STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Cynthia Persily, PhD,
Cabinet Secretary

Cynthia Beane, MSW, LCSW
Commissioner

# *Pharmaceutical and Therapeutics Committee*

**October 23, 2024**

Location: In person - Diamond Building, Rooms B10 and B11
350 Capitol Street Charleston, WV 25301
Charleston, WV 25301
(304) 558-1700
Time: Open Session 9:00 AM – 10:30 AM EST
Time: Executive Session 10:30 AM – 1:30 PM EST
Time: Open Session 1:30 PM – 5:00 PM EST

# MINUTES

**Committee Members Present:**
Philip Galapon, MD FAAFP, Chair
Scott Brown, RPh, Vice Chair (virtual)
Chris Terpening, PharmD, PhD
John (JJ)Bernabei, RPh
Charles Rohrbaugh, RPh
Krista Capehart, PharmD
Toni DiChiacchio, DNP
Laura Davisson, MD
Schelley Schliesser, PharmD
Michael Cheshire, DO
Brian Hardman, FNP-C
Mitzi Payne, MD (virtual)
David Gloss, MD (virtual)

**Absent:**

**Bureau for Medical Services Staff Present:**
Vicki Cunningham, R.Ph., Pharmacy Director
Hyla Harvey, MD, BMS Medical Director
Gail Goodnight, RPh, Rebate Program Coordinator
Lori Moles, RPh, Appeals Pharmacist
Bill Hopkins, Operations Manager
Doug Sorvig, EDS Operations Manager

**Contract Staff Present:**
*WVU School of Pharmacy/Rational Drug Therapy Program (RDTP)*
Angela Wowzuk, PharmD, RDTP Director
Priya Shah, PharmD, Drug Utilization Review Coordinator
*Change Healthcare*
Upasna Bhatnagar, MD
Roberta Capp, MD
Joseph Bergondo, PharmD
Paige Clayton, PharmD (virtual)
Eric Sears, PharmD, Gainwell Technology

# I. Call to Order

Philip Galapon, 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 for Medical Services staff, and Change Healthcare staff introduced themselves.

# III. Housekeeping Items/Updates

## A. Approval of the August 28th, Meeting Minutes

The Committee moved to approve the August 28, 2024, 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; the most updated generic utilization data was unavailable and the data from the last available quarter was reported. Overall generic utilization for Q1 2024 was 85.5%

- Joe Bergondo reviewed the PDL Compliance Report; the most updated PDL Compliance Report data was unavailable and the data from the last available quarter was reported. Overall compliance for Q1 2024 was 92.8%

# IV. Drug Class Announcements

recommended that the following classes be extracted:

- Alzheimer's Agents
- Antibiotics, GI & Related Agents
- Antibiotics, Vaginal
- Anticonvulsants
- Antiparkinson's Agents
- Antihyperuricemics
- Antipsychotics, Atypical
- Antiretrovirals, Topicals
- Bladder Relaxant Preparations
- COPD Agents
- Diabetes Agents, DPP-4 Inhibitors
- Diabetes Agents, GLP-1 Agonists
- Diabetes Agents, SGLT2 Inhibitors
- Dry Eye Products
- Erythropoiesis Stimulating Proteins
- Immunosuppressive, Oral
- Macrolides
- Neuropathic Pain
- NSAIDs
- Ophthalmics for Allergic Conjunctivitis
- Opiate Dependence Treatments
- Pancreatic Enzymes
- Pituitary Suppressive Agents, LHRH
- Skeletal Muscle Relaxants
- Stimulants & Related Agents

# V. First Round of Extractions

Additional extractions presented by Committee members:

No Additional Classes were extracted by the committee at the time

# VI. Public Comments

Shantel Gooden - Tremfya
Micheal Beckelic - Suflave
Ryan Wakim - Auvelity
Ronald Depue - Sunosi
Katie Rocawich - Tezspire and Otezla
Timothy Birner - Lybalvi
Melissa Sigley - Airsupra
Saurabh Patel - Ubrelvy, Skyrizi, & Rinvoq
Dominic Mantella - Skytrofa

Robert Low - Bimzelx
Nicole Abolins - Nurtec ODT
Margaret Martin - Caplyta
Brett Stevenson - Zoryve
Brittany Waller - Sublocade
Madaline Shurtleff - Abilify Asimtufii

# VII. Second Round of Extractions

Additional extractions presented by Committee members:

- Antidepressants, Other
- Bronchodilators, Beta Agonists
- Glucocorticoids, Inhaled
- Lipotropics, Other (Non-Statins)

