

**DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS FROM
THE AUGUST 2022 MEETING**

**INFORMATION FOR THE UNIFORM FORMULARY
BENEFICIARY ADVISORY PANEL MEETING SEPTEMBER 29, 2022**

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 nonformulary (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 DRUG CLASS REVIEWS— Antidepressants and Non-Opioid Pain Agents:
Subclasses for the following:**

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Selective Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs)
- Norepinephrine/Dopamine Reuptake Inhibitors (NDRIs)
- Gamma-Aminobutyric Acid Analogs (GABAs)

P&T Comments

**A. Antidepressants And Non-Opioid Pain Agents—Relative Clinical Effectiveness
Analysis And Conclusion**

Background—The P&T Committee evaluated the relative clinical effectiveness of 4 subclasses in the Antidepressants and Non-Opioid Pain Drug Class. The full drug class was first reviewed for formulary placement in November 2011, with several new entrants to the class individually reviewed as new drugs. There are currently 30 products from 8 different subclasses on the uniform formulary. The drugs in the class are now largely available as generic formulations, however, 9 branded products remain. The clinical and cost effectiveness review focused on these 9 branded products.

The drugs in the class are approved for a variety of indications, including major depressive disorder (MDD), generalized anxiety disorder, (GAD), obsessive compulsive disorder (OCD), panic disorder (PD), seasonal affective disorder (SAD), diabetic peripheral neuropathic pain (DPNP), fibromyalgia (FM), and restless leg syndrome (RLS).

The clinical review focused on an extensive review of professional treatment guidelines for the various indications, provider feedback from the pertinent subspecialties, meta-analyses evaluating efficacy and safety, and other factors, including dosing frequency, dosage titration

and tapering, and issues in special populations, including pregnancy and adolescents. The major clinical attributes of the drugs are discussed below.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

Selective Serotonin Reuptake Inhibitors (SSRIs)

- *vortioxetine (Trintellix) (note that the previous brand name was Brintellix)*
 - Trintellix has been designated nonformulary since it was first reviewed in February 2014. Trintellix carries a single indication for MDD, in contrast to the other generic SSRIs (including citalopram, fluoxetine, paroxetine and sertraline) that are indicated for multiple conditions.
 - The 2022 Department of Defense/Veterans Affairs (DoD/VA) Clinical Practice Guideline for MDD lists Trintellix as an initial pharmacotherapy option, along with other SSRIs, SNRIs, bupropion, mirtazapine, trazadone, and vilazodone, although this is based on an overall weak recommendation.
 - A 2018 Lancet network meta-analysis concluded Trintellix did not demonstrate significantly improved efficacy or tolerability when compared to other SSRIs for MDD.
 - Limited data suggests Trintellix carries less risk for sexual dysfunction and cognitive impairment compared to other antidepressants. Trintellix also has the unique advantage among SSRIs for allowing abrupt discontinuation of treatment, if needed.
- *vilazodone (Viibryd)*
 - Viibryd has been designated as nonformulary since the original review in November 2011. Viibryd carries a single indication for MDD. It is also listed in the 2022 VA/DoD Clinical Practice Guideline for MDD as an initial pharmacotherapy option along with numerous other options, as previously stated with Trintellix.
 - A 2018 Lancet network meta-analysis concluded Viibryd did not demonstrate significantly improved efficacy or tolerability compared to other SSRIs for MDD. When compared to other SSRIs, Viibryd has a higher incidence of gastrointestinal adverse effects including diarrhea and nausea.
- *paroxetine mesylate (Pexeva)*
 - Pexeva is indicated for major depressive disorder (MDD), generalized anxiety disorder, obsessive compulsive disorder (OCD), and panic disorder. Unlike its competitor, paroxetine hydrochloride (Paxil), Pexeva lacks additional approval for post-traumatic stress disorder and seasonal affective disorder. Several clinical practice guidelines for each of Pexeva's indications recommends SSRIs

overall for first-line treatment, with no recommendation for a superiority of a specific formulation or brand product.

- There is limited clinical data available with Pexeva, as FDA-approval was based on the information using data from paroxetine hydrochloride (Paxil). There is no data to show that Pexeva confers any clinically relevant advantages over Paxil.

Selective Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs)

- *levomilnacipran (Fetzima)*
 - Fetzima is an enantiomer of milnacipran (Savella). It is only indicated to treat MDD. Among the wide array of other treatment options for MDD, several generic SNRIs are available on the formulary, including duloxetine, venlafaxine, and desvenlafaxine.
 - A 2018 Lancet network meta-analysis concluded Fetzima did not confer significantly improved efficacy or tolerability compared to other SNRIs for MDD. Among the SNRIs, Fetzima carries a lower risk for gastrointestinal adverse effects, however, this has not resulted in improved efficacy for treating MDD.
- *milnacipran (Savella)*
 - Savella is only approved for treating fibromyalgia. The 2016 European Alliance of Associations for Rheumatology guideline supports treatment of fibromyalgia with Savella, however, this is in addition to a variety of other treatment options, including duloxetine, amitriptyline, and pregabalin.
 - A 2016 Rheumatology International network meta-analysis concluded that Savella did not demonstrate greater efficacy or tolerability when compared to duloxetine or pregabalin.
- *duloxetine delayed release (Drizalma Sprinkle)*
 - Duloxetine delayed-release capsules are a sprinkle formulation of duloxetine that was originally designated nonformulary in November 2019. No clinical trials were used to gain FDA approval, as the efficacy and safety relied on the data from duloxetine (Cymbalta). Drizalma has the same FDA indications as duloxetine.
 - Although Drizalma Sprinkle provides a formulation for patients with swallowing difficulties, it provides no compelling advantages compared to existing formulary agents, including generic duloxetine.
 - DoD specialists (child and adult psychiatrists, and neurologists) also supported that Drizalma Sprinkle is not needed on the formulary.

Norepinephrine/Dopamine Reuptake Inhibitors (NDRIs)

- *bupropion hydrobromide (Aplenzin)*
 - Aplenzin is an extended release hydrobromide formulation of bupropion; its generic counterpart is bupropion hydrochloride extended release (Wellbutrin XL). Both agents are bioequivalent and approved for the same indications (MDD and SAD).
 - Guidelines from the 2010 American Psychiatric Association and 2019 National Institute for Health Care and Excellence recommend the same array of medication options for MDD and SAD. As previously stated, the most recent clinical guideline for MDD (2022 DoD/VA CPG) lists bupropion, but does not endorse a specific formulation (e.g., hydrochloride vs. hydrobromide). Several other subclasses are also listed as initial pharmacotherapy options for MDD.
 - There are no compelling benefits of Aplenzin compared to generic bupropion formulations.

Gamma-Aminobutyric Acid Analogs (GABAs)

- *gabapentin ER 24 hour tablets (Gralise)*
 - Gralise is an extended release formulation of gabapentin indicated for Post Herpetic Neuralgia (PHN). The 2004 American Academy of Neurology PHN guidelines recommend multiple first line treatment options, including gabapentin, pregabalin, tricyclic antidepressants, opioid, and the lidocaine patch.
 - A 2015 Lancet Neurology network meta-analysis concluded Gralise did not result in significantly greater efficacy for pain relief for PHN when compared to gabapentin and gabapentin enacarbil.
 - Notably, Gralise carries a possible lower risk for dizziness and somnolence when compared to other gabapentin formulations. It also requires a large tablet burden to reach recommended dosing.
- *gabapentin enacarbil (Horizant)*
 - Horizant is another extended release gabapentin formulation due to its prodrug characteristics. Horizant is indicated for PHN and Restless Leg Syndrome. The 2016 American Academy of Neurology guideline lists Horizant as a first-line treatment option, along with multiple other drugs from other classes, as mentioned previously.
 - Network Meta-analyses evaluating fibromyalgia (2015 Lancet Neurology) and RLS (2013 JAMA Internal Medicine) both concluded that Horizant did not confer additional efficacy when compared to other gabapentin formulations and pregabalin, respectively.
 - Although Horizant is unique among the GABAs for allowing abrupt discontinuation if administered at doses lower than 600 mg per day, it carries a

possible high risk of dizziness and somnolence when compared to other agents in the subclass.

