STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bill J. Crouch
Cabinet Secretary

Bureau for Medical Services
Pharmacy Services
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1542

Cynthia E. Beane
Commissioner

Pharmaceutical and Therapeutics Committee

October 30, 2019

Location: Charleston Civic Center
Time: 9:00 AM – 5:00 PM
200 Civic Center Drive
Charleston, WV 25301
(304) 558-1700

MINUTES

Committee Members Present:
Bradley Henry, MD, Chair
Tom Kines, RPh, Vice-Chair
John Bernabei, RPh
Toni DiChiacchio, DNP
Philip Galapon, MD FAAFP
David Gloss, MD
Kelli Lynn Jennings, PharmD
Heather Jones, PA-C
Karrie Murphy, Pharm
Hani Nahza, MD
Steve Neal, RPh
Charles Rohrbaugh, RPh
Chris Terpening, PharmD, PhD

Absent:

Division of Medicaid Staff Present:
Bill Hopkins
Lori Moles
Doug Sorvig
Brian Thompson, PharmD, MS
Gail Goodnight

Contract Staff Present:
Change Healthcare
Laureen Biczak, DO
Brent Breeding, RPh

Other Contract / State Staff Present:

I. Call to Order

Dr. Bradley Henry, Chairman, called the meeting to order at 9:10am.

II. Welcome and Introductions

Dr. Henry welcomed all present to the committee meeting. Committee members, Bureau of Medical Services staff, and Change Healthcare staff introduced themselves.

III. Administrative Items / Updates

A. Approval of the August 28, 2019 Minutes

The Committee moved to approve the August 28, 2019 Meeting minutes. All were in favor with no objections or revisions.

B. PDL Compliance / Generic Percent Report Updates

Dr. Biczak provided an explanation of the PDL Compliance and Generic Percent reports.

i. Dr. Biczak reviewed the Generic Percent Report; overall generic utilization for Q3 2019 was 86.1%

ii. Dr. Biczak reviewed the PDL Compliance Report; overall compliance for Q3 2019 was 90.9%.

IV. Drug Class Announcements

Change Healthcare recommended that the following classes be extracted:

- Analgesics, Narcotics- Long Acting (Non-Parenteral)
- Angiotensin Modulators
- Antibiotics, Vaginal
- Antiemetics
- Antihemophilia Factor Agents
- Antimigraine Agents, CGRP Inhibitors
- Antiparasitics, Topical
- Antiparkinson’s Agents
- Antipsychotics, Atypical
- Antiretrovirals
- Bladder Relaxant Preparations
- COPD Agent

- Cytokine & Cam Antagonists
- Glucocorticoids, Inhaled
- Hepatitis C Treatments
- Hypoglycemics, Insulins & Related Agents
- Hypoglycemics, Sodium Glucose Cotransporter-2 Inhibitors
- Immunomodulators, Atopic Dermatitis
- Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents
- Multiple Sclerosis Agents
- Ophthalmic Antibiotics/Steroid Combinations
- Ophthalmics for Allergic Conjunctivitis
- Ophthalmics, Anti-Inflammatories-Immunomodulators
- Ophthalmics, Anti-Inflammatories
- Ophthalmics, Glaucoma Agents
- PAH Agents – Endothelin Receptor Antagonists
- Phosphate Binders
- Pituitary Suppressive Agents, LHRH
- Platelet Aggregation Inhibitors
- Stimulants & Related Agents
- Ulcerative Colitis Agents

V. Extractions – First Round

Additional extractions presented by Committee members:

- Anticoagulants – requested by Dr. Galapon
- Anticonvulsants - requested by Dr. Galapon
- Bronchodilators, Beta Agonists - requested by Dr. Murphy
- Hypoglycemics, GLP-1 Agonists - requested by Dr. Galapon
- Lipotropics, Other (Non-Statins) - requested by Dr. Galapon
- Neuropathic Pain - requested by Dr. Jennings
- Opiate Dependence Treatments - requested by Toni DiChiacchio
- Skeletal Muscle Relaxants - requested by Dr. Galapon

VI. Public Comments

Dr. Thompson called the first speaker. He described the 3-minute limit per speaker, per drug.