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

- Acne Agents, Topical
- Analgesics, Narcotics - Long Acting (Non-Parenteral)
- Analgesics, Narcotics - Short Acting (Non-Parenteral)
- Androgenic Agents
- Anesthetics, Topical
- Angiotensin Modulators
- Antianginal & Anti-Ischemic
- Antibiotics, Inhaled
- Antibiotics, Topical
- Anticoagulants
- Antidepressants, SSRIs
- Antiemetics
- Antifungals, Oral
- Antifungals, Topical
- Antihemophilia Factor Agents
- Antihypertensives, Sympatholytics
- Antihyperuricemics
- Antimigraine Agents, Prophylaxis
- Antimigraine Agents, Acute
- Antiparasitics, Topical
- Antipsoriatics, Topical
- Antiretrovirals
- Antivirals, Oral
- Beta Blockers
- Bone Resorption Suppression & Related Agents
- BPH Treatments
- Calcium Channel Blockers
- Cephalosporins & Related Antibiotics
- Crohn’s Disease Oral Steroids
- Cytokine & Cam Antagonists

- Diabetes Agents, Biguanides
- Diabetes Agents, Insulins & Related Agents
- Diabetes Agents, Meglitinides
- Diabetes Agents, Miscellaneous Agents
- Diabetes Agents, TZDs
- Epinephrine, Self-Injected
- Fluoroquinolones, Oral
- Growth Hormones
- H. Pylori Treatment
- Heart Failure Treatments
- Hepatitis B Treatments
- Hepatitis C Treatments
- Hyperparathyroid Agents
- Hyperphosphatemia Agents
- Hypoglycemia Treatments
- Immunomodulators, Atopic Dermatitis
- Immunomodulators, Genital Warts & Actinic Keratosis Agents
- Intranasal Rhinitis Agents
- Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents
- Laxatives and Cathartics
- Leukotriene Modifiers
- Lipotropics, Statins
- MABS, Anti-IL/IgE
- Multiple Sclerosis Agents
- Ophthalmic Antibiotics
- Ophthalmic Antibiotics/Steroid Combinations
- Ophthalmics, Anti-Inflammatories
- Ophthalmics, Glaucoma Agents
- Oral and Topical Contraceptives
- Otic Antibiotics
- PAH Agent
- Phosphate Binders
- Platelet Aggregation Inhibitors
- Potassium Removing Agents
- Progestational Agents
- Progestins for Cachexia
- Proton Pump Inhibitors
- Sedative Hypnotics
- Steroids, Topical
- Tetracyclines
- Ulcerative Colitis Agents
- Vaginal Ring Contraceptives
- Vasodilators, Coronary
- VMAT Inhibitors

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 10:21 AM for Executive Session and lunch until afternoon session.

# X. New Business

## A. New Drug Reviews

### i. Alzheimer's Agents

| ALZHEIMER'S AGENTS[AP] | | |
|---|---|---|
| CLASS PA CRITERIA: 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.<br><br>Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease. | | |
| **CHOLINESTERASE INHIBITORS** | | |
| donepezil 5 and 10 mg<br>donepezil ODT<br>EXELON PATCH (rivastigmine)<br>galantamine tablet<br>galantamine ER capsule<br>RAZADYNE ER (galantamine)<br>rivastigmine capsule | ADLARITY PATCH (donepezil)<br>ARICEPT (donepezil)<br>donepezil 23 mg*<br>galantamine solution<br>rivstigmine patch | *Donepezil 23 mg tablets will be authorized if the following criteria are met:<br>1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and**<br>2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month. |
| **NMDA RECEPTOR ANTAGONIST** | | |
| memantine<br>memantine ER | memantine solution<br>NAMENDA (memantine) solution, titration pak<br>NAMENDA XR (memantine)* | *Namenda XR requires ninety (90) days of compliant therapy with Namenda. |

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

### ii. Antibiotics, GI & Related Agents

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIBIOTICS, GI & RELATED AGENTS** | | |
| CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| metronidazole tablet<br>neomycin<br>tinidazole<br>VANCOCIN (vancomycin)<br>vancomycin capsules<br>XIFAXAN 200 MG (rifaximin)* | AEMCOLO (rifamycin) tablet**<br>DIFICID (fidaxomicin)*<br>FIRVANQ (vancomycin) solution<br>FLAGYL (metronidazole)<br>LIKMEZ (metronidazole)***<br>metronidazole capsule<br>paromomycin<br>vancomycin solution<br>VOWST (fecal microbiota spores) capsules*<br>XIFAXAN 550 MG (rifaximin)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Aemcolo may be authorized after a trial of Xifaxan 200mg tablets.<br><br>***Likmez may be authorized for those who are unable to ingest solid dosage forms of metronidazole due to documented oral motor difficulties or dysphagia. |