Overall Conclusions

- The 2011 P&T efficacy conclusions remain largely unchanged; the brand-only agents reviewed do not offer significantly improved efficacy when compared to other generic agents across similar indications and subclass.
- A comprehensive clinical efficacy evaluation for mood disorders is not possible at this time, as some agents were approved based on bioequivalence to a generic competitor, and did not have new clinical data for review.
- The 2011 P&T safety conclusions remain largely unchanged; the brand only agents do not offer significantly improved tolerability when compared to other generic competitors across like indications.
- Of note, Trintellix offers limited data supporting a lower risk of sexual dysfunction and cognitive impairment compared to other antidepressants.

B. Antidepressants And Non-Opioid Pain Agents—Relative Cost Effectiveness Analysis And Conclusion

Relative Cost Effectiveness Analysis and Conclusion—The Committee reviewed the solicited bids from manufacturers and also conducted a budget impact analysis (BIA). The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- Cost minimization analysis (CMA) results showed the following: All 9 branded products, Trintellix, Viibryd, Pexeva, Fetzima, Savella, Drizalma Sprinkles, Gralise, Horizant, and most notably, Aplenzin, were not cost effective relative to the generic formulations in the 4 respective subclasses.
- Budget Impact Analysis (BIA) and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating vortioxetine (Trintellix), vilazodone (Viibryd), and all generically-available agents as UF, with bupropion hydrobromide (Aplenzin), duloxetine delayed release (Drizalma Sprinkle), gabapentin (Gralise), gabapentin enacarbil (Horizant), levomilnacipran (Fetzima), milnacipran (Savella), and paroxetine mesylate (Pexeva) as NF demonstrated significant cost avoidance for the MHS.

C. Antidepressants And Non-Opioid Pain Agents—UF/NF Recommendation

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF
 - vortioxetine (Trintellix) *moves from NF to UF*
 - vilazodone (Viibryd) *moves from NF to UF*
 - Note that the antidepressants in the class that are currently available in generic formulations will remain UF.
- NF
 - paroxetine mesylate (Pexeva) *moves from UF to NF*
 - duloxetine DR (Drizalma sprinkle)
 - levomilnacipran (Fetzima)
 - milnacipran (Savella)
 - bupropion hydrobromide XR (Aplenzin)
 - gabapentin ER 24 hr tablets (Gralise)
 - gabapentin enacarbil (Horizant)
- Tier 4 (Not covered) – None

D. ANTIDEPRESSANTS AND NON-OPIOID PAIN AGENTS—PA CRITERIA

The P&T Committee recommended (16 for, 0 opposed, 0 abstained) the following with regard to PA criteria for all 9 branded agents. There was no change to the current PA criteria for Drizalma Sprinkles, which requires the provider to justify why this formulation is needed (write-in). New manual PA criteria were recommended for paroxetine mesylate (Pexeva) and vilazodone (Viibryd), in new users.

For the remaining products where PA criteria are already in place (Trintellix, Fetzima, Savella, Gralise, Horizant, and Aplenzin), updates were recommended in new users. Automation that is currently in place for Trintellix, Fetzima, Savella, Gralise, and Horizant was removed. For all the PAs, the provider should consider non-pharmacologic options along with drug therapy. Additionally, a trial of two to three alternate formulary agents is recommended first for all the branded drugs.

The PA Criteria is as follows:

1. paroxetine mesylate (Pexeva)

PA criteria apply to all new users of Pexeva. (New PA criteria)

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

- Patient is 18 years of age or older.
- Provider acknowledges that patient and provider have discussed that non-pharmacologic interventions (i.e. Cognitive Behavioral Therapy

[CBT], sleep hygiene) are encouraged to be used in conjunction with this medication.

- Patient has a diagnosis of depression, anxiety, obsessive compulsive disorder, or panic disorder
- Patient has tried and failed generic paroxetine at maximally tolerated dose AND
- The patient has a contraindication to, intolerability to, or has failed a trial of TWO other formulary antidepressant medications (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose).

Non-FDA-approved uses are not approved.
Authorization does not expire.

2. vilazodone (Viibryd)

PA criteria apply to all new users of Viibryd. (New PA criteria)

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

- Patient is 18 years of age or older.
- Provider acknowledges that patient and provider have discussed that non-pharmacologic interventions (i.e. CBT, sleep hygiene) are encouraged to be used in conjunction with this medication.
- Patient is being treated for depression
- The patient has a contraindication to, intolerability to, or has failed a trial of THREE formulary antidepressant medications (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose).

Non-FDA-approved uses are not approved.
Prior Authorization does not expire.

3. vortioxetine (Trintellix)

Updates to the Feb 2014 meeting are in bold and ~~strikethrough~~

Note that previous automation has been removed

PA criteria apply to all new users of Trintellix.

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

- Patient is 18 years of age or older.

- **Provider acknowledges that patient and provider have discussed that non-pharmacologic interventions (i.e. CBT, sleep hygiene) are encouraged to be used in conjunction with this medication.**
- **Patient is being treated for depression**
- **The patient has a contraindication to, intolerance to, or has failed a trial of TWO formulary antidepressant medications (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose).**
- **~~Patients are required to try a generic SSRI, duloxetine, SNRI (except milnacipran), tricyclic antidepressant, mirtazapine, bupropion, serotonin antagonist reuptake inhibitor (trazodone, nefazodone), or monoamine oxidase inhibitor first~~**

Non-FDA-approved uses are not approved.
Prior Authorization does not expire.

4. duloxetine DR (Drizalma Sprinkle)

Note – There were no changes made at the August 2022 meeting.

PA does not apply to patients 12 years of age and younger (age edit).
PA criteria apply to all new users of Drizalma Sprinkle older than 12 years of age.

Manual PA Criteria: Drizalma Sprinkle is approved if all criteria are met:

- Provider must explain why the patient requires Drizalma sprinkle capsules and cannot take alternatives.

Non-FDA-approved uses are not approved.
PA expires in one year.

Renewal PA criteria: No renewal allowed. When the PA expires, the next fill/refill will require submission of a new PA.

5. levomilnacipran XR (Fetzima)

Updates to the Feb 2014 meeting are in bold and ~~strikethrough~~
Note that previous automation has been removed

PA criteria apply to all new users of Fetzima

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

- Patient is 18 years of age or older.

- **Provider acknowledges that patient and provider have discussed that non-pharmacologic interventions (i.e. CBT, sleep hygiene) are encouraged to be used in conjunction with this medication.**
- ~~Patients are required to try a generic SSRI, duloxetine, SNRI (except milnacipran), tricyclic antidepressant, mirtazapine, bupropion, serotonin antagonist reuptake inhibitor (trazodone, ornefazodone), or monamine oxidase inhibitor first~~
- **Patient is being treated for depression**
- **The patient has a contraindication to, intolerability to, or has failed a trial of THREE formulary antidepressant medications (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose).**

Non-FDA-approved uses are not approved.
Prior Authorization does not expire.

6. **milnacipran (Savella)**

Updates to the Nov 2011 meeting are in bold ~~and strikethrough~~

Note that previous automation has been removed

PA criteria apply to all new users of Savella

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

- Patient is 18 years of age or older.
- ~~All new users of Savella are required to try a non-opioid pain syndrome agent including SNRI including milnacipran, TCA, cyclobenzaprine, gabapentin or pregabalin~~
- **Patient is being treated for fibromyalgia**
- **Patient has tried and failed duloxetine at maximally tolerated dose**

AND

- **The patient has a contraindication to, intolerability to, or has failed a trial of ONE other formulary medication at maximally tolerated dose (examples of formulary agents include pregabalin, amitriptyline, cyclobenzaprine).**

Non-FDA-approved uses are not approved.
Prior Authorization does not expire.

