DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS FROM THE FEBRUARY 2021 MEETING

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) or their designee, on formulary or Tier 4/not covered status, prior authorization (PA), pre-authorizations, and the effective date for a drug's change from formulary to non-formulary (NF) or Tier 4 status are received from the Beneficiary Advisory Panel (BAP), which must be reviewed by the Director or their designee before making a final decision.

II. UF CLASS REVIEWS—Breast Cancer Agents: Cyclin-Dependent Kinase (CDK) Inhibitors Subclass

P&T Comments

A. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass Relative Clinical Effectiveness Analysis and Conclusion

Background— The P&T Committee evaluated the relative clinical effectiveness of the CDK inhibitor subclass used for advanced or metastatic hormone receptor-positive (HR(+)), human epidermal growth factor receptor 2-negative (HER2(-)) breast cancer. The drugs include abemaciclib (Verzenio), palbociclib (Ibrance), and ribociclib (Kisqali). Ribociclib is also co-packaged with the aromatase inhibitor letrozole (Kisqali Femara Co-Pack), which is a convenience formulation.

The Committee comprehensively reviewed the evidence, including what was reviewed when Verzenio, Kisqali, and Kisqali Femara were presented as innovators in November, May, and August of 2017, respectively.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

Efficacy

- A comprehensive review of the evidence shows that each CDK inhibitor offers a statistically and clinically significant advantage in objective response rate (ORR) and progression free survival (PFS), relative to the respective controls used in the individual clinical trials.

- There is no clear efficacy superiority of any one CDK inhibitor over another, and no clear superiority of the sequencing of when to use the CDK inhibitors. Overall, efficacy considerations do not drive selection of one particular agents.
- There are no head-to-head trials available directly comparing one CDK inhibitor with another.
- Indirect comparison of the hazard ratios of various efficacy endpoints (including ORR and PFS) from systematic reviews and network meta-analyses show that no one particular CDK inhibitor exhibits superiority over any other.

Guidelines

- The National Comprehensive Cancer Network (NCCN) guidelines recommend Verzenio, Ibrance, and Kisqali as preferred first-line, second-line or subsequent therapy, supported by the highest level of evidence.
- Abemaciclib (Verzenio) is also recommended as monotherapy for disease that has progressed on chemotherapy, but this is supported by a lower level of evidence (e.g., useful in certain circumstances).
- Other guidelines (e.g., American Society of Clinical Oncology, European Society for Medical Oncology) are in agreement with one another and make no distinction in the choice of a particular agent. Each CDK inhibitor has the same preference and strength of recommendation.

Safety

- There is no one clearly superior CDK inhibitor in terms of safety or tolerability.
- The safety profiles of the CDK inhibitors overlap, however, there are unique adverse events associated with each agent. Hematologic adverse events (e.g., neutropenia, anemia, and thrombocytopenia) are considered class effects.
    - Palbociclib (Ibrance) has the highest absolute risk of neutropenia, and a unique warning for the risk of pulmonary embolism.
    - Abemaciclib's (Verzenio's) safety profile includes a lower relative risk of neutropenia, but higher relative risk for diarrhea and unique warnings (amongst these agents) for hepatotoxicity and venous thromboembolism (VTE).
    - Ribociclib (Kisqali) has a lower relative risk of anemia, thrombocytopenia, and VTE, but higher relative risk for QT-

prolongation and a unique warning (amongst these agents) for hepatobiliary toxicity.

Overall Clinical Conclusion

- Choice of treatment in HR(+)/HER2(-) advanced or metastatic breast cancer depends on several factors, including the safety profile of the individual CDK inhibitor, patients' preference, comorbidities, and disease burden.

B. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—Relative Cost-Effectiveness Analysis and Conclusion

A cost-minimization analysis (CMA) and budget impact analysis (BIA) were performed. The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that Kisqali, Kisqali Femara Co-Pack, Verzenio and Ibrance were all cost-effective.
- BIA was performed to evaluate the potential impact of designating selected agents as formulary, NF, or Tier 4 on the UF. BIA results showed that designating all CDK inhibitors as UF demonstrated significant cost avoidance for the Military Health System (MHS).

C. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—UF/Tier 4/Not Covered Recommendation

The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF
    - abemaciclib (Verzenio)
    - palbociclib (Ibrance)
    - ribociclib (Kisqali)
    - ribociclib/letrozole (Kisqali Femora Co-Pack)
- NF - None
- Tier 4/Not Covered - None

D. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—Manual PA Criteria

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent), updating the PA criteria to follow the NCCN guidelines, with the additional indication for Verzenio noted, and including all four drugs on one PA form. The unique safety and monitoring factors will also be outlined for each drug.

The PA criteria are as follows:

1. Ibrance, Verzenio, Kisqali, Kisqali Femara Co-Pack

The PA criteria below replaces the current PA criteria for the CDK inhibitors.

Manual PA criteria apply to all new users of Ibrance, Verzenio, Kisqali, or Kisqali Femara Co-Pack

Note that Verzenio received a new FDA indication in October 2021, prior to the BAP meeting and P&T Committee minute's signing. The new indication is noted below in bold.

Manual PA Criteria: Ibrance, Verzenio, Kisqali, or Kisqali Femara Co-Pack is approved if all criteria are met:

- Drug is prescribed by or in consultation with an oncologist
- The patient is not currently taking another cyclin-dependent kinase inhibitor
- **For Verzenio only: The patient has hormone receptor HR(+)/HER2(-), node(+) *early* breast cancer at high risk of recurrence and a Ki67 score ≥ 20% as determined by an FDA approved test.**
- The patient has advanced or metastatic hormone receptor HR(+)/HER2(-) breast cancer
- If the patient is female, the patient meets one of the following criteria:
    - Ibrance, Verzenio, Kisqali, or Kisqali Femara Co-Pack will be used as first-line endocrine therapy in combination with anastrozole, exemestane, or letrozole; OR
    - Ibrance, Verzenio, Kisqali or Kisqali Femara Co-Pack will be as first-line or later-line endocrine therapy in combination with fulvestrant; OR
    - For Verzenio only: Will be used as monotherapy following metastatic progression on chemotherapy

- If the patient is a premenopausal or perimenopausal woman, she is receiving ovarian suppression/ablation with a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex [goserelin]), surgical bilateral oophorectomy, or ovarian irradiation.
- Provider is aware and has informed the patient of the risks of neutropenia and interstitial lung disease
- For Ibrance only: provider is aware and has informed the patient of the risk of pulmonary embolism
- For Verzenio only: provider is aware and has informed the patient of the risk of venous thromboembolism, diarrhea, and hepatotoxicity
- For Kisqali and Kisqali Femara Co-Pack only: provider is aware and has informed the patient of the risk of QT prolongation and hepatobiliary toxicity
- Female patients of childbearing age are not pregnant confirmed by (-) HCG
- Female patients will not breastfeed during treatment and for at least 3 weeks after the cessation of treatment
- Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 3 weeks after cessation of therapy if female; and for 3 months if male if using Ibrance only
- Male patients have been informed of the risk of infertility
- For Kisqali Femara Co-Pack only, female patients have been informed of the risk of infertility from letrozole
- The diagnosis is NOT listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, the provider must list the diagnosis:_____.