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

### iii. Antibiotics, Vaginal

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| CLEOCIN OVULE (clindamycin)<br>CLEOCIN CREAM (clindamycin)<br>metronidazole gel | clindamycin cream<br>CLINDESSE (clindamycin)<br>METROGEL (metronidazole)<br>NUVESSA (metronidazole)<br>VANDAZOLE (metronidazole)<br>SOLOSEC (secnidazole)<br>XACIATO GEL (clindamycin) | |

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

## iv. 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.<br><br>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.<br><br>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** | | |
| topiramate IR sprinkle caps<br>topiramate ER sprinkle caps (generic Qudexy)<br>TRILEPTAL SUSPENSION (oxcarbazepine)<br>valproic acid<br>zonisamide | OXTELLAR XR (oxcarbazepine)<br>rufinamide oral suspension, tablets<br>SABRIL (vigabatrin)<br>SPRITAM (levetiracetam)<br>TEGRETOL TABLETS (carbamazepine)<br>tiagabine<br>TOPAMAX SPRINKLE CAPS (topiramate)<br>TOPAMAX TABLETS (topiramate)<br>TRILEPTAL TABLETS (oxcarbazepine)<br>TROKENDI XR (topiramate)***<br>vigabatrin tablet/powder pack<br>VIGAFYDE (vigabatrin solution)<br>VIMPAT (lacosamide) tablets, solution<br>XCOPRI (cenobamate)<br>ZONISADE (zonisamide) suspension****** | 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.<br><br>*******Motpoly XR capsules may be authorized after a medical reason beyond convenience or enhanced compliance, as to why the clinical need cannot be met by using a preferred lacosamide agent, is provided. |

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.

## v. Antidepressants, Others

| **ANTIDEPRESSANTS, OTHER** | | |
|---|---|---|
| **CLASS PA CRITERIA:** See below for individual subclass criteria. | | |
| **MAOIs[AP]** | | |
| | MARPLAN (isocarboxazid)<br>NARDIL (phenelzine)<br>phenelzine<br>tranylcypromine | Patients stabilized on MAOI agents will be grandfathered. |
| **SNRIS[AP]** | | |
| desvenlafaxine succinate ER (generic Pristiq)<br>duloxetine capsules<br>venlafaxine ER capsules<br>venlafaxine IR tablets | CYMBALTA (duloxetine)<br>desvenlafaxine fumarate ER<br>EFFEXOR XR (venlafaxine)<br>FETZIMA (levomilnacipran)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine ER tablets | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this subclass **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **SECOND GENERATION NON-SSRI, OTHER[AP]** | | |

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.

The committee made a motion to recommend that AUVELITY be brought to the DUR board for criteria review at the next meeting. The motion was seconded and all members were in favor.

## vi. Antiparkinson's Agents

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |

| ANTIPARKINSON'S AGENTS | | |
|---|---|---|
| CLASS PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding sub-class, before a non-preferred agent will be authorized. | | |
| OTHER ANTIPARKINSON'S AGENTS | | |
| amantadine*AP<br>carbidopa/levodopa<br>levodopa/carbidopa/entacapone<br>selegiline | AZILECT (rasagiline)<br>Carbidopa<br>CREXONT (carbidopa/levodopa)<br>GOCOVRI ER (amantadine)<br>INBRIJA (levodopa)<br>levodopa/carbidopa ODT<br>LODOSYN (carbidopa)<br>NOURIANZ (istradefylline)<br>OSMOLEX ER (amantadine)<br>PARLODEL (bromocriptine)<br>rasagiline | *Amantadine will not be authorized for the treatment or prophylaxis of influenza. |

