotics, Vaginal
- Anticoagulants
- Antidepressants, Other
- Antidepressants, SSRIs
- Antifungals, Oral
- Antifungals, Topical
- Antihypertensives, Sympatholytics
- Antimigraine Agents, Prophylaxis
- Antimigraine Agents, Acute
- Antiparasitics, Topical
- Antiparkinson's Agents
- Antipsoriatics, Topical
- Antivirals, Oral
- Antivirals, Topical
- Beta Blockers
- Bladder Relaxant Preparations
- Bone Resorption Suppression & Related Agents
- BPH Treatments
- Calcium Channel Blockers
- Cephalosporins & Related Antibiotics
- Crohns Disease Oral Steroids
- Dry Eye Products
- Erythropoiesis Stimulating Proteins
- Fluoroquinolones, Oral
- Glucocorticoids, Inhaled
- Guanylate Cyclase Stimulators
- H. Pylori Treatment
- Hepatitis B Treatments
- Hepatitis C Treatments
- Hyperparathyroid Agents
- Hypoglycemia Treatments
- Hypoglycemics, Biguanides
- Hypoglycemics, DPP-4 Inhibitors
- Hypoglycemics, GLP-1 Agonists
- Hypoglycemics, Insulins & Related Agents
- Hypoglycemics, Meglitinides
- Hypoglycemics, SGLT2 Inhibitors
- Hypoglycemics, TZDs
- Immunomodulators, Atopic Dermatitis

- Immunomodulators, Genital Warts & Actinic Keratosis Agents
- Immunosuppressive, Oral
- Leukotriene Modifiers
- Lipotropics, Statins
- Macrolides
- Neuropathic Pain
- NSAIDs
- Ophthalmics for Allergic Conjunctivitis
- Ophthalmics, Anti-Inflammatories
- Oral and Topical Contraceptives
- Otic Antibiotics
- PAH Agents – Endothelin Receptor Antagonists
- PAH Agents – PDE5s
- Pancreatic Enzymes
- Phosphate Binders
- Pituitary Suppressive Agents, LHRH
- Platelet Aggregation Inhibitors
- Progestational Agents
- Progestins for Cachexia
- Sedative Hypnotics
- Skeletal Muscle Relaxants
- Steroids, Topical
- Tetracyclines
- Ulcerative Colitis Agents
- Vaginal Ring Contraceptives
- Vasodilators, Coronary

A motion was made and seconded to accept all non-extracted categories as presented by Change Healthcare. All members were in favor and the motion was approved.

IX. Break/Lunch and Executive Session

The committee adjourned at 10:10 AM for Executive Session and lunch until afternoon session.

X. New Business

A. New Drug Reviews

i. Acne Agents, Topical

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required. Acne kits are non-preferred. **Specific Criteria for sub-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.		
RETINOIDS		
adapalene gel RETIN-A (tretinoin) RETIN-A MICRO (tretinoin)	adapalene cream, lotion AKLIEF CREAM (trifarotene) ALTRENO LOTION (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) tazarotene cream, foam, gel tretinoin cream, gel tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.
COMBINATION AGENTS		
ACANYA (clindamycin phosphate/benzoyl peroxide) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (generic DUAC only) ONEXTON (clindamycin phosphate/benzoyl peroxide) sulfacetamide sodium/sulfur suspension ZIANA (clindamycin/tretinoin)*	adapalene-benzoyl peroxide* AVAR/-E/LS (sulfur/sulfacetamide) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/erythromycin benzoyl peroxide/urea clindamycin phosphate/benzoyl peroxide (generic Acanya) clindamycin-tretinoin gel* NEUAC (clindamycin phosphate/benzoyl peroxide) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads sulfacetamide/sulfur wash, cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) TWYNEO (tretinoin/benzoyl peroxide) ZMA CLEAR (sulfacetamide sodium/sulfur)	**In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.

