

**DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS**

**INFORMATION FOR THE UNIFORM FORMULARY
BENEFICIARY ADVISORY PANEL**

I. UNIFORM FORMULARY REVIEW PROCESS

Under 10 United States Code § 1074g, as implemented by 32 Code of Federal Regulations 199.21, the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee is responsible for developing the Uniform Formulary (UF). Recommendations to the Director, Defense Health Agency (DHA), on formulary status, prior authorization (PA), pre-authorizations, and the effective date for a drug's change from formulary to nonformulary (NF) status are received from the Beneficiary Advisory Panel (BAP), which must be reviewed by the Director before making a final decision.

II. UF CLASS REVIEWS—MIGRAINE AGENTS – CALCITONIN GENE-RELATED PEPTIDE (CGRP) ANTAGONIST PROPHYLAXIS SUBCLASS

P&T Comments

A. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—Relative Clinical Effectiveness Analysis and Conclusion

Background—The P&T Committee evaluated the relative clinical effectiveness of the CGRP antagonists, which provide a new mechanism for migraine headache prevention. The drugs in the subclass include erenumab (Aimovig), fremanezumab (Ajovy), and galcanezumab (Emgality). The CGRP antagonists are available as once monthly injections and were individually reviewed as new drugs at the August and November 2018 DoD P&T Committee meetings. All three products are FDA-approved for the preventive treatment of migraines in adults.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

CGRP antagonists vs. oral preventive therapies

- Oral drugs, including the antiepileptics, beta-blockers and antidepressants, remain the first-line treatment for migraine headache prevention, based on the 2012/2015 American Academy of Neurology/American Headache Society (AHS) migraine prevention guidelines and the 2018 AHS consensus statement for instituting the new migraine treatments into clinical practice. CGRP antagonists are recommended following 2 or 3 trials of oral medications.
- A 2018 network meta-analysis from the Institute for Clinical and Economic Review (ICER) found that oral preventive treatment and CGRP antagonists decrease monthly migraine days (MMD) by approximately 2 days from baseline, compared to placebo. ICER also concluded that the evidence is inadequate to distinguish the net health benefit between treatment with the CGRP inhibitors versus oral preventive therapies (e.g., amitriptyline, topiramate, or propranolol).

CGRP antagonist vs. CGRP antagonist

- Although there are no head-to-head trials comparing Aimovig, Ajovy, or Emgality, or there do not appear to be clinically relevant differences in efficacy, based on indirect comparisons. For episodic migraine, a meta-analysis showed similar improvements between the three CGRP antagonists in terms of change from baseline in MMD and the patients who had a $\geq 50\%$ reduction in migraine days (50% responders) (*Zhu, et al, Neurological Sciences 2018*).
- The 2018 ICER network meta-analysis reported reductions in MMDs ranging from 1.2 to 1.9 days with the CGRP inhibitors for episodic migraine, with the odds of achieving a 50% response rate ranging from 1.7 to 2.7. For chronic migraine, the decrease in MMDs ranged from 1.3 to 2.4 days. ICER concluded the evidence was inadequate to distinguish the net health benefits among the three CGRP inhibitors.
- The FDA review noted that some patients treated with a CGRP antagonist experienced relatively large reductions in migraine headache days. However, there are no clinical characteristics to prospectively identify those patients most likely to respond to therapy. Additionally, there was a high placebo response rate noted in the individual trials used to gain FDA approval.
- Some distinguishing characteristics among the CGRP inhibitors are as follows:
 - Aimovig is available in two dosages, 70 mg and 140 mg. There are no clear data to suggest that the two doses differ in their efficacy or safety.
 - Ajovy is the only CGRP inhibitor approved for quarterly dosing in addition to monthly dosing. However, administration of three pens at the same time is required.
 - Emgality requires a loading dose, administered as two pens at the same time.
 - All three products require refrigeration; however, advantages of Aimovig and Emgality include the ability to be stored up to 7 days at room temperature vs. only 24 hours with Ajovy.

Safety

- The CGRP antagonists have a relatively mild side effect profile, with injection site reactions the most commonly reported adverse event. Injection site reactions occurred at an incidence of 5.6% with Aimovig, 18%-23% with Emgality, and 45% with Ajovy.
- The ICER report concluded that there were no differences in the discontinuation rates due to adverse events among the CGRP inhibitors.
- There is concern for theoretical cardiovascular adverse events with long-term use of the CGRP antagonists. The FDA has required postmarketing surveillance for myocardial infarction and stroke for the class.

Other Factors

- Botulinum toxin (Botox) injection is approved for prevention of chronic migraine, but is not part of the TRICARE pharmacy benefit. Botulinum toxin has similar efficacy to the oral preventive medications and CGRP antagonists in chronic migraine patients, based on the 2018 ICER review.
- There is a high degree of interchangeability between the CGRP antagonists. However, there remains uncertainty regarding the long-term efficacy and safety of this new class of therapy. At least one CGRP inhibitor should be on the UF to meet the needs of the majority of patients in the MHS.

B. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—Relative Cost-Effectiveness Analysis and Conclusion

Cost-minimization analysis (CMA) and budget impact analysis (BIA) were performed to evaluate the CGRP Antagonist Prophylaxis agents. The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

- CMA results showed that Emgality was the most cost-effective CGRP antagonist, followed by Aimovig, and Ajovy.
- BIA was performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results found that designating Emgality, Aimovig, and Ajovy as uniform formulary demonstrated significant cost avoidance for the Military Health System (MHS).

C. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—UF Recommendation

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) the following for the CGRP Antagonist Prophylaxis agents, as outlined below, based on clinical and cost-effectiveness:

- UF
 - erenumab (Aimovig)
 - fremanezumab (Ajovy)
 - galcanezumab (Emgality)
- NF
 - None

D. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—Manual Prior Authorization (PA) Criteria

PA criteria currently apply to the CGRP products, requiring a trial of at least one drug from two oral classes used for migraine prophylaxis, including antiepileptic medications, beta-blockers or antidepressants. PA criteria were originally recommended when the individual CGRP products were first evaluated as new drugs.

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) updates to the current manual PA criteria for all three CGRP antagonists in new users. The PA criteria and updates reflect the recommendations from the 2018 AHS Consensus Statement regarding candidates for a CGRP and assessment of response.

Aimovig, Ajovy, and Emgality
February 2019 updates are in BOLD and strikethrough.

Manual PA criteria apply to all new users of Aimovig, Ajovy, or Emgality.

Manual PA Criteria: Aimovig, Ajovy, or Emgality is approved if all criteria are met:

- Patient \geq 18 years old and not pregnant
- Must be prescribed by or in consultation with a neurologist
- **The patient also meets one of the following:**
 - **Patient has episodic migraines at a rate of 4 to 7 migraine days per month for 3 months and has at least moderate disability shown by Migraine Disability Assessment (MIDAS) Test score $>$ 11 or Headache Impact Test-6 (HIT-6) score $>$ 50 OR**
 - Patient has **episodic migraine at a rate** of at least 8 migraine days per month for 3 months **OR**
 - **Patient has a diagnosis of chronic migraine**
- Patient has a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE drug from TWO of the following migraine prophylactic drug classes:
 - Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate
 - Prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol, **timolol**
 - Prophylactic antidepressants: amitriptyline, **duloxetine, nortriptyline**, venlafaxine
- **Patient is not currently on botulinum toxin or patient must not have received a botulinum toxin injection within the last 2 months**
- Concurrent use with other CGRP inhibitors (e.g., Aimovig, Emgality) is not allowed
- For Emgality, a loading dose will be allowed

Non-FDA-approved uses are NOT approved.

PA expires after 6 months.

Renewal PA Criteria: Coverage will be approved indefinitely for continuation of therapy if **one of the following apply:**

- ~~The patient has shown improvement in migraine prevention (e.g., reduced migraine headache days, reduced migraine frequency, reduced use of acute abortive migraine medication)~~
- **The patient has had a reduction in mean monthly headache days of \geq 50% relative to the pretreatment baseline (as shown by patient diary documentation or healthcare provider attestation) OR**
- **The patient has shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures:**
 - **Migraine Disability Assessment (MIDAS)**
 - **Reduction of \geq 5 points when baseline score is 11–20**
 - **Reduction of \geq 30% when baseline score is $>$ 20**
 - **Headache Impact Test (HIT-6)**
 - **Reduction of \geq 5 points**

- **Migraine Physical Functional Impact Diary (MPFID)**
 - **Reduction of ≥ 5 points**

E. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—UF and PA Implementation Plan

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) an effective date of the first Wednesday 30 days after the signing of the minutes in all points of service (POS).

III. UF CLASS REVIEWS—MIGRAINE AGENTS – CGRP ANTAGONIST PROPHYLAXIS SUBCLASS

BAP Comments

A. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—UF Recommendation

The P&T Committee recommended the formulary status for the Migraine Agents as discussed above.

- UF
 - Aimovig
 - Ajovy
 - Emgality
- NF
 - None

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

B. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—Manual PA Criteria

The P&T Committee recommended updates to the current manual PA criteria for new users of Aimovig, Ajovy, and Emgality, as discussed previously.

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

C. Migraine Agents – CGRP Antagonist Prophylaxis Subclass—UF and PA Implementation Plan

The P&T Committee recommended an effective date the first Wednesday 30 days after the signing of the minutes in all points of service.

