STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Cynthia E. Beane
Commissioner

Pharmaceutical and Therapeutics Committee

OCTOBER 26, 2022

Location: WebEx only
Time: Open Session 9:00 AM – 10:00 AM and 2:00 PM – 5:00 PM
Time: Executive Session 10:00 AM – 12:00 PM
Charleston, WV 25301
(304) 558-1700

MINUTES

Committee Members Present:
Tom Kines, RPh, Chair
Chris Terpening, PharmD, PhD, Vice-Chair
Philip Galapon, MD FAAFP
David Gloss, MD
Bradley Henry, MD
John Bernabei, RPh (JJ)
Charles Rohrbaugh, RPh
Scott Brown, RPh
Krista Capehart, PharmD
Mary Payne, MD
Laura Davisson, MD
Toni DiChiacchio, DNP

Absent:

Division of Medicaid Staff Present:
Gail Goodnight, RPH Rebate Manager
Bill Hopkins, Operations Manager
Lori Moles, RPH Appeals Pharmacist
Priya Shah, PharmD, DUR Coordinator
Doug Sorvig, Data Analyst
Brian Thompson, PharmD, MS, Director

Contract Staff Present:
Change Healthcare
Ryan Fell, PharmD
Joseph Bergondo, PharmD
Chris Dolfi, PharmD
Jeffrey Barkin, MD

Other Contract / State Staff Present:

I. Call to Order

Tom Kines, Chairman, called the meeting to order at 9:00 AM.

II. Welcome and Introductions

Tom Kines, 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, 24, 2022 Minutes

The Committee moved to approve the August 24, 2022 meeting minutes. All were in favor with no objections or revisions.

B. PDL Compliance / Generic Percent Report Updates

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

- Joseph Bergondo reviewed the Generic Percent Report; overall generic utilization for Q3 2022 was 85.3 %

- Joseph Bergondo reviewed the PDL Compliance Report; overall compliance for Q3 2022 was 92.8%

IV. Drug Class Announcements

Change Healthcare recommended that the following classes be extracted:

- Alzheimer's Agents
- Analgesics, Narcotic Short Acting (Non-parental)
- Angiotensin Modulators
- Antianginal & Anti-Ischemic
- Antibiotics, Inhaled
- Antibiotics, Vaginal
- Anticoagulants
- Antidepressants, Other
- Antifungals, Oral
- Antifungals, Topical
- Antimigraine Agents, Acute
- Antiparkinson's Agents
- Antipsoriatics, Topical
- Antiretrovirals
- Bladder Relaxant Preparations
- Calcium Channel Blockers
- Cephalosporins & Related Antibiotics
- Cytokine & Cam Antagonists
- Glucocorticoids, Inhaled

- Hyperparathyroid Agents
- Hypoglycemics, Insulins & Related Agents
- Immunomodulators, Genital Warts and Actinic Keratosis Agents
- Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents
- Multiple Sclerosis Agents
- Neuropathic Pain
- NSAIDs
- Ophthalmics for Allergic Conjunctivitis
- Oral and Topical Contraceptives
- PAH Agents – Prostacyclins
- Phosphate Binders
- Pituitary Suppressive Agents, LHRH
- Proton Pump Inhibitors
- Skeletal Muscle Relaxants
- Stimulants & Related Agents
- Tetracyclines

V. First Round of Extractions

Additional extractions presented by Committee members:

- COPD Agents
- Hypoglycemics, GLP-1 Agonists
- Lipotropics, Other (Non-Statins)
- Progestational Agents
- Sedative Hypnotics

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.

VI. Second Round of Extractions

Additional extractions presented by Committee members:

- No additional rounds of extractions were recommended by committee members

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

- Acne Agents, Topical
- Analgesics, Narcotic Long Acting (Non-Parental)
- Androgenic Agents
- Anesthetics, Topical
- Antibiotics, GI & Related Agents
- Antibiotics, Topical
- Antidepressants, SSRIs
- Antiemetics

