STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Cabinet Secretary

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Cynthia E. Beane
Commissioner

Pharmaceutical and Therapeutics Committee

April 24, 2019

Location: Diamond, Rooms B10 and B11
Time: 2:00 PM – 5:00 PM
Charleston, WV 25301
(304) 558-1700

MINUTES

Committee Members Present:
Bradley Henry, MD, Chair
Tom Kines, RPh, Vice-Chair
John Bernabei, RPh
Philip Galapon, MD FAAFP
David Gloss, MD
Kelli Lynn Jennings, PharmD
Karrie Murphy, PharmD
Hani Nahza, MD
Steve Neal, RPh
Chris Terpening, PharmD, PhD

Absent:
Toni DiChiacchio, DNP
Heather Jones, PA-C
James Rising, MD
Charles Rohrbaugh, RPh

Division of Medicaid Staff Present:
Vicki Cunningham, RPh
Brian Thompson, PharmD, MS
Lori Moles, R.Ph.
Bill Hopkins
Doug Sorvig

BMS Staff Absent
Gail Goodnight, R.Ph.

Contract Staff/CHC Staff Present:
Brent Breeding, RPh
Jacquelyn Hedlund, MD, MS
Bettina Lewis, MS, Operational Account Coordinator (by phone)

Other Contract / State Staff Present:
Angie Wowczuk, PharmD (Rational Drug Therapy Program)
Aleshia Heil, PharmD (RDTP, Safe Effective Management of Pain)

I. Call to Order

Dr. Bradley Henry called the meeting to order at 2:06pm

II. Welcome and Introductions

P&T committee members introduced themselves.

III. Administrative Items / Updates

There were no administrative items / updates.

A. Approval of the Previous Meeting Minutes

Karrie Murphy requested a correction to her last name in the January 23, 2019 minutes. Chris Terpening made a motion to approve the minutes from the January 23, 2019 meeting with the correction and to approve the minutes as-is from October 24, 2018. The motion was seconded by Philip Galapon. All were in favor and the minutes were approved.

B. PDL Compliance/Generic Percent Report Updates

Brent Breeding provided an explanation of the PDL Compliance and Generic Percent reports.

A. Brent Breeding reviewed the PDL Compliance Report; overall compliance for Q1 2019 was 91.4%.

B. Brent Breeding reviewed the Generic Percent Report; overall generic utilization for Q1 2019 was 85.6%

IV. Public Comments

Jordyn Stuart representing Greenwick Biosciences spoke in favor of Epidiolex.
Kayleen Daly representing Johnson & Johnson spoke in favor of Symtuza.
Paul Isikwe representing Teva spoke in favor of Ajovy.

V. Executive Session

A motion was made to move to executive session by Chris Terpening and seconded by Philip Galapon and all were in favor.

The Committee adjourned for executive session at 2:26pm.

The Committee reconvened at 3:38pm.

VI. New Business

A. Adjustments to Existing Classes

i. Lidozion Lotion (Anesthetics, Topical)

ANESTHETICS, TOPICAL[AP]		
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.		
lidocaine lidocaine/prilocaine xylocaine	LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) lidocaine/hydrocortisone LIDOTRAL CREAM (lidocaine) LIDOZION LOTION (lidocaine) SYNERA (lidocaine/tetracaine) VOPAC MDS (ketoprofen/lidocaine)	

Philip Galapon made a motion to approve the change to non-preferred for Lidozion Lotion (lidocaine) as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

B. New Therapeutic Class

i. Pituitary Suppressive Agents, LHRH

PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]		
CLASS PA CRITERIA: Non-preferred agents **are available only on appeal.**		
LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) ORILISSA (elagolix) SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin) VANTAS (histrelin) ZOLADEX (goserelin)	Leuprolide SUPPRELIN LA KIT (histrelin)	

Recommending to add this class with all agents preferred with the exception of Leuprolide and Supprelin LA Kit (histrelin). No discussion. Chris Terpening made a motion to approve the new therapeutic class of Pituitary Suppressive Agents, LHRH as recommended; the motion was seconded by Philip Galapon. All members were in favor and the motion was approved.

C. New Therapeutic Sub-Class

i. Antimigraine Agents, CGRP Inhibitors

ANTIMIGRAINE AGENTS, CGRP INHIBITORS[AP]		
CLASS PA CRITERIA:		
	AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY (galcanezumab)	

Dr. Hedlund provided robust exposition and research on this sub-class and recommendations for Aimovig, Ajovy and Emgality to be non-preferred. Hani Nahza made a motion to approve; the motion was seconded by Steve Neal. All members were in favor and the motion was approved.

D. New Drug Reviews

i. Altreno Lotion (Acne Agents, Topical – Retinoids)

ACNE AGENTS, TOPICAL[AP]

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present.

In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required.
Acne kits are non-preferred.

Specific Criteria for sub-class will be listed below. NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.

RETINOIDS		
TAZORAC (tazarotene) tretinoin cream, gel	adapalene ALTRENO LOTION (tretinoin) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) PLIXDA SOLUTION (adapalene) RETIN-A (tretinoin) RETIN-A MICRO (tretinoin) tazarotene cream tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.