A motion to approve the changes to the Acne Agents, Topical class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

ii. Analgesics, Narcotic Short Acting (Non-Parental)

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.		
APAP/codeine butalbital/APAP/caffeine/codeine 50-325-30 mg codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydromorphone tablets meperidine oral solution morphine NUCYNTA (tapentadol) oxycodone capsule, tablets, solution oxycodone/APAP oxycodone/ASA tramadol tablets tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine 50-300-30 mg butalbital/ASA/caffeine/codeine butorphanol DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) LORTAB SOLUTION (hydrocodone/acetaminophen) meperidine tablet morphine rectal suppository NORCO (hydrocodone/APAP) oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) QDOLO SOLUTION (tramadol) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)* tramadol solution ULTRACET (tramadol/APAP) VICOPROFEN (hydrocodone/ibuprofen)	Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days. *Seglentis requires medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents

A motion to approve the changes to the Analgesics, Narcotic Short Acting (Non-Parental) class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

iii. Anticonvulsants

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICONVULSANTS		
CLASS PA CRITERIA: For a diagnosis of seizure disorder, non-preferred agents require a fourteen (14) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered. For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed.		
ADJUVANTS		
BRIVIACT (brivaracetam) carbamazepine carbamazepine ER CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPITOL (carbamazepine) GABITRIL (tiagabine) lacosamide tablets, solution LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine lamotrigine ODT levetiracetam IR levetiracetam ER	APTIOM (eslicarbazepine) BANZEL (rufinamide) carbamazepine oral suspension DEPAKOTE (divalproex) DEPAKOTE DR (divalproex DEPAKOTE ER (divalproex) DIACOMIT CAPSULE/POWDER PACK (stripentol)** ELEPSIA XR (levetiracetam) EPRONTIA SOLUTION (topiramate)**** EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) SOLUTION***** FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA SOLUTION (levetiracetam) KEPPRA XR (levetiracetam)	*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR. **Diacomit may only be approved as adjunctive therapy for diagnosis of Dravet Syndrome when prescribed by, or in consultation with, a neurologist AND requires a thirty (30) day trial of valproate and clobazam unless one (1) of the exceptions on the PA form is present. Diacomit must be used concurrently with clobazam. *** Trokendi XR are only approvable on appeal. ****Eprontia requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met by using the preferred Topamax (topiramate) sprinkle capsules.
levetiracetam IR suspension oxcarbazepine tablets QUDEXY XR (topiramate ER) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) topiramate IR tablet topiramate ER* topiramate IR sprinkle caps topiramate ER sprinkle caps (generic Qudexy) TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	LAMICTAL ODT (lamotrigine) lamotrigine dose pack lamotrigine ER methsuximide oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) rufinamide oral suspension, tablets SABRIL (vigabatrin) SPRITAM (levetiracetam) TEGRETOL TABLETS (carbamazepine) tiagabine TOPAMAX SPRINKLE CAPS (topiramate) TOPAMAX TABLETS (topiramate) TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate)*** vigabatrin tablet/powder pack VIMPAT (lacosamide) tablets, solution XCOPRI (cenobamate) ZONISADE (zonisamide) suspension******	*****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink. ******Zonisade may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia AND have had a (14) fourteen day trial with a preferred agent available in a non-solid dosage form resulting in an inadequate treatment response.

A motion to approve the changes to the Anticonvulsants class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

iv. Antiretrovirals

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIRETROVIRALS[AP]		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.		
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate	

A motion to approve the changes to the Antiretrovirals class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