Non-FDA approved uses are not approved, except as noted above

Prior Authorization does not expire

E. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—UF, PA, and Implementation Plan

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent): an effective date of the first Wednesday 30 days after signing of the P&T minutes at all points of service.

Addendum to the UF recommendation: After the P&T meeting, a review of the bids submitted by one manufacturer showed that a re-calculation of the cost analysis was required. The new cost model was presented to the DoD P&T Committee via electronic means. An electronic vote was taken to determine whether to maintain the UF recommendation originally determined at the February 2021 meeting.

COMMITTEE ACTION: ADDENDUM TO UF RECOMMENDATION: The P&T Committee reaffirmed (14 for, 0 opposed, 0 abstained, 2 absent) the recommendation made at the meeting, which maintains all four CDK inhibitors (Verzenio, Ibrance, Kisqali, and Kisqali Femora Co-Pack) on the UF.

III. UF CLASS REVIEWS—Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass

BAP Comments

A. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—UF/Tier 4/Not Covered Recommendation

The P&T Committee recommended the formulary status for the Breast Cancer CDK inhibitors as discussed above:

- UF
  - Verzenio
  - Ibrance
  - Kisqali
  - Kisqali Femora Co-Pack
- NF
  - None
- Tier 4/Not Covered
  - None

BAP Comment: ☐ Concur ☐ Non-concur

B. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—Manual PA Criteria

The P&T Committee recommended updating the PA criteria as outlined above.

BAP Comment: ☐ Concur ☐ Non-concur

C. Breast Cancer Agents: Cyclin-Dependent (CDK) Inhibitors Subclass—UF, PA and Implementation Plan

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

BAP Comment: ☐ Concur ☐ Non-concur

IV. UF CLASS REVIEWS—Pulmonary 3 Agents: Combinations Subclass

P&T Comments

A. Pulmonary 3 Agents: Combinations Subclass Relative Clinical Effectiveness Analysis and Conclusion

Background—The Pulmonary 3 agents contain a fixed-dose triple combination of inhaled corticosteroid, long-acting muscarinic antagonist, and long-acting beta agonist (ICS/LAMA/LABA) in one inhaler. A triple combination regimen can also be achieved using a variety of multiple inhalers used separately, or by using

various fixed does dual combination inhaler, including single ingredient inhalers, such as an ICS/LABA or LAMA/LABA.

The two drugs in the class are fluticasone/umeclidinium/vilanterol (Trelegy) and budesonide/glycopyrrolate/formoterol (Breztri). Triple combination therapy is used in severe chronic obstructive pulmonary disease (COPD) and severe asthma after failure with dual therapy ICS/LABA or LAMA/LABA. Both Trelegy and Breztri are approved for maintenance treatment of COPD, while Trelegy has an additional indication for maintenance treatment of asthma in adults.

Although this is the first time the Pulmonary 3 Agents have been reviewed as a class, both Trelegy and Breztri were originally reviewed as new drugs, in November 2017 and November 2020, respectively.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

Asthma

- The National Asthma Education and Prevention Program Coordinating Committee (NAEPPCC) Expert Panel Working Group guidelines recommend adding a LAMA to ICS/LABA in patients with uncontrolled asthma to improve symptom control and quality of life. Triple combination therapy does not affect asthma exacerbations requiring corticosteroids or rescue medication use.
- Although Trelegy was shown to improve forced expiratory volume in one second (FEV1), Trelegy lacks an indication in the label to reduce asthma exacerbations.

COPD

- The Global Initiative for Chronic Obstructive Lung Disease (GOLD 2020), strategy recommends reserving triple therapy for highly symptomatic patients after failure of dual therapy with LAMA/LABA or ICS/LABA.
- In the individual clinical trials used to gain FDA approval, both Trelegy and Breztri demonstrated statistically significant improvements in trough FEV1, and in the Saint George Respiratory Questionnaire (SGRQ) quality of life instrument; however these results did not reach the minimally clinically important difference threshold.
- Although varying results were shown in the clinical trials with regard to a reduction in COPD exacerbations, neither Trelegy nor Breztri are indicated to reduce COPD exacerbations.

- For COPD, despite the lack of head-to-head trials, indirect comparisons suggest there is not a clinically relevant difference in the drugs' effects on FEV1.

Safety

- The GOLD strategy and American Thoracic Society guidelines recommend withdrawing ICS in patients receiving triple therapy (ICS/LAMA/LABA), if the patient has had no exacerbations in the preceding year, due to the risk of pneumonia.
- In studies with longer treatment durations, there was a higher rate of pneumonia with Trelegy, Breztri and ICS-containing regimens, compared to regimens lacking an ICS component.
- Overall drug discontinuation due to adverse events was low in the individual clinical trials with Trelegy and Breztri, versus respective comparators.

Clinical Considerations

- Breztri advantages include that it is less reliant on a patient's inspiratory flow rate to activate the inhaler; however, it is dosed twice daily, and is only indicated for COPD. The Breztri Aerosphere metered dose inhaler requires patient breath-hand coordination to activate. Clinical trials evaluating Breztri in adults with asthma are ongoing.
- Trelegy's advantages include FDA-approval for both asthma and COPD, and once daily dosing. The Ellipta inhaler device is breath-activated, requiring the patient to have a higher minimum inspiratory flow rate; however, it does not require patient breath-hand coordination.

Overall Clinical Conclusion

- The triple combination inhalers provide a convenience to patients in terms of offering three drugs in one inhaler for one copay. However there is no data to show the triple combination inhalers result in improved outcomes compared to taking multiple inhalers to comprise a regimen of LABA/ICS/LAMA, for example, taking an ICS/LABA (e.g., Advair) plus LAMA (e.g., Spiriva).
- In order to meet the needs of Military Health System (MHS) patients with COPD, at least one option for a triple combination of ICS/LAMA/LABA is required on the formulary; however, it does not have to be a three-ingredients-in-one inhaler.

B. Pulmonary 3 Agents: Combinations Subclass—Relative Cost-Effectiveness Analysis and Conclusion

CMA and BIA were performed to evaluate the Pulmonary 3 Agents. The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that budesonide/glycopyrrolate/formoterol (Breztri) and fluticasone/umeclidinium/vilanterol (Trelegy) were both cost-effective.
- BIA was performed to evaluate the potential impact of designating selected agents as formulary, NF, or Tier 4 on the UF. BIA results showed that designating Breztri and Trelegy as UF demonstrated the greatest cost avoidance for the Military Health System (MHS).