- Antihemophilia Factor Agents
- Antihypertensives, Sympatholytics
- Antihyperuricemics
- Antimigraine Agents, Prophylaxis
- Antiparasitics, Topical
- Antipsychotics, Atypical
- Antivirals, Oral
- Antivirals, Topical
- Beta Blockers
- Bone Resorption Suppression & Related Agents
- BPH Treatments
- Bronchodilators, Beta Agonists
- Crohns Disease Oral Steroids
- Dry Eye Products
- Epinephrine, Self-Injected
- Erythropoiesis Stimulating Proteins
- Fluoroquinolones (Oral)
- Guanylate Cyclase Stimulators
- Growth Hormones
- H. Pylori Treatment
- Hepatitis B Treatments
- Hepatitis C Treatments
- Hypoglycemia Treatments
- Hypoglycemics, Biguanides
- Hypoglycemics, DPP-4 Inhibitors
- Hypoglycemics, Meglitinides
- Hypoglycemics, Miscellaneous Agents
- Hypoglycemics, Sodium Glucose Cotransporter-2 Inhibitors
- Hypoglycemics, TZDs
- Immunomodulators, Atopic Dermatitis
- Immunosuppressive, Oral
- Intranasal Rhinitis Agents
- Laxatives and Cathartics
- Leukotriene Modifiers
- Lipotropics, Statins
- MABS-Anti-IL, Anti IgE
- Macrolides
- Ophthalmic Antibiotics
- Ophthalmic Antibiotics/Steroid Combinations
- Ophthalmics, Anti-Inflammatories
- Ophthalmics, Glaucoma Agents
- Opiate Dependence Treatments
- PAH Agents – Endothelin Receptor Antagonists
- PAH Agents – PDE5s

- Pancreatic Enzymes
- Platelet Aggregation Inhibitors
- Progestins for Cachexia
- Steroids, Topical
- Ulcerative Colitis Agents
- 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.

VIII. Break/Lunch and Executive Session

The committee adjourned at 9:35 AM for Executive Session and lunch until afternoon session.

IX. Extracted Therapeutic Category Reviews/Committee Recommendations

Tom Kines, Chairman, called the second open session to order at 1:05 PM. ***Some posted criteria will be adjusted after DUR Board review***

A. 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. 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 donepezil ODT galantamine tablet galantamine ER capsule EXELON PATCH (rivastigmine) RAZADYNE ER (galantamine) rivastigmine capsule	ADLARITY PATCH (donepezil) ARICEPT (donepezil) donepezil 23 mg* galantamine solution rivstigmine patch	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and** 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.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

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

ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)ΔP		
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) 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.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

C. Angiotensin Modulators

ANGIOTENSIN MODULATORS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent in the same sub-class, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ACE INHIBITORS		
benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ALTACE (ramipril) enalapril solution EPANED (enalapril)* LOTENSIN (benazepril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)** VASOTEC (enalapril) ZESTRIL (lisinopril)	*Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia. **Qbrelis solution may be authorized for children ages 6-10 who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan losartan valsartan olmesartan telmisartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) MICARDIS (telmisartan)	
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril)[AP]* irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/amlodipine/HCTZ olmesartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) telmisartan/amlodipine telmisartan/HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ)	*Entresto may be authorized only for patients ≥ 1 year of age diagnosed with chronic heart-failure.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

D. Antianginal & Anti-Ischemic

ANTIANGINAL & ANTI-ISCHEMIC		
CLASS PA CRITERIA: Agents in this class may only be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.		
ranolazine[AP]	ASPRUZYO SPRINKLE ER (ranolazine) RANEXA	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

E. Antibiotics, Inhaled

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	BETHKIS (tobramycin) CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER (tobramycin)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

F. Antibiotics, Vaginal

ANTIBIOTICS, VAGINAL		
CLASS PA CRITERIA: Non-preferred agents require trials of each chemically unique preferred agent at the manufacturer's recommended duration, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CLEOCIN OVULE (clindamycin)	CLEOCIN CREAM (clindamycin)	
CLINDESSE (clindamycin)	clindamycin cream	
metronidazole gel	METROGEL (metronidazole)	
NUVESSA (metronidazole)	VANDAZOLE (metronidazole)	
SOLOSEC (secnidazole)		

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

G. Anticoagulants

ANTICOAGULANTS		
CLASS PA CRITERIA: Non-preferred agents require a trial of each preferred agent in the same sub-class, unless one (1) of the exceptions on the PA form is present.		
	ORAL	
ELIQUIS (apixaban)	dabigatran	
PRADAXA (dabigatran)	SAVAYSA (edoxaban)	
warfarin	XARELTO SUSPENSION (rivaroxaban)	
XARELTO TABLETS (rivaroxaban)		

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

H. Anticonvulsants

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

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 levetiracetam IR suspension oxcarbazepine tablets	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) 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.
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 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)	*****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

I. Antidepressants, Other

ANTIDEPRESSANTS, OTHER

CLASS PA CRITERIA: See below for individual sub-class criteria.

