STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Cynthia E. Beane
Commissioner

Pharmaceutical and Therapeutics Committee

OCTOBER 28, 2020

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

MINUTES

Committee Members Present:
Tom Kines, RPh, Chair
Chris Terpening, PharmD, PhD, Vice-Chair
Toni DiChiacchio, DNP (dekiakio)
Philip Galapon, MD FAAFP
David Gloss, MD
Bradley Henry, MD
John Bernabei, RPh (JJ)
Charles Rohrbaugh, RPh

Absent:
Kelli Lynn Jennings, PharmD
Heather Jones, PA-C
Hani Nahza, MD

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

Contract Staff Present:
Change Healthcare
Ryan Fell, PharmD
Robert Dinwiddie, PharmD
Ashleigh Holeman, PharmD
Laureen Biczak, MD
Steve Liles, PharmD

Other Contract / State Staff Present:

I. Call to Order

Tom Kines, Chairman, called the meeting to order at 9:03 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, 26, 2020 Minutes

The Committee moved to approve the August 26, 2020 Meeting minutes. All were in favor with no objections or revisions.

B. PDL Compliance / Generic Percent Report Updates

Ryan Fell provided an explanation of the PDL Compliance and Generic Percent reports.

- Ryan Fell reviewed the Generic Percent Report; overall generic utilization for Q3 2020 was 85.7%

- Ryan Fell reviewed the PDL Compliance Report; overall compliance for Q3 2020 was 91.8%

IV. Drug Class Announcements

Change Healthcare recommended that the following classes be extracted:

- Acne Agents, Topical
- Antibiotics, Vaginal
- Anticonvulsants
- Antihyperuricemics
- Antimigraine Agents, CGRP Inhibitors
- Anitretrovirals
- Bronchodilators, Beta Agonists
- Cytokine & Cam Antagonists
- Gluocorticoids, Inhaled
- Hypoglycemics, Insulins and Related Agents
- Hypoglycemics, Sodium Glucose Cotransporter-2 Inhibitors
- Immunomodulators, Atopic Dermatitis
- Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents
- Laxatives and Cathartics
- Lipotropics, Other (Non-Statins)
- MABS-Anti-IL, Anti IgE

- Multiple Sclerosis Agents
- Neuropathic Pain
- Ophthalmics for Allergic Conjunctivitis
- Otic Antibiotics
- Sedative Hypnotics
- Steroids, Topical
- Stimulants & Related Agents

V. First Round of Extractions

Additional extractions presented by Committee members:

- Analgesics, Narcotics- Long Acting (Non-Parenteral)-Philip Galapon
- COPD Agents-Bradley Henry
- Hypoglycemics, GLP-1 Agonists -Bradley Henry
- Opiate Dependence Treatments-Charles Rohrbaugh

VI. 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.

VII. Second Round of Extractions

Additional extractions presented by Committee members:

- None

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

- Alzheimer's Agents
- Analgesics, Narcotics- Short Acting (Non-Parenteral)
- Androgenic Agents
- Anesthetics, Topical
- Angiotensin Modulators
- Antianginal & Anti-Ischemic
- Antibiotics, GI & Related Agents
- Antibiotics, Inhaled
- Antibiotics, Topical
- Anticoagulants
- Antidepressant-Other
- Antidepressants- SSRIs
- Antiemetics
- Antifungals, Oral
- Antifungals, Topical
- Antihemophilia Factor Agents
- Antihypertensives, Sympatholytics
- Antimigraine Agents, Other
- Antimigraine Agents, Triptans
- Antiparasitics, Topical
- Antiparkinson's Agents
- Antipsoriatics, Topical
- Antipsychotics, Atypical
- Antivirals, Oral
- Antivirals, Topical
- Beta Blockers
- Bladder Relaxant Preparations
- Bone Resorption Suppression & Related Agents
- BPH Treatments
- Calcium Channel Blockers
- Cephalosporins & Related Antibiotics