C. Pulmonary 3 Agents: Combinations Subclass—UF Recommendation

The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF
  - fluticasone/umeclidinium/vilanterol (Trelegy)
  - budesonide/glycopyrrolate/formoterol (Breztri)
- NF – None
- Tier 4/Not Covered – None

D. Pulmonary 3 Agents: Combinations Subclass—UF Implementation Plan

The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday two weeks after signing of the minutes in all points of service.

V. UF CLASS REVIEWS—Pulmonary 3 Agents: Combinations Subclass

BAP Comments

A. Pulmonary 3 Agents: Combinations Subclass—UF Recommendation

The P&T Committee recommended the formulary status for the Pulmonary 3 Combinations as discussed above:

- UF

- Trelegy
- Breztri

- NF – None
- Tier 4/Not Covered – None

BAP Comment: ☐ Concur ☐ Non-concur

B. Pulmonary 3 Agents: Combinations Subclass—UF Implementation Period

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

BAP Comment: ☐ Concur ☐ Non-concur

VI. 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 for group 1: (18 for, 0 opposed, 1 abstained, 0 absent); group 2: (18 for, 0 opposed, 1 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 for group 1: (17 for, 0 opposed, 2 abstained, 0 absent); group 2: (18 for, 0 opposed, 1 abstained, 0 absent) the following:

- UF
    - berotralstat (Orladeyo) – Corticosteroids-Immune-modulators; for hereditary angioedema (HAE)
    - hydrocortisone oral sprinkle capsules (Alkindi) – Adrenocortical insufficiency in children
    - lonafarnib (Zokinvy) – Miscellaneous metabolic agent for Hutchinson-Gilford Progeria Syndrome or processing-deficient Progeroid Laminopathies
    - PEGfilgrastim-apgf syringe (Nyvepria) – White Blood Cell Stimulants Note that as part of this recommendation, Nyvepria will be designated as step-preferred.
    - setmelanotide injection (Imcivree) – Weight loss agent for obesity due to proopiomelanocortin (POMC) deficiency, proprotein convertase subtilisin/kexin type 1 (PCSK1) deficiency, or leptin receptor (LEPR) deficiency

- NF
    - clascoterone 1% cream (Winlevi) – Acne Agents: Topical acne and rosacea agents
    - loteprednol 0.25% ophthalmic solution (Eysuvis) - Ophthalmic: Corticosteroid for short term use in dry eye disease
    - relugolix (Orgovyx) – Luteinizing hormone-releasing hormone (LHRH) agonists-antagonists for advanced prostate cancer
    - sodium sulfate/magnesium sulfate/potassium chloride (Sutab) – Laxatives-Cathartics-Stool Softeners: Bowel Preparation for colonoscopy
    - tramadol oral solution (Qdolo) – Narcotic analgesics and combinations

- Tier 4/Not Covered
    - calcipotriene/betamethasone dipropionate 0.005%/0.064% topical cream (Wynzora) - Topical Psoriasis agent.
        - Wynzora was recommended for Tier 4 status as it is has little to no clinical benefit relative to other formulations of calcipotriene/betamethasone dipropionate formulations, and the needs of TRICARE beneficiaries are met by alternative agents.

- Formulary alternatives to Wynzora include using a vitamin D analog (calcipotriene 0.005% cream, ointment or solution) with a high potency topical corticosteroid (clobetasol propionate 0.05% ointment, cream, solution and gel; fluocinonide 0.05% cream, gel and solution), or calcipotriene 0.005% and betamethasone 0.064% foam (Enstilar) [Nonformulary].

- clobetasol propionate 0.05% lotion metered dose pump (Impeklo) – High Potency Topical Corticosteroid for steroid-responsive dermatoses.
  - Impeklo was recommended for Tier 4 status as it is has little to no clinical benefit relative to other formulations of clobetasol propionate, and the needs of TRICARE beneficiaries are met by alternative agents.
    - Formulary alternatives to Impeklo include betamethasone/propylene glycol 0.05% lotion; betamethasone dipropionate 0.05% gel; clobetasol propionate/emollient 0.05 % (emulsion) foam; clobetasol propionate 0.05% solution, lotion, gel, foam, spray, and shampoo, and fluocinonide 0.05% solution and gel

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

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

- PEGfilgrastim: No PA is required for Nyvepria, however, note that Nyvepria will be step-preferred, along with Udenyca and Fulphila (from the August 2020 meeting); new patients receiving a non-step-preferred PEGfilgrastim (Neulasta, Neulasta Onpro, and Ziextenzo) will be required to have a trial of Nyvepria, Udenyca and Fulphila first. The PA forms for the non-step-preferred products will be updated accordingly.
- LHRH agonists-antagonists for advanced prostate cancer: Applying manual PA criteria to new users of Orgovyx.
- HAE drugs: applying manual PA criteria to new users of Orladeyo. Note that as part of this recommendation, the PAs for all the HAE drugs were updated, and included on one PA form. The prophylactic HAE drugs were evaluated for formulary status in August 2017. The manual PA criteria for the HAE prophylactic drugs were updated to reflect the 2020 U.S. Hereditary Angioedema Association guidelines

which do not recommend a trial of anabolic androgens prior to other available prophylactic agents.

- Applying manual PA criteria to new users of Alkindi Sprinkle, Imcivree, Qdolo, and Zokinvy.
- Applying manual PA criteria to new and current users of Eysuvis and Winlevi.

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

1. **The HAE drugs: berotralstat (Orladeyo), lanadelumab (Takhzyro), C1-INH (Cinryze IV), C1-INH (Haegarda SC)**

   Manual PA criteria apply to all new users of Orladeyo, Takhzyro, Cinryze, and Haegarda.

   Manual PA criteria: Orladeyo, Takhzyro, Cinryze, or Haegarda is approved if all criteria are met:

   - Patient Age
     - For Orladeyo, the patient is 12 years of age or older
     - For Takhzyro, the patient is 12 years of age or older
     - For Cinryze, the patient is 13 years of age or older
   - The patient has a diagnosis of hereditary angioedema (HAE)
   - Orladeyo, Takhzyro, Cinryze or Haegarda is prescribed by an allergist, immunologist, or rheumatologist, or in consultation with an HAE specialist
   - The patient must have monthly HAE attacks or a history of severe attacks that require prophylaxis treatment (i.e., ≥2 HAE attacks/month, laryngeal attacks, etc.)
   - The patient is not currently receiving another drug for HAE prophylaxis (e.g., Orladeyo, Takhzyro, Cinryze or Haegarda will not be used concomitantly).

   Non-FDA approved uses are not approved.

   PA does not expire

2. **clascoterone cream (Winlevi)**

Manual PA is required for all new and current users of clascoterone cream (Winlevi).