SECOND GENERATION NON-SSRI, OTHER[AP]

bupropion IR bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone HCl) vilazodone WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

J. Antifungals, Oral

ANTIFUNGALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present.		
clotrimazole fluconazole* griseofulvin*** nystatin terbinafine[CL]	ANCOBON (flucytosine) CRESEMBA (isovuconazonium)[CL]** BREXAFEMME (ibrexafungerp) DIFLUCAN (fluconazole) flucytosine itraconazole ketoconazole**** MYCELEX (clotrimazole) NOXAFIL (posaconazole) ORAVIG (miconazole) posaconazole tablet SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) VIVJOA (oteseconazole) voriconazole suspension voriconazole tablets	*PA is required when limits are exceeded. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis. ****Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment **and** 4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.) **and** 5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole. **Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.**

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

K. Antifungals, Topical

ANTIFUNGALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (i.e. ketoconazole shampoo) is required.		
ANTIFUNGALS		
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) GYNAZOLE 1 CREAM (butoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) luliconazole cream LUZU (luliconazole) miconazole/petrolatum/zinc oxide naftifine cream NAFTIN GEL (naftifine) oxiconazole cream OXISTAT (oxiconazole)* sulconazole nitrate solution, cream tavaborole 5% topical solution VUSION (miconazole/petrolatum/zinc oxide)	*Oxistat cream will be authorized for children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

L. Antimigraine Agents, Acute

ANTIMIGRAINE AGENTS, ACUTE[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.		
TRIPTANS		
IMITREX NASAL SPRAY (sumatriptan) naratriptan rizatriptan ODT rizatriptan tablet sumatriptan injection vials, pens sumatriptan nasal spray sumatriptan tablets zolmitriptan tablets zolmitriptan ODT	almotriptan AMERGE (naratriptan) eletriptan FROVA (frovatriptan) frovatriptan MAXALT (rizatriptan) MAXALT MLT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) sumatriptan cartridges TOSYMRA NASAL SPRAY (sumatriptan)* ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

M. Antiparkinson's Agents

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.		
DOPAMINE AGONISTS		
APOKYN (apomorphine) PEN bromocriptine pramipexole ropinirole	apomorphine pen, cartridge KYNMOBI (apomorphine) FILM MIRAPEX ER (pramipexole)* NEUPRO (rotigotine) pramipexole ER ropinirole ER	*Mirapex ER will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

N. Antipsoriatics, Topical

ANTIPSORIATICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of two (2) preferred unique chemical entities before they will be approved, unless one (1) of the exceptions on the PA form is present.		
TACLONEX (calcipotriene/ betamethasone) VECTICAL (calcitriol)	calcipotriene cream calcipotriene ointment calcipotriene solution calcipotriene/betamethasone ointment, suspension calcitriol DOVONEX (calcipotriene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) tazarotene cream VTAMA (tapinarof)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

O. Antiretrovirals

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.		
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc SELZENTRY (maraviroc)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

P. Bladder Relaxant Preparations

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) GELNIQUE (oxybutynin)	darifenacin ER tablet DETROL (tolterodine)	
MYRBETRIQ TABLET (mirabegron) oxybutynin IR oxybutynin ER OXYTROL (oxybutynin) solifenacin TOVIAZ (fesoterodine)	DITROPAN XL (oxybutynin) ENABLEX (darifenacin) fesoterodine ER flavoxate GEMTESA (vibegron) MYRBETRIQ SUSPENSION (mirabegron) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin) VESICARE LS (solifenacin)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