BAP Comment: Concur Non-concur

IV. ONCOLOGICAL AGENTS – CYP-17 INHIBITORS (CYP17) SUBCLASS AND 2ND-GENERATION ANTIANDROGENS (2ND-GEN AA) SUBCLASS

P&T Comments

A. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—Relative Clinical Effectiveness Analysis and Conclusion

Background—The P&T Committee evaluated the relative clinical effectiveness of two subclasses of drugs used for Prostate Cancer. The agents in the CYP17 inhibitor subclass include abiraterone acetate (Zytiga, generics) and abiraterone acetate micronized (Yonsa), while the 2nd-generation antiandrogen (AA) subclass is comprised of enzalutamide (Xtandi) and apalutamide (Erleada). The Committee reviewed new data available since the previous formulary decision in February 2015.

The P&T Committee concluded (17 for, 0 opposed, 0 abstained, 1 absent) the following:

CYP17 Inhibitors Subclass

- The 2018 guidelines from the National Comprehensive Cancer Network (NCCN) included updated recommendations for metastatic castration-resistant prostate cancer (mCRPC). Yonsa used with methylprednisolone was added to the mCRPC algorithm. The guidelines continue to recommend Zytiga, with prednisone for this indication.
- The American Urological Association (AUA) guidelines for mCRPC were updated in 2018 and continue to include abiraterone with prednisone.
- Zytiga and Yonsa contain the same active ingredient, abiraterone acetate. Both products must be co-administered with a corticosteroid to reduce the incidence and severity of mineralocorticoid excess (hypertension, hypokalemia, and fluid retention). Differences include that Zytiga is given with prednisone while Yonsa is administered with methylprednisolone.
- There is no clinical trial data available with Yonsa; FDA approval was based upon the clinical trial data with Zytiga and bioequivalence studies.
- There are no head-to-head comparative trials between Zytiga and Yonsa. However, the NCCN guidelines recommend that either formulation can be used in place of the other.
- The micronized formulation of Yonsa results in a smaller tablet particle size; therefore, the dosages differ between the two preparations. Under fasting conditions, single doses of Yonsa 500 mg were equivalent to single doses of Zytiga 1,000 mg.

- Zytiga has an advantage of a lower tablet burden. Yonsa has an advantage in that it can be dosed without regard to meals, while Zytiga must be taken on an empty stomach.
- Generic formulations of Zytiga recently entered the market in December 2018, but the generics only include one tablet strength.
- Based on available safety data, the FDA review of Yonsa concluded that there is no evidence that there are differences in safety between Zytiga and Yonsa. Both products have similar warnings and precautions for mineralocorticoid excess, adrenocortical insufficiency, and hepatotoxicity. The FDA review noted that adverse events occurred at similar rates between the two formulations.
- Overall, there is a high degree of therapeutic interchangeability between Zytiga and Yonsa. At least one CYP17 inhibitor is required on the formulary in order to meet the needs of MHS patients.

2nd-Generation AA Subclass

- Enzalutamide (Xtandi) and apalutamide (Erleada) are both FDA-approved for use in non-metastatic castration-resistant prostate cancer (nmCRPC). The 2018 NCCN and 2018 AUA guidelines also recommend both Xtandi and Erleada for nmCRPC. However, of the two 2nd-generation antiandrogens, only Xtandi has FDA approval for use in metastatic CRPC and is included in both the NCCN and AUA guidelines for mCRPC.
- FDA approval for the 2nd-generation AAs for non-metastatic CRPC was based on two randomized, placebo-controlled trials, PROSPER with Xtandi and SPARTAN with Erleada. Men with prostate-specific antigen (PSA) doubling times of ≤ 10 months were included in the trials.
 - Metastasis-free survival (MFS), defined as the delay in development of metastatic disease until metastasis is detected, was the primary endpoint used in both the PROSPER and SPARTAN trials. The study results showed that both Xtandi and Erleada provided a benefit in terms of MFS compared to placebo.
 - An indirect comparison of the two trials showed a similar effect on MFS. For Xtandi the median MFS was 36.6 months vs. 14.7 months with placebo, resulting in a 71% risk reduction for the endpoint. In comparison, with Erleada the median MFS was 40.5 months vs. 16.2 months with placebo, corresponding with a 72% risk reduction in the primary endpoint.
 - Although overall survival data are not yet mature, interim analyses indicate a trend toward improved survival with both drugs when compared to placebo.
- A 2018 ICER report concluded that, when compared to placebo, Erleada and Xtandi showed delays in disease progression and a trend toward improved survival in patients with non-metastatic CRPC, and were given an “A” rating.
- Xtandi and Erleada have relatively similar adverse effect profiles. Both drugs are associated with hypertension, fatigue, falls, fractures, and seizures.
- Although the PROSPER trial using Xtandi in patients with non-metastatic CRPC showed a disproportionate rate of adverse cardiac effects and death compared to placebo, this finding was not reproduced in other studies with Xtandi conducted in

varying populations, including patients with non-metastatic hormone-sensitive prostate cancer (HSPC), metastatic HSPC, non-metastatic CRPC, and metastatic CRPC.

- Comparative effectiveness of Xtandi and Erleada, when used in non-metastatic CRPC, cannot be determined at this time, due to the lack of head-to-head trials.
- At least one 2nd-generation antiandrogen must be included on the formulary for MHS patients.

B. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—Relative Cost-Effectiveness Analysis and Conclusion

CMA and BIA were performed to evaluate the prostate cancer agents. The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

CYP17 Inhibitors

- CMA results for the CYP17 inhibitor subclass showed that Yonsa was more cost-effective than Zytiga brand and generics.
- BIA was performed for the CYP17 inhibitor subclass to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating Yonsa as formulary and step-preferred and Zytiga brand and generics as UF and non-step-preferred demonstrated the greatest cost avoidance for the MHS.

2nd-Generation AA Subclass

- CMA results for the 2nd-generation antiandrogen subclass showed that Xtandi was the most cost-effective 2nd-generation AA.
- BIA was performed for the 2nd-generation antiandrogen subclass to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating Xtandi as formulary and step-preferred and Erleada as UF and non-step-preferred demonstrated significant cost avoidance for the MHS.

C. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—UF Recommendation

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) the following for the Prostate Cancer agents, as outlined below, based on clinical and cost-effectiveness:

CYP 17 Inhibitor Subclass

- UF and step-preferred
 - abiraterone acetate micronized (Yonsa)
- UF and non-step-preferred
 - abiraterone acetate (Zytiga, generics)
- NF
 - None

2nd-Generation Antiandrogen Subclass

- UF and step-preferred
 - enzalutamide (Xtandi)
- UF and non-step-preferred
 - apalutamide (Erleada)
- NF
 - None

D. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—Manual PA Criteria

Updated manual PA criteria for all four prostate cancer drugs were recommended by the P&T Committee (18 for, 0 opposed, 0 abstained, 0 absent). For both Yonsa and Zytiga/generics, the prescription must be written by an oncologist or urologist, and off-label use for non-localized disease was added. The Zytiga PA criteria were also updated to include step therapy, requiring a trial of Yonsa first, unless there is a contraindication, inadequate response, or adverse reaction to Yonsa, for all new and current users of Zytiga/generics (i.e., “no grandfathering” scenario). Additionally, for Zytiga, the 250 mg tablets are the preferred formulation, based on cost-effectiveness. All new and current users of Zytiga/generic 500 mg tablets will need to try the 250 mg tablets first.

The Committee also recommended updating the current PAs for Xtandi and Erleada to include the Xtandi step-therapy requirements. All new users (i.e., “grandfathering” scenario) of Erleada will require a trial of Xtandi first, unless contraindicated or if the patient has had an inadequate response or adverse reaction to previous use of Xtandi. Additionally, for nmCRPC, both Xtandi and Erleada will require patients to have documented prostate-specific antigen doubling time (PSADT) of ≤ 10 months, consistent with the trial design of PROSPER and SPARTAN.

1. Yonsa

February 2019 updates are in BOLD and strikethrough.

Manual PA criteria apply to all new users of Yonsa.

Manual PA Criteria: Coverage is approved if all criteria are met:

- **Age ≥ 18 years**
- **Prescribed by or in consultation with an oncologist or urologist**
- Provider is aware that Yonsa may have different dosing and food effects than other abiraterone acetate products (medication errors and overdose warning)
- ~~Patient has documented diagnosis of metastatic castration-resistant prostate cancer (mCRPC)~~
- ~~Patient has documented diagnosis of metastatic high-risk castration-sensitive prostate cancer (mCSPC)~~
- **Patient has documented diagnosis of non-localized disease including:**

- **Metastatic castration-resistant prostate cancer (mCRPC)**
 - **Metastatic castration-sensitive prostate cancer (mCSPC)**
 - **Regional disease (T_xN1M0) OR**
- **If patient has a diagnosis other than those listed above, list the diagnosis: _____ . AND**
 - **The diagnosis is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**
- Patient must receive concomitant therapy with methylprednisolone
- Patient must be receiving a gonadotropin-releasing hormone (GnRH) analog concomitantly OR have had a bilateral orchiectomy

Other non-FDA-approved uses are NOT approved.
PA does not expire.

2. Zytiga, Generics

February 2019 updates are in **BOLD** and strikethrough.

Manual PA criteria apply to **all new and current users** of Zytiga and generics.