7. **bupropion hydrobromide XR (Aplenzin)**

Updates to the Nov 2017 meeting are in bold and ~~strikethrough~~

Note that previous automation has been removed

PA criteria apply to all new users of Aplenzin

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

- **The patient is 18 years or older.**
- **The patient does not have a history of seizure disorder or conditions that increase the risk of seizure (e.g. bulimia, anorexia nervosa, severe head injury).**
- **Provider acknowledges that patient and provider have discussed that non-pharmacologic interventions (i.e. CBT, sleep hygiene) are encouraged to be used in conjunction with this medication.**
- ~~**New and current users of Aplenzin are required to try generic bupropion ER and a second antidepressant first.**~~
- **The patient has being treated for depression or seasonal affective disorder**
- **Patient has tried and failed bupropion extended release at maximally tolerated dose**

AND

- **The patient has a contraindication to, intolerability to, or has failed a trial of TWO other formulary antidepressant medications (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose).**

Non-FDA-approved uses are not approved.

Prior Authorization does not expire.

8. gabapentin ER 24 hr tablets (Gralise)

Updates to the May 2012 meeting are in bold and strikethrough

Note that previous automation has been removed

PA criteria apply to all new users of Gralise

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

- **Patient is 18 years of age or older.**
- ~~**The patient has a contraindication to or experienced adverse events with gabapentin or the formulary non-opioid pain syndrome agents which is not expected to occur with Horizant or Gralise.**~~
- **Patient is being treated for post herpetic neuralgia and:**

- Patient has tried and failed gabapentin or pregabalin at maximally tolerated dose AND
- Patient has a contraindication to, intolerability to or has tried and failed a TCA at maximally tolerated dose.

Non-FDA-approved uses are not approved.
Prior Authorization does not expire.

9. gabapentin enacarbil (Horizant)

Updates to the May 2012 meeting are in bold ~~and strikethrough~~
Note that previous automation has been removed

PA criteria apply to all new users of Horizant

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

- ~~The patient has a contraindication to gabapentin or the formulary non-opioid pain syndrome agents, which is not expected to occur with Horizant or Gralise.~~
- ~~The patient has experienced adverse events (AEs) with gabapentin or the formulary non-opioid pain syndrome agents, which is not expected to occur with Horizant or Gralise.~~

For post herpetic neuralgia:

- Patient is 18 years of age or older
- Patient has tried and failed gabapentin or pregabalin at maximally tolerated dose AND
- Patient has a contraindication to, intolerability to or has tried and failed a tricyclic antidepressant (TCA) at maximally tolerated dose.

For restless leg syndrome:

- Patient is 18 years of age or older.
- Patient has tried and failed gabapentin or pregabalin at maximally tolerated dose AND
- Patient has contraindication to, intolerability to or has tried and failed pramipexole or rotigotine at maximally tolerated dose.

Non-FDA-approved uses are not approved.
Prior Authorization does not expire.

E. ANTIDEPRESSANTS AND NON-OPIOID PAIN AGENTS—UF, PA AND IMPLEMENTATION PERIOD

The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 1 absent) 1) an effective date of the first Wednesday 60 days after signing of the minutes in all points of service, and 2) DHA send letters to beneficiaries who are affected by the nonformulary recommendation for Pexeva.

III. UF DRUG CLASS REVIEWS—Antidepressants and Non-Opioid Pain Agents

BAP Comments

A. Antidepressants and Non-Opioid Pain Agents—UF Recommendations

The P&T Committee recommended the formulary status for the Antidepressants and Non-Opioid Agents in the four subclasses as discussed above.

- UF
 - Trintellix *moves from NF to UF*
 - Viibryd *moves from NF to UF*
 - Note that the antidepressant in the class that are currently available in generic formulations will remain UF
- NF
 - Pexeva *moves from UF to NF*
 - Drizalma sprinkle
 - Fetzima
 - Savella
 - Aplenzin
 - Gralise
 - Horizant
- Tier 4 (Not covered) – None

BAP Comments

Concur: **Non-Concur:** **Abstain:** **Absent:**

B. Antidepressants and Non-Opioid Pain Agents—Manual PA Criteria

The P&T Committee recommended the updated PA criteria for Trintellix, Fetzima, Savella, Gralise, Horizant and Aplenzin, and the new PA criteria for Pexeva and Viibryd as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Antidepressants and Non-Opioid Pain Agents—UF, PA and Implementation Plan

The P&T Committee recommended 1) an effective date of the first Wednesday 60 days after signing of the minutes in all points of service, and 2) DHA send letters to beneficiaries who are affected by the nonformulary recommendation for Pexeva.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

IV. UF DRUG CLASS REVIEWS—Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass

P & T Comments

A. Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass—Relative Clinical Effectiveness Analysis and Conclusion

Background—The P&T Committee evaluated the relative clinical effectiveness of the OAB β-3 adrenergic agonists. The subclass is comprised of mirabegron (Myrbetriq), vibegron (Gemtesa) and mirabegron extended-release (ER) granules for oral suspension (Myrbetriq Granules); the products were previously reviewed as new drugs in May 2014, May 2021, and November 2021, respectively. PA currently applies to all three drugs.

The previous OAB formulary review in November 2012 included the older antimuscarinic drugs [e.g. oxybutynin (Ditropan), tolterodine (Detrol), and solifenacin (Vesicare), etc.], however, they were not part of this current review.

Mirabegron (Myrbetriq) and vibegron (Gemtesa) are both approved for the treatment of OAB, while Myrbetriq Granules are only approved for neurogenic detrusor overactivity (NDO).

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

Professional Treatment Guidelines

- The 2019 OAB guidelines from the American Urological Association/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (AUA/SUFU) state the following:
 - Clinicians should offer behavioral therapies (e.g., bladder training, bladder control strategies, pelvic floor muscle training, and fluid management) as first-line therapy to all patients with OAB. (*Standard, Evidence strength: Grade B*)
 - Clinicians should offer oral anti-muscarinics or oral β -3-adrenoceptor agonists as second-line therapy (*Standard, Evidence Strength Grade B*)
 - If a patient experiences inadequate symptom control and/or unacceptable adverse drug events with one antimuscarinic medication, then a dose modification or a different anti-muscarinic medication or a β -3-adrenoceptor agonist may be tried. (*Clinical Principle*)

Antimuscarinics vs. β -3-adrenergic agonists

- The antimuscarinics and β -3-agonists show similar efficacy for treating OAB, however the β -3-agonists have fewer side effects, such as dry mouth. One retrospective, matched cohort study found a higher risk of dementia with the antimuscarinics compared to the β -3 agonists. Limitations to this analysis include the observational study design, and that overall the difference in dementia rates between the groups was relatively small. (*BJU Intl 2020*)

Mirabegron vs. Vibegron

- For mirabegron, there was no new data that would support changes to the previous clinical conclusions from 2014; compared to placebo, mirabegron produced statistically significant reductions in incontinence episodes, but the clinical effect is small and there is a high placebo response rate.
- Vibegron has not been directly compared against mirabegron in a head-to-head trial, but indirect comparisons suggest similar efficacy.

Mirabegron

- Advantages of mirabegron include its long marketing history (it was FDA-approved in 2012), and existing high utilization in the Military Health System (MHS). It is also indicated for use in combination with the antimuscarinic solifenacin (Vesicare). Disadvantages include that mirabegron is formulated as an ER tablet that cannot be crushed.
- The Myrbetriq granules are solely indicated for NDO, and currently have very low MHS utilization.

Vibegron

- Benefits of vibegron compared to mirabegron include fewer drug interactions, lack of clinically significant effects on blood pressure, and that the tablets can be crushed.