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

- The provider is aware and acknowledges that adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and spironolactone (tablets) are available to DoD beneficiaries without requiring prior authorization
- Patient has a diagnosis of acne vulgaris
- Patient is 12 years of age or older
- The drug is prescribed by or in consultation with a dermatologist.
- Provider acknowledges a potential increased risk of hypothalamic-pituitary-adrenal axis suppression in adolescents compared to adults
- Patient has tried and failed or has contraindications to a topical retinoid product and to a combination of topical clindamycin and benzoyl peroxide product. The provider must fill in the dates of when the patient previously tried these agents or document the contraindication that exists.
    - Topical retinoid: Date _____ Contraindication _____
    - Combination topical clindamycin with benzoyl peroxide: Date _____ Contraindication _____
- Patient has tried and failed or has contraindications to at least one oral medication (i.e., spironolactone, a combined oral contraceptive, OR isotretinoin) for acne. The provider must fill in the dates of when the patient previously tried these agents or document the contraindication that exists
    - Oral medication: _____ Date _____ Contraindication _____

Non-FDA-approved uses are not approved, including for hair loss

Prior authorization does not expire.

3. hydrocortisone oral sprinkle (Alkindi Sprinkle)

PA is not required for patients 6 years of age and younger.

Manual PA Criteria for all new patients older than 6 years of age: Alkindi Sprinkle is approved if all criteria are met:

- The provider is aware and acknowledges that 5 mg generic hydrocortisone tablets and prednisone Intensol oral syrup are available to DoD beneficiaries without requiring prior authorization
- Patient is between the ages of 6 and 18 years of age.
- Patient has a documented diagnosis of adrenocortical insufficiency
- Provider acknowledges that the patient's dosing regimen requires small doses of hydrocortisone and the patient cannot accurately split the dose using 5 mg hydrocortisone tablets or use the Intensol oral syrup

Non-FDA-approved uses are not approved

Prior authorization does not expire.

4. lonafarnib (Zokinvy)

Manual PA is required for all new users of Zokinvy.

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

- Patient is 12 months of age or older
- Patient has a body surface area (BSA) of 0.39 m^2 and greater
- Patient has a documented diagnosis of Hutchinson-Gilford Progeria Syndrome or the following processing deficient Progeroid Laminopathies:
    - Heterozygous LMNA mutation with progerin-like protein accumulation
    - Homozygous or compound heterozygous ZMPSTE24 mutations
- Patient is not concomitantly receiving strong or moderate CYP3A inhibitors or inducers, midazolam, lovastatin, simvastatin, or atorvastatin
- Patient's renal function, electrolytes, complete blood counts, and liver enzymes will be monitored at regular intervals

- Female patients with reproductive potential have been advised of the risk to a fetus and effective contraception is used

Non-FDA-approved uses are not approved including for other Progeroid Syndromes or processing-proficient Progeroid Laminopathies.

Prior authorization does not expire.

5. loteprednol 0.25% ophthalmic solution (Eysuvis)

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

Manual PA Criteria: Coverage will be approved if all criteria are met:

- The provider is aware and acknowledges that generic loteprednol, and other loteprednol formulations, 0.5%, Lotemax SM, Lotemax FML and Inveltys are available to DoD beneficiaries without requiring prior authorization
- Eysuvis is prescribed by an optometrist or ophthalmologist
- The patient has a diagnosis of dry eye disease as evidenced by at least one diagnostic test (e.g., Tear Film Break-Up Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)
- Patient has tried and failed or had an adverse event to a two week course of generic loteprednol 0.5%
- Patient has tried and failed or had an adverse event to a two week course of at least one low-dose ophthalmic steroid formulation (e.g. Lotemax SM, Inveltys, Alrex, and FML)
- Use of Eysuvis will not exceed 14 days per course of therapy for dry eye disease

Non-FDA-approved uses are NOT approved, including allergic conjunctivitis and for post-operative use to decrease inflammation

PA expires in 6 months.

Renewal Criteria: Note that initial TRICARE PA approval is required for renewal. Eysuvis will be approved for an additional 6 months if the following is met:

- The patient has experienced improvement in dry eye signs and symptoms.

6. **relugolix (Orgovyx)**

Manual PA is required for all new users of relugolix (Orgovyx).

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

- The provider is aware and acknowledges that leuprolide acetate IM (Lupron Depot), leuprolide acetate SQ (Eligard), and degarelix SQ (Firmagon) are available to DoD beneficiaries without requiring prior authorization
- Patient is 18 years of age or older
- Orgovyx is prescribed by or in consultation with an oncologist or urologist
- Patient has advanced prostate cancer
- Patient has tried and failed OR is unable to use injectable leuprolide formulations (i.e. subcutaneous injection or implant, subcutaneous injection)

Non-FDA-approved uses are not approved including cancers other than prostate cancer, and in women for endometrial thinning, endometriosis, and uterine leiomyomata (fibroids).

Prior authorization does not expire.

7. **setmelanotide (Imcivree)**

Manual PA is required for all new users of Imcivree.

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

- Patient is 6 years of age or older
- Patient has a confirmed diagnosis (via genetic testing) of POMC-, PCSK1-, or LEPR-deficiency that are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS)
- Patient and provider agree to evaluate weight loss after 12-16 weeks of treatment. Imcivree should be discontinued if a patient has not lost at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential

Initial prior authorization expires in 4 months.

Renewal criteria: Note that initial TRICARE PA approval is required for renewal. Imcivree is approved for 1 year for continuation of therapy if all criteria are met:

- The patient has a documented improvement (a decrease from baseline) in at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential.

Non-FDA approved uses are NOT approved including Alström Syndrome, Bardet-Biedl Syndrome (BBS), POMC-, PCSK1-, or LEPR-deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign, other types of obesity not related to POMC, PCSK1 or LEPR deficiency, including obesity associated with other genetic syndromes and general (polygenic) obesity.

8. Tramadol oral solution (Qdolo)

Manual PA is required for all new users of tramadol oral solution (Qdolo).

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

- The provider is aware and acknowledges that several opioid analgesics are available to DoD beneficiaries without requiring prior authorization, including tramadol IR tablets, and codeine with acetaminophen tablets and solution.
- Patient is 12 years of age or older
- For patients less than 18 years of age, Qdolo will not be approved for pain following tonsillectomy or adenoidectomy
- Patient has tried and failed or has a contraindication to liquid acetaminophen
- Patient has tried and failed or has a contraindication to liquid ibuprofen
- Patient has tried and failed or has a contraindication to tramadol IR tablets

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

D. Newly Approved Drugs per 32 CFR 199.21 (g)(5) – Tier 1 Co-Pay for PEGfilgrastim (Nyvepria)

The P&T Committee recommended (18 for, 0 opposed, 1 abstained, 0 absent) lowering the current Tier 2 cost-share for Nyvepria to the generic Tier 1 cost-share, with an effective date of the fist Wednesday two weeks after signing of the minutes at all points of service.

The authority for this recommendation is codified in 32 CFR 199.21(e)(3) from the Final Rule published June 3, 2020 which states "in implementing this rule, the Committee will not only evaluate drugs for exclusion from coverage, but will also include identifying branded drugs that may be moved to Tier 1 status with a lower copayment for beneficiaries. The intent of identifying agents in this manner as well as the new exclusion authority is to yield improved health, smarter spending, and better patient outcomes." Lowering the cost-share for Nyvepria will provider a greater incentive for beneficiaries to use a cost-effective PEGfilgrastim.in the purchased care points of service.