Manual PA Criteria: Coverage is approved if all criteria are met:

- **Yonsa is the Department of Defense's preferred CYP-17 Inhibitor agent.**
 - **Has the patient tried Yonsa?**
 - OR**
 - **Does the patient have or have they had a contraindication/inadequate response/adverse reaction to Yonsa that is not expected to occur with the requested agent?**
- **Age ≥ 18 years**
- **Prescribed by or in consultation with an oncologist or urologist**
- ~~Patient has documented diagnosis of metastatic castration-resistant prostate cancer (mCRPC)~~
- ~~Patient has documented diagnosis of metastatic high-risk castration-sensitive prostate cancer (mCSPC)~~
- **Patient has documented diagnosis of non-localized disease including:**
 - **Metastatic castration-resistant prostate cancer (mCRPC)**
 - **Metastatic castration-sensitive prostate cancer (mCSPC)**
 - **Regional disease (T_xN1M0) OR**
- **If patient has a diagnosis other than those listed above, list the diagnosis: _____ . AND**

- **The diagnosis is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**
- Patient must receive concomitant therapy with prednisone
- Patient must be receiving a gonadotropin-releasing hormone (GnRH) analog concomitantly OR have had a bilateral orchiectomy
- **Zytiga 250 mg is the DoD's preferred strength. Is the prescription for Zytiga 250 mg OR will the prescription be changed to the 250 mg?**
 - **Note: If the prescription is being changed to the 250 mg strength, please submit a new prescription with this PA form**
 - OR**
 - **Please state why the patient cannot take multiple 250 mg tablets to achieve the patient's daily dose (fill-in blank)**

Other non-FDA-approved uses are NOT approved.
PA does not expire.

3. **Xtandi** **February 2019 updates are in BOLD.**

Manual PA criteria apply to all new users of Xtandi.

Manual PA Criteria: Coverage is approved if all criteria are met:

- **Age ≥ 18 years**
- **Prescribed by or in consultation with an oncologist or urologist**
- Patient has documented diagnosis of **metastatic OR non-metastatic** castration-resistant prostate cancer (CRPC)
 - If used in non-metastatic castration-resistant prostate cancer (nmCRPC), patient must have: prostate-specific antigen doubling time (**PSADT**) ≤ **10 months OR**
- **If patient has a diagnosis other than those listed above, list the diagnosis:**
_____. **AND**
 - **The diagnosis is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**
- Patient must be receiving a gonadotropin-releasing hormone (GnRH) analog concomitantly OR have had a bilateral orchiectomy

Other non-FDA-approved uses are NOT approved.
PA does not expire.

4. **Erleada** **February 2019 updates are in BOLD.**

Manual PA criteria apply to all new users of Erleada.

Manual PA Criteria: Coverage is approved if all criteria are met:

- **Xtandi is the Department of Defense's preferred 2nd-Generation Antiandrogen agent.**
 - **Has the patient tried Xtandi?**
 - OR**
 - **Does the patient have or have they had a contraindication/inadequate response/adverse reaction to Xtandi that is not expected to occur with Erleada?**
- **Age ≥ 18 years**
- Prescribed by or in consultation with an oncologist or urologist
- Patient has documented diagnosis of non-metastatic castration-resistant prostate cancer (nmCRPC) **AND**
 - Negative CT scan of abdomen/pelvis and/or negative bone scan, **AND**
 - **PSADT ≤ 10 months OR**
- **If patient has a diagnosis other than those listed above, list the diagnosis:**
_____. **AND**
 - **The diagnosis is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**
- Patient must be receiving a gonadotropin-releasing hormone (GnRH) analog concomitantly OR have had a bilateral orchiectomy

Other non-FDA-approved uses are NOT approved.

PA expires in 1 year.

Renewal PA Criteria: Coverage will be approved for 1 year for continuation of therapy if:

- Patient continues to be metastases-free
- No toxicities have developed
- Patient has not progressed onto subsequent therapy (such as abiraterone)

E. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—Tier 1 Cost-Share

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) lowering the current tier 2 cost-share for the CYP17 inhibitor Yonsa and the 2nd-generation AA Xtandi to the generic Tier 1 cost-share.

The authority for this recommendation is codified in 32 CFR 199.21(j)(3), which states that "when a blanket purchase agreement, incentive price agreement, Government contract, or other

circumstances results in a brand pharmaceutical agent being the most cost effective agent for purchase by the Government, the Pharmacy and Therapeutics Committee may also designate that the drug be cost-shared at the generic rate." Lowering the cost-share for both Yonsa and Xtandi will provide a greater incentive for beneficiaries to use the most cost-effective CYP 17 or 2nd-generation antiandrogen product, respectively, in the purchased care points of service.

F. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—UF and PA Implementation Plan

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) 1) an effective date of 90 days after signing of the P&T minutes at all points of service, and 2) DHA send letters to beneficiaries who are affected by the step decision in the CYP17 subclass (those patients currently on Zytiga brand or generics).

V. ONCOLOGICAL AGENTS – CYP17 SUBCLASS AND 2ND-GEN AA SUBCLASS

BAP Comments

A. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—UF Recommendation

The P&T Committee recommended the formulary status, as stated above.

CYP 17 Inhibitor Subclass

- UF and step-preferred
 - Yonsa
- UF and non-step-preferred
 - Zytiga brand and generics
- NF
 - None

2nd-Generation Antiandrogen Subclass

- UF and step-preferred
 - Xtandi
- UF and non-step-preferred
 - Erleada
- NF
 - None

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

B. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—Manual PA Criteria

The P&T Committee recommended updates to manual PA criteria for Yonsa, Zytiga, Xtandi, and Erleada as discussed above.

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

C. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—Tier 1 Cost-Share

The P&T Committee recommended lowering the current Tier 2 cost-share for Yonsa and Xtandi to the generic Tier 1 cost-share.

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

D. Oncological Agents – CYP17 Subclass and 2nd-Gen AA Subclass—UF and PA Implementation Plan

The P&T Committee recommended an effective date of 90 days after the signing of the P&T minutes in all points of service. DHA will send letters to beneficiaries who are affected by the step decision for Zytiga brand and generics.

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

VI. SECTION 702, NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FOR FISCAL YEAR (FY) 2018: TRICARE TIER 4/NOT COVERED DRUGS PER 32 CFR 199.21(E)(3)

P&T Comments

Background—An interim final rule implementing Section 702(b)(10) of the NDAA 2018 was published on December 11, 2018, and is found at: <https://www.federalregister.gov/documents/2018/12/11/2018-26562/tricare-pharmacy-benefits-program-reforms>. The interim rule allows for complete exclusion of drugs from TRICARE pharmacy benefit coverage when certain criteria are met.

The interim rule amends 32 CFR 199.21(e)(3). The P&T Committee may recommend, and the Director may, after considering the comments and recommendations of the Beneficiary Advisory Panel, approve uniform formulary actions to encourage use of pharmaceutical agents that provide the best clinical effectiveness to covered beneficiaries and DoD, including consideration of better care, healthier people, and smarter spending. Specifically, the P&T Committee may recommend complete exclusion of any pharmaceutical agent from the TRICARE pharmacy benefits program the Director determines provides very little or no clinical effectiveness relative to similar agents.

The P&T Committee was briefed on the above provisions at the February 2019 meeting. The Committee considered several factors when identifying candidates for complete exclusion from the TRICARE pharmacy benefit. These factors include, but are not limited to, the availability and quality of clinical efficacy evidence compared to alternative similar agents, determination of significant safety issues in which risks may outweigh potential benefit, identification of drugs that contain ingredients not covered by the TRICARE pharmacy benefit, or other negative concerns identified by regulatory authorities or nationally recognized expert organizations. The Committee also reviewed the practices regarding exclusion of drugs from several commercial, state, and Federal Government health care plans. Complete exclusion of drugs from the TRICARE pharmacy benefit will apply to both new and current users.

Relative Clinical and Cost-Effectiveness Summary/Rationale for Complete Exclusion—The Committee reviewed clinical efficacy, safety, and cost-effectiveness data for four candidates considered for Tier 4/Not Covered status under the TRICARE pharmacy benefit program.

- **Diabetes Non-Insulin Drugs – Biguanides Subclass: metformin ER (Glumetza brand and generics)** is an extended release formulation of metformin approved in 2005. It uses a polymer-based oral drug delivery system that makes the tablet swell, which causes retention in the stomach. Clinical trials show Glumetza is at least as efficacious as metformin immediate-release (IR) (Glucophage) in all measures of glycemic control. There is no evidence to suggest that differences in the extended-release properties of Glumetza confer any benefits in efficacy or safety compared to the other metformin ER formulations (Glucophage XR).

Overall conclusion: A significant cost difference exists between Glumetza and other generic metformin ER formulations (Glucophage XR), with no additional clinical benefit. The P&T Committee concluded that the needs of TRICARE beneficiaries can be met by other metformin ER or metformin IR products available on the Uniform Formulary.

- **Pain Agents – Combinations Subclass: naproxen/esomeprazole (Vimovo)** is a fixed-dose combination of two over-the-counter (OTC) drugs, a nonsteroidal anti-inflammatory drug (NSAID) and a proton pump inhibitor (PPI). The Committee agreed that use of fixed dose combination therapies offers patients a convenient formulation for improving adherence. However, this particular combination of an NSAID, which is typically targeted for short-term use, and a PPI, which has limited data to support use beyond eight weeks, is potentially harmful. There is no data to suggest that using other prescription or OTC

NSAIDs concurrently with PPIs would not provide the claimed benefit of the individual ingredients found in Vimovo.