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

## vii. 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.<br><br>Non-preferred agents require thirty (30) day trials of two (2) preferred Atypical Antipsychotics approved or medically accepted for the member's diagnosis or indication, 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. *<br><br>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.<br>*According to manufacturer dosing recommendations | | |
| SINGLE INGREDIENT | | |
| ARISTADA (aripiprazole)CL/PA<br>ARISTADA INITIO (aripiprazole)CL/PA<br>asenapine sublingual tablets<br>clozapine<br>INVEGA HAFYERA (paliperidone)*CL/PA<br>INVEGA SUSTENNA (paliperidone)CL/PA<br>INVEGA TRINZA (paliperidone)** CL/PA<br>lurasidone<br>olanzapine<br>olanzapine ODT<br>paliperidone ER<br>PERSERIS (risperidone)CL/PA<br>quetiapine** AP for the 25 mg Tablet Only<br>quetiapine ER<br>RYKINDO (risperidone)*****<br>risperidone solution, tablet, ODT<br>VRAYLAR (cariprazine)*****<br>ziprasidone | aripiprazole solution<br>CAPLYTA (lumateperone)<br>clozapine ODT<br>CLOZARIL (clozapine)<br>FANAPT (iloperidone)<br>GEODON (ziprasidone)<br>GEODON IM (ziprasidone)<br>INVEGA ER (paliperidone)<br>LATUDA (lurasidone)<br>LYBALVI (olanzapine and samidorphan)***<br>NUPLAZID (pimavanserin) ****<br>olanzapine IMCL/PA<br>REXULTI (brexipiprazole)<br>RISPERDAL (risperidone)<br>RISPERDAL CONSTA (risperidone)CL/PA<br>SAPHRIS (asenapine)<br>SECUADO (asenapine)<br>SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine)<br>UZEDY (risperidone) | *Invega Hafyera may only be authorized after four months' treatment with Invega Sustenna or at least a one three-month cycle with Invega Trinza.<br><br>**Invega Trinza will be authorized after four months' treatment with Invega Sustenna<br><br>**Quetiapine 25 mg will be authorized:<br>1. For a diagnosis of schizophrenia **or**<br>2. For a diagnosis of bipolar disorder **or**<br>3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.<br>**Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.**<br><br>***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 |

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

## viii. Antivirals, Topical

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| ANTIVIRALS, TOPICALAP | | |
| CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of the preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| acyclovir ointment<br>ZOVIRAX CREAM (acyclovir)<br>DENAVIR (penciclovir) | acyclovir cream<br>docosanol cream<br>penciclovir cream<br>ZOVIRAX OINTMENT (acyclovir) | |

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

## ix. Bladder Relaxant Preparations

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BLADDER RELAXANT PREPARATIONS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present | | |
| DETROL LA (tolterodine)<br>fesoterodine ER<br>GELNIQUE (oxybutynin)<br>MYRBETRIQ TABLET (mirabegron)<br>oxybutynin IR<br>oxybutynin ER<br>OXYTROL (oxybutynin)<br>solifenacin | darifenacin ER<br>DETROL (tolterodine)<br>DITROPAN XL (oxybutynin)<br>ENABLEX (darifenacin)<br>flavoxate<br>GEMTESA (vibegron)<br>mirabegron ER<br>MYRBETRIQ SUSPENSION (mirabegron)<br>tolterodine<br>tolterodine ER<br>TOVIAZ (fesoterodine)<br>trospium<br>trospium ER<br>VESICARE (solifenacin)<br>VESICARE LS (solifenacin) | |

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

## x. Bronchodilators, Beta Agonist

| **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. | | |
| **INHALATION SOLUTION** | | |
| albuterol | arformoterol<br>BROVANA (arformoterol)<br>formoterol<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>XOPENEX (levalbuterol)* | *Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease. |
| **INHALERS, LONG-ACTING** | | |
| SEREVENT (salmeterol) | STRIVERDI RESPIMAT (olodaterol) | |
| **INHALERS, SHORT-ACTING** | | |
| albuterol HFA<br>PROAIR HFA (albuterol)<br>PROAIR RESPICLICK (albuterol)<br>PROVENTIL HFA (albuterol)<br>VENTOLIN HFA (albuterol) | PROAIR DIGIHALER (albuterol)<br>XOPENEX HFA (levalbuterol) | *Airsupra can be found in Glucocorticoids, Inhaled section of PDL. |

Category was extracted in the second round of extractions, a note will be added to PDL stating Airsupra can be found in the Glucocorticoids, Inhaled category. No vote necessary.

## xi. COPD Agents

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **COPD AGENTS**<br>**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. | | |
| **PHOSPHODIESTERASE INHIBITORS** | | |
| | DALIRESP (roflumilast)*<br>OHTUVAYRE (ensifentrine) | *Daliresp will be authorized if the following criteria are met:<br>1. Patient is forty (40) years of age or older **and**<br>2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and**<br>3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and**<br>4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and**<br>5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin) |

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.