v. Cytokine and CAM Antagonists

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CYTOKINE & CAM ANTAGONISTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis, unless one (1) of the exceptions on the PA form is present. *Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication AND a more cost-effective biosimilar product is not available). In cases where a biosimilar exists but is also non-preferred, the PA vendor shall advise the provider which product is the most cost-effective agent. All off-label requests require review by the Medical Director.* **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.**		
ANTI-TNFs		
AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) infliximab SIMPONI subcutaneous (golimumab)	adalimumab-fkjp CIMZIA (certolizumab pegol) CYLTEZO (adalimumab-adbm) HADLIMA (adalimumab-bwwd) HULIO (adalimumab-fkjp) HYRIMOZ (adalimumab-adaz) IDACIO (adalimumab-aacf) INFLECTRA (infliximab) REMICADE (infliximab) RENFLEXIS (infliximab) SIMPONI ARIA (golimumab) YUFLYMA (adalimumab-aacf) YUSIMRY (adalimumab-aqvh)	
OTHERS		
ACTEMRA subcutaneous (tocilizumab) KINERET (anakinra) ORENCIA CLICKJET/VIAL (abatacept) OTEZLA (apremilast) TALTZ (ixekizumab)* XELJANZ (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) AMJEVITA (adalimumab-atto) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) LITFULO (ritlecitinib tosylate) OLUMIANT (baricitinib) ORENCIA SYRINGE (abatacept) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) STELARA subcutaneous (ustekinumab) TREMFYA (guselkumab) XELJANZ XR (tofacitinib)	*Taltz will be authorized for treatment of plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of one preferred ANTI-TNF agent.

A motion to approve the changes to Cytokine and CAM Antagonists class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

vi. Epinephrine, Self-Injected

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPINEPHRINE, SELF-INJECTED		
CLASS PA CRITERIA: A non-preferred agent may be authorized with documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for the preferred agent(s).		
epinephrine (labeler 49502 only)	AUVI-Q (epinepherine) epinephrine (all labelers except 49502) EPIPEN (epinephrine) EPIPEN JR (epinephrine) SYMJEPI (epinephrine)	

A motion to approve the changes to Epinephrine, Self-Injected class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

vii. Growth Hormones and Achondroplasia Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GROWTH HORMONES AND ACHONDROPLASIA AGENTS CL/PA		
CLASS PA CRITERIA: Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NGENLA (somatrogon-ghla) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan-beco) VOXZOGO (vosoritide)** ZOMACTON (somatropin) ZORBTIVE (somatropin)	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA. *Full PA criteria for Voxzogo may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the changes to the Growth Hormones and Achondroplasia Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

viii. Heart Failure

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HEART FAILURE		
This is not an all-inclusive list of agents available for the treatment of heart failure. Please see beta blockers and SGLT-2 agents.)		
ENTRESTO (sacubitril/valsartan)*	INPEFA (sotagliflozin) VERQUVO (vericiguat)**	*Entresto may be authorized only for patients ≥ 1 year of age diagnosed with chronic heart-failure. **Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the changes to the Heart Failure class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

ix. Laxatives and Cathartics

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LAXATIVES AND CATHARTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
CLENPIQ (sodium picosulfate, magnesium oxide, citric acid) COLYTE GOLYTELY MOVIPREP NULYTELY OSMOPREP peg 3350 SUPREP	peg 3350-sod sulf-NaCL-KCL-asb powder SUFLAVE (peg 350-sod sulf, chl-pot-mag) SUTAB (magnesium sulfate, potassium sulfate, sodium sulfate)	

A motion to approve the changes to Laxatives and Cathartics class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

x. MABs, ANTI-IL/IgE

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
MABS, ANTI-IL/IgE		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis. **Full PA Criteria may be found on the PA Criteria page by clicking the hyperlink.**		
DUPIXENT (dupilumab) FASENRA (benralizumab) NUCALA AUTO INJECTOR/SYRINGE (mepolizumab) XOLAIR VIAL (omalizumab)	NUCALA VIAL (mepolizumab) TEZSPIRE (tezepelumab-ekko) XOLAIR SYRINGES (omalizumab)	

A motion to approve the changes to MABs, ANTI-IL/IgE class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xi. Ophthalmics, Glaucoma Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPHTHALMICS, GLAUCOMA AGENTS		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class.		
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	brimonidine-timolol COSOPT PF (dorzolamide/timolol) IYUZEH (latanoprost) tafluprost	

A motion to approve the changes to Ophthalmics, Glaucoma Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xii. Opiate Dependence Treatments