Q. Calcium Channel Blockers

CALCIUM CHANNEL BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
LONG-ACTING		
amlodipine diltiazem ER/CD felodipine ER	CALAN SR (verapamil) CARDIZEM CD, LA (diltiazem) DILT-XR	*Katerzia will be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Katerzia may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
nifedipine ER verapamil ER	diltiazem LA KATERZIA SUSPENSION (amlodipine)* MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) NORLIQVA (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

R. Cephalosporins and Related Antibiotics

CEPHALOSPORINS AND RELATED ANTIBIOTICS

CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

	CEPHALOSPORINS	
cefaclor capsule cefadroxil tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	cefaclor suspension cefaclor ER tablet cefadroxil capsule cefadroxil suspension cefixime cefpodoxime cefprozil cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) SUPRAX (cefixime)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

S. Cytokine & CAM Antagonists

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) SIMPONI subcutaneous (golimumab)	CIMZIA (certolizumab pegol) INFLECTRA (infliximab) infliximab REMICADE (infliximab) RENFLEXIS (infliximab) SIMPONI ARIA (golimumab)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

T. Glucocorticoids, Inhaled

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.

	GLUCOCORTICOIDS	
ASMANEX TWISTHALER (mometasone) budesonide nebulizer 0.5 mg/2 ml & 0.25 mg/2 ml solution* FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide) ARMONAIR DIGIHALER (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide nebulizer 1 mg/2ml solution fluticasone HFA PULMICORT NEBULIZER SOLUTION (budesonide) QVAR REDIHALER (beclomethasone)	*Budesonide Respules are only preferred for children up to nine (9) years of age. For patients nine (9) and older, prior authorization is required and will be approved only for a diagnosis of severe nasal polyps.
	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) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol fluticasone/salmeterol fluticasone/vilanterol WIXELA (fluticasone/salmeterol)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

U. Hyperparathyroid Agents

HYPERPARATHYROID AGENTS[AP]		
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.		
cinacalcet paricalcitol capsule	doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

V. Hypoglycemics, Insulins & Related Agents

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
APIDRA (insulin glulisine) HUMALOG (insulin lispro) HUMALOG JR KWIKPEN (insulin lispro) HUMALOG KWIKPEN U-100 (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN 70/30 (insulin) HUMULIN R U-500 VIAL (insulin) HUMULIN R U-500 KWIKPEN (insulin) insulin aspart flexpen, penfill, vial insulin aspart/aspart protamine pens, vials insulin lispro kwikpen U-100, vial LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) NOVOLIN N (insulin) TOUJEO SOLOSTAR (insulin glargine)	ADMELOG (insulin lispro) AFREZZA (insulin)[CL] BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG KWIKPEN U-200 (insulin lispro) HUMULIN PENS (insulin) HUMULIN R VIAL (insulin) HUMULIN N VIAL (insulin) insulin glargine insulin lispro junior kwikpen insulin lispro protamine mix LYUMJEV (insulin lispro) NOVOLIN (insulin) SEMGLEE (insulin glargine) SOLIQUA (insulin glargine/lixisenatide)* TRESIBA (insulin degludec)** TRESIBA FLEXTOUCH (insulin degludec)** XULTOPHY (insulin degludec/liraglutide)*	* Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the combination product, and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents. **Patients stabilized on Tresiba may be grandfathered at the request of the prescriber, if the prescriber considers the preferred products to be clinically inappropriate. **Tresiba U-100 may be approved only for: Patients who have demonstrated at least a 6-month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.
TOUJEO MAX SOLOSTAR (insulin glargine		**Tresiba U-200 may be approved only for: Patients who require once-daily doses of at least 60 units of long-acting insulin and have demonstrated at least a 6-month history of compliance on preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

W. Immunomodulators, Genital Warts & Actinic Keratosis

IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
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.		
CONDYLOX GEL (podofilox) EFUDEX (fluorouracil) imiquimod cream	ALDARA (imiquimod) CARAC (fluorouracil) diclofenac 3% gel fluorouracil 0.5% cream fluorouracil 5% cream imiquimod pump podofilox TOLAK (fluorouracil 4% cream) VEREGEN (sinecatechins) ZYCLARA CREAM, PUMP (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