Overall conclusion: The Committee concluded that Vimovo is not cost-effective relative to other NSAIDs and PPIs used concurrently. The needs of TRICARE beneficiaries can be met by the concurrent use of similar single ingredient OTC or prescription NSAIDs and PPIs available on the Uniform Formulary.

- **Pancreatic Enzyme Replacement Therapy: pancrelipase (Zenpep)** and the other pancreatic enzyme replacement therapies (PERTs) were reviewed for formulary status in May 2018. The Committee concluded there is a high degree of therapeutic interchangeability among the PERT products, and having one on the formulary is sufficient to meet the needs of Military Health System (MHS) patients. Creon was designated as the sole step-preferred PERT, and the cost-share was lowered to the generic Tier 1 cost-share to provide a greater incentive for beneficiaries to use the more cost effective PERT formulation. Zenpep was designated nonformulary and non-step-preferred, requiring a trial of Creon in all users. Zenpep provides very little to no clinical effectiveness relative to Creon or the other PERTs.

Overall conclusion: The needs of TRICARE beneficiaries can be met by Creon and the other available PERTs.

- **Targeted Immunomodulatory Biologics (TIBs): brodalumab (Siliq)** is an injectable TIB approved for treating plaque psoriasis and is the only TIB that carries a black box warning for suicide. An FDA safety review of all clinical trials with Siliq reported 36 patients with attempted suicide, or suicidal ideation, and 6 patients with completed suicides. This safety risk is comparable to other biologic agents that the FDA denied marketing approval, and is significantly greater than any of Siliq's clinical comparators. The drug also has Risk Evaluation and Mitigation Strategies (REMS) requirements that mandate certification of both prescribers and pharmacies.

Siliq was reviewed as a newly approved drug at the August 2017 DoD P&T Committee meeting and recommended for nonformulary status, with PA criteria requiring a trial of adalimumab (Humira) and secukinumab (Cosentyx) first.

Overall conclusion: The P&T Committee concluded that relative to the other nine TIBs that are FDA-approved to treat psoriasis, Siliq imposes a significant safety risk without offering any unique advantage in efficacy or in specific sub-populations. However, a subset of patients with plaque psoriasis will develop highly refractory disease, and Siliq may be of value as an alternate agent for patients who do not respond to other treatment options.

A. TRICARE Tier 4/Not Covered Recommendation—The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) designating the following products as Tier 4/Not Covered under the TRICARE pharmacy benefits program.

- metformin ER (Glumetza) brand and generics
- naproxen/esomeprazole (Vimovo)

- pancrelipase (Zenpep)

B. Recommendation Maintaining Current NF Status for Siliq—The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) maintaining the current formulary status for brodalumab (Siliq). The Committee acknowledged Siliq’s place in therapy for highly selected patients who are refractory to other treatment options. Siliq will remain NF and non-step-preferred, requiring a trial of Humira, Cosentyx, Stelara, Tremfya, Ilumya and Taltz first. The current PA will remain in place to mitigate risk of suicidal ideation.

C. Tier 4/Not Covered Implementation Period—The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) for pancrelipase (Zenpep), metformin ER (Glumetza brand and generics), and naproxen/esomeprazole (Vimovo): 1) an effective date of the first Wednesday after a 120-day implementation period at all points of service, and 2) DHA send letters to beneficiaries who are affected by the Tier 4/Not Covered recommendation.

VII. SECTION 702, NDAA FOR FY 2018: TRICARE TIER 4/NOT COVERED DRUGS PER 32 CFR 199.21(E)(3)

BAP Comments

A. TRICARE Tier 4/Not Covered Recommendation

The P&T Committee recommended designating the following products as Tier 4/Not Covered, as stated above.

- Glumetza brand and generics
- Vimovo
- Zenpep

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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B. Recommendation Maintaining Current NF Status for Siliq

The P&T Committee recommended maintaining the current nonformulary status for Siliq.

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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C. Tier 4/Not Covered Implementation Plan

The P&T Committee recommended: 1) an effective date of the first Wednesday after a 120-day implementation period at all points of service, and 2) DHA send letters to beneficiaries who are affected by the Tier 4/Not Covered recommendation.

BAP Comment: Concur Non-concur

VIII. NEWLY APPROVED DRUGS PER 32 CFR 199.21(G)(5)

P&T Comments

A. Newly Approved Drugs per 32 CFR 199.21(g)(5)—Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions

The P&T Committee agreed (group 1 and group 3: 17 for, 0 opposed, 0 abstained, 1 absent; and group 2: 18 for, 0 opposed, 0 abstained, 0 absent) with the relative clinical and cost-effectiveness analyses presented for the newly approved drugs reviewed according to 32 CFR 199.21(g)(5).

B. Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF/Tier 4/Not Covered Recommendation

The P&T Committee recommended (group 1 and group 3: 17 for, 0 opposed, 0 abstained, 1 absent; and group 2: 18 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF:
 - amifampridine (Firdapse) – Miscellaneous Neurological Agent for Lambert-Eaton Myasthenic Syndrome (LEMS)
 - baloxavir (Xofluza) – Antiviral for Influenza
 - cenegermin-bkbj ophthalmic solution (Oxervate) – Anti-Inflammatory Immunomodulatory Ophthalmic Agent for Neurotrophic Keratitis
 - elapegademase-lvlr IM injection (Revcovi) – Miscellaneous Metabolic Agent for Adenosine Deaminase Severe Combined Immune Deficiency (ADA-SCID)
 - gilteritinib (Xospata) – Oncological Agent for Acute Myelogenous Leukemia (AML)
 - glasdegib (Daurismo) – Oncological Agent for AML
 - inotersen injection (Tegsedi) – Miscellaneous Neurological Agent for Hereditary Transthyretin Amyloidosis
 - larotrectinib (Vitrakvi) – Oncological Agent for Solid Tumors
 - lorlatinib (Lorbrena) – Oncological Agent for Non-Small Cell Lung Cancer (NSCLC)

- loteprednol ophthalmic suspension (Inveltys) – Ophthalmic Corticosteroid for Postoperative Inflammation
- pegfilgrastim-cbqv injection (Udenyca) – White Blood Cell Stimulant and Biosimilar to Neulasta
- riluzole oral suspension (Tiglutik) – Miscellaneous Neurological Agent for Amyotrophic Lateral Sclerosis (ALS)
- tafenoquine 100 mg tablet (Arakoda) – Antimalarial Agent for Prophylaxis of Malaria
- tafenoquine 150 mg tablet (Krintafel) – Antimalarial Agent for Prevention of Relapse and Radical Cure of Malaria
- talazoparib (Talzenna) – Oncological Agent for Breast Cancer
- testosterone enanthate, subcutaneous (SQ) injection (Xyosted) – Androgens-Anabolic Steroids: Testosterone Replacement Therapies
- NF:
 - aripiprazole tablet with ingestible event marker (Abilify MyCite) – Atypical Antipsychotic
 - clobazam oral film (Sympazan) – Anticonvulsant-Antimania Agent for Lennox-Gastaut Syndrome
 - cyclosporine 0.09% ophthalmic solution (Cequa) – Anti-Inflammatory Immunomodulatory Ophthalmic Agent for Dry Eye Disease
 - desmopressin acetate sublingual (SL) tablet (Nocurna) – Miscellaneous Endocrine Agent for Nocturia due to Nocturnal Polyuria
 - filgrastim vials (Granix) – White Blood Cell Stimulant and Biosimilar to Neupogen
 - halobetasol propionate 0.01% lotion (Bryhali) – High Potency Corticosteroid-Immune Modulator for Plaque Psoriasis
 - itraconazole 65 mg capsules (Tolsura) – Antifungal Agent
 - latanoprost (Xelpros) – Ophthalmic Prostaglandin
 - omadacycline (Nuzyra) – Tetracycline Antibiotic for Community-Acquired Bacterial Pneumonia (CABP) and Acute Bacterial Skin and Skin Structure Infections (ABSSSI)
 - revefenacin nebulized solution (Yupelri) – Pulmonary-2: Long Acting Anti-Muscarinic Agent (LAMA) for Chronic Obstructive Pulmonary Disease (COPD)
 - rifamycin (Aemcolo) – Miscellaneous Gastrointestinal Antibiotic for Traveler’s Diarrhea
 - sarecycline (Seysara) – Tetracycline Antibiotic for Acne Vulgaris
- Tier 4/Not Covered
 - halobetasol propionate 0.05% foam (Lexette) – corticosteroids-Immune Modulators – High Potency for Plaque Psoriasis:

The topical corticosteroids were reviewed for formulary placement in August 2013. There is a high degree of therapeutic interchangeability within a particular potency category and vehicle. There are currently 28 other high-potency topical corticosteroids on the formulary, including 12 products formulated in a hair-friendly vehicle, including foam, gel, lotion, shampoo, and solution. The new foam formulation of Lexette offers no clinically meaningful advantages over the high-potency topical steroids available on the UF.

Overall conclusion: The P&T Committee concluded that Lexette provides little to no clinical benefit and its cost is prohibitive relative to the numerous formulary alternatives. Currently, the needs of TRICARE beneficiaries can be met by the 28 other formulary high-potency topical steroids.