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone strips AND buprenorphine/naloxone tablets. *WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
BRIXADI (buprenorphine)CL/PA buprenorphine/naloxone tablets* naloxone vial/syringe/cartridge naloxone nasal spray (OTC) NARCAN NASAL SPRAY (naloxone) SUBLOCADE (buprenorphine soln)CL/PA* SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	BUNAVAIL (buprenorphine/naloxone)* buprenorphine tablets* buprenorphine/naloxone film* KLOXXADO SPRAY (naloxone) LUCEMYRA (lofexidine)** naloxone nasal spray (RX) OPVEE (nalmefene) ZIMHI (naloxone hydrochloride) ZUBSOLV (buprenorphine/naloxone)*	** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the changes to Opiate Dependence Treatments class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xiii. Stimulants and Related Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
STIMULANTS AND RELATED AGENTS		
CLASS PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Children under the age of 18 may continue their existing therapy at the discretion of the prescriber.		
AMPHETAMINES		
ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR DYANAVEL XR SUSP (amphetamine) PROCENTRA solution (dextroamphetamine)	ADDERALL (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) amphetamine tablets DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) dextroamphetamine solution DYANAVEL XR TABLETS (amphetamine) EVEKEO (amphetamine) EVEKEO ODT (amphetamine) lisdexamfetamine methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)* VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine) XELSTRYM (dextroamphetamine) patches ZENZEDI (dextroamphetamine)	**In addition to the Class Criteria**: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression. *Mydayis requires a 30-day trial of at least one long-acting preferred agent in this subclass and a trial of Adderall XR.

A motion to approve the changes to Stimulants and Related Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

B. Class Review

i. Antibiotics, Inhaled

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIBIOTICS, INHALED		
CLASS PA CRITERIA: Non-preferred agents require a twenty-eight (28) day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one (1) of the exceptions on the PA form is present.		
KITABIS PAK (tobramycin) tobramycin 300 mg/5 ml	BETHKIS (tobramycin) CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin 300 mg/4 ml	

A motion to approve the changes to the Antibiotics, Inhaled class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

ii. Antiemetics

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for sub-class criteria.		
COMBINATIONS		
DICLEGIS (doxylamine/pyridoxine)*	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) doxylamine/pyridoxine (generic Diclegis)	Non-preferred agents will only be approved on appeal. *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the changes to the Antiemetics class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

iii. Antihemophilia Factor Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIHEMOPHILIA FACTOR AGENTS[CL/PA]		
CLASS PA CRITERIA: All agents will require prior-authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
FACTOR VIII		
AFSTYLA ALPHANATE HEMOFIL M HUMATE-P JIVI KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ WILATE XYNTHA XYNTHA SOLOFUSE	ADVATE ADYNOVATE ALTUVIIIO ELOCTATE ESPEROCT RECOMBINATE VONVENDI	
FACTOR IX		
ALPHANINE SD ALPROLIX BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	

A motion to approve the changes to the Antihemophilia Factor Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

iv. Antihyperuricemics

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIHYPERURICEMICS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTIMITOTICS		
colchicine tablets	colchicine capsules COLCRYS (colchicine) tablets MITIGARE (colchicine) GLOPERBA (colchicine)*	In the case of acute gouty attacks, a ten (10) day supply (twenty (20) units) of the preferred agent(s) in this subclass will be authorized per ninety (90) days. *Gloperba may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
XANTHINE OXIDASE INHIBITORS		
allopurinol febuxostat tablets	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	

A motion to approve the changes to the Antihyperuricemics class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

v. Antimigraine Agents, Prophylaxis

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIMIGRAINE AGENTS, PROPHYLAXIS CL/PA		
CLASS PA CRITERIA: All agents require a prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents.		
AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY (galcanezumab)* auto-injector, 120 mg syringes	EMGALITY (galcanezumab)* 300 mg syringes NURTEC ODT (rimegepant)** QULIPTA (atogepant)	*Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal. **Nurtec ODT for a diagnosis of **Migraine prophylaxis**: Maximum Quantity limit of 16 tablets per 32 days.