- Epinephrine, Self-Injected
- Erythropoiesis Stimulating Proteins
- Fluoroquinolones (Oral)
- Growth Hormones
- H. Pylori Treatment
- Hepatitis B Treatments
- Hepatitis C Treatments
- Hyperparathyroid Agents
- Hypoglycemics, Biguanides
- Hypoglycemics, DPP-4 Inhibitors
- Hypoglycemics, Meglitinides
- Hypoglycemics, Miscellaneous Agents
- Hypoglycemics, TZDs
- Immunomodulators, Genital Warts & Actinic Keratosis Agents
- Immunosuppressive, Oral
- Intranasal Rhinitis Agents
- Leukotriene Modifiers
- Lipotropics, Statins
- Macrolides
- NSAIDs
- Ophthalmic Antibiotics
- Ophthalmic Antibiotics/Steroid Combinations
- Ophthalmics, Anti-Inflammatories-Immunomodulators
- Ophthalmics, Anti-Inflammatories
- Ophthalmics, Glaucoma Agents
- PAH Agents – Endothelin Receptor Antagonists
- PAH Agents – Guanylate Cyclase Stimulator
- PAH Agents – PDE5s
- PAH Agents - Prostacyclins
- Pancreatic Enzymes
- Phosphate Binders
- Pituitary Suppressive Agents, LHRH
- Platelet Aggregation Inhibitors
- Progestational Agents
- Progestins for Cachexia
- Proton Pump Inhibitors
- Skeletal Muscle Relaxants
- Tetracyclines
- Ulcerative Colitis Agents
- Vasodilators, Coronary

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

IX. Break/Lunch and Executive Session

The committee adjourned at 9:16 AM for Executive Session and lunch until afternoon session.

X. Extracted Therapeutic Category Reviews/Committee Recommendations

Tom Kines, Chairman, called the second open session to order atPM

A. Acne Agents, Topical

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.

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTI-INFECTIVE		
ACZONE (dapsone) CLINDAGEL (clindamycin) clindamycin lotion, medicated swab, solution erythromycin gel, solution	AKNE-MYCIN (erythromycin) ARAZLO (tazarotene) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDACIN ETZ kit, medicated swab (clindamycin) CLINDACIN P (clindamycin) CLINDACIN PAC (clindamycin) clindamycin gel, foam dapsone ERYGEL (erythromycin) erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide cleanser sulfacetamide cleanser ER sulfacetamide shampoo sulfacetamide suspension	
RETINOIDS		
DIFFERIN (adapalene) RETIN-A (tretinoin) RETIN-A MICRO (tretinoin) TAZORAC (tazarotene)	adapalene AKLIEF CREAM (trifarotene) ALTRENO LOTION (tretinoin) ATRALIN (tretinoin) AVITA (tretinoin) PLIXDA SOLUTION (adapalene) tazarotene cream tretinoin cream, gel tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.
KERATOLYTICS		
benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC PANOXYL-4 OTC (benzoyl peroxide)	BENZEFOAM ULTRA (benzoyl peroxide) BP 10-1 (benzoyl peroxide) BPO (benzoyl peroxide) PANOXYL-8 OTC (benzoyl peroxide) SULPHO-LAC (sulfur)	
COMBINATION AGENTS		
ACANYA (clindamycin phosphate/benzoyl peroxide) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (generic DUAC only) EPIDUO (adapalene/benzoyl peroxide)* EPIDUO FORTE (adapalene/benzoyl peroxide)* ONEXTON (clindamycin phosphate/benzoyl peroxide) sulfacetamide sodium/sulfur suspension ZIANA (clindamycin/tretinoin)*	adapalene-benzoyl peroxide* AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/urea CERISA (sulfacetamide sodium/sulfur) CLARIFOAM EF (sulfacetamide/sulfur) CLENIA (sulfacetamide sodium/sulfur) clindamycin-tretinoin gel DUAC (benzoyl peroxide/clindamycin) erythromycin/benzoyl peroxide NEUAC (clindamycin phosphate/benzoyl peroxide) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) VELTIN (clindamycin/tretinoin)*	**In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
ROSACEA AGENTS		
FINACEA GEL (azelaic acid)	AMZEEQ FOAM (minocycline)	**Subclass criteria**: Non-preferred agents are available only on