C. Newly Approved Drugs per 32 CFR 199.21(g)(5)—PA Criteria

The P&T Committee recommended (group 1 and group 3: 17 for, 0 opposed, 0 abstained, 1 absent; and group 2: 18 for, 0 opposed, 0 abstained, 0 absent) the following:

- Oral Tetracycline Agents: Applying the same automated (step therapy) and manual PA criteria for sarecycline (Seysara) in new and current users that is currently in place for the other non-step-preferred oral tetracyclines. Patients must first try one generic doxycycline IR product, either the hyclate or monohydrate salt and one generic minocycline IR product first, before Seysara.
- Androgens-Anabolic Steroids: Testosterone Replacement Therapies: Applying new manual PA criteria for Xyosted SQ in new and current users. In addition to a trial of the step-preferred testosterone 2% topical gel (Fortesta), patients must also try one injectable testosterone product and meet the Risk Evaluation and Mitigation Strategies (REMS) requirements listed in the Xyosted product label regarding the risk of increases in blood pressure and potential increase in the risk of major adverse cardiovascular events (MACE).
- Applying manual PA criteria to new users of Abilify MyCite, Arakoda, Daurismo, Firdapse, Lorbrena, Oxervate, Talzenna, Tegsedi, Tolsura, Vitrakvi, and Xospata.
- Applying manual PA criteria to new and current users of Aemcolo, Cequa, Nocdurna, Tiglutik, and Yupelri.

Full PA Criteria for the Newly Approved Drugs per 32 CFR 199.21(g)(5)

1. amifampridine (Firdapse)

Manual PA applies to all new users of Firdapse.

Manual PA Criteria: Firdapse is approved if:

- Age \geq 18 years old
- Drug is prescribed by an oncologist or neurologist
- Has laboratory evidence of Lambert-Eaton myasthenic syndrome (LEMS)

Non-FDA-approved uses are NOT approved.
PA does not expire.

2. aripiprazole tablet with ingestible event marker (Abilify MyCite)

Manual PA criteria apply to all new users of Abilify MyCite.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Patient must have documented attempt to use generic aripiprazole tablets, with non-compliance documented in prescriber notes. Prescriber notes must also document the prescriber's attempted medication adherence counseling.
- Patient must have documented trial of at least 12 weeks of Abilify Maintena first
- Provider acknowledges that FDA labeling states the ability of Abilify MyCite to improve patient compliance or modify aripiprazole dosage has not been established.

Non-FDA-approved uses are NOT approved.
PA does not expire.

3. cenegermin-bkbj ophthalmic solution (Oxervate)

Manual PA criteria apply to all new users of Oxervate.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age ≥ 2 years
- Patient has a documented diagnosis of neurotrophic keratitis
- Drug is prescribed by a cornea specialist or ophthalmologist
- Patient does not wear contact lenses during treatment course

Non-FDA-approved uses are NOT approved.
PA does not expire.

4. cyclosporine 0.09% ophthalmic solution (Cequa)

February 2019 criteria specific for Cequa are in BOLD for the PA form that also includes Xiidra and Restasis.

PA criteria apply to all **new and current** users. A new user is defined as a patient who has not filled a prescription for Restasis, **Cequa** or Xiidra in the past 120 days.

- If there is no Restasis, **Cequa**, or Xiidra prescription in the past 120 days, a manual PA is required.

Manual PA Criteria: Coverage is approved if all the criteria are met:

- The drug is prescribed by an ophthalmologist or optometrist
- **For Cequa: the patient is ≥ 18 years old**

- A diagnosis of moderate to severe dry eye disease is supported by both of the criteria below:
- Positive symptomatology screening for moderate to severe dry eye disease from an appropriate measure
- At least one positive diagnostic test (e.g., Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)
- Patient must try and fail the following:
 - At least 1 month of one ocular lubricant used at optimal dosing and frequency (e.g., carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc.], polyvinyl alcohol [Liquitears, Refresh Classic, etc.], or wetting agents [Systane, Lacrilube])
 - Followed by at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol)
- Concomitant use of Restasis, **Cequa**, or Xiidra is NOT allowed.

Non-FDA-approved uses for Cequa are NOT approved.

PA expires in one year.

Renewal Criteria: Coverage will be approved indefinitely if all criteria are met:

- The drug is prescribed by an ophthalmologist or optometrist.
- The patient must have documented improvement in ocular discomfort.
- The patient must have documented improvement in signs of dry eye disease.

5. desmopressin acetate sublingual (SL) tablet (Nocdurna)

Manual PA criteria apply to all new and current users of Nocdurna.

Manual PA criteria apply to all new users of Nocdurna SL tablets. Updates are in BOLD for the PA that also has Noctiva nasal spray

Manual PA Criteria: Coverage is approved if all criteria are met:

- For Nocdurna: Age \geq 18 years old
- For Nocdurna: For females: must use 27.7 mcg dosage; for males: must use 55.3 mcg dosage
- For Noctiva Nasal Spray: Age \geq 50 years old (Only the low dose is allowed for pts $>$ 65 years old)
- Patient has nocturia defined as having \geq 2 nocturnal voids nightly for \geq 6 months
- Causes of nocturia have been evaluated and nocturnal polyuria is confirmed with a 24-hour urine collection
- **Patient has tried non-pharmacologic techniques or lifestyle interventions to manage the nocturia (e.g., nighttime fluid restriction, avoidance of caffeine and alcohol, earlier timing of medications, leg elevation and/or use of compression stockings)**

- **The patient has tried oral desmopressin acetate tablets (DDAVP tablets, generics)**
- Patient is not currently taking any of the following medications:
 - Loop diuretics, alpha₁-adrenoceptor antagonists, 5-alpha reductase inhibitors (ARIs), thiazide diuretics, anticholinergics, antispasmodics, sedative/hypnotic agents, NSAIDs, SSRIs, SNRIs, antidepressants, anti-epileptics, opioids, or SGLT2s
 - Systemic or inhaled corticosteroids or lithium
- Prescribed by a urologist, a geriatrician, an endocrinologist, or a **nephrologist**
- **Provider must supply most recent serum sodium and date**
 - **Sodium _____ mEq/mL Date _____**
- Patient has normal sodium (135-145 mEq/L) prior to initiation, recheck sodium after one week of therapy, and another sodium recheck at 1 month
- **Provider acknowledges that patients over 65 years old are at greater risk of hyponatremia and has advised the patient about this significant safety concern**
- Patient does not have the following conditions for both Noctiva Nasal Spray and Nocturna:
 - **Renal impairment (eGFR < 50 mL/min)**
 - **Hyponatremia or history of hyponatremia**
 - **Polydipsia**
 - **Nocturnal enuresis**
 - **SIADH**
 - **Congestive heart failure**
 - **Uncontrolled hypertension or uncontrolled diabetes mellitus**
 - **Interstitial cystitis**
 - **Chronic prostatitis/chronic pelvic pain syndrome**
 - **Suspicion of bladder outlet obstruction (BOO) or urine flow < 5 mL/sec**
 - **Surgical treatment, including transurethral resection, for BOO or benign prostatic hyperplasia within the past 6 months**
 - **Urinary retention or a post-void residual volume in excess of 250 mL as confirmed by bladder ultrasound performed after suspicion of urinary retention**
 - **Current or a history of urologic malignancies (e.g., urothelium, prostate, or kidney cancer)**
 - **Genitourinary tract pathology (e.g., infection or stone in the bladder and urethra causing symptoms)**
 - **Neurogenic detrusor activity (detrusor overactivity)**
 - **Suspicion or evidence of cardiac failure**
 - **History of obstructive sleep apnea**
 - **Hepatic and/or biliary diseases**
 - **Treatment with another investigational product within 3 months prior to initiating therapy**
 - **Known alcohol or substance abuse**
 - **Work or lifestyle that may have interfered with regular nighttime sleep**

AND

- **Patient does not have the following conditions for Noctiva Nasal Spray**
 - **acute or chronic rhinitis (for Noctiva nasal spray only)**
 - **atrophy of nasal mucosa (for Noctiva nasal spray only)**

Non-FDA-approved uses are NOT approved.

PA expires in ~~6 months~~ **4 months**.

Renewal Criteria: Coverage will be approved for an additional 6 months if all of the following apply:

- Patient has not developed any of the conditions above
- **Patient is not taking any of the medications mentioned above**
- Patient has shown a reduction in nocturia episodes

6. gilteritinib (Xospata)

Manual PA criteria apply to all new users of Xospata.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age \geq 18
- Has laboratory evidence of relapsed or refractory acute myeloid leukemia with a Ferline McDonough Sarcoma (FMS)-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test
- The patient will be monitored for posterior reversible encephalopathy syndrome (PRES), prolonged QTc, and pancreatitis
- Patient is not pregnant or actively trying to become pregnant
- Prescribed by or in consultation with a hematologist/oncologist

Non-FDA-approved uses are NOT approved.

PA does not expire.

7. glasdegib (Daurismo)

Manual PA criteria apply to all new users of Daurismo.

Manual PA criteria: Coverage is approved if all criteria are met:

- Treatment of newly diagnosed acute myeloid leukemia (in combination with low-dose cytarabine) in adult patients who are \geq 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy.
- Provider acknowledges and patient has been informed that limitations of use include that this drug has not been studied in patients with severe renal impairment or moderate to severe hepatic impairment.
- Patient is not pregnant or actively trying to become pregnant
- Patient will be monitored for febrile neutropenia and QTc prolongation
- Prescribed by or in consultation with a hematologist/oncologist

Non-FDA-approved uses are NOT approved.
PA does not expire.