Philip Galapon made a motion to approve the changes to the Acne Agents, Topical - Retinoids category as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

ii. Plixda Solution (Acne Agents, Topical – Retinoids)

ACNE AGENTS, TOPICAL[AP]

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present.

In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required.
Acne kits are non-preferred.

Specific Criteria for sub-class will be listed below. NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.

RETINOIDS		
TAZORAC (tazarotene) tretinoin cream, gel	adapalene ALTRENO LOTION (tretinoin) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) PLIXDA SOLUTION (adapalene) RETIN-A (tretinoin) RETIN-A MICRO (tretinoin) tazarotene cream tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.

Karrie Murphy made a motion to approve the changes to the Acne Agents, Topical – Retinoids category as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

iii. Roxybond (Analgesics, Narcotic Short Acting)

ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.		
APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets LORTAB SOLUTION (hydrocodone/acetaminophen) morphine oxycodone tablets, concentrate, solution oxycodone/APAP oxycodone/ASA pentazocine/naloxone tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) 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 hydromorphone liquid, suppositories IBUDONE (hydrocodone/ibuprofen) LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXECTA (oxycodone) oxycodone capsules oxycodone/ibuprofen oxymorphone PERCOCET (oxycodone/APAP) PRIMLEV (oxycodone/APAP) REPREXAIN (hydrocodone/ibuprofen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VERDROCET (hydrocodone/APAP) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) XYLON (hydrocodone/ibuprofen) ZAMICET (hydrocodone/APAP)	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.

Hani Nahza made a motion to approve the changes to the Analgesics, Narcotic Short Acting category as recommended; the motion was seconded by David Gloss. All members were in favor and the motion was approved.

iv. Epidiolex (Anticonvulsants, Cannabinoids)

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.		
CANNABINOIDS[AP]		
	EPIDIOLEX SOLUTION (cannabidiol)	

David Gloss made a motion to approve the changes to the Anticonvulsants, Cannabinoids category as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

v. Jivi (Antihemophilia Agents, Factor VIII)

ANTIHEMOPHILIA FACTOR AGENTS[CL]		
CLASS PA CRITERIA: All agents will require prior-authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
FACTOR VIII		
ALPHANATE HEMOFIL M HUMATE-P KOATE KOATE-DVI MONOCLATE-P NOVOEIGHT WILATE XYNTHA XYNTHA SOLOFUSE	ADVATE ADYNOVATE ELOCTATE JIVI KOGENATE FS KOVALTRY NUWIQ RECOMBINATE VONVENDI	

Steve Neal made a motion to approve the changes to the Antihemophilia Agents, Factor VIII category as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

vi. Perseris (Antipsychotics, Atypical)

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. All trials must be at the maximum recommended dose for the diagnosis provided before they would be considered a failure unless an adverse reaction is documented necessitating a change in therapy.

Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at FDA recommended dosages. For off-label indications or dosages, a thirty (30) day prior-authorization shall be granted pending BMS review.

SINGLE INGREDIENT		
ABILIFY MAINTENA (aripiprazole)CL aripiprazole tablets ARISTADA (aripiprazole)CL clozapine INVEGA SUSTENNA (paliperidone)CL INVEGA TRINZA (paliperidone)* CL olanzapine olanzapine ODT quetiapine** AP for the 25 mg Tablet Only quetiapine ER RISPERDAL CONSTA (risperidone)CL risperidone ziprasidone	ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone)*** AP NUPLAZID (pimavanserin) **** olanzapine IMCL paliperidone ER PERSERIS (risperidone)CL REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) VRAYLAR (capriprazine) VRAYLAR DOSE PAK (capriprazine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)CL ZYPREXA RELPREVV (olanzapine)	**In addition to class criteria:** *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.** ***For the indication of bipolar depression only, prior authorization of Latuda requires failure of a 30-day trial of quetiapine OR a combination of olanzapine + fluoxetine. All trials must be at the maximum recommended dose for the diagnosis provided before they would be considered a failure unless an adverse reaction is documented necessitating a change in therapy. All other indications follow class criteria. Patients already stabilized on Latuda shall be grandfathered. ****Nuplazid will only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine.

Hani Nahza made a motion to approve the changes to the Antipsychotics, Atypical category as recommended; the motion was seconded by David Gloss. All members were in favor and the motion was approved.

vii. Delstrigo (Antiretrovirals, Single Tablet Regimens)

ANTIRETROVIRALS[AP]		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.		
SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide) GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir)* DELSTRIGO (doravirine/lamivudine/tenofovir df) JULUCA (dolutegravir/rilpivirine) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)** TRIUMEQ (abacavir/lamivudine/ dolutegravir)***	*Complera requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Truvada and Edurant. **Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya. ***Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.