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

The P&T Committee recommended for group 1: (17 for, 0 opposed, 2 abstained, 0 absent); group 2: (18 for, 0 opposed, 1 abstained, 0 absent) an effective date of the following:

- **New Drugs Recommended for UF or NF Status, and PA criteria:** An effective date of the first Wednesday two weeks after signing of the minutes in all points of service.

- **New Drugs Recommended for Tier 4 Status:** 1) An effective date of the first Wednesday after a 120-day implementation period at all POS; and 2) DHA send letters to beneficiaries who are affected by the Tier 4/Not Covered recommendation at 30 days and 60 days prior to implementation.

VII. 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 Recommendation

The P&T Committee recommended the formulary status for the newly approved drugs as discussed above:

- **UF**
  - Orladeyo
  - Alkindi

- Zokinvy
- Nyvepria
- Imcivree

- **NF**
  - Winlevi
  - Eysuvis
  - Orgovyx
  - Sutab
  - Qdolo

- **Tier 4/Not Covered**
  - Wynzora
  - Impeklo

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)—Tier 1 Co-Pay for PEGfilgrastim (Nyvepria)

The P&T Committee recommended lowering the current Tier 2 cost-share for Nyvepria to the generic Tier 1 cost-share, with an effective date of the first Wednesday two weeks after signing of the minutes, as discussed above.

BAP Comment: ☐ Concur ☐ Non-concur

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

- **New Drugs Recommended for UF or NF Status, and PA criteria:** An effective date of the first Wednesday two weeks after signing of the minutes in all points of service.

- **New Drugs Recommended for Tier 4 Status:** 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 at 30 days and 60 days prior to implementation.

BAP Comment: ☐ Concur ☐ Non-concur

VIII. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA

P&T Comments

A. New Manual PA Criteria

The P&T Committee recommended new manual PA criteria for orphenadrine-aspirin-caffeine tablets (Norgesic, Orphengesic Forte), and levorphanol tartrate tablets as discussed below.

1) Skeletal Muscle Relaxants and Combinations – orphenadrine-aspirin-caffeine tablets (Norgesic, Orphengesic Forte)

The P&T Committee recommended (18 for, 0 opposed, 1 abstained, 0 absent) manual PA criteria in new users, to ensure that other therapies for musculoskeletal pain are tried first.

The non-opioid combination product containing orphenadrine 50 mg, aspirin 770 mg, and caffeine 60 mg is indicated for mild to moderate acute musculoskeletal pain. The fixed dose combination generic Norgesic and Orphengesic products are not cost effective relative to the individual components, which are all available in low-cost formulations. Several other cost-effective prescription and OTC non-opioid alternatives (i.e., baclofen, cyclobenzaprine, NSAIDs, acetaminophen) are also available.

The manual PA criteria are as follows:

Manual PA criteria applies to all new users of orphenadrine-aspirin-caffeine 50 mg-770 mg-60 mg (Norgesic, Orphengesic Forte).

Manual PA Criteria: Norgesic, Orphengesic Forte is approved if all criteria are met:

- Provider is aware and acknowledges that orphenadrine extended release, baclofen, cyclobenzaprine, acetaminophen, and numerous NSAIDs are available to DoD beneficiaries without requiring prior authorization
- The provider must explain why the patient requires orphenadrine-aspirin-caffeine tablets (Norgesic, Orphengesic Forte) and cannot take the available alternatives.

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

2) Narcotic Analgesics and Combinations-levorphanol tartrate tablets

The P&T Committee recommended (17 for, 0 opposed, 2 abstained, 0 absent) manual PA criteria for levorphanol tartrate tablets in new users to ensure that other therapies for pain are tried first.

Levorphanol tartrate is reserved for patients who require an opioid for severe pain where alternative options (i.e., non-opioid analgesics, opioid combination products) are ineffective, not tolerated, or otherwise inadequate. It is not a first line treatment for pain, due to safety concerns related to the long half-life. Provider feedback mentioned unfamiliarity with this product and supported PA criteria. Numerous other appropriate pain management options are available.

The Manual PA criteria is as follows:

Manual PA criteria applies to all new users of levorphanol tartrate tablets.

- Provider acknowledges that morphine sulfate immediate release (IR), codeine IR, hydromorphone IR, meperidine IR, oxycodone IR, hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/ acetaminophen, and tapentadol IR are available to DoD beneficiaries without requiring prior authorization.
- Patient has tried and failed at least one of the following short acting opioids: morphine sulfate IR, codeine IR, hydromorphone IR, meperidine IR, oxycodone IR, hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, tapentadol IR

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

B. New Manual PA Criteria—Implementation Plan

The P&T Committee recommended (18 for, 0 opposed, 1 abstained, 0 absent) the new PA for orphenadrine-aspirin-caffeine tablets (Norgesic, Orphengesic Forte) become effective in new users the first Wednesday 30 days after the signing of the minutes.

The P&T Committee also recommended (17 for, 0 opposed, 2 abstained, 0 absent) the new PA criteria for levorphanol tartrate tablets will become effective in new users the first Wednesday 90 days after the signing of the minutes.

IX. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA

BAP Comments

A. New Manual PA Criteria

The P&T Committee recommended manual PA criteria for Norgesic, Orphengesic Forte and levorphanol tartrate in new users, as outlined above.

BAP Comment: □ Concur □ Non-concur

B. New Manual PA Criteria—Implementation Plan

The P&T Committee recommended the new PA criteria for Norgesic, Orphengesic Forte become effective at 30 days and the new PA criteria for levorphanol tartrate become effective at 90 days.

BAP Comment: ☐ Concur ☐ Non-concur

X. UTILIZATION MANAGEMENT—UPDATED MANUAL PA CRITERIA

P&T Comments

A. Updated Manual PA Criteria

The P&T Committee recommended updates to the PA criteria for several drugs, based on new clinical trial data, clinical practice guidelines, or MTF provider requests. The updated PA criteria discussed below apply to new users.

1) Diabetes Non-Insulin: Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors-empagliflozin (Jardiance), dapagliflozin (Farxiga), canagliflozin (Invokana), and ertugliflozin (Steglatro)

The SGLT2 inhibitors were originally approved for treating type 2 diabetes mellitus (T2DM) when the class was reviewed for formulary status in 2015. Empagliflozin (Jardiance) is currently the preferred SGLT2 inhibitor; canagliflozin (Invokana), dapagliflozin (Farxiga), and ertugliflozin (Steglatro) are nonformulary and non-step-preferred, requiring a trial of empagliflozin first. The SGLT2 inhibitors are also available in fixed-dose combinations with metformin.