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

IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS [CL]		
CLASS PA CRITERIA: All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.**		
CONSTIPATION		
AMITIZA (lubiprostone) LINZESS 145 and 290 mcg (linaclotide) MOVANTIK (naloxegol) TRULANCE (plecanatide)	IBSRELA (tenapanor) LINZESS 72 mcg (linaclotide) lubiprostone capsule MOTEGRITY (prucalopride)	All agents in this subclass require documentation of the current diagnosis and evidence that the patient has failed to find relief with dietary modification and a fourteen (14) day trial of an osmotic laxative.
	RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine)	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 Amitiza 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. **Lubiprostone** may only be authorized with a documented allergy or intolerance to Amitiza. **Motegrity** requires a 30-day trial of both Amitiza and Linzess. **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza. **Trulance** requires thirty (30) day trials of both Amitiza and Linzess, however for the indication of IBS-C in males, a trial of Amitiza is not required. **Zelnorm** is indicated for females < 65 years of age diagnosed with irritable bowel syndrome with constipation (IBS-C) AND requires thirty (30) day trials of Amitiza and Linzess.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

Y. Multiple Sclerosis Agents

MULTIPLE SCLEROSIS AGENTS[CL]		
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	
AUBAGIO (teriflunomide)* COPAXONE 20 mg (glatiramer) dalfampridine ER** dimethyl fumerate*** GILENYA (fingolimod) KESIMPTA INJECTION (ofatumumab)	AMPYRA (dalfampridine)** BAFIERTAM CAPSULES (monomethyl fumarate) COPAXONE 40 mg (glatiramer)**** glatiramer GLATOPA (glatiramer) MAVENCLAD (cladribine)	**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**
	MAYZENT (siponimod)***** PONVORY (ponesimod) TASCENSO ODT TABLETS (fingolimod lauryl sulfate) TECFIDERA (dimethyl fumarate)*** VUMERITY (diroximel) ZEPOSIA (ozanimod)	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. ***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. ****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 recommended changes of dimethyl fumerate, Tascenso ODT tablets, and Tecfidera by Change Healthcare was made and seconded, all were in favor and the motion was approved.

The committee made a motion to move Kesimpta to a preferred status by the Committee and seconded, all were in favor and the motion was approved.

Z. Neuropathic Pain

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 duloxetine gabapentin lidocaine patch 5% LYRICA CAPSULE/SOLUTION (pregabalin) pregabalin capsule	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* GRALISE (gabapentin)** HORIZANT (gabapentin) lidocaine patch 4% LIDODERM (lidocaine) LYRICA CR (pregabalin)*** NEURONTIN (gabapentin) pregabalin ER tablet (generic Lyrica CR) pregabalin solution QUTENZA (capsaicin) SAVELLA (milnacipran)**** 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. **Gralise will be authorized only if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800 mg maximum daily dosage. ***Lyrica CR requires medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules. ****Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

AA. NSAIDs

NSAIDS[AP]		
CLASS PA CRITERIA: See below for sub-class PA criteria.		
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol ibuprofen/famotidine naproxen/esomeprazole VIMOVO (naproxen/esomeprazole)	Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

BB. Ophthalmics for Allergic Conjunctivitis

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) ALREX (loteprednol) azelastine BEPREVE (bepotastine) cromolyn ketotifen ZADITOR OTC (ketotifen)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) bepotastine epinastine LUMIFY (brimonidine) olopatadine 0.1% olopatadine 0.2% PATADAY ONCE AND TWICE DAILY (olopatadine) ZERVIATE (cetirizine)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