Overall Conclusions

- Overall, there is a high degree of therapeutic interchangeability between mirabegron and vibegron based on efficacy data. For safety, although there are subtle differences that favor vibegron over mirabegron, most patients could use either drug.
- In order to meet the needs of MHS beneficiaries, at least one β -3 agonist is required on the formulary.

B. Overactive Bladder Agents (OAB) – Beta3 (β -3) Adrenergic Agonists Subclass—Relative Cost Effectiveness Analysis and Conclusion

Relative Cost-Effectiveness Analysis and Conclusion—CMA and BIA were performed. The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that mirabegron (Myrbetriq) was more cost effective than vibegron (Gemtesa).
- BIA and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating mirabegron (Myrbetriq) and vibegron (Gemtesa) both as UF demonstrated significant cost avoidance for the MHS.

C. Overactive Bladder Agents (OAB) – Beta3 (β -3) Adrenergic Agonists Subclass—UF Recommendation

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF
 - mirabegron tablets (Myrbetriq)
 - mirabegron ER granules for oral suspension (Myrbetriq granules) *moves from NF to UF*
 - vibegron (Gemtesa)
- NF – None
- Tier 4 (Not covered) – None

D. Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass— Manual PA Criteria

PA criteria have been in place for Myrbetriq, Gemtesa and the Myrbetriq Granules since they were originally reviewed as new drugs. The PA criteria requires a trial of an antimuscarinic first. Additionally, at the May 2021 review of Gemtesa, the Myrbetriq PA was revised to require a trial of Gemtesa in new users, based on cost-effectiveness. However due to the delay of the Beneficiary Advisory Panel meeting (due to the zero-based review), implementation did not occur until March 2022.

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) minor updates to the current manual PA criteria for Myrbetriq and Gemtesa in new users. The current requirements for a trial of an antimuscarinic first before use of a β-3 agonist will be maintained, as the AUA/SUFU guidelines place the antimuscarinics and β-3 agonists on equal footing, and do not prefer the β-3 agonists over the antimuscarinics. Practices from commercial healthcare plans also require an antimuscarinic before a β-3 agonist. A trial of only one antimuscarinic will be required, instead of the current requirement for two prior drugs.

Minor updates were made to the dosage modifications based on renal function. Additionally, the current requirement for a trial of Gemtesa prior to Myrbetriq will be removed. There were no changes made to the existing Myrbetriq Granules PA criteria.

1. mirabegron tablets (Myrbetriq)

Updates from the August 2022 meeting are in bold and ~~strikethrough~~

Manual PA criteria apply to all new users of mirabegron (Myrbetriq).

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

Overactive Bladder:

- The patient has a confirmed diagnosis of overactive bladder (OAB) with symptoms of urge incontinence, urgency, and urinary frequency AND
- The patient has tried and failed behavioral interventions to include pelvic floor muscle training in women, and bladder training
- The patient has had a 12-week trial with **one ~~two~~ formulary step-preferred products generic antimuscarinic medication** (oxybutynin IR, oxybutynin ER, tolterodine ER, **trospium, solifenacin, darifenacin** or fesoterodine) and had therapeutic failure

OR

- The patient has experienced central nervous system adverse events with oral OAB medications OR is at increased risk for such central

nervous system effects due to comorbid conditions, **advanced** age or other medications

- ~~Patient has tried and failed or has a contraindication to vibegron (Gemtesa)~~
- The patient's ~~does not have a CrCl < 15 mL/min~~ estimated creatinine clearance (CrCl)/glomerular filtration rate (eGFR) is **≥15 mL/min/1.73m²** and the provider is aware that the dose should not exceed 25 mg a day in patients with a CrCl/eGFR between 15 – 29 mL/min/1.73m²
- ~~If the CrCl is between 15-29 mL/min, the dosage does not exceed 25 mg QD~~

OR

Neurogenic Detrusor Overactivity (NDO)

- The patient has a confirmed diagnosis of neurogenic detrusor overactivity (NDO) secondary to detrusor overactivity and/or myelomeningocele
- The drug is prescribed by or in consultation with a urologist or nephrologist
- The provider acknowledges that the granules are not bioequivalent and cannot be substituted on a mg to mg basis with the tablets and will not combine dosage forms to achieve a specific dose
- Provider acknowledge that there are detailed renal and hepatic dose adjustments in the package labeling and agrees to consult this before prescribing in this special population
- Provider acknowledge that oxybutynin is available for patients with neurogenic detrusor overactivity and does not require prior authorization
- Patient has tried and failed or has a contraindication to oxybutynin
- The patient weighs greater than or equal to 35 kg

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

2. mirabegron extended release granules for oral suspension (Myrbetriq Granules)

No changes made at the August 2022 meeting

Manual PA criteria: Myrbetriq Granules are approved if all criteria are met:

- Myrbetriq granules for oral suspension are prescribed by or in consultation with a urologist or nephrologist
- The prescription is written for neurogenic bladder secondary to detrusor overactivity and/or myelomeningocele, and not for overactive bladder
- Provider acknowledges that oxybutynin oral syrup is available for patients with neurogenic detrusor overactivity and does not require prior authorization
- Patient has tried and failed or has a contraindication to oxybutynin
- Patient requires Myrbetriq granules for oral suspension for one of the following reasons:
 - The patient cannot swallow due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis, etc) and not convenience. OR
 - The patient weighs less than 35 kg
- Provider acknowledges that Myrbetriq granules for suspension are not bioequivalent to and cannot be substituted on a mg to mg basis to the Myrbetriq tablets
- Provider acknowledges that Myrbetriq granules for suspension and the Myrbetriq tablets will not be combined to achieve a specific dose
- Provider acknowledges the detailed renal and hepatic dosing adjustments in the package labeling and agrees to consult this before prescribing the granules in these special populations

Non-FDA-approved uses are not approved.
 Prior authorization does not expire.

3. vibegron (Gemtesa)

Updates from the August 2022 meeting are in bold and ~~strikethrough~~

Manual PA criteria apply to all new users of Gemtesa.

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

- The patient has a confirmed diagnosis of overactive bladder (OAB) with symptoms of urge incontinence, urgency, and urinary frequency
- The patient has tried and failed behavioral interventions to include pelvic floor muscle training in women, and bladder training,

- The patient has had a 12-week trial with ~~one two formulary step-preferred products generic~~ antimuscarinic (oxybutynin IR, oxybutynin ER, tolterodine ER, **trospium, solifenacin, darifenacin or fesoterodine**) and had therapeutic failure OR
- The patient has experienced central nervous system adverse events with at least one oral OAB medication OR is at increased risk for such central nervous system effects due to comorbid conditions, advanced age or other medications,
- The patient's creatinine clearance (CrCl) ~~/glomerular filtration rate (eGFR) is ≥ 15 mL/min/1.73m² is greater than 15 mL/min~~

Non-FDA-approved uses are not approved.
Prior authorization does not expire.

E. Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass—UF, PA and Implementation Period

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday 30 days after signing of the minutes in all points of service.