A motion to approve the changes to the Antimigraine Agents, Prophylaxis class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

vi. Antipsychotics, Atypical

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIPSYCHOTICS, ATYPICAL		
CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist. Non-preferred agents require thirty (30) day trials of two (2) preferred agents, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. When determining requests for non-preferred products, any trial utilizing a preferred agent whose dose or duration was limited due to adverse effects or clear lack of efficacy will be considered complete only if the agent was being taken within the FDA-approved therapeutic range.* Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior-authorization while the Medical Director reviews the request. *According to manufacturer dosing recommendations		
SINGLE INGREDIENT		
ABILIFY ASIMTUFII (aripiprazole) CL/PA ABILIFY MAINTENA (aripiprazole)CL/PA aripiprazole tablets ARISTADA (aripiprazole)CL/PA ARISTADA INITIO (aripiprazole)CL/PA asenapine sublingual tablets clozapine INVEGA HAFYERA (paliperidone)*CL/PA INVEGA SUSTENNA (paliperidone)CL/PA INVEGA TRINZA (paliperidone)** CL/PA lurasidone olanzapine olanzapine ODT paliperidone ER PERSERIS (risperidone)CL/PA quetiapine** AP for the 25 mg Tablet Only quetiapine ER RISPERDAL CONSTA (risperidone)CL/PA risperidone solution, tablet, ODT VRAYLAR (capriprazine)**** ziprasidone	ABILIFY MYCITE (aripiprazole) ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) aripiprazole ODT aripiprazole solution CAPLYTA (lumateperone) clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone) LYBALVI (olanzapine and samidorphan)*** NUPLAZID (pimavanserin) **** olanzapine IMCL/PA REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) UZEDY (risperidone) VERSACLOZ (clozapine) VRAYLAR DOSE PAK (capriprazine)***** ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)CL/PA ZYPREXA RELPREVV (olanzapine)	**The following criteria exceptions apply to the specified products:** *Invega Hafyera may only be authorized after four months' treatment with Invega Sustenna or at least a one three-month cycle with Invega Trinza. **Invega Trinza will be authorized after four months' treatment with Invega Sustenna **Quetiapine 25 mg will be authorized: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. **Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.** ***Patient must have had a positive response with olanzapine and experienced clinically significant weight gain (documentation must be provided) which necessitated disruption of treatment. Patient must also have had an intolerance, inadequate treatment response or contraindication to 2 preferred antipsychotics (such as aripiprazole and ziprasidone) which have a lower potential of weight gain prior to Lybalvi approval. ***Prior to initiating Lybalvi, there should be at least a 7-day opioid-free interval from the last use of short-acting opioids, and at least a 14-day opioid-free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.*** ****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine. ***** Vraylar may be authorized for the indication of Bipolar Depression only after failure of a 30-day trial of Latuda and a 30-day trial of either quetiapine OR a combination of olanzapine + fluoxetine. All other indications require class criteria to be followed.

A motion to approve the changes to the Antipsychotics, Atypical class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

vii. Antiretrovirals

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIRETROVIRALS[AP]		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.		
SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide) COMPLERA(emtricitabine/rilpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/ tenofovir df) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) efavirenz/lamivudine/tenofovir JULUCA (dolutegravir/rilpivirine) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir) STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)* SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide) TRIUMEQ PD (abacavir/lamivudine/ dolutegravir)	*Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya.
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) REYATAZ POWDER PACK (atazanavir) ritonavir tablet	fosamprenavir LEXIVA (fosamprenavir) NORVIR (ritonavir) REYATAZ CAPSULE (atazanavir) VIRACEPT (nelfinavir mesylate)	
COMBINATION PRODUCTS – NRTIs		
abacavir/lamivudine lamivudine/zidovudine	abacavir/lamivudine/zidovudine CIMDUO (lamivudine/tenofovir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TEMIXYS (lamivudine/tenofovir) TRIZIVIR (abacavir/lamivudine/zidovudine)	

A motion to approve the changes to the Antiretrovirals class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

viii. Bronchodilators, Beta Agonist

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BRONCHODILATORS, BETA AGONIST[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present.		
INHALERS, SHORT-ACTING		
albuterol HFA PROAIR HFA (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol) XOPENEX HFA (levalbuterol)	

A motion to approve the changes to the Bronchodilators, Beta Agonist class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

ix. COPD Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
COPD AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTICHOLINERGIC[AP]		
ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium nebulizer solution SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium)	LONHALA MAGNAIR (glycopyrrolate) TUDORZA (aclidinium) YUPELRI SOLUTION (revefenacin)	*Spiriva Respimate may be approved for a diagnosis of asthma in patients ≥ 6 years.