## xii. Diabetes Agents, DPP-4 Inhibitors

**DIABETES AGENTS, DPP-4 INHIBITORS**
**CLASS PA CRITERIA:** Non-preferred agents are available only on appeal. **NOTE:** DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| JANUMET (sitagliptin/metformin)<br>JANUMET XR (sitagliptin/metformin)<br>JANUVIA (sitagliptin)<br>JENTADUETO (linagliptin/metformin)<br>TRADJENTA (linagliptin) | alogliptin<br>alogliptin/metformin<br>alogliptin/pioglitazone<br>JENTADUETO XR (linagliptin/metformin)<br>KAZANO (alogliptin/metformin)<br>KOMBIGLYZE XR (saxagliptin/metformin)<br>NESINA (alogliptin)<br>ONGLYZA (saxagliptin)<br>OSENI (alogliptin/pioglitazone)<br>sitagliptin<br>sitagliptin/metformin<br>ZITUVIO (sitagliptin) | |

A motion to approve the changes to the Diabetes Agents, DPP-4 Inhibitors class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

## xiii. Diabetes Agents, GLP-1 Agonists

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **DIABETES AGENTS, GLP-1 AGONISTS**CL/PA | | |
| **Preferred agents may be authorized with a diagnosis of Diabetes Mellitus Type II.**<br><br>**CLASS PA CRITERIA:** Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:<br><br>1) Diagnosis of Diabetes Mellitus Type II.<br>2) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.<br>3) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.<br>4) Documentation demonstrating treatment failure with all unique preferred agents in the same class.<br><br>Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement). | | |
| **NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.** | | |
| OZEMPIC (semaglutide)<br>TRULICITY (dulaglutide)<br>VICTOZA (liraglutide) | ADLYXIN (lixisenatide)<br>BYDUREON BCISE (exenatide)<br>BYETTA (exenatide)<br>liraglutide<br>MOUNJARO (tirzepatide)<br>RYBELSUS (semaglutide) | |

A motion to approve the changes to the Diabetes Agents, GLP-1 Agonists class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

## xiv. Diabetes Agents, SGLT2 Inhibitors

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **DIABETES AGENTS, SGLT2 INHIBITORS** | | |
| | **SGLT2 INHIBITORS** | |
| FARXIGA (dapagliflozin)<br>JARDIANCE (empagliflozin) | dapagliflozin<br>INVOKANA (canagliflozin)<br>STEGLATRO (ertugliflozin) | |
| | **SGLT2 COMBINATIONS** | |
| SYNJARDY (empagliflozin/metformin)<br>XIGDUO XR (dapagliflozin/metformin) | dapagliflozin/metformin<br>GLYXAMBI (empagliflozin/linagliptin)<br>INVOKAMET (canagliflozin/metformin)<br>INVOKAMET XR (canagliflozin/metformin) | |

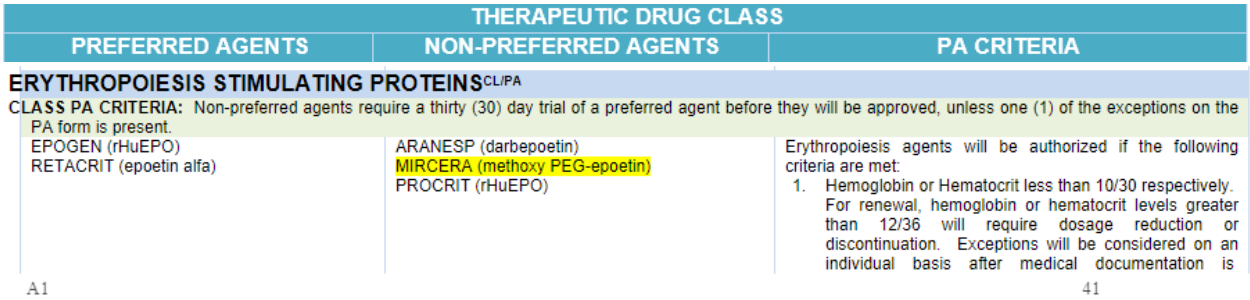
A motion to approve the changes to the Diabetes Agents, SGLT2 Inhibitors class as recommended was made; the motion was seconded. All members were in favor and the motion was approved.