V. UF DRUG CLASS REVIEWS—Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass

BAP Comments

A. Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass—UF Recommendation

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF
 - Myrbetriq tablets
 - Myrbetriq granules *moves from NF to UF*
 - Gemtesa
- NF – None
- Tier 4 (Not covered) – None

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass— Manual Prior Authorization

The P&T Committee recommended minor updates to the current manual PA criteria in new users as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Overactive Bladder Agents (OAB) – Beta3 (β-3) Adrenergic Agonists Subclass—UF, PA, and Implementation Period

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

BAP Comments

Concur: Non-Concur: Abstain: Absent:

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

Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions—The P&T Committee agreed (16 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 Recommendations

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF
 - alpelisib (Vijoice) – Oncological agent for PIK3CA-related overgrowth spectrum (PROS)
 - daridorexant (Quviviq) – Sleep Disorders: dual orexin receptor antagonist (DORA) for treating insomnia

- edaravone oral suspension (Radicava ORS) – Miscellaneous Neurological Agent for amyotrophic lateral sclerosis (ALS) and a new oral version of an IV medication
- ganaxolone oral suspension (Ztalmey) – Anticonvulsant for treating seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency
- insulin glargine solostar unbranded authorized biologic (from Winthrop labs) – Basal insulin; note that as part of this recommendation, this product will be designated as non-step-preferred.
- mavacamten (Camzyos) – Miscellaneous Cardiovascular Agent for symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (oHCM)
- NF:
 - amlodipine oral solution (Norliqva) – Dihydropyridine Calcium Channel Blocker (CCB) alternate dosage form for hypertension
 - cyclosporine 0.1% ophthalmic emulsion (Verkazia) – Ophthalmic for vernal keratoconjunctivitis
 - donepezil patch (Adlarity) – Alzheimer’s agent for mild, moderate, to severe dementia and a patch version of an available oral agent
 - leuprolide SC injection (Camcevi Kit) – Leuprolide-hormone-release hormone (LHRH) agent for treatment of advanced prostate cancer
 - tapinarof 1% cream (Vtama) – Psoriasis Agent
 - tirzepatide SC injection (Mounjaro) – Glucagon-like peptide-1 (GLP-1) receptor agonist for type 2 diabetes
 - testosterone undecanoate 112.5 mg capsule (Tlando) – Oral Testosterone Replacement Therapy; note that as part of this recommendation, this product will be designated as non-step-preferred.
 - vonoprazan/amoxicillin (Voquezna Dual Pak) – Miscellaneous Anti-infective for *Helicobacter pylori* (*H. pylori*) infection
 - vonoprazan/amoxicillin/clarithromycin; (Voquezna Triple Pak) – Miscellaneous Anti-infective for *Helicobacter pylori* (*H. pylori*) infection
- Tier 4 (Not covered): The drugs listed below were recommended for Tier 4 status, as they provide little to no additional clinical effectiveness relative to similar agents in their respective drug classes, and the needs of TRICARE beneficiaries are met by available alternative agents.
 - baclofen oral granules (Lyvispah) – Skeletal Muscle Relaxant; another alternative formulation of baclofen for multiple sclerosis spasticity
 - Alternatives include baclofen tablets, baclofen oral solution (Ozobax) and baclofen oral suspension (Fleqsuvy)
 - benzoyl peroxide 5% cream (Epsolay) – keratolytic for rosacea

- Alternatives include other legend and OTC benzoyl peroxide formulations, metronidazole, and azelaic acid products.

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

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 0 absent) the following:

- Applying manual PA criteria to new users of tirzepatide (Mounjaro) consistent with the other NF GLP1-RA, Ozempic. A trial of metformin will be required before Mounjaro.
- Applying manual PA criteria to new users of Quviviq, similar to the criteria in place for the other DORAs, Belsomra and Dayvigo. A trial of zolpidem extended-release or eszopiclone is required first before a DORA.
- Applying manual PA criteria to new users of the insulin glargine solostar unbranded authorized biologic, consistent with the criteria for the other non-preferred basal insulins. A trial of Lantus is required first.
- Applying manual PA criteria to new users of Tlando, consistent with the criteria already in place for the oral testosterone products (Jatenzo) and the other topical testosterone replacement products. A trial of the step-preferred product Fortesta is required first.
- Applying manual PA criteria to new users of Verkazia, consistent with the existing PA criteria for other ophthalmic cyclosporine products. Patients who are younger than age 21 years and who have a history of cyclosporine 0.05% ophthalmic emulsion (Restasis) in the past 180 days do not require a manual PA for Verkazia (age edit and auto-look back). The Restasis PA was also updated to allow use in patients younger than 18 years.
- Applying PA criteria to new users of Vtama, consistent with what is already in place for other topical Psoriasis Drugs.
- Applying PA criteria to new users of Vijoje, Radicava ORS, Ztalmy, Camzyos, Voquezna Double Pak, Voquezna Triple Pak, Adlarity, and Camcevi Kit

The PA Criteria is as follows:

1. alpelisib (Vijoje)

PA criteria apply to all new users of alpelisib (Vijoje)

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

- Prescription is written by or in consultation with a medical geneticist or vascular surgeon
- Patient has a documented diagnosis of PIK3CA Related Overgrowth Spectrum (PROS) which the provider determines to be severe and requiring systemic therapy

- Patient has documented evidence of a mutation in the PIK3CA gene

Non-FDA-approved uses are not approved

PA expires in one year

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

Coverage will be approved indefinitely for continuation of therapy if

- The patient has a documented positive clinical response to therapy

2. amlodipine oral solution (Norliqva)

PA does not apply to patients less than 12 years of age (age edit).

PA criteria apply to all new users of Norliqva.

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

- Provider must explain why the patient requires amlodipine oral solution and cannot take amlodipine tablets or amlodipine suspension

Non-FDA-approved uses are not approved

PA does not expire

3. cyclosporine 0.1% ophthalmic emulsion (Verkazia)

Note that an age edit and automated look back apply.

- Patients who are younger than age 21 years who have a history of Restasis do not require a PA; Verkazia is approved
- Patients younger than age 21 who do not have a history of Restasis require manual PA
- Manual PA is required in all new patients 21 years of age and older

Automated PA criteria: The patient is younger than age 21 years AND has filled a prescription for cyclosporine 0.05% ophthalmic solution (Restasis) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 720 days.

Manual PA Criteria: If automated criteria are not met, coverage is approved for Verkazia if all criteria are met:

- Verkazia is prescribed by or in consultation with an optometrist or ophthalmologist
- Patient has moderate to severe vernal keratoconjunctivitis (VKC)
- Patient has tried and failed an adequate course of at least one mast cell stabilizer/antihistamine (i.e., olopatadine, azelastine, epinastine, lodoxamide, cromolyn)

- Patient has tried and failed, or has a contraindication to an adequate course of cyclosporine 0.05% ophthalmic emulsion (Restasis)

Non-FDA-approved uses are NOT approved including dry eye disease, graft rejection/graft versus host disease (GvHD), corneal transplant, atopic keratoconjunctivitis (AKC) and LASIK associated dry eye

PA does not expire

4. **daridorexant (Quviviq)**

Manual PA criteria apply to all new users of Quviviq, Belsomra, and Dayvigo.

Manual PA Criteria: Quviviq, Belsomra, Dayvigo is approved if all criteria are met:

- Provider acknowledges the following agents are available without prior authorization: zolpidem IR and ER, zaleplon, eszopiclone
- Patient has documented diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance
- Non-pharmacologic therapies have been inadequate in improving functional impairment, including but not limited to relaxation therapy, cognitive behavioral therapy for insomnia (CBT-I), sleep hygiene, and the patient will continue with non-pharmacologic therapies throughout treatment
- Patient has tried and failed or had clinically significant adverse effects to zolpidem extended-release OR eszopiclone
- Patient has no current or previous history of narcolepsy
- Patient has no current or previous history of drug abuse

Non FDA-approved uses are not approved

Prior authorization expires in 1 year

Renewal criteria: Note that initial TRICARE PA approval is required for renewal. PA will be renewed for an additional 1 year if the renewal criteria are met:

- Patient has not adequately responded to non-pharmacologic therapies
- Patient agrees to continue with non-pharmacologic therapies including but not limited to relaxation therapy, cognitive behavioral therapy for insomnia (CBT-I), and/or sleep hygiene
- Patient continues to respond to the drug

5. donepezil patch (Adlarity)

Manual PA criteria apply to all new users of donepezil transdermal system (Adlarity).