Ahmad Nessar of Amgen spoke for Aimovig & Repatha
Robert Touchon of Novartis spoke for Eliquis
Amy Gamble, no affiliation, spoke on behalf of antipsychotics in general
Julian Espiritu of Janssen spoke for Invokana
Kimberlee Woomer of Scilex spoke for Ztlido
Rejena Azad of UCB spoke for Briviact and Vimpat
Cheryl Winter of Lilly spoke for Trulicity
Juan Avila of UCB spoke for Cimzia

Janelle Schafer of Teva spoke for Ajovy
Debra Stult spoke for Spravato
Nancy Njuguna of Lilly spoke for Trulicity & Emgality
Kevin Lynch of Pfizer spoke for Eucrisa
Susan Steinbis of United Therapeutics spoke for Orenitram
Andrea Wilson of Indivior spoke for Sublocade
Andrea Meyer of Otsuka spoke for Abilify Maintenna
Tia Ly of Novartis spoke for Mayzent
Steve St. Onge of Paratek Pharma spoke for Nuzyra
Daniel Macias of Lilly spoke for Trulicity
Adan Sosa of Sunovian spoke for Latuda
Steven Petrosino of Bristol Meyers Squibb spoke for Orencia
Judge William Thomson spoke for Sublocade

VII. Extractions – Second Round

Additional extractions presented by Committee members:

- Sedative Hypnotics – requested by Charles Rohrbaugh
- Tetracyclines – requested by Dr. Murphy

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

Change Healthcare recommended that the following list be approved with no changes.

- Acne Agents, Topical
- Alzheimer's Agents
- Analgesics, Narcotics- Short Acting (Non-Parenteral)
- Androgenic Agents
- Anesthetics, Topical
- Antianginal & Anti-Ischemic
- Antibiotics, GI & Related Agents
- Antibiotics, Inhaled
- Antibiotics, Topical
- Antidepressant-Other
- Antidepressants- SSRIs
- Antifungals, Oral
- Antifungals, Topical
- Antihypertensives, Sympatholytics
- Antihyperuricemics
- Antimigraine Agents, Other
- Antimigraine Agents, Triptans
- Antipsoriatics, Topical
- Antivirals, Oral
- Antivirals, Topical
- Beta Blockers
- 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
- 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
- Laxatives and Cathartics
- Leukotriene Modifiers
- Lipotropics, Statins
- Macrolides
- NSAIDs
- Ophthalmic Antibiotics
- Otic Antibiotics
- PAH Agents – Guanylate Cyclase Stimulator
- PAH Agents – PDE5s
- PAH Agents - Prostacyclins
- Pancreatic Enzymes
- Progestational Agents
- Progestins for Cachexia
- Proton Pump Inhibitors
- Steroids, Topical
- 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. Executive Session

The Committee adjourned for Executive Session at 11:30 am.

X. Lunch Break

The Committee's lunch break was taken during the Executive Session.

XI. Extracted Therapeutic Category Reviews/Committee Recommendations

NOTE: Due to last minute price increases/decreases, enhanced Supplemental Rebate offers, clinical updates and other last minute changes, the Draft PDL available to the public did not accurately reflect all of the recommendations Change HealthCare presented to the P&T Committee. Specific details of recommendations will be listed in affected categories.

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

Change Healthcare recommended that the following list be approved. Recommendation to move Xtampza ER to preferred as indicated on Draft PDL was rescinded. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets	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*** ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) XTAMPZA ER (oxycodone)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 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.

B. Angiotensin Modulators

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril)[AP]* irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine) valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine telmisartan HCTZ	*Entresto will only be authorized for patients 18 years of age or older who are diagnosed with chronic heart-failure.

C. Antibiotics, Vaginal

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream GYNAZOLE-1 (butoconazole) METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)	

D. Anticoagulants

Committee Member asked for class extraction. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

E. Anticonvulsants

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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	APTIOM (eslicarbazepine)
carbamazepine ER	BANZEL (rufinamide)
carbamazepine XR	BRIVIACT (brivaracetam)
divalproex	carbamazepine oral suspension
divalproex ER	CARBATROL (carbamazepine)
divalproex sprinkle	DEPAKENE (valproic acid)
EPITOL (carbamazepine)	DEPAKOTE (divalproex)
GABITRIL (tiagabine)	DEPAKOTE ER (divalproex)
lamotrigine	DEPAKOTE SPRINKLE (divalproex)
levetiracetam IR	EQUETRO (carbamazepine)
levetiracetam ER	FANATREX SUSPENSION (gabapentin)
levetiracetam IR suspension	felbamate
oxcarbazepine suspension and tablets	FELBATOL (felbamate)
TEGRETOL SUSP (carbamazepine)	FYCOMPA (perampanel)
topiramate IR	KEPPRA (levetiracetam)
topiramate ER*	KEPPRA XR (levetiracetam)
valproic acid	KEPPRA SOLUTION (levetiracetam)
VIMPAT (lacosamide)	LAMICTAL CHEWABLE (lamotrigine)
Zonisamide	LAMICTAL (lamotrigine)
	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 (carbamazepine)
	TEGRETOL XR (carbamazepine)
	tiagabine
	TOPAMAX (topiramate)
	TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine)
	TROKENDI XR (topiramate)**
	ZONEGRAN (zonisamide)