8. inotersen injection (Tegsedi)

Manual PA applies to all new users of Tegsedi.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age \geq 18 and has genetically confirmed transthyretin mutation resulting in familial amyloidotic polyneuropathy (FAP) stage 1 or 2 hereditary transthyretin-mediated amyloidosis (hTTRA)
- Has polyneuropathy secondary to hereditary transthyretin-mediated amyloidosis with either 1) a polyneuropathy disability (PND) score \leq IIIB or 2) a Neuropathy Impairment Score between 10 and 130
- Provider and patient are both registered and enrolled with the Tegsedi Risk Evaluation and Mitigation Strategies (REMS) program
- Patient has no evidence of thrombocytopenia
- Patient does not have chronic kidney disease (CKD) stage 3b and has no history of glomerulonephritis
- The provider will monitor the patient's platelet counts and renal and hepatic function
- Patient will take an oral Vitamin A supplement at the recommended daily allowance
- Provider is aware and patient is informed of the following potential adverse drug reactions: stroke, encephalitis, carotid arterial dissection, hypercoagulability and thrombosis (venous and arterial), QRS prolongation and other arrhythmias, elevated liver-associated enzymes, autoimmune hepatitis, primary biliary cirrhosis, biliary obstruction, glomerulonephritis, nephrotic syndrome, interstitial nephritis, thrombocytopenia, idiopathic thrombocytopenia (ITP), antineutrophil cytoplasmic antibody-associated (ANCA) vasculitis, and hypersensitivity
- Prescribed by or in consultation with a specialist that manages hereditary transthyretin amyloidosis (e.g., cardiologist, geneticist, neurologist)
- Concomitant use of Onpattro and Tegsedi is not allowed

Non-FDA-approved uses are NOT approved.
PA does not expire.

9. itraconazole 65 mg capsules (Tolsura)

Manual PA criteria apply to all new users of Tolsura.

Manual PA Criteria: Tolsura is approved if:

- Patient has one of the following diagnoses:
 - Histoplasmosis
 - Pulmonary or Extrapulmonary Blastomycosis
 - Pulmonary or Extrapulmonary Aspergillosis
AND
- For histoplasmosis or blastomycosis:
 - Patient has had serious side effects with generic itraconazole 100 mg tablets/capsules OR
 - Patient has failed drug treatment with generic itraconazole 100 mg tabs/capsules
- For aspergillosis
 - Patient has had serious side effects with generic itraconazole 100 mg tablets/capsules and amphotericin B OR
 - Patient has failed drug treatment with generic itraconazole 100 mg tabs/capsules and amphotericin B

Non-FDA-approved uses are NOT approved including onychomycosis.
PA does not expire.

10. larotrectinib (Vitrakvi) capsules and oral solution

Manual PA criteria apply to all new users of Vitrakvi capsules and oral solution.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Patient diagnosed with a solid tumor that:
 - has a neurotrophic tropomyosin receptor kinase (NTRK) gene fusion without a known acquired resistance mutation,
 - is metastatic OR where surgical resection is likely to result in severe morbidity, AND
 - has no satisfactory alternative treatments OR that has progressed following such treatment(s).
- Larotrectinib (Vitrakvi) is prescribed by or in consultation with a hematologist/oncologist
- For Vitrakvi oral solution: in addition to the above criteria, the patient has difficulty swallowing the capsules

Non-FDA-approved uses are NOT approved.
PA does not expire.

11. lorlatinib (Lorbrena)

Manual PA criteria apply to all new users of Lorbrena.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Patient is 18 years of age or older

- Drug is prescribed by or in consultation with hematologist or oncologist
- Patient has a diagnosis of metastatic anaplastic lymphoma kinase (ALK) positive non-small cell lung cancer
- Patient has experienced disease progression on one of the following treatments:
 - crizotinib (Xalkori) and at least one other ALK inhibitor
 - alectinib (Alecensa) as a first-line agent
 - ceritinib (Zykadia) as a first-line agent **OR**
- **If patient has a diagnosis other than those listed above, list the diagnosis:**
 _____ . **AND**
 - **The diagnosis is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**

Non-FDA-approved uses NOT approved.
 PA does not expire.

12. revefenacin nebulized solution (Yupelri)

Manual PA is required for all new and current users of Yupelri.

Manual PA Criteria: Yupelri is approved if all criteria are met:

- The patient has a diagnosis of chronic obstructive pulmonary disease
- The patient has tried and failed an adequate course of a nebulized Short-Acting Muscarinic Antagonist (e.g., ipratropium)
- The patient has tried and failed an adequate course of Spiriva Respimat
- The patient has tried and failed an adequate course of therapy with at least one of the following dry powder inhalers: Tudorza Pressair, Incruse Ellipta, Spiriva Handihaler, or Seebri Neohaler **OR**
- The patient cannot generate the peak inspiratory flow needed to activate at least one of the following dry powder inhalers: Tudorza Pressair, Incruse Ellipta, Spiriva Handihaler, or Seebri Neohaler

Non-FDA-approved uses are NOT approved.
 PA does not expire.

13. rifamycin (Aemcolo)

Manual PA criteria apply to all new and current users of Aemcolo.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age \geq 18
- Patient has a diagnosis of traveler's diarrhea caused by noninvasive strains of *Escherichia coli*

- Patient does not have diarrhea complicated by fever and/or bloody stool
- Patient does not have diarrhea due to pathogens other than noninvasive strains of *E. coli*
- Patient has tried and failed a 3-day trial of ciprofloxacin unless a contraindication exists or patient has tried and failed azithromycin unless a contraindication exists

Non-FDA-approved uses are NOT approved including but not limited to diarrhea-predominant irritable bowel syndrome (IBS-D), non-alcoholic steatohepatitis (NASH), small intestine bacterial overgrowth (SIBO), and inflammatory bowel disease (IBD).

PA renewal not allowed. A new prescription will require a new PA to be submitted.

14. riluzole oral suspension (Tiglutik)

Manual PA criteria apply to all new and current users of Tiglutik.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Patient is diagnosed with amyotrophic lateral sclerosis
- Patient has dysphagia/swallowing dysfunction

Non-FDA-approved uses are NOT approved.
PA does not expire.

15. sarecycline (Seysara)

February 2019 criteria specific to Seysara are in BOLD.

PA applies to both new and current users of Seysara.

Automated PA Criteria:

- Patient has filled a prescription for one generic IR doxycycline (either hyclate or monohydrate salt; does not include doxycycline monohydrate 40 mg IR/DR) **AND** one generic minocycline IR product at any Military Treatment Facility (MTF), retail network pharmacy, or the mail order pharmacy in the previous 180 days

Manual PA Criteria: If automated PA criteria are not met, the non-step-preferred product is allowed if:

Acne Vulgaris or Rosacea

- **For Solodyn or generic minocycline ER, Minolira, or Seysara:** The patient has acne with inflammatory lesions **AND**

- the patient cannot tolerate generic minocycline IR due to gastrointestinal adverse events

Non-FDA-approved uses are NOT approved.

PA expires in 1 year.

Renewal Criteria:

- **Seysara: PA renewal is not allowed; repeat courses will require a new PA to be submitted.**

16. tafenoquine 100 mg tablet (Arakoda)

Manual PA criteria apply to all new users of tafenoquine (Arakoda).

Manual PA Criteria: Coverage will be approved for tafenoquine (Arakoda) if all criteria are met:

- Age \geq 18 and Arakoda is being prescribed for malaria chemoprophylaxis
- Patient has a contraindication or intolerance to both atovaquone-proguanil (Malarone) and doxycycline (e.g., pregnancy)
- Patient does not have a major psychiatric disorder to include but not limited to:
 - Active or recent history of depression
 - Generalized anxiety disorder
 - Psychosis or schizophrenia
 - Post-Traumatic Stress Disorder or Traumatic Brain Injury
- Patient does not have a history of seizures or vestibular disorders
- Patient does not have a cardiac conduction abnormality
- Patient has been tested and is negative for glucose 6 phosphate dehydrogenase (G6PD) deficiency
- The above information must be documented in the patient's medical record, and the patient must be educated on Arakoda adverse effects and dosing

Non-FDA-approved uses are NOT approved.

PA expires after 2 years. PA renewal is not allowed; repeat courses will require a new PA to be submitted.

17. talazoparib (Talzenna)

Manual PA criteria apply to all new users of Talzenna.

Manual PA Criteria: Coverage is approved if all criteria are met:

- Patient is 18 years of age or older
- Drug is prescribed by or consultation with a hematologist or oncologist

- Patient has a diagnosis of deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) and human epidermal growth factor receptor 2-negative (HER2-) breast cancer

Non-FDA-approved uses are NOT approved.
PA does not expire.

18. testosterone enanthate injection (Xyosted)

February 2019 criteria specific to Xyosted are in BOLD for the PA that also includes topical testosterone replacement therapies.

Manual PA criteria apply to all new and current users of Xyosted.