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

- The patient is 18 years of age or older
- The medication is being prescribed in consultation with a neurologist, psychiatrist, or specialist in geriatric medicine.
- The patient is being treated for mild, moderate, or severe dementia of the Alzheimer's type.
- The patient must have tried and failed, have a contraindication to, or have had an adverse reaction to both of the following:
 - One oral donepezil formulation (e.g., donepezil 5 mg or, 10 mg tab or orally dissolving tablets [ODT]) AND
 - One topical agent: rivastigmine transdermal system (Exelon patch).

Non-FDA approved uses are NOT approved.

PA does not expire.

6. edaravone oral suspension (Radicava ORS)

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

- Patient is 18 years of age or older
- The medication is prescribed by a neurologist.
- The patient has a diagnosis of amyotrophic lateral sclerosis (ALS).
- The disease duration is two years or less
- The patient has a score of ≥ 2 points for each item of ALS Functional Rating Scale–Revised (ALSFRS-R).
- The patient has preserved respiratory function (forced vital capacity $\geq 80\%$)

Non-FDA approved uses are NOT approved.

PA does not expire.

7. ganaxolone oral suspension (Ztalmy)

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

- Drug is prescribed by or in consultation with pediatric neurologist

- Patient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder confirmed with a genetic test

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

8. insulin glargine soloSTAR authorized biologic

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

- Provider acknowledges that Lantus is the DoD's preferred basal insulin and preferred insulin glargine. Prescriptions written for Lantus do not require prior authorization and are available at the lowest Tier 1 copay.
- Patient must have tried and failed insulin glargine (Lantus)

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

9. leuprolide SC injection (Camcevi Kit)

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 an oncologist or urologist
- Patient has a diagnosis of advanced prostate cancer
- Patient has intolerance to, or has failed alternative formulary leuprolide injections (i.e. Lupron Depot, Eligard)

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

10. mavacamten (Camzyos)

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

- The patient is 18 years of age and older
- Drug is prescribed by a cardiologist
- The patient has documented evidence of obstructive hypertrophic cardiomyopathy (HCM)
- Left ventricular outflow tract (LVOT) pressure gradient is greater than or equal to 50 mmHg

- The patient has NYHA Class II to III obstructive HCM that is symptomatic (e.g., dyspnea, chest pain, light headedness, syncope, fatigue, reduced exercise capacity)
- The patient's left ventricular ejection fraction (LVEF) is greater than or equal to 55%
- Patient has failed therapy with at least one agent from both of the following classes:
 - Beta blocker (non-vasodilating) – propranolol, metoprolol AND
 - Calcium channel blockers (non-dihydropyridine) – verapamil, diltiazem
- Patient must not be on dual calcium channel blocker and beta blocker therapy concurrently
- Patient must not be receiving ranolazine or disopyramide concurrently
- Patient and provider must be aware of the risks of systolic dysfunction as outlined by REMS
- Provider and patient must agree to comply to all requirements of the REMS program, including echocardiogram at 0, 4, 8, 12 weeks follow by every 12 weeks and drug interaction monitoring requirements
- If the patient is of child-bearing age, the patient must not be pregnant and will receive counseling for effective contraception during therapy and for 4 months after the last dose

Non-FDA-approved uses are not approved
PA expires in 1 year

- Renewal criteria: Note that initial TRICARE PA approval is required for renewal. PA will be renewed indefinitely if the patient has responded to therapy, as evidenced by improvement in obstructive hypertrophic cardiomyopathy symptoms

11. **tapinarof 1% cream (Vtama)**

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

- Patient is 18 years of age or older.
- The patient has a diagnosis of plaque psoriasis.
- The medication is being prescribed in consultation with a dermatologist.

- The patient must have tried for at least 2 weeks and failed, have a contraindication to, or have had an adverse reaction to both of the following:
 - at least one moderate to high potency topical corticosteroid (e.g., clobetasol propionate 0.05% ointment, cream, solution and gel; fluocinonide 0.05% ointment, cream, solution) AND
 - at least one topical calcineurin inhibitor (e.g. tacrolimus, pimecrolimus)

Non-FDA approved uses are not approved.

PA does not expire.

12. testosterone undecanoate 112.5 mg capsules (TLando)

Manual PA criteria applies to new users of users of Jatenzo and TLando

Manual PA Criteria: Jatenzo or TLando is approved if all criteria are met:

- Patient has a confirmed diagnosis of hypogonadism as evidenced by morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions
- Patient is a male age 18 years of age or older
- The patient has a diagnosis of hypogonadism as evidenced by 2 or more morning total testosterone levels below 300 ng/dL.
- Provider has investigated the etiology of the low testosterone levels and acknowledges that testosterone therapy is clinically appropriate and needed
- Patient is experiencing signs and symptoms usually associated with hypogonadism
- Patient has tried testosterone 2% gel (Fortesta) OR testosterone 1% gel (Androgel generic) for a minimum of 90 days AND failed to achieve total serum testosterone levels above 400 ng/dL (labs drawn 2 hours after use of the agent) AND without improvement in symptoms

OR

- Patient has a contraindication to or has experienced a clinically significant adverse reaction to Fortesta OR generic testosterone 1% gel, that is not expected to occur with Jatenzo or TLando
- The patient requires a testosterone replacement therapy (TRT) that has a low risk of skin-to-skin transfer between family members

OR

- Coverage approved for female-to-male gender reassignment (endocrinologic masculinization) if:
- Patient has diagnosis of gender dysphoria made by a TRICARE authorized mental health provider according to most current edition of the DSM
- Patient is an adult, or is 16 years or older who has experienced puberty to at least Tanner stage 2 AND
- Patient has no signs of breast cancer AND
- For gender dysphoria biological female patients of childbearing potential, the patient IS NOT pregnant or breastfeeding AND
- Patient has no psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (e.g. unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment) AND
- Patient does not have any of the following:
 - Hypogonadism conditions not associated with structural or genetic etiologies (e.g. “age-related” hypogonadism), carcinoma of the breast or suspected carcinoma of the prostate
 - Uncontrolled hypertension or is at risk for cardiovascular events (e.g., myocardial infarction or stroke) prior to start of Jatenzo or Tlando therapy or during treatment (based on the product’s boxed warning of increased risk of major adverse cardiovascular events and hypertension)

Non-FDA-approved uses are NOT approved.

Not approved for concomitant use with other testosterone products.

Prior Authorization does not expire

13. **tirzepatide (Mounjaro)**

Manual PA criteria apply to all new users of Mounjaro.

All new users of a GLP1RA are required to try metformin before receiving a GLP1RA. Patients currently taking a GLP1RA must have had a trial of metformin first.

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

- Provider acknowledges that Trulicity is available on the UF and has an indication to reduce the risk of major adverse cardiovascular

events in adults with Type 2 diabetes mellitus (T2DM) who have established cardiovascular disease or multiple cardiovascular risk factors, Mounjaro does not have this indication

- The patient has a confirmed diagnosis of Type 2 diabetes mellitus
- The patient has experienced any of the following issues on metformin:
 - impaired renal function precluding treatment with metformin
 - OR
 - history of lactic acidosis
- The patient has had inadequate response to metformin OR
- The patient has a contraindication to metformin

Non-FDA approved uses are NOT approved, including for weight loss in patients who do not have diabetes

PA does not expire

**14. vonoprazan, amoxicillin (Voquezna Dual Pak)
vonoprazan, amoxicillin, clarithromycin (Voquezna Triple Pak)**

Manual PA criteria apply to all new users of Voquezna Dual & Triple Pak

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

- The provider acknowledges that other medications to treat *H. pylori* including lansoprazole, amoxicillin, and clarithromycin are on the TRICARE formulary and are available without a PA
- Patient is 18 years of age or older
- Prescription is written by or in consultation with a gastroenterologist or infectious disease specialist
- Patient has tried and failed two 14-day trials of therapy with guideline-recommended first-line therapies (Appropriate treatment combinations of omeprazole, lansoprazole, amoxicillin, rifabutin, clarithromycin, bismuth subsalicylate, metronidazole, tetracycline, and PPI or H2 blockers) for *H. pylori*
 - Note: Failure is defined as failure to eradicate *H. pylori* infection after a 14-day course of therapy

Non-FDA approved uses are NOT approved

PA renewal is not allowed; a new PA is required for each course of therapy

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

The P&T Committee recommended for (16 for, 0 opposed, 0 abstained, 0 absent) an effective date of the following:

- **New Drugs Recommended for UF or NF Status:** 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 120 days after signing of the minutes in 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.