A motion to approve the changes to the COPD Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

x. Diabetes Agents, Miscellaneous Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIABETES AGENTS, MISCELLANEOUS AGENTS		
CLASS PA CRITERIA: Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral diabetic agent.		
colesevelam	SYMLIN (pramlintide)* WELCHOL (colesevelam)[AP]	*Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.

A motion to approve the changes to the Diabetes Agents, Miscellaneous Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xi. Intranasal Rhinitis Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
INTRANASAL RHINITIS AGENTS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
ANTIHISTAMINES		
azelastine olopatadine	PATANASE (olopatadine)	Non-preferred agents require thirty (30) day trials of one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid before they will be approved, unless one (1) of the exceptions on the PA form is present.

A motion to approve the changes to the Intranasal Rhinitis Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xii. Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS CL/PA		
CLASS PA CRITERIA: All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.**		
CONSTIPATION		
LINZESS 145 and 290 mcg (linaclotide) lubiprostone capsule (labeler 00254 only) MOVANTIK (naloxegol) TRULANCE (plecanatide)	AMITIZA (lubiprostone) IBSRELA (tenapanor) LINZESS 72 mcg (linaclotide) lubiprostone capsule MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine)	All agents in this subclass require documentation of the current diagnosis. No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90-days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use. **Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply, unless one (1) of the exceptions on the PA form is present:** **Ibsrela** requires thirty (30) day trials of each preferred agent for IBS-C, however for males, a trial of lubiprostone is not required. **Linzess 72mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145mcg dose. **Motegrity** requires a 30-day trial of both lubiprostone and Linzess. **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and lubiprostone.

A motion to approve the changes to the Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xiii. Lipotropics, Other (Non-statins)

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BILE ACID SEQUESTRANTSAP		
cholestyramine colesevelam colestipol tablets	COLESTID (colestipol) colestipol granules QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	*Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.

A motion to approve the changes to the Lipotropics, Other (Non-statins) class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xiv. Multiple Sclerosis Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
MULTIPLE SCLEROSIS AGENTSCL/PA		
CLASS PA CRITERIA: All agents require a prior authorization and documented diagnosis of multiple sclerosis. Preferred oral agents require a ninety (90) day trial of any preferred injectable agent. Non-preferred agents require ninety (90) day trials of two (2) chemically unique preferred agents (in the same sub-class) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	NON-INTERFERONS	
COPAXONE 20 mg (glatiramer) dalfampridine ER** dimethyl fumerate*** fingolimod KESIMPTA INJECTION (ofatumumab)**** teriflunomide	AMPYRA (dalfampridine)** AUBAGIO (teriflunomide)* BAFIERTAM CAPSULES (monomethyl fumarate) COPAXONE 40 mg (glatiramer)***** GILENYA (fingolimod) glatiramer GLATOPA (glatiramer) MAVENCLAD (cladribine) MAYZENT (siponimod)****** PONVORY (ponesimod) TASCENSO ODT TABLETS (fingolimod lauryl sulfate) TECFIDERA (dimethyl fumarate)*** VUMERITY (diroximel) ZEPOSIA (ozanimod)	**In addition to class PA criteria, the following conditions and criteria may also apply:** *Aubagio requires the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 5. Patient is between eighteen (18) up to sixty-five (65) years of age **and** 6. Negative tuberculin skin test before initiation of therapy **Dalfampridine ER and Ampyra require the following additional criteria to be met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment. Initial authorization will be issued for thirty (30) days, with a limit of two (2) tablets per day. If the patient shows improvement, additional quantities may be authorized. ***Dimethyl fumerate and Tecfidera require the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 3. Complete blood count (CBC) annually during therapy. ****Kesimpta may be approved with documentation of treatment failure/inadequate treatment response after a 90-day trial of at least one preferred MS agent. Documentation of a negative Hepatits B test must be provided. *****Copaxone 40mg will only be authorized for documented injection site issues. ******Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS.