Recently published trials provide evidence for the SGLT2 inhibitors in patients with heart failure with reduced ejection fraction (HFrEF) or chronic kidney disease (CKD), regardless of DM status. Clinical practice guidelines from the American College of Clinical Cardiology (ACC) (2021 ACC Consensus Decision Pathway for HFrEF Optimization) and the American Heart Association (AHA) (2020 Scientific Statement on cardiorenal protection in patients with DM and CKD) support a class effect for the SGLT2 inhibitors for improving cardiovascular outcomes. Some of

the package inserts for the SGLT2 inhibitors have not yet been updated to reflect the new clinical trial data. *Note that Jardiance received FDA approval for treating HFrEF on August 18, 2021.*

Provider input from MHS cardiologists and nephrologists overwhelmingly supported maintaining empagliflozin as the preferred SGLT2 inhibitor for T2DM, HFrEF and CKD, based on professional guidelines and clinical trial data, regardless of diabetes status or formal FDA-approval.

The P&T Committee recommended (18 for, 0 opposed, 1 abstained, 0 absent) removing the current PA criteria for empagliflozin and empagliflozin/metformin. The PA criteria for canagliflozin, dapagliflozin, and ertugliflozin and their respective combinations with metformin were revised to require a trial of empagliflozin first for patients with T2DM, HFrEF, and CKD. The nonformulary SGLT2 inhibitors will be allowed if the patient has a contraindication or has experienced adverse effects from empagliflozin.

The updated PA criteria for the NF, non-step-preferred SGLT2-inhibitors is as follows:

> The criteria below replaces the current SLGT2 inhibitor PA criteria and applies to new users of canagliflozin (Invokana), canagliflozin/metformin (Invokamet, Invokamet XR), dapagliflozin (Farxiga), dapagliflozin/metformin (Xigduo XR), and ertugliflozin (Steglatro):
>
> Manual PA Criteria: Invokana, Invokamet, Farxiga, Xigduo XR, or Steglatro will be approved if all criteria are met:
>
> *For all indications:*
>
> - The patient is 18 years of age or older
> - Provider is aware and acknowledges that empagliflozin (Jardiance), empagliflozin/metformin (Synjardy, Synjardy XR) and empagliflozin/linagliptin (Glyxambi) are DoD's preferred SGLT2 inhibitor, and that PA is not required for empagliflozin products.
>
> *For Type 2 Diabetes Mellitus:*
>
> - Canagliflozin (Invokana, Invokamet), dapagliflozin (Farxiga, Xigduo XR), or ertugliflozin (Steglatro) are requested to improve glycemic control in patients with T2DM OR
> - Canagliflozin, (Invokana, Invokamet), dapagliflozin (Farxiga, Xigduo XR), or ertugliflozin (Steglatro) are requested to reduce the risk of cardiovascular death in patients with T2DM and established cardiovascular disease

- Patient must have had an inadequate response or experienced significant adverse events, or have a contraindication to metformin
- Patient must have tried one of the preferred SGLT2 inhibitors (Jardiance, Glyxambi, Synjardy, and Synjardy XR) and had an inadequate response or experienced significant adverse reactions or have a contraindication.

For Heart Failure with reduced ejection fraction (HFrEF):

- Canagliflozin, (Invokana), dapagliflozin (Farxiga), or ertugliflozin (Steglatro) are requested for reduction in risk of heart failure hospitalization and/or cardiovascular death in patients with HFrEF
- Patient has experienced significant adverse reactions has a contraindication to empagliflozin
- Initial prescription is written by or in consultation with a cardiologist
- Patient has a documented diagnosis of chronic HF (New York Heart Association class II through IV) with a left ventricular ejection fraction (LVEF) ≤ 40 % and with continued heart failure symptoms
- Patient is receiving appropriate guideline-directed medical therapy including the following: angiotensin-converting enzyme inhibitor (ACEI), angiotensin II receptor blocker (ARB), or angiotensin receptor neprilysin inhibitor (ARNI); beta blocker; and aldosterone antagonist, unless contraindicated or if the patient has experienced adverse effects or could not tolerate these therapies

For Chronic Kidney Disease (CKD):

- Canagliflozin, (Invokana, Invokamet), dapagliflozin (Farxiga, Xigduo XR), or ertugliflozin (Steglatro) are requested to reduce kidney disease progression and cardiovascular outcomes in patients with CKD.
- Patient has experienced significant adverse reactions or has a contraindication to empagliflozin
- Initial prescription is written by or in consultation with a nephrologist
- Patient's estimated glomerular filtration rate (eGFR) is higher than 25 ml/min/1.73m2 AND the Urinary Albumin-to-Creatinine Ratio is greater than or equal to 200 mg/gram

- Patient is receiving maximum tolerated labeled dose of an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor blocker (ARB), or is unable to use an ACEI or ARB

Non-FDA-approved uses are not approved, including type 1 diabetes mellitus, heart failure with preserved ejection fraction, or acute decompensated heart failure

Prior authorization does not expire.

The P&T Committee recommended (17 for, 0 opposed, 2 abstained, 0 absent) updated PA criteria for Xhance, Symbicort, Dulera, and Evrysdi, as discussed below.

2) Nasal Allergy Agents: Corticosteroids - fluticasone propionate 93 mcg nasal spray (Xhance)

An MTF provider requested the Committee review the current PA criteria for Xhance, which was designated NF at the February 2018 meeting. Xhance is the fourth fluticasone nasal product marketed, but it is only indicated for adults with nasal polyps and is not approved for allergic rhinitis.

A review of the evidence shows that Xhance may provide improved penetration of medication into the nasal cavity, but there is no evidence that this results in better outcomes for the patient. Xhance provides no confirmed benefit in reducing nasal polyp size compared to alternative intranasal corticosteroids or steroid lavage. However, changes to the Xhance manual PA criteria were made to align with current rhinosinusitis guidelines for treating nasal polyps, and to follow DHA Specialist recommendations.

Additions to the criteria include a new requirement for nasal saline irrigation. The option of nasal corticosteroid lavage (e.g., irrigation, rinse) was added to the list of treatments that are required prior to Xhance (patients must still try two nasal steroids before Xhance).

Updates from the February 2021 meeting are in bold and strikethrough.

Manual PA criteria apply to all new users of fluticasone propionate 93-mcg nasal spray (Xhance).

Manual PA Criteria: Xhance is approved if ALL criteria are met:

- **Patient has chronic rhinosinusitis with nasal polyposis confirmed by imaging or direct visualization**
- **Patient is 18 years of age or older**
- The prescription is written by or in consultation with an allergist, immunologist, pulmonologist, or otolaryngologist
- **The symptoms of chronic rhinosinusitis with nasal polyposis are inadequately controlled despite all of the following maximized treatments:**
  - **Nasal saline irrigation**
  - **Adequate duration of at least TWO of the following**
    - **fluticasone propionate (generic Flonase)**
    - **flunisolide (generic Nasarel)**
    - **beclomethasone (Beconase AQ, QNASL)**
    - **budesonide (Rhinocort Aqua, generic)**
    - **mometasone (Nasonex, generics)**
    - **nasal corticosteroid irrigation/rinse**
    - ~~azelastine~~
    - ~~ipratropium nasal spray (Atrovent nasal spray)~~
  - ~~Patient has tried and failed mometasone (Nasonex) OR beclomethasone (Beconase)~~

Non-FDA-approved uses are not approved, including allergic rhinitis

Prior authorization does not expire.