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/NF/Tier 4 Recommendation

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

- UF
 - Vijoice
 - Quviviq
 - Radicava ORS
 - Ztalmy
 - Basal insulin
 - Camzyos

- NF:
 - Norliqva
 - Verkazia
 - Adlarity
 - Camcevi Kit
 - Vtama
 - Mounjaro

- Tlando
 - Voquezna Dual Pak
 - Voquezna Triple PAK
- Tier 4 (Not covered)
 - Lyvispah
 - Epsolay

BAP Comments

Concur: Non-Concur: Abstain: Absent:

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 above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

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

The P&T Committee recommended the implementation plans as stated above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

VIII. UTILIZATION MANAGEMENT—NEW MANUAL CRITERIA SPIRIVA HANDIHALER

P & T Comments

A. Prior Authorization Criteria—Spiriva HandiHaler New Manual PA Criteria

Pulmonary II Agents: Long-Acting Muscarinic Antagonists (LAMAs)—tiotropium dry powder inhaler (Spiriva HandiHaler)—Spiriva HandiHaler was reviewed in February 2013 and added to the BCF. In November 2016, a follow-on product, tiotropium soft mist inhaler (Spiriva Respimat), was reviewed as a new drug. Both formulations are indicated for maintenance treatment of chronic obstructive pulmonary disease (COPD), and to reduce the risk of COPD exacerbations. They produce similar improvements in forced expiratory volume in one second (FEV1), and have safety profiles that reflect the other LAMAs.

The Spiriva HandiHaler requires insertion of the dry powder capsules into the device, and also requires a minimum inspiratory flow rate of 30 mL/min to activate the inhaler. Generics are not expected for at least two years. For Spiriva Respimat, patients with dexterity issue may have difficulty assembling and priming the device. However, advantages of the Respimat device include that more drug is deposited in the lungs, rather than the oral cavity; it is a passive inhalation device which does not rely on the patient's inspiratory effort; and it has an additional indication for maintenance treatment of asthma in patients 6 years of age and older. Spiriva Respimat is more cost-effective than Spiriva HandiHaler.

The P&T Committee recommended (13 for, 0 opposed, 0 abstained, 3 absent) manual PA criteria in new and current users of Spiriva HandiHaler, in order to encourage use of Spiriva Respimat, due to compelling advantages of the delivery mechanism.

The PA criteria is as follows:

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

Manual PA criteria: Spiriva HandiHaler is approved if all the following criteria are met:

- The provider acknowledges that Spiriva Respimat is the Department of Defense's preferred long-acting muscarinic antagonist and does not require prior authorization.
- The provider must document a patient-specific reason as to why the patient requires Spiriva Handihaler and cannot use the Spiriva Respimat device. (blank write-in)

Non-FDA-approved uses are NOT approved

Prior authorization does not expire.

B. Prior Authorization Criteria—Spiriva HandiHaler New Manual PA Criteria Implementation Plan

The P&T Committee recommended (13 for, 0 opposed, 0 abstained, 3 absent) the new PA will become effective the first Wednesday 120 days after the signing of the minutes, and DHA will send letters to affected patients prior to and following implementation.

IX. UTILIZATION MANAGEMENT—SPIRIVA HANDIHALER NEW MANUAL PA CRITERIA

BAP Comments

A. Prior Authorization Criteria—Spiriva HandiHaler New Manual PA Criteria

The P&T Committee recommended manual PA criteria in new and current users of Spiriva HandiHaler, as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Prior Authorization Criteria—Spiriva HandiHaler New Manual PA Criteria Implementation Plan

The P&T Committee recommended new PA will become effective the first Wednesday 120 days after the signing of the minutes, and DHA will send letters to affected patients prior to and following implementation.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

X. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA FOR NEWLY APPROVED DRUGS NOT SUBJECT TO 32 CFR 199.21(G)(5)

P & T Comments

A. New Manual Pa Criteria For Newly Approved Drugs Not Subject To 32 CFR 199.21(G)(5)

Manual PA criteria were recommended for several recently marketed drugs which contain active ingredients that are widely available in low-cost generic formulations. These products are usually produced by a single manufacturer. Due to the pathway used to gain FDA approval, these products do not meet the criteria for innovators and cannot be reviewed for formulary status. These drugs all have numerous cost-effective formulary alternatives available that do not require prior authorization. For the products listed below, PA criteria is recommended in new and current users, requiring a trial of cost effective generic formulary medications first.

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) manual PA criteria for valsartan 20 mg/5 mL oral solution and metformin 625 mg IR tablets in new and current users, due to the significant cost differences compared with numerous available alternative agents.

- 1) Non-Insulin Diabetes Drugs: Biguanides Subclass - metformin immediate release (IR) 625 mg tablets**—Numerous other metformin IR (500 mg and 850 mg) and ER (750 mg and 1000 mg) formulations are more cost-effective than this 625 mg IR formulation made by a sole manufacturer.

Manual PA criteria apply to all new and current users of metformin IR 625 mg tablets.

Manual PA criteria: Metformin IR 625 mg tablets are approved if all criteria are met:

- Provider acknowledges other metformin formulations, including the 500 mg and 850 mg immediate release tablets, and 750 mg and 1000 mg extended release tablets are available without requiring prior authorization.
- The provider must explain why the patient can't take a different metformin formulation. (blank write-in)

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

- 2) Renin-Angiotensin Anti-hypertensives (RAAs) - valsartan 20 mg/5 mL oral solution**—Valsartan is an angiotensin receptor blocker (ARB) that is available in cost-effective generic formulations, along with several other ARBs (e.g., losartan, candesartan, telmisartan, etc). Valsartan oral solution is not cost effective compared to the other ARBs.

Manual PA criteria apply to all new and current users of valsartan 20 mg/5mL oral solution.

Manual PA criteria: Valsartan 20 mg/5mL oral solution is approved if all criteria are met:

- Provider acknowledges other angiotensin receptor blockers (ARBs) including valsartan, telmisartan and losartan are available without requiring prior authorization.
- The provider must explain why the patient can't take a tablet formulation of an (ARB) (blank write-in)

Non-FDA-approved uses are not approved.

Prior authorization does not expire.

B. New Manual Pa Criteria For Newly Approved Drugs Not Subject To 32 CFR 199.21(G)(5) Implementation Plan

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) that the new PAs will become effective the first Wednesday 60 days after the signing of the minutes, and DHA will send letters to affected patients.

XI. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA FOR NEWLY APPROVED DRUGS NOT SUBJECT TO 32 CFR 199.21(G)(5)

BAP Comments

A. New Manual Pa Criteria For Newly Approved Drugs Not Subject To 32 CFR 199.21(G)(5)

The P&T Committee recommended manual PA criteria for valsartan 20 mg/5 mL oral solution and metformin 625 mg IR tablets in new and current users, as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. New Manual Pa Criteria For Newly Approved Drugs Not Subject To 32 CFR 199.21(G)(5) Implementation Plan

The P&T Committee recommended the new PAs will become effective the first Wednesday 60 days after the signing of the minutes, and DHA will send letters to affected patients.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XII. PRIOR AUTHORIZATION CRITERIA—UPDATED PA CRITERIA FOR NEW FDA-APPROVED INDICATIONS

P&T Comments

A. Prior Authorization Criteria—Updated PA Criteria for New FDA-Approved Indications

The P&T Committee evaluated updates to the PA criteria for several drugs, due to new FDA-approved indications. The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) updates to the manual PA criteria for Dupixent, Rinvoq, Otezla, Qelbree and Imcivree in new users.