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

B. 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) CLINDESSE (clindamycin) metronidazole NUVESSA (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)	

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

C. 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		
THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) QUDEXY XR (topiramate ER)** SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL TABLETS (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX (topiramate) TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine) TROKENDI XR (topiramate)** vigabatrin tablet/powder pack XCOPRI (cenobamate) ZONEGRAN (zonisamide)	

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

D. Antihyperuricemics

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

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

E. Antimigraine Agents, CGRP Inhibitors

ANTIMIGRAINE AGENTS, PROPHYLAXIS[CL]		
CLASS PA CRITERIA: **All agents require a prior authorization.** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents.		
THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AIMOVIG (erenumab) AJOVY (fremanezumab)	EMGALITY (galcanezumab) 120mg/mL EMGALITY (galcanezumab) 300mg/3 mL*	*Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal.

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

F. Antiretrovirals

ANTIRETROVIRALS[AP]	
COMBINATION PRODUCTS - NRTIs	
abacavir/lamivudine CIMDUO (lamivudine/tenofovir) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TEMIXYS (lamivudine/tenofovir) TRIZIVIR (abacavir/lamivudine/zidovudine)

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

G. Bronchodilators, Beta Agonists

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

Dr. Henry brought forth a recommendation to move Ventolin HFA to preferred. A motion to approve the recommended changes (as above) by Change Healthcare and to move Ventolin HFA to preferred was made by Dr. Galapon and seconded by Dr. Henry, all were in favor and the motion was approved

H. Cytokine & Cam Antagonists

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. *Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indicaton). All off-label requests require review by the Medical Director.*

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ENBREL (etanercept)* HUMIRA (adalimumab)*	CIMZIA (certolizumab pegol) REMICADE (infliximab) RENFLEXIS (infliximab) SIMPONI subcutaneous (golimumab)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
	OTHERS	
TALTZ (ixekizumab) XELJANZ (tofacitinib)**	ACTEMRA subcutaneous (tocilizumab) COSENTYX (secukinumab)* ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA subcutaneous (abatacept) OTEZLA (apremilast) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) STELARA subcutaneous (ustekinumab) TREMFYA (guselkumab) 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. **Xeljanz is preferred for treatment of rheumatoid arthritis and ulcerative colitis only.

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

I. 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	AEROSPAN (flunisolide)** ALVESCO (ciclesonide) ARMONAIR RESPICLICK (fluticasone)	*Pulmicort 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
THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) PULMICORT NEBULIZER SOLUTION (budesonide) QVAR REDIHALER (beclomethasone)	diagnosis of severe nasal polyps. **Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent.
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS	
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) fluticasone/salmeterol WIXELA (fluticasone/salmeterol)	

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

J. Hypogclycemics, 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 gluisine)[AP]* FIASP (insulin aspart) 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 N VIAL (insulin) HUMULIN R U-500 VIAL (insulin) HUMULIN R U-500 KWIKPEN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) TRESIBA (insulin degludec) TRESIBA FLEXTOUCH (insulin degludec)	ADMELOG (insulin lispro) AFREZZA (insulin)[CL] BASAGLAR (insulin glargine) HUMULIN PENS (insulin) HUMULIN R VIAL (insulin) HUMULIN 70/30 (insulin) insulin aspart insulin aspart/aspart protamine insulin lispro NOVOLIN (insulin) SOLIQUA (insulin glargine/lixisenatide)** TOUJEO SOLOSTAR (insulin glargine)*** XULTOPHY (insulin degludec/liraglutide)**	*Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.. ** 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. ***Toujeo Solostar and Toujeo Max Solostar may be approved only for: 1.) 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. **OR** 2.) Patients who currently require over 200 units per day of long-acting insulin.

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

K. Hypoglycemics, Sodium Glucose Cotransporter-2 Inhibitors

HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:

1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.
2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TRIJARDY XR (empagliflozin/linagliptin/metformin) QTERN (dapagliflozin/saxagliptin) XIGDUO XR (dapagliflozin/metformin)	

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

L. Immunomodulators, Atopic Dermatitis

IMMUNOMODULATORS, ATOPIC DERMATITIS

CLASS PA CRITERIA: Non-preferred agents require 30-day trial of a medium to high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds.

ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)	DUPIXENT (dupilumab)* EUCRISA (crisaborole)[AP]** pimecrolimus cream tacrolimus ointment	*Full PA criteria for Dupixent may be found on the PA Criteria page by clicking the hyperlink **Eucrisa requires a 30-day trial of Elidel OR a medium to high potency corticosteroid unless contraindicated.

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

M. 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) MOVANTIK (naloxegol) LINZESS (linaclotide)	LINZESS 72 mcg (linaclotide) MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod maleate)	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. 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:** **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.

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

N. Laxatives and Cathartics

LAXATIVES AND CATHARTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
COLYTE GOLYTELY NULYTELY peg 3350	CLENPIQ (sodium picosulfate, magnesium oxide, citric acid) HALFLYTELY-BISACODYL KIT MOVIPREP OSMOPREP PREPOPIK SUPREP	

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

O. Lipotropics, Other (Non-Statins)

LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
PCSK-9 INHIBITORS/BEMPEDOIC ACID		
	PRALUENT (alirocumab)* REPATHA (evolocumab)* NEXLETOL (bempedoic acid)* NEXLIZET (bempedoic acid/ezetimibe)*	*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 by Charlie Rohrbaugh and seconded by Dr. Terpening, all were in favor and the motion was approved

P. MABS-Anti-IL, Anti IgE

MABS, ANTI-IL/IgE		
CLASS PA CRITERIA: Full PA Criteria may be found on the PA Criteria page by clicking the hyperlink.		
XOLAIR (omalizumab)	DUPIXENT (dupilumab) FASENRA (benralizumab) FASENRA PEN (benralizumab) NUCALA SYRINGE/VIAL (mepolizumab) NUCALA AUTO INJECTOR (mepolizumab)	

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

Q. 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 each chemically unique preferred agent (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)** dalfampridine ER* COPAXONE 20 mg (glatiramer) dimethyl fumerate***** GILENYA (fingolimod)	AMPYRA (dalfampridine)* COPAXONE 40 mg (glatiramer)*** glatiramer GLATOPA (glatiramer) MAYZENT (siponimod)**** MAVENCLAD (cladribine) TECFIDERA (dimethyl fumarate)***** VUMERITY (diroximel) ZINBRYTA (daclizumab)	**In addition to class PA criteria, the following conditions and criteria may also apply:** *Ampyra and dalfampridine ER 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. **Aubagio requires the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 5. Patient is between eighteen (18) up to sixty-five (65) years of age **and** 6. Negative tuberculin skin test before initiation of therapy ***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. *****Tecfidera and dimethyl fumerate 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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

Charlie Rohrbaugh made a motion to move dimethyl fumerate to preferred. A motion to approve the recommended changes (as above) by Change Healthcare and to move dimethyl fumerate to preferred was made by Charlie Rohrbaugh and seconded by Dr. Gloss, all were in favor and the motion was approved

R. 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 pregabalin capsule ZTLIDO PATCH (lidocaine)	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* GRALISE (gabapentin)** HORIZANT (gabapentin) IRENKA (duloxetine) LIDODERM (lidocaine) LYRICA CR (pregabalin)*** LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin)^AP QUTENZA (capsaicin) SAVELLA (milnacipran)**** LYRICA CAPSULE (pregabalin)	*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**

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

S. 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) BEPREVE (bepotastine) cromolyn ketotifen LASTACAFT (alcaftadine) olopatadine 0.1% (Generic PATANOL labeler 61314 only) ZADITOR OTC (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) Epinastine LUMIFY (brimonidine)	
THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	olopatadine 0.1% (all formulations except Generic PATANOL labeler 61314) olopatadine 0.2% (all labelers) OPTICROM (cromolyn) OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) ZERVIATE (cetirizine)	

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

T. Otic Antibiotics

OTIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) ofloxacin CORTISPORIN-TC (colistin/hydrocortisone/ neomycin)	ciprofloxacin ciprofloxacin/fluocinolone neomycin/polymyxin/HC solution/suspension OTOVEL (ciprofloxacin/fluocinolone)	

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

U. 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	
Melatonin ROZEREM (ramelteon) zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) chloral hydrate DAYVIGO (lemborexant) EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)[CL]* INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg ZOLPIMIST (zolpidem)	Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate. 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.