CC. Oral and Topical Contraceptives

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.		
AFIRMELLE	ALYACEN	
ALTAVERA	AMETHIA 3MO	
AMETHYST	ARANELLE	
APRI	ASHLYNA 3MO	
AUBRA	AUROVELA 24 FE	
AUBRA EQ	AUROVELA FE	
AUROVELA	BALCOLTRA	
AVIANE	BALZIVA	
AYUNA	BLISOVI 24 FE	
AZURETTE	BRIELLYN	
BEYAZ	CAMRESE LO 3MO	*Phexxi may be approvable when it is prescribed for the prevention of pregnancy; **AND** reasoning is provided as to why the clinical need cannot be met with a preferred agent. Phexxi will not be approved for use by patients who are also using hormonal contraceptive vaginal rings.
BLISOVI FE	CAZIANT	
CAMILA	CHARLOTTE 24 FE CHEW TAB	
CAMRESE 3MO	CRYSELLE	
CHATEAL	DASETTA	
CHATEAL EQ	DAYSEE 3MO	
CYCLAFEM	drospirenone-ethy estra-levomef	
CYRED	ECONTRA EZ	
CYRED EQ	ECONTRA ONE-STEP	
DEBLITANE	ELINEST	
desogestrel-ethinyl estradiol	ELLA	
desogestrel-ethinyl estradiol/ethinyl estradiol	ENPRESSE	
DOLISHALE	ethynodiol-ethinyl estradiol	
drospirenone-ethinyl estradiol	FAYOSIM 3MO	
EMOQUETTE	GEMMILY	
ENSKYCE	GENERESS FE CHEW TAB	
ERRIN	HAILEY	
ESTARYLLA	HAILEY 24 FE	
ESTROSTEP FE	ICLEVIA 3MO	
FALMINA	INTROVALE 3MO	
FEMYNOR	JAIMIESS 3MO	
HAILEY FE	JASMIEL	
HEATHER	JUNEL	
INCASSIA	JUNEL FE 24	
ISIBLOOM	KAITLIB FE	
JENCYCLA	KALLIGA	
JOLESSA 3MO	KELNOR 1-35	
JULEBER	KELNOR 1-50	
JUNEL FE	LARIN	
KARIVA	LARIN 24 FE	
KURVELO	LARIN FE	
LESSINA	LARISSIA	
LEVONEST	LAYOLIS FE CHEW TAB	
levonorgestrel	LEENA	
levonorgestrel-ethinyl estradiol	levonorgestrel-ethinyl estradiol (generic Jolessa) 3 MO	
levonorgestrel-ethinyl estradiol (generic Loseasonique) 3MO	LEVORA-28	
LILLOW	LOESTRIN	
LO LOESTRIN FE	LOESTRIN FE	
LUTERA	LOJAIMIESS 3MO	
LYLEQ	LORYNA	
LYZA	LOSEASONIQUE 3MO	
MARLISSA	LOW-OGESTREL	
MICROGESTIN FE	LO-ZUMANDIMINE	
MILI	MERZEE	
MONO-LINYAH	MICROGESTIN	
MY CHOICE	MICROGESTIN 24 FE	
MY WAY	MINASTRIN 24 FE CHEW TAB	
NATAZIA	MIRCETTE	
NEW DAY	NECON	
NIKKI	NEXTSTELLIS	
NORA-BE	norethindrone-e.estradiol-iron cap	
norethindrone	norethindrone-e.estradiol-iron chew tab	
norethindrone-e.estradiol-iron tab	NORTREL	
norethindrone-ethinyl estradiol	OPTION 2	
norgestimate-ethinyl estradiol	PHEXXI VAGINAL GEL*	
NORLYDA	PHILITH	
NYLIA	PIMTREA	
NYMYO	PIRMELLA	
OCELLA	QUARTETTE	
OPCICON ONE-STEP	RECLIPSEN	

ORSYTHIA	RIVELSA 3MO	
PORTIA	SAFYRAL	
PREVIFEM	SEASONIQUE 3MO	
SHAROBEL	SETLAKIN 3MO	
SIMLIYA	SIMPESSE 3MO	
SPRINTEC	SLYND	
SRONYX	SYEDA	
TARINA FE	TARINA 24 FE	
TARINA FE 1-20 EQ	TAYSOFY	
TAYTULLA	TILIA FE	
TRI-ESTARYLLA	TRI-LEGEST FE	
TRI FEMYNOR	TRIVORA-28	
TRI-LINYAH	TYBLUME CHEW TAB	
TRI-LO-ESTARYLLA	TYDEMY	
TRI-LO-MARZIA	VELIVET	
TRI-LO-MILI	VESTURA	
TRI-LO-SPRINTEC	VYFEMLA	
TRI-MILI	WERA	
TRI-NYMYO	WYMZYA FE CHEW TAB	
TRI-PREVIFEM	ZAFEMY PATCH	
TRI-SPRINTEC		
TRI-VYLIBRA		
TRI-VYLIBRA LO		
TULANA		
TWIRLA PATCH		
VIENVA		
VIORELE		
VOLNEA		
VYLIBRA		
XULANE PATCH		
YASMIN 28		
YAZ		
ZOVIA 1-35		
ZOVIA 1-35E		
ZUMANDIMINE		