## xv. Dry Eye Products

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **DRY EYE PRODUCTS**CL/PA | | |
| **CLASS PA CRITERIA: All agents require a prior authorization.** Non-preferred agents require a 60-day trial of the preferred agent(s) | | |
| RESTASIS (cyclosporine)<br>XIIDRA (lifitegrast) | CEQUA (cyclosporine)<br>cyclosporine droperette<br>RESTASIS MULTIDOSE (cyclosporine)*<br>TYRVAYA (varenicline)<br>VEVYE (cyclosporine) | **All agents must meet the following prior-authorization criteria:**<br>1.) Patient must be sixteen (16) years of age or greater; **AND**<br>2.) Prior Authorization must be requested by an |

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

## xvi. Erythropoiesis Stimulating Proteins



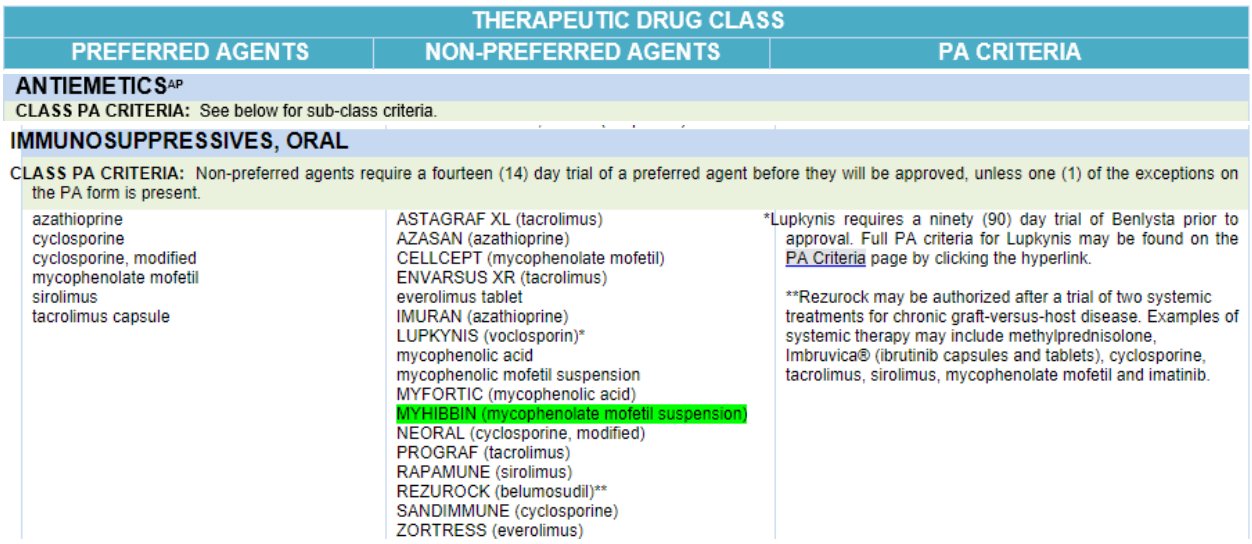
| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| **ERYTHROPOIESIS STIMULATING PROTEINS** CL/PA | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| EPOGEN (rHuEPO)<br>RETACRIT (epoetin alfa) | ARANESP (darbepoetin)<br>MIRCERA (methoxy PEG-epoetin)<br>PROCRIT (rHuEPO) | Erythropoiesis agents will be authorized if the following criteria are met:<br>1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is |
| A1 | | 41 |

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

## xvii. Glucocorticoids, Inhaled

Category was extracted in the second round of extractions, a note was added to the Bronchodilators, Beta Agonist category stating that Airsupra can be found in Glucocorticoids, Inhaled category. No vote necessary.

## xviii. Immunosuppressive, Oral



| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| **ANTIEMETICS** AP | | |
| **CLASS PA CRITERIA:** See below for sub-class criteria. | | |
| **IMMUNOSUPPRESSIVES, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| azathioprine<br>cyclosporine<br>cyclosporine, modified<br>mycophenolate mofetil<br>sirolimus<br>tacrolimus capsule | ASTAGRAF XL (tacrolimus)<br>AZASAN (azathioprine)<br>CELLCEPT (mycophenolate mofetil)<br>ENVARSUS XR (tacrolimus)<br>everolimus tablet<br>IMURAN (azathioprine)<br>LUPKYNIS (voclosporin)*<br>mycophenolic acid<br>mycophenolic mofetil suspension<br>MYFORTIC (mycophenolic acid)<br>MYHIBBIN (mycophenolate mofetil suspension)<br>NEORAL (cyclosporine, modified)<br>PROGRAF (tacrolimus)<br>RAPAMUNE (sirolimus)<br>REZUROCK (belumosudil)**<br>SANDIMMUNE (cyclosporine)<br>ZORTRESS (everolimus) | *Lupkynis requires a ninety (90) day trial of Benlysta prior to approval. Full PA criteria for Lupkynis may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Rezurock may be authorized after a trial of two systemic treatments for chronic graft-versus-host disease. Examples of systemic therapy may include methylprednisolone, Imbruvica® (ibrutinib capsules and tablets), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil and imatinib. |

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

## xix. Lipotropics, Other (Non-Statins)

Category was extracted in the second round of extractions, a recommendation was made to bring Nexletol and Nexlizet to the DUR Board meeting in November. No vote necessary.