3) Pulmonary-1 Agents: Combinations: budesonide/formoterol (Symbicort) and mometasone/formoterol (Dulera)

Manual PA criteria for Symbicort and Dulera were originally recommended in February 2014, requiring a trial of fluticasone/salmeterol (Advair) first. The PA criteria were most recently revised in November 2019, allowing inhaled corticosteroid (ICS) with formoterol (e.g., budesonide/formoterol, or mometasone/formoterol) as a rescue inhaler, based on the 2019 Global Initiative for Asthma (GINA) evidence-based strategy.

In 2020, the U.S. based National Asthma Education and Prevention Program Coordinating Committee (NAEPPCC) focused update to the Asthma Management Guidelines now prefers combination ICS-formoterol for daily (maintenance) and as needed use (PRN or quick-relief therapy) for

moderate persistent asthma (Steps 3 and 4 in the algorithm) over other ICS/LABA combinations. The traditional regimens of ICS with as-needed short-acting beta agonist (SABA) or ICS/long acting beta agonist (LABA) with as-needed SABA are now considered alternate treatments. However, no changes are needed if a patient's current regimen of maintenance ICS/LABA with SABA as quick-relief therapy is providing adequate asthma control.

This approach using ICS-formoterol for maintenance and as-needed use was based on 10 studies comparing ICS-formoterol dual combination inhalers with the same dose ICS or higher dose ICS single ingredient inhalers. A reduction in asthma exacerbations was noted with ICS-formoterol therapy. Limitations to the studies were the inclusion of ICS-formoterol and SABA inhalers that are not commercially available in the U.S. and significant industry funding. Also, note that the current FDA labeling for Symbicort and Dulera does not include quick-relief use.

Provider feedback was solicited regarding the NAEPPCC recommendations, and overall, providers supported increased access to ICS-formoterol combinations for DoD beneficiaries. Manual PA criteria for both drugs were updated in accordance with the 2020 NAEPPCC recommendations.

Updates from the February 2021 meeting are in bold and strikethrough.

Manual PA criteria apply to all new users of Symbicort and Dulera

Note: fluticasone/salmeterol (Advair Diskus/Advair HFA) is DoDs preferred ICS/LABA and is available without a PA.

Automated PA Criteria: Symbicort or Dulera is approved if:

- The patient has filled a prescription for Advair Diskus or Advair HFA at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. OR
- The patient is 12 years of age and younger

Manual PA Criteria: Symbicort or Dulera is approved (i.e., trial of Advair Diskus or Advair HFA is NOT required) if one of the options below applies:

- Use of formulary agents (Advair Diskus and Advair HFA) is contraindicated

- Patient has experienced significant adverse effects from Advair that is not expected to occur with the non-formulary ICS/LABA medication
- Formulary agents (Advair Diskus and Advair HFA) result or are like to result in therapeutic failure
- Patient previously responded to the non-formulary agent and changing to a formulary agent (Advair Diskus and Advair HFA) would incur unacceptable risk
- The patient has asthma and requires rescue therapy **or intermittent and daily ICS-LABA therapy** with an ICS-formoterol combination ~~in accordance with GINA Strategy~~
    - ~~Symbicort: patient requires an MDI because they have decreased inspiratory effort and cannot use a DPI (Advair Diskus)~~
    - ~~Breo Ellipta: patient has complicated drug regimen and requires once daily dosing~~

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

4) Miscellaneous Neurologic Agent for spinal muscular atrophy (SMA): risdiplam (Evrysdi) oral solution

Manual PA criteria for Evrysdi were added when it was first reviewed as a new drug at the November 2020 meeting. The Director, DHA, recommended that the P&T Committee re-review the criteria. The Committee re-evaluated the current age restriction, which limits use to patients younger than 25. After further review, despite a lack of clinical evidence supporting Evrysdi in patients older than 25 years of age, for humanistic reasons the age restriction was removed from the PA. Patients meeting all the other criteria will be allowed to use Evrysdi, regardless of age.

Updates from the February 2021 meeting are in strikethrough.

Manual PA criteria applies to new users of risdiplam (Evrysdi).

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

- ~~The patient is between the ages of 2 months to 25 years of age (Fill-in-the-blank)~~
- The drug is prescribed by a pediatric or adult neurologist

- Patient has genetic confirmation of homozygous deletion or compound heterozygosity predictive of loss of function of the SMN1 gene (documentation required)
- Patient has confirmation of at least two SMN2 gene copies (documentation required)
- Patient has a confirmed diagnosis of Spinal Muscular Atrophy Types 1, 2, or 3 (Fill-in-the-blank)
- Female patients of childbearing age are not pregnant confirmed by (-) HCG
- Female patients of childbearing potential have been counseled to use effective contraception during treatment and for at least 1 month after the cessation of therapy
- Male patients of reproductive potential are counseled about the potential effects on fertility
- Patient does not have evidence of hepatic impairment
- Patient does not have permanent ventilator dependence
- Patient does not have complete paralysis of all limbs
- Evrysdi will not be used concurrently with Spinraza (nusinersen injection for intrathecal use)
- Patient weight must be documented (Fill-in-the-blank) – (Any answer acceptable)
- Patient dose in total mg/day and mg/kg per day must be documented (Fill-in-the blank)
    - The dose must be 0.2 mg/kg if the patient is 2 months to < 2 years of age; OR 0.25 mg/kg for patients ≥ 2 years of age who weigh < 20 kg; OR 5 mg for patients ≥ 2 years of age who weigh ≥ 20 kg

Non-FDA-approved uses are NOT approved.

Prior authorization expires in 6 months.

Renewal Criteria: (Initial TRICARE PA approval is required for renewal)

- According to the prescriber, the patient's level of disease has improved or stabilized to warrant continuation on Evrysdi as determined by an objective measurement and/or assessment tool and/or clinical assessment of benefit. (documentation required)

Renewal criteria expires in 1 year.

B. Updated Manual PA Criteria—Implementation Plan

The P&T Committee recommended the following implementation periods:

- The P&T Committee recommended (18 for, 0 opposed, 1 abstained, 0 absent) the updated PA for the SGLT2-inhibitors and the removal of the age restriction for Evrysdi become effective in new users the first Wednesday 30 days after signing of the minutes. *Note that due to the BAP meeting delay and subsequent delay of the signing of the February 2021 P&T Committee meeting minutes, the PA was updated in June 2021, based on the direction of the Director, DHA.*

  The P&T Committee also recommended (17 for, 0 opposed, 2 abstained, 0 absent) the updated PAs for Xhance, Symbicort, and Dulera become effective in new users the first Wednesday 60 days after the signing of the minutes.