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

DD. PAH Agents - Prostacyclins

PAH AGENTS – PROSTACYCLINS[CL]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.		
epoprostenol (generic Flolan) epoprostenol (generic Veletri) VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) TYVASO DPI (treprostinil) UPTRAVI (selexipag) VELETRI (epoprostenol)	*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

EE. Phosphate Binders

PHOSPHATE BINDERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present.		
calcium acetate capsules CALPHRON (calcium acetate) MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) sevelamer carbonate	AURYXIA (ferric citrate) calcium acetate tablets FOSRENOL (lanthanum) lanthanum chewable RENAGEL (sevelamer) RENVELA (sevelamer carbonate) sevelamer carbonate powder packet sevelamer hcl VELPHORO (sucroferric oxyhydroxide)	

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

FF. Pituitary Suppressive Agents, LHRH

PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]		
CLASS PA CRITERIA: Unless otherwise noted, non-preferred agents are available only on appeal.		
FENSOLVI SYRINGE (leuprolide acetate) LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) MYFEMBREE (relugolix, estradiol, norethindrone)* SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin) ZOLADEX (goserelin)	leuprolide ORIAHNN (elagolix-estradiol-norethindrone)* ORILISSA (elagolix)* SUPPRELIN LA KIT (histrelin)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

GG. Proton Pump Inhibitors

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.		
NEXIUM PACKETS (esomeprazole)** omeprazole (Rx) pantoprazole tablets PROTONIX GRANULES (pantoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) dexlansoprazole DR capsule esomeprazole magnesium lansoprazole Rx NEXIUM (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 recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

HH. Sedative Hypnotics

SEDATIVE HYPNOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH** sub-classes before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. NOTE: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred if available, however all NDCs are payable.		
OTHERS		
BELSOMRA (suvorexant) melatonin ROZEREM (ramelteon) zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) DAYVIGO (lemborexant) doxepin 3mg and 6mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)[CL*] LUNESTA (eszopiclone) ramelteon SILENOR (doxepin) zaleplon zolpidem ER 6.25, 12.5 mg	For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day. *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

The committee made a motion to extract the Sedative Hypnotics class. A motion was made to move Belsomra to a preferred status by the Committee and seconded, all were in favor and the motion was approved.

II. Skeletal Muscle Relaxants

SKELETAL MUSCLE RELAXANTS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	baclofen solution DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) LYVISPAH GRANULE PACKET (baclofen) tizanidine capsules 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.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

JJ. 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.		
AMPHETAMINES		
ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR	ADDERALL (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) amphetamine tablets DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) dextroamphetamine solution DYANAVEL XR SUSP, TABLETS (amphetamine) EVEKEO (amphetamine) EVEKEO ODT (amphetamine) methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)* PROCENTRA solution (dextroamphetamine) VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine) 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.
NON-AMPHETAMINE		
atomoxetine* clonidine IR clonidine ER CONCERTA (methylphenidate) dexmethylphenidate IR dexmethylphenidate XR FOCALIN XR (dexmethylphenidate) 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) 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 recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

KK. Tetracyclines

TETRACYCLINES		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules	demeclocycline** DORYX (doxycycline hyclate) doxycycline hyclate 50, 75, 150 mg tablets doxycycline hyclate tablet DR 75, 100, 150, 200 mg doxycycline hyclate tablet DR 50 mg doxycycline monohydrate 40, 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension MINOCIN (minocycline) minocycline ER capsules minocycline tablets MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline) NUZYRA (omadacycline)* ORACEA (doxycycline monohydrate) SOLODYN (minocycline) tetracycline VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) XIMINO (minocycline)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. Demeclocycline will also be authorized for SIADH.

A motion to approve the recommended changes (as above) by Change Healthcare was made and seconded, all were in favor and the motion was approved.

X. Next Meeting

The next P&T Committee Meeting is scheduled for January 25th, 2023, from 2:00 PM-5:00 PM, Virtual Meeting

XI. Other Business

XII. Adjournment

The Committee adjourned the meeting at 2:27 PM.