## xx. Macrolides

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **MACROLIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **MACROLIDES** | | |
| azithromycin tablet, suspension, packet<br>clarithromycin tablets | clarithromycin ER<br>clarithromycin suspension<br>E.E.S. (erythromycin ethylsuccinate)<br>ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin tablet/capsule DR<br>erythromycin tablet<br>erythromycin estolate<br>ZITHROMAX (azithromycin) | |

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

## xxi. Neuropathic Pain

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NEUROPATHIC PAIN** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| capsaicin OTC<br>duloxetine<br>gabapentin<br>lidocaine patch 5%<br>LYRICA CAPSULE/SOLUTION (pregabalin)<br>pregabalin capsule | CYMBALTA (duloxetine)<br>DRIZALMA SPRINKLE (duloxetine)*<br>gabapentin ER (generic Gralise)<br>GRALISE (gabapentin)**<br>HORIZANT (gabapentin)***<br>lidocaine patch 4%<br>LIDODERM (lidocaine)<br>LYRICA CR (pregabalin)****<br>NEURONTIN (gabapentin)<br>pregabalin ER tablet (generic Lyrica CR)<br>pregabalin solution<br>SAVELLA (milnacipran)****<br>ZTLIDO PATCH (lidocaine) | *Drizalma SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.<br><br>**Gralise will be authorized only if the following criteria are met:<br>1. Diagnosis of post herpetic neuralgia **and**<br>2. Trial of a tricyclic antidepressant for a least thirty (30) days **and**<br>3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and**<br>4. Request is for once daily dosing with 1800 mg maximum daily dosage. |

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

## xxii. NSAIDS

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NSAIDS**[AP] | | |
| **CLASS PA CRITERIA:** See below for sub-class PA criteria. | | |
| **NON-SELECTIVE** | | |
| diclofenac (IR, SR)<br>flurbiprofen<br>ibuprofen tablet, capsule, suspension, chewable (Rx and OTC)<br>indomethacin | DAYPRO (oxaprozin)<br>diclofenac potassium capsule, tablets<br>diflunisal<br>DUEXIS (famotidine/ibuprofen)<br>EC-naproxen DR tablet<br>etodolac IR | 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. |

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

## xxiii. Ophthalmics for Allergic Conjunctivitis

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ALAWAY (ketotifen)<br>ALREX (loteprednol)<br>azelastine<br>BEPREVE (bepotastine)<br>cromolyn<br>EYSUVIS (loteprednol)<br>ketotifen<br>ZADITOR OTC (ketotifen) | ALOCRIL (nedocromil)<br>ALOMIDE (lodoxamide)<br>bepotastine<br>epinastine<br>loteprednol<br>LUMIFY (brimonidine)<br>olopatadine 0.1%<br>olopatadine 0.2%<br>PATADAY ONCE AND TWICE DAILY (olopatadine)<br>ZERVIATE (cetirizine) | |

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

## xxiv. 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.<br><br>*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]<br>buprenorphine/naloxone tablets*<br>KLOXXADO SPRAY (naloxone)<br>naloxone vial/syringe/cartridge<br>naloxone nasal spray (OTC) | BUNAVAIL (buprenorphine/naloxone)*<br>buprenorphine tablets*<br>buprenorphine/naloxone film*<br>lofexidine<br>LUCEMYRA (lofexidine)** | ** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |

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

## xxv. Oral and Topical Contraceptives

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ORAL AND TOPICAL CONTRACEPTIVES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial with three (3) preferred contraceptive products including a trial with a preferred product with the same route of administration as the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ENSKYCE | GEMMILY | |
| ERRIN | HAILEY | |
| ESTARYLLA | HAILEY 24 FE | |
| FALMINA | ICLEVIA 3MO | |
| HAILEY FE | INTROVALE 3MO | |
| HEATHER | JAIMIESS 3MO | |
| HER STYLE | JASMIEL | |
| INCASSIA | JOYEAUX | |
| ISIBLOOM | JUNEL | |
| JENCYCLA | JUNEL FE 24 | |
| JOLESSA 3MO | KAITLIB FE | |
| JULEBER | KALLIGA | |
| JUNEL FE | KELNOR 1-35 | |
| KARIVA | KELNOR 1-50 | |
| KURVELO | LARIN | |
| LARIN FE | LARIN 24 FE | |
| LESSINA | LAYOLIS FE CHEW TAB | |
| LEVONEST | LEENA | |
| levonorgestrel | levonorgestrel-ethinyl estradiol (generic Jolessa) 3 MO | |
| levonorgestrel-ethinyl estradiol | LEVORA-28 | |
| levonorgestrel-ethinyl estradiol (generic Loseasonique) 3MO | LOESTRIN | |
| levonorgestrel-ethinyl estradiol-ferrous bisglycinate | LOESTRIN FE | |
| LILLOW | LOJAIMIESS 3MO | |
| LO LOESTRIN FE | LOSEASONIQUE 3MO | |
| LORYNA | LOW-OGESTREL | |
| | LO-ZUMANDIMINE | |
| TRI-LO-MILI | XULANE PATCH | |
| ZAFEMY PATCH | | |
| ZOVIA 1-35 | | |
| ZOVIA 1-35E | | |
| ZUMANDIMINE | | |

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

## xxvi. Pancreatic Enzymes

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PANCREATIC ENZYMES**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. - For members with cystic fibrosis, a trial of a preferred agent will not be required. | | |
| CREON | PANCREAZE | |
| PERTZYE | VIOKACE | |
| ZENPEP | | |

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

## xxvii. Pituitary Suppressive Agents, LHRH

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PITUITARY SUPPRESSIVE AGENTS, LHRH**CL/PA | | |
| **CLASS PA CRITERIA:** Unless otherwise noted, non-preferred agents are available only on appeal. | | |
| FENSOLVI SYRINGE (leuprolide acetate)<br>LUPANETA (leuprolide)<br>LUPRON DEPOT KIT (leuprolide)<br>LUPRON DEPOT-PED KIT (leuprolide)<br>MYFEMBREE (relugolix, estradiol, norethindrone)*<br>ORILISSA (elagolix)*<br>SYNAREL (nafarelin)<br>TRELSTAR (triptorelin) | leuprolide<br>ORIAHNN (elagolix-estradiol-norethindrone)*<br>SUPPRELIN LA KIT (histrelin) | *Full PA criteria for Myfembree, Orilissa and Oriahnn may be found on the PA Criteria page by clicking the hyperlink. In addition, Orilissa and Oriahnn may only be approved if there is a documented side effect, allergy, or treatment failure with Myfembree. Use of GnRH receptor antagonists will be limited to 24 months. |

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

## xxviii. Skeletal Muscle Relaxants

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SKELETAL MUSCLE RELAXANTS**AP | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| **MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY** | | |
| baclofen<br>tizanidine tablets | baclofen solution*, suspension<br>DANTRIUM (dantrolene)<br>dantrolene<br>FLEQSUVY (baclofen)*<br>LYVISPAH GRANULE PACKET (baclofen)*<br>tizanidine capsules<br>ZANAFLEX (tizanidine) | 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.<br><br>*Oral baclofen solution, Fleqsuvy (baclofen suspension) and Lyvispah granules may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. In addition, Fleqsuvy and Lyvispah may only be authorized if there is a documented intolerance to oral baclofen solution. |

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

## xxix. Stimulants & Related Agents

**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.

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NARCOLEPTIC AGENTS** | | |
| armodafinil*<br>modafinil*<br>NUVIGIL (armodafinil)*<br>PROVIGIL (modafinil)* | sodium oxybate**<br>SUNOSI (solriamfetol)*<br>WAKIX (pitolisant)***<br>XYREM (sodium oxybate)**<br>XYWAV (calcium, magnesium, potassium, and sodium oxybate)** | *Full PA criteria for narcoleptic agents may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Full PA criteria for Xyrem/Xywav may be found on the PA Criteria page by clicking the hyperlink.<br><br>***Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi. |

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

# II. Old Business

# III. Other Business

There was no other business discussed at this time.

# IV. Next Meeting

The next P&T Committee Meeting is scheduled for January 22, 2025 from 2:00PM-5:00PM, Virtual Meeting.

# V. Adjournment