Manual PA for Xyosted requires a trial of the step-preferred product, Fortesta, **and one injectable testosterone product.**

Manual PA Criteria: Coverage is approved if all criteria are met:

- Age \geq 18 years and male
- Patient has documentation of experiencing signs and symptoms usually associated with hypogonadism
- **Xyosted is prescribed for the treatment of men with hypogonadal conditions associated with structural or genetic etiologies**
- Diagnosis of hypogonadism is confirmed and evidenced by morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions
- Patient has one of the following criteria:
 - Patient has tried Fortesta (testosterone 2% gel) **AND an injectable testosterone formulation for a minimum of 90 days AND** failed to achieve total serum testosterone levels above 400 ng/dL (labs drawn 2 hours after Fortesta application or the injectable testosterone formulation) **AND** without improvement in symptoms
– **OR** –
 - **Patient has a contraindication to or has experienced a clinically significant adverse reaction to Fortesta that is not expected to occur with the Xyosted autoinjector**
- **The provider has considered the patient’s baseline cardiovascular risk and ensured blood pressure is adequately controlled before initiating Xyosted and periodically during the course of treatment (based on the product’s boxed warning of increased risk of major adverse cardiovascular events and hypertension).**
- Patient does not have any of the following:
 - **Carcinoma of the breast or suspected carcinoma of the prostate**

Non-FDA-approved uses are NOT approved.
Not approved for concomitant use with other testosterone products.
PA does not expire.

D. Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF/Tier 4/Not Covered and PA Implementation Plan

The P&T Committee recommended:

- **New Drugs Recommended for UF or NF status:** (group 1 and group 3: 17 for, 0 opposed, 0 abstained, 1 absent; and group 2: 18 for, 0 opposed, 0 abstained, 0 absent) an effective date upon the first Wednesday 30 days after signing of the minutes in all points of service.
- **Drugs Recommended for Tier 4 status halobetasol propionate 0.05% foam (Lexette):** (17 for, 0 opposed, 0 abstained, 1 absent) for Lexette 1) an effective date of the first Wednesday after a 120-day implementation period at all points of service, and 2) DHA send letters to beneficiaries who are affected by the Tier 4/Not Covered recommendation.

IX. NEWLY APPROVED DRUGS PER 32 CFR 199.21(G)(5)

BAP Comments

A. Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF/Tier 4/Not Covered Recommendation

The P&T Committee recommended the formulary status for the new drugs as stated previously.

- UF:
 - Firdapse
 - Xofluza
 - Oxervate
 - Revcovi
 - Xospata
 - Daurismo
 - Tegsedi
 - Vitrakvi
 - Lorbrena
 - Inveltys
 - Udenyca
 - Tiglutik
 - Arakoda
 - Krintafel
 - Talzenna
 - Xyosted
- NF:
 - Abilify MyCite
 - Sympazan
 - Cequa
 - Nocdurna

- Granix vials
- Bryhali
- Tolsura
- Xelpros
- Nuzyra
- Yupelri
- Aemcolo
- Seysara
- Tier 4/Not Covered:
 - Lexette

BAP Comment: Concur Non-concur

B. Newly Approved Drugs per 32 CFR 199.21(g)(5)—PA Criteria

The P&T Committee recommended the PA criteria for the new drugs as stated previously.

BAP Comment: Concur Non-concur

C. Newly Approved Drugs per 32 CFR 199.21(g)(5)—UF/Tier 4/Not Covered and PA Implementation Plan

The P&T Committee recommended an effective date upon the first Wednesday 30 days after signing of the minutes in all points of service for the UF and NF drugs, and an effective date 120 days after the signing of the minutes for Lexette, the Tier 4/Not Covered drug. DHA will send letters to beneficiaries who are affected by the Tier 4/Not Covered recommendation for Lexette.

BAP Comment: Concur Non-concur

X. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA

P&T Comments

A. New PA Criteria

New manual PA criteria were recommended for the following drugs, which will be discussed below.

- 1. Antihistamine-1: First generation and combinations – Dexchlorpheniramine 2 mg/5 mL oral solution (Ryclora)**—Ryclora is a new liquid formulation of a dexchlorpheniramine, which had previously been removed from the market. Cost-effective generic formulations of chlorpheniramine are available on the UF without a PA required, and low-cost OTC liquid formulations for fexofenadine and loratadine are widely available.

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria for dexchlorpheniramine 2 mg/5 mL oral syrup (Ryclora) in new and current users, due to the significant cost differences and lack of clinically compelling benefits over generic alternatives.

Manual PA criteria apply to all new and current users of dexchlorpheniramine liquid (Ryclora). Coverage will be approved for dexchlorpheniramine liquid if all criteria are met:

Ryclora liquid has been identified as having cost-effective alternatives. The provider must describe why Ryclora is required as opposed to available alternatives (chlorpheniramine liquid, loratadine liquid, cetirizine liquid, and fexofenadine liquid).

Non-FDA-approved uses are NOT approved.
PA does not expire.

- 2. Hepatitis C Agents: Direct-Acting Agents (HCV DAAs): generic ledipasvir/sofosbuvir (authorized generic for Harvoni) and generic sofosbuvir/velpatasvir (authorized generic for Epclusa)**—The P&T Committee most recently reviewed the HCV DAAs for formulary status in August 2018. Since the review, authorized generics for Harvoni and Epclusa entered the market in December 2018. An “authorized generic” is the brand company's own product repackaged and marketed as a generic drug. An authorized generic is considered therapeutically equivalent to the name brand drug because it is the same drug. The FDA does not consider authorized generics as AB-rated generic formulations.

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria for the authorized generic products ledipasvir/sofosbuvir and sofosbuvir/velpatasvir in new users, requiring a trial of the branded Harvoni or Epclusa, due to cost-effectiveness. The PA requirement will be removed when it is no longer cost advantageous.

Manual PA criteria apply to all new users of ledipasvir/sofosbuvir (authorized generic for Harvoni) or sofosbuvir/velpatasvir (authorized generic for Epclusa). . Ledipasvir/sofosbuvir authorized generic products or sofosbuvir/velpatasvir authorized generic products are approved if all of the following criteria are met:

- For ledipasvir/sofosbuvir: The brand Harvoni formulation is preferred over the authorized generic product. The provider must provide a patient-specific justification as to why the brand Harvoni product cannot be used in this patient.
- For sofosbuvir/velpatasvir: The brand Epclusa formulation is preferred over the authorized generic product. The provider must provide a patient-specific justification as to why the brand Epclusa product cannot be used in this patient.

AND the patient must meet the following criteria for a HCV DAA product:

- \geq 18 years of age
- Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician
- Patient has laboratory evidence of hepatitis C virus infection
- The HCV genotype is documented. (Check box – GT1a, GT1b, GT2, GT3, GT4, GT5, GT6)

Coverage for the HCV DAA is only allowed for the FDA-approved indications or as outlined in the AASLD/IDSA HCV guidelines.

PA expires in 1 year.

- 3. Skeletal Muscle Relaxants and Combinations: cyclobenzaprine 7.5 mg**—Generic formulations of the skeletal muscle relaxant cyclobenzaprine are available in 5 mg, 7.5 mg, and 10 mg tablets. Cyclobenzaprine 7.5 mg tablets are significantly less cost-effective compared to the 5 mg or 10 mg strengths. Cost-effective generic formulations of cyclobenzaprine 5 mg and 10 mg and multiple comparable muscle relaxants (e.g., baclofen, methocarbamol) are available on the UF without PA required. The Committee did note that skeletal muscle relaxants are not considered first-line therapy for musculoskeletal conditions.

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria for new and current users of cyclobenzaprine 7.5 mg tablets, due to the significant cost differences and lack of clinically compelling benefits compared with administering one and a half of a 5 mg tablet or using other generic muscle relaxants.

Manual PA criteria apply to all new and current users of cyclobenzaprine 7.5 mg tablets or capsules. Coverage will be approved for cyclobenzaprine 7.5 mg tablets if all criteria are met:

- Cyclobenzaprine 7.5 mg tablets have been identified as having cost-effective alternatives. The provider must describe why cyclobenzaprine 7.5 mg is required as opposed to available alternatives, including generic cyclobenzaprine 5 mg tablets and cyclobenzaprine 10 mg tablets

Non-FDA-approved uses are NOT approved.
PA does not expire.

B. New PA Criteria—PA Implementation

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) new PAs for Ryclora, cyclobenzaprine 7.5 mg, authorized generic ledipasvir/sofosbuvir and authorized generic sofosbuvir/velpatasvir become effective 90 days after the signing of the minutes. DHA will send letters to beneficiaries affected by the new PA requirements for the cyclobenzaprine 7.5 mg and Ryclora if applicable, as new and current users will be subject to the PA.

XI. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA

BAP Comments

A. New Manual PA Criteria

The P&T Committee recommended new manual PA criteria for the drugs discussed above.

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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B. New Manual PA Criteria—PA Implementation Plan

The P&T Committee recommended the new PA criteria for the drugs discussed above become effective 90 days after the signing of the minutes.

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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XII. UTILIZATION MANAGEMENT—UPDATED MANUAL PA CRITERIA

P&T Comments

A. Updated PA Criteria

Updates to the manual PA criteria for several drugs were recommended by the P&T Committee due to a variety of reasons, including expanded FDA indications and safety. The updated manual PA as outlined below will apply to new users.

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) updates to the manual PA criteria for Kalydeco, Noctiva nasal spray, Xifaxan, Doptelet, Humira, Kineret, Corlanor.