Chris Terpening made a motion to approve the changes to the Antiretrovirals, Single Tablet Regimens category as recommended; the motion was seconded by Philip Galapon. All members were in favor and the motion was approved.

viii. Symtuza (Antiretrovirals, Single Tablet Regimens)

ANTIRETROVIRALS[AP]		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.		
SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide) GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir)* DELSTRIGO (doravirine/lamivudine/tenofovir df) JULUCA (dolutegravir/rilpivirine) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)** TRIUMEQ (abacavir/lamivudine/ dolutegravir)***	*Complera requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Truvada and Edurant. **Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya. ***Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.

Chris Terpening made a motion to approve the changes to the Antiretrovirals, Single Tablet Regimens category as recommended; the motion was seconded by Philip Galapon. All members were in favor and the motion was approved.

ix. Pifeltro (Antiretrovirals, NNRTI)

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.		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
EDURANT (rilpivirine) SUSTIVA (efavirenz)	efavirenz INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) VIRAMUNE ER 24H (nevirapine) VIRAMUNE SUSPENSION (nevirapine)	

Chris Terpening made a motion to approve the changes to the Antiretrovirals, NNRTI category as recommended; the motion was seconded by Philip Galapon. All members were in favor and the motion was approved.

x. Xofluza (Antivirals, Anti-Influenza)

ANTIVIRALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTI-INFLUENZA		
oseltamivir RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine XOFLUZA (baloxavir)	**In addition to the Class Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza.

Philip Galapon made a motion to approve the changes to the Antivirals, Anti-Influenza category as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

xi. Ilumya (Cytokine and CAM Antagonists, Others)

CYTOKINE & CAM ANTAGONISTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For FDA-approved indications, an additional ninety (90) day trial of Cosentyx will also be required.		
OTHERS		
COSENTYX (secukinumab)*	ACTEMRA subcutaneous (tocilizumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA subcutaneous (abatacept) OTEZLA (apremilast) SILIQ (brodalumab) STELARA subcutaneous (ustekinumab) TALTZ (ixekizumab) TREMFYA (guselkumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib)	*Cosentyx 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 agent.

Chris Terpening made a motion to approve the changes to the Cytokine and CAM Antagonists, Others category as recommended; the motion was seconded by Karrie Murphy. All members were in favor and the motion was approved.

xii. Olumiant (Cytokine and CAM Antagonists, Others)

CYTOKINE & CAM ANTAGONISTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For FDA-approved indications, an additional ninety (90) day trial of Cosentyx will also be required.		
OTHERS		
COSENTYX (secukinumab)*	ACTEMRA subcutaneous (tocilizumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA subcutaneous (abatacept) OTEZLA (apremilast) SILIQ (brodalumab) STELARA subcutaneous (ustekinumab) TALTZ (ixekizumab) TREMFYA (guselkumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib)	*Cosentyx 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 agent.

Chris Terpening made a motion to approve the changes to the Cytokine and CAM Antagonists, Others category as recommended; the motion was seconded by Karrie Murphy. All members were in favor and the motion was approved.

xiii. Retacrit (Erythropoiesis, Stimulating Proteins)

ERYTHROPOIESIS STIMULATING PROTEINS[CL]		
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) RETACRIT (epoetin alfa)	ARANESP (darbepoetin) MIRCERA (methoxy PEG-epoetin) PROCRIT (rHuEPO)	Erythropoiesis agents will be authorized if the following criteria are met: 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 reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.

David Gloss made a motion to approve the changes to the Erythropoiesis, Stimulating Proteins category as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

xiv. Ztlido Patch (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 LYRICA CAPSULE (pregabalin)	CYMBALTA (duloxetine) GRALISE (gabapentin)* HORIZANT (gabapentin) IRENKA (duloxetine) LIDODERM (lidocaine) LYRICA CR (pregabalin)** LYRICA SOLUTION (pregabalin)** NEURONTIN (gabapentin)[AP] QUTENZA (capsaicin) SAVELLA (milnacipran)*** ZTLIDO PATCH (lidocaine)	*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 and Lyrica Solution require medical reasoning beyond convenience as to why the need cannot be met using preferred Lyrica capsules. ***Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent

Chris Terpening made a motion to approve the changes to the Neuropathic Pain category as recommended; the motion was seconded by Steve Neal. All members were in favor and the motion was approved.

xv. Lucemyra (Opiate Dependence Treatments)

OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Buprenorphine/naloxone tablets, Bunavail and Zubsolv will only be approved with a documented intolerance of or allergy to Suboxone strips. WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
naloxone NARCAN NASAL SPRAY (naloxone) SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	buprenorphine tablets buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) LUCEMYRA (lofexidine) SUBLOCADE (buprenorphine soln)** ZUBSOLV (buprenorphine/naloxone)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Sublocade is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with a preferred product. VIVITROL no longer requires a PA.

Philip Galapon made a motion to approve the changes to the Opiate Dependence Treatents category as recommended; the motion was seconded by Hani Nahza. All members were in favor and the motion was approved.

VII. Old Business

There was no old business discussed at this time.

VIII. Other Business

There was no other business discussed at this time.

IX. Next Meeting

The next meeting will be held on August 28, 2019, 2pm-5pm in Diamond Rooms B10 and B11.

X. Adjournment

Dr. Henry adjourned the meeting at 4:12pm.