F. Antiemetics

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for sub-class criteria.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	COMBINATIONS	
	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine)	Non-preferred agents will only be approved on appeal.

G. Antihemophilia Factor Agents

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	FACTOR VIII	
ADVATE AFSTYLA ALPHANATE HELIXATE FS HEMOFIL M HUMATE-P KOATE KOATE-DVI KOGENATE FS MONOCLATE-P NOVOEIGHT NUWIQ WILATE XYNTHA XYNTHA SOLOFUSE	ADYNOVATE ELOCTATE JIVI KOVALTRY RECOMBINATE VONVENDI	
	FACTOR IX	
ALPHANINE SD ALPROLIX BEBULIN BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	
	FACTOR IXa/IX	
	HEMLIBRA (emicizumab-kxwh)	

H. Antimigraine Agents, CGRP Inhibitors

Change Healthcare recommended making Emgality preferred. After review of Supplemental Rebate offers, conditions and pricing a committee member recommended also making Amovig preferred. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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

I. Antiparasitics, Topical

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

ANTIPARASITICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NATROBA (spinosad) permethrin 5% cream pyrethrins-piperonyl butoxide OTC SKLICE (ivermectin)	ELIMITE CREAM (permethrin) EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl/pyrethin)	

J. Antiparkinson's Agents

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OTHER ANTIPARKINSON'S AGENTS		
amantadine*[AP] APOKYN (apomorphine) bromocriptine carbidopa/levodopa	AZILECT (rasagiline) carbidopa ELDEPRYL (selegiline) GOCOVRI ER (amantadine)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.

ANTIPARKINSON'S AGENTS		
levodopa/carbidopa/entacapone selegiline	INBRIJA (levodopa) levodopa/carbidopa ODT LODOSYN (carbidopa) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) rasagiline RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) XADAGO (safinamide) ZELAPAR (selegiline)	

K. Antipsychotics, Atypical

Change Healthcare recommended moving Zyprexa Relprevv to preferred status and moving aripiprazole solution and Abilify Maintenna to non-preferred status. Committee member recommended leaving Abilify Maintenna as preferred and also adding Perseris to preferred status. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SINGLE INGREDIENT		
ABILIFY MAINTENA (aripiprazole)[CL] aripiprazole tablets ARISTADA (aripiprazole)[CL] ARISTADA INITIO (aripiprazole)[CL] clozapine INVEGA SUSTENNA (paliperidone)[CL] INVEGA TRINZA (paliperidone)* [CL] olanzapine PERSERIS (risperidone)[CL] quetiapine** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone)[CL] risperidone solution, tablet ziprasidone ZYPREXA RELPREVV (olanzapine)	ABILIFY MYCITE (aripiprazole) ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) aripiprazole solution clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone)*** NUPLAZID (pimavanserin) **** olanzapine IM[CL] olanzapine ODT paliperidone ER quetiapine ER REXULTI (brexipiprazole) RISPERDAL (risperidone) risperidone ODT	**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.**

ANTIPSYCHOTICS, ATYPICAL		
	SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) VRAYLAR (capriprazine)*** VRAYLAR DOSE PAK (capriprazine)*** ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)[CL]	***For the indication of bipolar depression only, prior authorization of LATUDA or VRAYLAR requires failure of a 30-day trial of either 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 or Vraylar shall be grandfathered. ****Nuplazid will only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine.

L. Antiretrovirals

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide) COMPLERA (emtricitabine/rilpivirine/tenofovir)* DELSTRIGO(doravirine/lamivudine/tenofovir df) GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir	ATRIPLA (efavirenz/emtricitabine/tenofovir) 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.