Dr. Gloss made a motion to add a non-benzo alternative to the preferred list and recommended Rozerem be moved to preferred. A motion to approve the recommended changes (as above) by Change Healthcare and to move Rozerem to preferred was made by Dr. Gloss and seconded by Dr. Galapon, all were in favor and the motion was approved

V. Steroids, Topical

STEROIDS, TOPICAL

CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present.

LOW POTENCY		
DERMA-SMOOTHE FS (fluocinolone acetonide) hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DESONATE (desonide) desonide cream, ointment desonide lotion DESOWEN (desonide) fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone)	

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

W. Stimulants & Related Agent

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**: Non-preferred agents will NOT be "grandfathered" for adults. Children under the age of 18 may continue their current therapy until the end of the school year after which they will be required to switch to a preferred agent.		
NON-AMPHETAMINE		
atomoxetine CONCERTA (methylphenidate) clonidine IR dexmethylphenidate IR FOCALIN XR (dexmethylphenidate) guanfacine ER guanfacine IR methylphenidate IR methylphenidate ER tablet (generic RITALIN SR) methylphenidate solution QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate)	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) clonidine ER COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) dexmethylphenidate XR FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine extended-release) JORNAY PM (methylphenidate) KAPVAY (clonidine extended-release) METHYLIN SOLUTION (methylphenidate) methylphenidate CD methylphenidate chewable tablets methylphenidate ER 24 tablet (generic CONCERTA) methylphenidate ER capsule methylphenidate LA capsule RITALIN (methylphenidate) RITALIN LA (methylphenidate) STRATTERA (atomoxetine)*	* Strattera is limited to a maximum of 100 mg per day.

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

X. Analgesics, Narcotics- Long Acting (Non-Parenteral)

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of two (2) chemically distinct preferred agents **AND** a six (6) day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one (1) of the exceptions on the PA form is present. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **NOTE: All long-acting opioid agents require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted.		
BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER tablets (generic Ultram ER) XTAMPZA ER (oxycodone)	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal film)* buprenorphine patch (all labelers including 00093) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EMBEDA (morphine/naltrexone) EXALGO ER (hydromorphone) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) LAZANDA SPRAY (fentanyl) methadone** MORPHABOND ER (morphine sulfate) morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER** OXYCONTIN (oxycodone) oxymorphone ER** tramadol ER (generic Conzip ER)*** ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) ZOHYDRO ER (hydrocodone)	*Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. ***Tramadol ER (generic Conzip) requires a manual review and may be authorized for ninety (90) days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber.

The above category was recommended for extraction by Dr. Galapon who recommended moving Xtampza ER to preferred for an additional long-acting narcotic option. A motion to approve the recommended changes was made by Dr. Galapon and seconded by Charlie Rohrbaugh, all were in favor and the motion was approved.

Y. COPD Agents

The above category was recommended for extraction by Dr. Henry. There was no change to this category. A motion to approve the category as is was made by Dr. Henry and seconded by Dr. Galapon, all were in favor and the motion was approved.

Z. Hypoglycemics, GLP-1 Agonists-Dr. Henry

The above category was recommended for extraction by Dr. Henry. There was no change to this category. A motion to approve the category as is was made by Dr. Henry and seconded by Dr. Galapon, all were in favor and the motion was approved.

AA. Opiate Dependence Treatments-Charlie Rohrbaugh

The above category was recommended for extraction by Charlie Rohrbaugh. There was no change to this category. A motion to approve the category as is was made by Charlie Rohrbaugh and seconded by Dr. Galapon, all were in favor and the motion was approved.

XI. Next Meeting

The next P&T Committee Meeting is scheduled for January 27th, 2021, from 2:00 PM-5:00 PM, Virtual Meeting

XII. Other Business

There was no other business discussed at this time.

XIII. Adjournment

The Committee adjourned the meeting at 2:26 PM.