A motion to approve the changes to the Multiple Sclerosis Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xv. Ophthalmic Antibiotics

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPHTHALMIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin moxifloxacin** neomycin/bacitracin/polymyxin ofloxacin* polymyxin/trimethoprim tobramycin TOBREX OINT (tobramycin)	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin)* BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) gatifloxacin neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops sulfacetamide ointment TOBREX (tobramycin) VIGAMOX (moxifloxacin) ZYMAXID (gatifloxacin)	*Prior authorization of any fluoroquinolone agent requires three (3) day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone.

A motion to approve the changes to the Ophthalmic Antibiotics class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xvi. Ophthalmic Antibiotic/Steroid Combinations

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BLEPHAMIDE (prednisolone/sulfacetamide) MAXITROL ointment/suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/hydrocortisone neomycin/polymyxin/dexamethasone PRED-G SUSPENSION (prednisolone/gentamicin) sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	BLEPHAMIDE S.O.P. (prednisolone/sulfacetamide) neomycin/polymyxin/hydrocortisone PRED-G OINTMENT (prednisolone/gentamicin)	

A motion to approve the changes to the Ophthalmic Antibiotic/Steroid Combinations class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xvii. Proton Pump Inhibitors

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PROTON PUMP INHIBITORS[AP]		
CLASS PA CRITERIA: Non-preferred agents require sixty (60) day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose*, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist before they will be approved, unless one (1) of the exceptions on the PA form is present.		
omeprazole (Rx) pantoprazole tablets PROTONIX GRANULES (pantoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) dexlansoprazole DR capsule esomeprazole magnesium KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole Rx NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole)** omeprazole/sodium bicarbonate (Rx) pantoprazole granules packet PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)** PRILOSEC Rx (omeprazole) PROTONIX DR TABLETS (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	*Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink. **Prior authorization is required for members nine (9) years of age or older for these agents.

A motion to approve the changes to the Proton Pump Inhibitors class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xviii. Stimulants and Related Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
STIMULANTS AND RELATED AGENTS		
CLASS PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Children under the age of 18 may continue their existing therapy at the discretion of the prescriber.		
NON-AMPHETAMINE		
atomoxetine* clonidine IR clonidine ER CONCERTA (methylphenidate) dexmethylphenidate IR dexmethylphenidate XR guanfacine ER guanfacine IR methylphenidate IR methylphenidate CD capsules methylphenidate ER 24 tablet (generic CONCERTA) methylphenidate ER tablet (generic RITALIN SR) methylphenidate ER CD capsules methylphenidate solution QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) RITALIN LA (methylphenidate)	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) AZSTARYS (dexmethylphenidate/serdexmethylphenidate) COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) INTUNIV (guanfacine extended-release) JORNAY PM (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate chewable tablets methylphenidate ER capsule methylphenidate ER 72 mg tablet methylphenidate ER LA capsule methylphenidate LA capsule methylphenidate patches QELBREE (viloxazine)** RITALIN (methylphenidate) STRATTERA (atomoxetine)*	*Strattera (atomoxetine) is limited to a maximum of 100 mg per day. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the changes to the Stimulants and Related Agents class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

xix. VMAT Inhibitors

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
VMAT INHIBITORS		
CLASS PA CRITERIA: All agents require a prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
AUSTEDO TABLET (deutetrabenazine) AUSTEDO XR (deutetrabenazine) tetrabenazine tablet	INGREZZA CAPSULE (valbenazine) xenazine tablet	

A motion to approve the changes to the VMAT Inhibitors class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

XI. Old Business

XII. Other Business

There was no other business discussed at this time.

XIII. Next Meeting

The next P&T Committee Meeting is scheduled for January 24th, 2024 from 2:00-5:00 PM, Virtual Meeting.

XIV. Adjournment

The committee adjourned the meeting at 3:11 PM.