ANTIRETROVIRALS[AP]		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
SUSTIVA (efavirenz)	EDURANT (rilpivirine) efavirenz INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) VIRAMUNE ER 24H (nevirapine) VIRAMUNE SUSPENSION (nevirapine)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir)	TRUVADA (emtricitabine/tenofovir)	

M. Bladder Relaxant Preparations

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GELNIQUE (oxybutynin) oxybutynin IR oxybutynin ER solifenacin TOVIAZ (fesoterodine)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin)	

N. Bronchodilator, Beta Agonists

Committee Member asked for class extraction. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

O. COPD Agents

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

COPD AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICHOLINERGIC[AP]		
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium)	INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) SEEBRI NEOHALER (glycopyrrolate) YUPELRI SOLUTION (revefenacin)	
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
ANORO ELLIPTA (umeclidinium/vilanterol) albuterol/ipratropium nebulizer solution BEVESPI (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) UTIBRON (indacaterol/glycopyrrolate)	DUONEB (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)*	*In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of Anoro Ellipta.

P. Cytokine & CAM Antagonists

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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) SKYRIZI (risankizumab) 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.

Q. Glucocorticoids, Inhaled

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GLUCOCORTICOIDS		
ASMANEX TWISTHALER (mometasone) FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide) PULMICORT NEBULIZER (budesonide) 0.5mg/2ml & 0.25mg/2ml PULMICORT RESPULES (budesonide)* QVAR REDIHALER (beclomethasone)	AEROSPAN (flunisolide)** ALVESCO (ciclesonide) ARMONAIR RESPICLICK (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide nebulizer solution PULMICORT NEBULIZER (budesonide) 1mg/2ml	*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 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 HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) fluticasone/salmeterol SYMBICORT(budesonide/formoterol)	ADVAIR DISKUS (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) fluticasone/salmeterol WIXELA (fluticasone/salmeterol)	

R. Hepatitis C Treatments

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

HEPATITIS C TREATMENTS[CL]		
CLASS PA CRITERIA: For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPCLUSA (sofosbuvir/velpatasvir)* MAVYRET (pibrentasvir/glecaprevir)* ribavirin ZEPATIER (elbasvir/grazoprevir)*	COPEGUS (ribavirin) DAKLINZA (daclatasvir)* HARVONI (ledipasvir/sofosbuvir)* ledipasvir/sofosbuvir* MODERIBA 400 mg, 600 mg MODERIBA DOSE PACK PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) OLYSIO (simeprevir)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

HEPATITIS C TREATMENTS[CL]		
	REBETOL (ribavirin) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin) sofosbuvir/velpatasvir* SOVALDI (sofosbuvir)* TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	

S. Hypoglycemics, GLP-1 Agonists

Committee Member asked for class extraction. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

T. Hypoglycemics, Insulin and Related Agents

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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. Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
APIDRA (insulin glulisine)[AP]* FIASP (insulin aspart) HUMALOG (insulin lispro) HUMALOG JR KWIKPEN (insulin lispro) HUMALOG KWIKPEN U-100 (insulin lispro) HUMALOG MIX KWIKPENS (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)	ADMELOG (insulin lispro) AFREZZA (insulin)[CL] BASAGLAR (insulin glargine) HUMULIN PENS (insulin) HUMULIN R VIAL (insulin) HUMULIN 70/30 (insulin) 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

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS		
NOVOLOG MIX (insulin aspart/aspart protamine) TRESIBA (insulin degludec) TRESIBA FLEXTOUCH (insulin degludec)		cannot be met with a combination of preferred single-ingredient agents.

U. Hypoglycemics, SGLT2 Inhibitors

Change Healthcare recommended that Synjardy be moved to Preferred status but NOT to move Farxiga and Invokana to non-preferred as indicated on draft PD. Committee member recommended also moving Invokamet to preferred status. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]		
CLASS PA CRITERIA: Agents in this class will not be approved for patients with a starting A1C < 7%. Non-preferred agents are available only on appeal. Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met. • Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient's current and stabilized regimen. • No agent in this class shall be approved except as add on therapy to a regimen consisting of at least one (1) other agent prescribed at the maximum tolerable dose for at least 90 days. • Re-authorizations require continued maintenance on a regimen consisting of at least one (1) other agent at the maximum tolerable dose AND an A1C of ≤8%.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) INVOKANA (canagliflozin JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	
SGLT2 COMBINATIONS		
INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) SEGLUROMET (ertugliflozin/metformin STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) XIGDUO XR (dapagliflozin/metformin)	

V. Immunomodulators, Atopic Dermatitis

Recommendation to move Elidel and Eucrisa as shown on Draft PDL was rescinded by Change Healthcare. Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ELIDEL (pimecrolimus) EUCRISA (crisaborole)[AP]* PROTOPIC (tacrolimus)***	DUPIXENT (dupilumab)** tacrolimus ointment	*Eucrisa requires a 30-day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated. **Full PA criteria for Dupixent may be found on the PA Criteria page by clicking the hyperlink ***Protopic brand is preferred over its generic equiviliant.

