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

Cynthia A. Persily, Ph.D.
Cabinet Secretary

Cynthia Beane
Commissioner

Pharmaceutical and Therapeutics Committee

January 24, 2024

Location: Webex only
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:
Philip Galapon, MD FAAFP, Chair
Chris Terpening, PharmD, PhD, Vice- Chair
Scott Brown, RPh
David Gloss, MD
John Bernabei, RPh (JJ)
Charles Rohrbaugh, RPh
Krista Capehart, PharmD
Toni DiChiacchio, DNP
Laura Davisson, MD
Michael Cheshire, DO
Brian Hardman, FNP-C
Shelley Schliesser, PharmD

Absent:
Mitzi Payne, MD

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

Contract Staff Present:
Change Healthcare
Joseph Bergondo, PharmD
Paige Clayton, PharmD
Jacqueline Hedlund, MD
Chris Dolfi, PharmD

Other Contract / State Staff Present:
Angela Wowzuk, PharmD, RDTP Director
Eric Sears, RPH, Gainwell Technologies

I. Call to Order

Philip Galapon, Chairman, called the meeting to order at 3:37 PM.

II. Welcome and Introductions

Philip Galapon welcomed all present to the committee meeting. Committee members, Bureau of Medical Services staff, and Change Healthcare staff introduced themselves. Dr. Galapon welcomed the three new members of the Committee: Dr. Michael Cheshire, Shelley Schleisser, PharmD, and Brian Hardman,FNP.

III. Housekeeping Items / Updates

A. Approval of the October 25th Meeting Minutes

The Committee moved to approve the October 25th, 2023, Meeting Minutes, with the addition of the committee's discussion surrounding Anti-Obesity Class coverage on the statewide PDL. All were in favor of approval with the 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 Q4 2023 was 85.5%.
- Joe Bergondo reviewed the PDL Compliance Report; overall compliance for Q4 2023 was 92.8%.

IV. Public Comments

Public comments for this meeting were only accepted in writing. Written statements were provided to State and Committee members for review prior to this meeting and are available to the public on the State's website.

V. New Business

A. New Drug Reviews

i. 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.		
FIRVANQ (vancomycin) metronidazole tablet neomycin tinidazole XIFAXAN 200 MG (rifaximin)*	AEMCOLO (rifamycin) tablet** DIFICID (fidaxomicin)* FLAGYL (metronidazole) LIKMEZ (metronidazole) metronidazole capsule paromomycin VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota spores) capsules* XIFAXAN 550 MG (rifaximin)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Aemcolo may be authorized after a trial of Xifaxan 200mg tablets.

Scott Brown made a motion to approve the changes to the Antibiotics, GI & Related Agents class as recommended; the motion was seconded by Charlie Rohrbaugh. All members were in favor and the motion was approved.

ii. 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) 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)	*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	KEPPRA XR (levetiracetam) LAMICTAL ODT (lamotrigine) lamotrigine dose pack lamotrigine ER methsuximide MOTPOLY XR (lacosamide) 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.

Charlie Rohrbaugh made a motion to approve the changes to the Anticonvulsants class; the motion was seconded by Scott Brown. All members were in favor and the motion was approved.

iii. 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 (cariprazine)***** 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) RYKINDO (risperidone) SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) UZEDY (risperidone) VERSACLOZ (clozapine) 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 major depressive disorder only after a 30-day trial and failure of 2 two preferred antidepressants. For all other indications a 30 day trial and failure of one preferred antipsychotic is required.

Scott Brown made a motion to approve the changes to the Antipsychotics, Atypical class as recommended; the motion was seconded by Krista Capehart. All members were in favor and the motion was approved.

iv. Cytokine & CAM Antagonists

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CYTOKINE & CAM ANTAGONISTS[CL/PA]		
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)	ABRILADA (adalimumab-afzb) adalimumab-fkjp AMJEVITA (adalimumab-atto) 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) BIMZELX (bimekizumab-bkzx) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) LITFULO (ritlecitinib tosylate) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) STELARA subcutaneous (ustekinumab) TREMFYA (guselkumab) VELSIPITY (estrasimod) 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.

Scott Brown made a motion to approve the changes to the Cytokine & CAM Antagonists class as recommended; the motion was seconded by Krista Capehart. All members were in favor and the motion was approved.

v. Glucocorticoids, Inhaled

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GLUCOCORTICOIDS, INHALED[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically unique preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) AIRSUPRA (albuterol/budesonide) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol fluticasone/salmeterol fluticasone/vilanterol WIXELA (fluticasone/salmeterol)	

Scott Brown made a motion to approve the changes to the Glucocorticoids, Inhaled as recommended; the motion was seconded by David Gloss. All members were in favor and the motion was approved.

vi. 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) XDEMY (lotilaner) 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.

Charlie Rohrbaugh made a motion to approve the changes to the Ophthalmic Antibiotics class as recommended; the motion was seconded by Krista Capehart. All members were in favor and the motion was approved.

vii. Sedative Hypnotics

Igalmi (dexmedetomidine) was presented to the P&T committee as a new drug in the Sedative hypnotics class. Scott Brown made a motion to approve the changes to the Sedative Hypnotics class as recommended; the motion was seconded by Krista Capehart. All members were in favor and the motion was approved.

Since Igalmi (dexmedtomidine) is recommended for administration by a medical provider, it was decided that it would not be added to the WV PDL and would remain unmanaged at this time.

VI. Old Business

VII. Other Business

There was no other business discussed at this time.

VIII. Next Meeting

The next P&T Committee Meeting is scheduled for April 24th, 2023, from 3:30-5:00 PM and will be a virtual meeting.

IX. Adjournment

The committee adjourned the meeting at 4:12 PM.