The updates are as follows:

- 1. Cardiovascular Agents Miscellaneous: ivabradine (Corlanor)**—The Committee reviewed a request to allow an off-label use for ivabradine (Corlanor). The Committee recommended updating the PA criteria to include treatment of patients with symptomatic inappropriate sinus tachycardia (IST) or postural tachycardia syndrome (POTS). The recommendation was based on supporting clinical trial data and the 2015 guidelines from the American College of Cardiology/American Heart Association/Heart Rhythm Society, which state that Corlanor is reasonable for ongoing management in patients with these conditions.
- 2. Cystic Fibrosis Agents: ivacaftor (Kalydeco)**—Kalydeco was first reviewed by the P&T Committee in July 2012, where PA was recommended, based on the package insert labeling. Additional updates were made in May 2014 and November 2018. The FDA has now approved Kalydeco for use in patients as young as 1 year of age, and the PA criteria were updated to reflect the new FDA-approved age range.
- 3. Gastrointestinal-2 Agents: Miscellaneous – rifaximin 200 mg (Xifaxan)**—Manual PA criteria were previously recommended for Xifaxan for Traveler’s Diarrhea at the May 2013 P&T Committee meeting. The Xifaxan PA was updated to reflect the most recent update of the 2017 Infectious Diseases Society of America Clinical Practice Guidelines for the Diagnosis and Management of Infectious Diarrhea, requiring a trial of azithromycin or ciprofloxacin.
- 4. Hematological Agents – Platelets: avatrombopag (Doptelet)**—Avatrombopag (Doptelet) and lusutrombopag (Mulpleta) are pre-procedure regimens for patients with thrombocytopenia associated with liver disease. Mulpleta does not require dose adjustment; therefore, the P&T Committee updated the Doptelet PA criteria to require use of Mulpleta first, to reduce the risk of dosing errors with Doptelet.
- 5. Immune Modulators Endocrine Agents: Miscellaneous – Desmopressin nasal spray (Noctiva)**—Noctiva nasal spray was most recently reviewed for formulary placement at the May 2018 DoD P&T Committee meeting. The PA criteria for Noctiva were updated to include a comprehensive list of safety concerns, and to mirror the PA criteria for the new drug desmopressin SL tablets (Nocdurna) discussed previously on page 22 to 24.
- 6. Targeted Immunomodulatory Biologics (TIBs): adalimumab (Humira) and anakinra (Kineret)**—The TIBs were most recently reviewed in August 2014, with step therapy requiring a trial of adalimumab (Humira) first. The FDA recently granted new indications for Humira for moderate to severe hidradenitis suppurativa in patients 12 years and older, and for Kineret for systemic juvenile idiopathic arthritis, and the respective PAs were updated for these additional indications.

B. Updated PA Criteria—Implementation Plan

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) updates to the current PA criteria for Kalydeco, Noctiva nasal spray, Xifaxan, Doptelet, Humira, Kineret, and Corlanor in new users become effective 60 days after the signing of the minutes.

XIII. UTILIZATION MANAGEMENT—UPDATED MANUAL PA CRITERIA

BAP Comments

A. Updated Manual PA Criteria

The P&T Committee recommended updates to the manual PA criteria for the drugs discussed above.

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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B. Updated Manual PA Criteria—PA Implementation Plan

The P&T Committee recommended the updates to the PA criteria for the drugs discussed above become effective 60 days after the signing of the minutes.

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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XIV. BRAND OVER GENERIC AUTHORIZATION FOR DIHYDROERGOTAMINE SPRAY/PUMP (MIGRANAL NASAL SPRAY)

P&T Comments

TRICARE Policy requires dispensing of generic products at the Retail Network and Mail Order Pharmacy. However, pricing for the branded Migranal nasal spray product is more cost-effective than the AB-rated generic formulations for dihydroergotamine nasal spray, which were launched in December 2018. Therefore, the branded Migranal Nasal Spray product will continue to be dispensed, and the generic will only be available with prior authorization (i.e., the reverse of the current brand to generic policy). The Tier 1 (generic) copayment will apply to Migranal Nasal Spray. The “brand over generic” requirement for Migranal Nasal Spray will be removed administratively when it is no longer cost-effective compared to the AB-rated generics.

A. Migranal Nasal Spray Brand over Generic Requirement and PA Criteria

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) implementing the requirement to prefer the branded Migranal Nasal Spray product over generic formulations. Manual PA criteria are required for generic dihydroergotamine mesylate in the Retail Network and Mail Order Pharmacy. The prescriber will provide patient-specific justification as to why the branded Migranal Nasal Spray product cannot be used.

Manual PA criteria apply to all new users of generic dihydroergotamine (DHE) nasal spray. Note that brand Migranal nasal spray is the preferred product in the DoD. Coverage for generic DHE nasal spray is approved if the following criterion is met:

- The provider has provided patient-specific justification as to why the brand Migranal nasal spray cannot be used.

B. Migranal Nasal Spray Brand Copayment

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) that the brand (Tier 2) formulary cost-share for Migranal Nasal Spray in the TRICARE Mail Order Pharmacy and the TRICARE Retail Network Pharmacy be lowered to the generic (Tier 1) formulary cost-share.

XV. BRAND OVER GENERIC AUTHORIZATION FOR DIHYDROERGOTAMINE SPRAY/PUMP (MIGRANAL NASAL SPRAY)

BAP Comments

A. Migranal Nasal Spray Brand over Generic Requirement and PA Criteria

The P&T Committee recommended brand over generic preference for Migranal Nasal Spray and manual PA criteria for generic dihydroergotamine.

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

B. Migranal Nasal Spray Brand Copayment

The P&T Committee recommended that the brand (Tier 2) formulary cost-share for Migranal Nasal Spray be lowered to the generic (Tier 1) formulary cost-share.

<i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur

XVI. SECTION 703, NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FOR FISCAL YEAR (FY) 2008

P&T Comments

At the November 2018 meeting, the P&T Committee designated Tobramycin Inhalation Solution Pak (NDC: 70644-0899-99) by Genericus, Inc. as not compliant with Section 703 requirements. After further review and comparison of tobramycin inhalation solution pak with the other available tobramycin inhalation products which do not include the nebulizer, the Committee recommended removing this drug from the Section 703 Non-Compliant Drug List and returning to its previous status of UF on the Uniform Formulary with no point of service (POS) restrictions.

A. Drugs Designated as NF

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) that the Section 703 non-compliant NDC of the following product return to its former UF status with no POS restrictions:

- Genericus, Inc.: tobramycin inhalation solution pak (*New Drug Application-authorized generic; NDC 70644-0899-99*) 300 mg/5 mL ampule-nebulizer

XVII. SECTION 703 NDAA FY 2008

BAP Comments

A. Drugs Designated NF

The P&T Committee recommended tobramycin inhalation solution pak return to its former UF status.

<p><i>BAP Comment:</i> <input type="checkbox"/> Concur <input type="checkbox"/> Non-concur</p>
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XVIII. INFORMATIONAL ITEM—SUMMARY OF RECOMMENDATIONS AND BENEFICIARY IMPACT FEBRUARY 2019

Table of Implementation Status of UF Recommendations/Decisions Summary

DoD PEC Drug Class	UF Drugs	NF Drugs	Implement Date	Notes and Unique Users Affected
<p>Migraine Agents – CGRP Antagonist Prophylaxis Subclass</p>	<ul style="list-style-type: none"> ▪ erenumab (Aimovig) ▪ fremanezumab (Ajovy) ▪ galcanezumab (Emgality) 	<ul style="list-style-type: none"> ▪ None 	<p>Pending signing of the minutes / 30 days</p>	<ul style="list-style-type: none"> ▪ Manual PA criteria applies to all new users <p><u>Unique Users Affected</u> not applicable; new users only</p>

DoD PEC Drug Class	UF Drugs	NF Drugs	Implement Date	Notes and Unique Users Affected
Oncological Agents: CYP-17 Inhibitors Subclass and 2nd-Generation Antiandrogen Subclass	<u>CYP-17 Inhibitors</u> <i>Step-preferred</i> <ul style="list-style-type: none"> abiraterone acetate micronized (Yonsa) <i>Non-step-preferred</i> <ul style="list-style-type: none"> abiraterone acetate (Zytiga, generics) <u>2nd-Generation Antiandrogens</u> <i>Step-preferred</i> <ul style="list-style-type: none"> enzalutamide (Xtandi) <i>Non-step-preferred</i> <ul style="list-style-type: none"> apalutamide (Erleada) 	<ul style="list-style-type: none"> None 	Pending signing of the minutes / 90 days	<ul style="list-style-type: none"> Manual PA required Yonsa and Erleada will be Tier 1 copay/cost-shared CYP-17 Inhibitors Subclass <u>Unique Users Affected</u> Mail – 464 MTF – 155 Retail – 620 Total – 1,239

Tier 4/Not Covered Drugs—Unique Utilizers Affected

Drug	MTF	Mail Order	Retail	Total
metformin ER (Glumetza brand) (Glumetza generic)	24 28	64 266	5 17	93 311
naproxen/esomeprazole (Vimovo)	47	455	54	556
pancrelipase (Zenpep)	115	297	179	591

Drugs with New Prior Authorization Criteria—Unique Utilizers Affected

Drug	MTF	Mail Order	Retail	Total
Antihistamine-1: First Generation and Combinations – dexchlorpheniramine maleate 2 mg/5 mL oral solution (Ryclora)	0	0	0	0
Skeletal Muscle Relaxants and Combinations: cyclobenzaprine 7.5 mg	16	52	379	447