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

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CONSTIPATION		
AMITIZA (lubiprostone)* LINZESS (linaclotide)*** MOVANTIK (naloxegol)**	MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone)**** RELISTOR TABLET (methylnaltrexone)**** SYMPROIC (naldemedine)**** TRULANCE (plecanatide)*****	All agents 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. In addition: * Amitiza is indicated for CIC, IBS-C (females only) and OIC. Approval for the diagnosis of OIC requires a concurrent and continuous 90-day history of opioid claims on record. ** Movantik will be approved per the FDA-approved label for OIC with a concurrent and continuous 90-day history of opioid claims on record.

IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS [CL]		
		*** Linzess is indicated for CIC and IBS-C and requires a thirty (30) day trial of Amitiza. . For the indication of IBS-C in males, a trial of Amitiza is not required. **** Relistor and Symproic are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza. ***** Trulance is indicated for CIC and requires a thirty (30) day trial of Amitiza. For the indication of IBS-C in males, a trial of Amitiza is not required.

X. Lipotropics, Other (Non-Statins)

Change Healthcare recommended no changes to the category. Committee Member made a motion to make changes listed below. Motion was seconded. Votes were taken, and the motion was adopted. The approved category is below.

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.		
FATTY ACIDS[CL]		
omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	LOVAZA (omega-3-acid ethyl esters)	These agents are recommended when the patient has an initial triglyceride level ≥ 500 mg/dL.

Y. Multiple Sclerosis Agents

Change Healthcare recommended moving Rebif and Ampyra to preferred and making Mayzent and Mavenclad non-preferred. Committee Member recommended also moving Aubagio to preferred. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

MULTIPLE SCLEROSIS AGENTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require a diagnosis of multiple sclerosis and thirty (30) 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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
INTERFERONS[AP]		
AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a)	

MULTIPLE SCLEROSIS AGENTS[CL]

NON-INTERFERONS

AMPYRA (dalfampridine)** AUBAGIO (teriflunomide)*** COPAXONE 20 mg (glatiramer) GILENYA (fingolimod) *	COPAXONE 40 mg (glatiramer)**** glatiramer GLATOPA (glatiramer) MAYZENT (siponimod) MAVENCLAD (cladribine) TECFIDERA (dimethyl fumarate)***** ZINBRYTA (daclizumab)	**In addition to class PA criteria, the following conditions and criteria also apply:** *Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent. **Ampyra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. Initial prescription will be authorized for thirty (30) days only. ***Aubagio will be authorized if the following criteria are 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 from 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. *****Tecfidera will be authorized if the following criteria are 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**

MULTIPLE SCLEROSIS AGENTS[CL]		
		3. Complete blood count (CBC) annually during therapy.

Z. Neuropathic Pain

Committee Member asked for class extraction. Cost of new Ztlido patch was discussed in Executive Session. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

AA. Ophthalmic Antibiotic/Steroid Combinations

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone) ZYLET (loteprednol/tobramycin)	BLEPHAMIDE (prednisolone/sulfacetamide) BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension	

BB. Ophthalmics for Allergic Conjunctivitis

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 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)	

CC. Ophthalmics, Anti-inflammatories - Immunomodulators

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
RESTASIS DROPERETTE (cyclosporine)	CEQUA (cyclosporine) RESTASIS MULTIDOSE (cyclosporine) XIIDRA (lifitegrast)	The following prior authorization criteria apply to both Restasis and Xiidra: 1.) Patient must be sixteen (16) years of age or greater; **AND** 2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND** 3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND** 4.) Patient must have a functioning lacrimal gland; **AND**

OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS		
		5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND** 6.) Patient must not have an active ocular infection

DD. Ophthalmics, Anti-Inflammatories

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

OPHTHALMICS, ANTI-INFLAMMATORIES		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent.		
dexamethasone diclofenac DUREZOL (difluprednate) fluorometholone FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ketorolac LOTEMAX DROPS, OINTMENT (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED MILD (prednisolone) prednisolone acetate prednisolone sodium phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) FLAREX (fluorometholone) flurbiprofen FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol) LOTEMAX GEL (loteprednol) OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone) VEXOL (rimexolone) XIBROM (bromfenac)	

EE. Ophthalmics, Glaucoma Agents

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

OPHTHALMICS, GLAUCOMA AGENTS		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
RHO-KINASE INHIBITORS		
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		Prior authorization of any agent in this sub-class requires a trial of at least

OPHTHALMICS, GLAUCOMA AGENTS		
		one (1) preferred agent from all other sub-classes.