XI. UTILIZATION MANAGEMENT—UPDATED MANUAL PA CRITERIA

BAP Comments

A. Updated PA Criteria

The P&T Committee recommended updates to the manual PA criteria for the SGLT2 inhibitors, Xhance, Symbicort, Dulera, and Evrysdi, as discussed above.

BAP Comment: ☐ Concur ☐ Non-concur

B. Updated PA Criteria—Implementation Plan

The P&T Committee recommended the updates to the PA criteria for the drugs discussed above become effective at 30 days for the SGLT2 inhibitors and Evrysdi; and at 60 days for Xhance, Symbicort and Dulera.

BAP Comment: ☐ Concur ☐ Non-concur

XII. UTILIZATION MANAGEMENT—UPDATED MANUAL PA CRITERIA FOR NEW FDA-APPROVED INDICATIONS, NCCN GUIDELINE UPDATES, OR AGE RANGES

P&T Comments

A. Updated Manual PA Criteria

The P&T Committee (17 for, 0 opposed, 2 abstained, 0 absent) recommended updates to the manual PA criteria and step therapy for several drugs due to expanded age indications, new FDA-approved indications, or other reasons. The updated PAs will apply to new users.

Note that since these types of updates expand the patient population eligible for the drug, only a summary of the PA criteria is provided here; the current full PA criteria can be found on the TRICARE Formulary Search Tool at https://www.express-scripts.com/frontend/open-enrollment/tricare/fst/#/.

1) **Targeted Immunomodulatory Biologics (TIBs) -anakinra (Kineret)**—Manual PA criteria now allow for the new indication of Deficiency of Interleukin-1 Receptor Antagonist (DIRA).
2) **Immunosuppressives - belimumab (Benlysta)—**belimumab injection SQ and IV (Benlysta)—Manual PA criteria were updated to include the new indication of active lupus nephritis in adults who are receiving standard therapy.
3) **Cystic Fibrosis Agents - ivacaftor (Kalydeco), elexacaftor/tezacaftor/ivacaftor (Trikafta), and tezacaftor/ivacaftor (Symdeko)**—The PA criteria for the cystic fibrosis drugs were revised to standardize the wording for all three drugs, and to reflect the new indications allowing for mutation types that are responsive to Kalydeco or Symdeko, based on clinical and/or *in vitro* assay data.
4) **Weight Loss Agents - liraglutide 3 mg (Saxenda)**—Manual PA criteria now allow use in patients as young as 12 years for weight loss. Patients age 16 years and older must first try phentermine, consistent with the

requirements for adults, however patients between the ages of 12 to 15 years are allowed to use Saxenda without first trying phentermine.

5) **Oncological Agents**

- **Breast Cancer - neratinib (Nerlynx)**—Includes the new FDA-approved indications for advanced or metastatic human epidermal growth factor receptor 2 positive (HER2+) breast cancer in adults, when used in combination with capecitabine, and when the patient has received two or more prior anti-HER2-based regimens in the metastatic setting. The previous lifetime duration of one year was removed, since the new indication of HER2+ breast cancer does not limit length of the treatment course.
- **Multiple Myeloma - selinexor (Xpovio)**—The manual PA criteria were updated to allow for the new indication for multiple myeloma, when used in combination with bortezomib and dexamethasone, and when the patient has received at least one prior therapy.
- **Multiple Myeloma - ixazomib (Ninlaro)**—The manual PA was updated to allow for NCCN recommended (category 1) use as a single-agent maintenance therapy for multiple myeloma when patients will receive Ninlaro following primary therapy and hematopoietic cell transplant (HCT).

6) **Sleep Disorders**

- **Wakefulness Promoting Agents - pitolisant (Wakix)**—The new indication of cataplexy in adults with narcolepsy is now included in the criteria.
- **Sleep Disorders: Insomnia tasimelteon capsule and liquid (Hetlioz, Hetlioz LQ)**— The manual PA criteria were updated to include the new indication of Smith-Magenis Syndrome (SMS) for the capsules in patients 16 years of age and older, and for the liquid in patients 3 to 15 years of age.

B. Updated PA Criteria—Implementation Plan

The P&T Committee recommended (17 for, 0 opposed, 2 abstained, 0 absent) the updates to the PA criteria for the drugs discussed above become effective at 60 days for Kineret, Benlysta, the CF drugs Kalydeco, Symdeko, and Trikafta; Saxenda; the oncology drugs Nerlynx, Xpovio, and Ninlaro, and the sleep disorder drugs Wakix, Hetlioz, and Hetlioz LQ. *Note that due to the BAP meeting delay and subsequent delay of the signing of the February 2021 P&T Committee meeting minutes, and the fact that the PA updates expand the potential patient eligible to receive the drugs listed above, the PAs were updated in June 2021.*

XIII. UTILIZATION MANAGEMENT—UPDATED MANUAL PA CRITERIA FOR NEW FDA-APPROVED INDICATIONS, NCCN GUIDELINE UPDATES, OR AGE RANGES

BAP Comments

A. Updated PA Criteria

The P&T Committee recommended updates to the manual PA criteria for the drugs discussed above: Kineret, Benlysta, the CF drugs Kalydeco, Symdeko, and Trikafta; Saxenda; the oncology drugs Nerlynx, Xpovio, and Ninlaro, and the sleep disorder drugs Wakix, Hetlioz, and Hetlioz LQ.

BAP Comment: ☐ Concur ☐ Non-concur

B. Updated PA Criteria—Implementation Plan

The P&T Committee recommended the updates to the PA criteria for the drugs discussed above become effective at 60 days. *Note that the PAs were implemented already in June 2021.*

BAP Comment: ☐ Concur ☐ Non-concur

XIV. INFORMATION ITEM—SUMMARY OF RECOMMENDATIONS AND BENEFICIARY IMPACT

Table of implementation Status of UF Recommendations/Decisions Summary

DoD PEC Drug Class	UF Drugs	NF Drugs	Tier 4/Not Covered Drugs	Implement Date	Notes and Unique Users Affected
Breast Cancer Agents: Cyclin-Dependent Kinase (CDK) Inhibitors Subclass	▪ abemaciclib (Verzenio) ▪ palbociclib (Ibrance) ▪ ribociclib (Kisqali) ▪ ribociclib/letrozole (Kisqali Femora Co-Pack)	▪ None	▪ None	Pending signing of the minutes / 30 days.	• All drugs remain UF • PAs were all updated and simplified, and are combined in one form
Pulmonary 3 Agents: Combinations Subclass	▪ fluticasone/umeclidinium/ vilanterol (Trelegy) ▪ budesonide/glycopyrrolate/formoterol (Breztri)	▪ None	▪ None	Pending signing of the minutes / 2 weeks.	• Both products remain UF • No PA requirements

Table of Newly Approved New Drugs Designated Tier 4—Unique Utilizers Affected

Drug	Total
calcipotriene/betamethasone dipropionate 0.005%/0.064% topical cream (Wynzora)	5
clobetasol propionate 0.05% lotion metered dose pump (Impeklo)	0