FF. Opiate Dependence Treatments

Committee Member asked for class extraction. Costs of all products were compared in Executive Session. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

GG. PAH Agents – Endothelin Receptor Antagonists

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LETAIRIS (ambrisentan) TRACLEER TABLET (bosentan)	ambrisentan bosentan OPSUMIT (macitentan) TRACLEER SUSP (bosentan)	

HH. Phosphate Binders

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
calcium acetate CALPHRON (calcium acetate) MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) sevelamer carbonate	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) lanthanum chewable PHOSLO (calcium acetate) RENAGEL (sevelamer) RENVELA (sevelamer carbonate) VELPHORO (sucroferric oxyhydroxide)	

II. Pituitary Suppressive Agents, LHRH

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]		
CLASS PA CRITERIA: Non-preferred agents **are available only on appeal.**		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin) VANTAS (histrelin) ZOLADEX (goserelin)	leuprolide ORILISSA(elagolix)* SUPPRELIN LA KIT (histrelin)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

JJ. Platelet Aggregation Inhibitors

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

PLATELET AGGREGATION INHIBITORS		
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.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
AGGRENOX (dipyridamole/ASA) BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel	clopidogrel kit dipyridamole/aspirin EFFIENT (prasugrel) PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine ZONTIVITY (vorapaxar)	

KK. Sedative Hypnotics

Committee Member asked for the class to be extracted and requested updated pricing. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

LL. Skeletal Muscle Relaxants

Committee Member asked for the class to be extracted and requested updated pricing. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

MM. Stimulants and Related Agents

Change Healthcare recommended moving Procentra Solution and Daytrana Patch to non-preferred. Committee Member recommended moving dextroamphetamine/amphetamine salt ER (generic Adderall XR) be moved to preferred. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

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.

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AMPHETAMINES		
amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) ADDERALL XR* (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) DEXEDRINE IR (dextroamphetamine) dextroamphetamine solution DYANAVEL XR SUSP (amphetamine) EVEKEO (amphetamine) methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)** PROCENTRA solution (dextroamphetamine) 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		
APTENSIO XR (methylphenidate) armodafinil[CL] atomoxetine clonidine IR dexmethylphenidate IR FOCALIN XR (dexmethylphenidate) guanfacine ER guanfacine IR METHYLIN SOLUTION (methylphenidate) methylphenidate IR modafinil[CL] QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate)	clonidine ER CONCERTA (methylphenidate) COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) dexmethylphenidate XR FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine extended-release) KAPVAY (clonidine extended-release) methylphenidate CD methylphenidate chewable tablets, solution methylphenidate ER methylphenidate ER (generic CONCERTA) methylphenidate LA NUVIGIL (armodafinil) PROVIGIL (modafinil) RITALIN (methylphenidate)	*Strattera is limited to a maximum of 100 mg per day.

STIMULANTS AND RELATED AGENTS		
	RITALIN LA (methylphenidate) STRATTERA (atomoxetine)*	

NN. Tetracyclines

Committee member asked for class to be extracted. Pricing of Nuzyra was discussed in Executive Session. Change Healthcare recommended no changes to the category. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

OO. Ulcerative Colitis Agents

Change Healthcare recommended that the following list be approved. Motion was made and seconded to approve as recommended. Votes were taken, and the motion was adopted. The approved category is below.

ULCERATIVE COLITIS AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred dosage form or chemical entity before the corresponding non-preferred agent of that dosage form or chemical entity will be approved, unless one (1) of the exceptions on the PA form is present.		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ORAL		
APRISO (mesalamine) ASACOL HD (mesalamine) balsalazide PENTASA (mesalamine) 250 mg PENTASA (mesalamine) 500 mg sulfasalazine	AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine UCERIS (budesonide)	
RECTAL		
CANASA (mesalamine) mesalamine	DELZICOL DR (mesalamine) mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	

XII. Next Meeting

The next P&T Committee Meeting is scheduled for January 22, 2020.

XIII. Other Business

XIV. Adjournment

The Committee adjourned the meeting at 3:30 pm.