1. Atopy Agents (now incorporates the previously titled Respiratory Interleukins)—dupilumab injection (Dupixent)

- a) **Eosinophilic Esophagitis (EoE):** Dupixent recently gained a new indication for treating EoE. A trial of both a proton pump inhibitor (PPI) and topical glucocorticoid is required prior to using Dupixent in new users, based on the current EoE clinical practice guidelines from the American Academy of Allergy, Asthma and Immunology (AAAAI) and MHS provider feedback. Note that topical glucocorticoids in this case refers to spraying a high potency inhaled corticosteroid in the mouth and then swallowing the dose (due to extensive first pass metabolism), or making a slurry out of budesonide capsules.
- b) **Atopic Dermatitis in young children:** The Dupixent manual PA criteria were also updated to allow for expanded use as add-on maintenance treatment of atopic dermatitis in children aged 6 months to 5 years whose disease is not adequately controlled with topical prescription treatments.

The PA criteria is as follows:

Only the updates for EoE and atopic dermatitis are included; note that no changes were made for the asthma or nasal polyps indications.

Manual PA is required for all new users of dupilumab (Dupixent).

Manual PA Criteria: Dupixent coverage will be approved for initial therapy for 12 months if all criteria are met:

For Eosinophilic Esophagitis:

- The patient is 12 years of age or older and weighs at least 40 kilograms (~88 lbs)
- The drug is prescribed by or in consultation with a gastroenterologist or allergy/immunology specialist
- Patient has a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy
 - For EoE, the patient has tried and failed an adequate course of both the following:
 - Proton pump inhibitor (PPI) at up to maximally indicated doses (adults 20-40 mg twice daily omeprazole equivalent; children: 1-2

mg/kg or equivalent), unless contraindicated or clinically significant adverse effects are experienced AND

- Topical glucocorticoids [e.g., fluticasone (Flovent), budesonide (Pulmicort)] at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced, or in children maximal doses can not be reached due to concerns for growth suppression or adrenal insufficiency.

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

For Eosinophilic Esophagitis (EoE):

- For maintenance: patient has experienced a beneficial clinical response, defined by ONE of the following (a, b, c, d, or e):
 - a) Reduced intraepithelial eosinophil count; OR
 - b) Decreased dysphagia/pain upon swallowing; OR
 - c) Reduced frequency/severity of food impaction; OR
 - d) Reduced vomiting/regurgitation; OR
 - e) Improvement in oral aversion/failure to thrive
- For relapse: prior authorization form or chart notes documenting a relapse after treatment was discontinued since last approval

2. Targeted Immunomodulatory Biologics (TIBs): oral Janus Kinase (JAK) inhibitors—upadacitinib (Rinvoq)

The manual PA criteria were updated for Rinvoq to expand use for treating ankylosing spondylitis (AS) in new users. There are currently no head-to-head trials comparing the efficacy of one biologic over another for AS. Based on current clinical practice guidelines for AS, availability of other TIBs with indications for AS [including the TNF-inhibitor adalimumab (Humira) and the anti-IL-17 product secukinumab (Cosentyx)], and due to safety issues with the oral JAK inhibitors as a class, a trial of two non-steroidal anti-inflammatory drugs (NSAIDs), Humira and Cosentyx is required prior to using Rinvoq.

The PA criteria are as follows:

Updates for the Ankylosing Spondylitis indication are shown below. Note that no changes were made to the criteria for the other indications (rheumatoid arthritis, psoriatic arthritis, atopic dermatitis, and ulcerative colitis).

Step therapy and manual PA criteria apply to all new users of upadacitinib (Rinvoq ER).

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

For Ankylosing Spondylitis

- Provider acknowledges that Humira is the Department of Defense's preferred targeted biologic agent for ankylosing spondylitis
- The patient is 18 years of age or older
- The patient has ankylosing spondylitis
- Patient has had an inadequate response to Humira OR
- Patient has experienced an adverse reaction to Humira that is not expected to occur with the requested agent OR
- Patient has a contraindication to Humira AND
- Patient has had an inadequate response to at least two NSAIDs over a period of at least two months

For all indications

- Patient has no evidence of active TB infection within the past 12 months
- Patient has no history of venous thromboembolic (VTE) disease
- Provider is aware of the FDA safety alerts AND Boxed Warnings
- Patient has no evidence of neutropenia (ANC < 1000)
- Patient has no evidence of lymphocytopenia (ALC < 500)
- Patient has no evidence of anemia (Hgb < 8)
- Patient is not taking Rinvoq concomitantly with other TIBs agents except for Otezla and other potent immunosuppressant's (e.g., azathioprine, cyclosporine)

Non-FDA-approved uses are not approved.

PA does not expire for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, **or ankylosing spondylitis**

3. **TIBs: apremilast (Otezla)**—PA criteria for Otezla have applied since August 2014 for the original indications of psoriatic arthritis and moderate-to-severe plaque psoriasis in patients who are candidates for phototherapy or systemic therapy. Step-therapy applies to the TIBs, requiring a trial of Humira first for these indications. Otezla's package labeling has recently been expanded to include adults with mild cases of plaque psoriasis.

Based on clinical practice guidelines for treating psoriasis and feedback from MHS dermatologists, a trial of Humira will not be required for patients with mild plaque psoriasis. However, other standard therapies, including phototherapy and a moderate-to-high potency topical corticosteroid, steroid sparing agent and other topical agents, will be required first.

The PA criteria is as follows:

Updates from the August 2022 meeting are in bold and ~~strikethrough~~. Note that there were no changes made to the existing criteria for active psoriatic arthritis (PsA).

Manual PA criteria applies to new users of Otezla

For Mild Plaque Psoriasis

Manual PA Criteria: Coverage approved for patients ≥ 18 years with mild plaque psoriasis who are candidates for systemic therapy or phototherapy if the following criteria are met:

- **The patient has a contraindication to, intolerability to, or has failed treatment with medications from at least TWO of these THREE categories:**
 - **Moderate to High Potency Topical Corticosteroids (class 1 – class 5) e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream, betamethasone dipropionate 0.05% cream/lotion/ointment, etc.**
 - **Steroid Sparing Agents: Vitamin D analogs (e.g. calcipotriene and calcitriol), tazarotene, or topical calcineurin inhibitors (e.g. tacrolimus and pimecrolimus)**
 - **Other Topicals: emollients, salicylic acid, anthralin, or coal tar**

AND

- **The patient has a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy**

For Psoriatic Arthritis and Moderate to Severe Plaque Psoriasis Note that no changes were made. Step therapy requiring a trial of Humira first is required, unless the patient has a contraindication to Humira, or has had an inadequate response or adverse reaction. Additionally, a patients must be candidates for systemic therapy or phototherapy.

Non-FDA-approved uses are not approved.

PA does not expire.

- 4. Attention Deficit Hyperactivity Disorder (ADHD): Non-Stimulants—viloxazine extended release (Qelbree)—**PA criteria have been in place for Qelbree since it was reviewed as a new drug at the August 2021 DoD P&T Committee meeting. At the time Qelbree was approved for treating ADHD only in children between the ages of 6 and 17 years. Qelbree has recently received an indication for treating adults.

For adults with ADHD, the PA criteria will be more stringent than in children, as a trial of methylphenidate (e.g., Concerta), mixed amphetamine salts (e.g., Adderall XR), atomoxetine (Strattera), and another non-stimulant [guanfacine ER (Intuniv) or clonidine

ER (Kapvay)] will be required before Qelbree in new users. This requirement is due to the limited number of patients included in the trials used to gain FDA-approval (only 175 adults were studied for six weeks); the safety concerns with Qelbree in adults (including increases in heart rate and blood pressure); and the availability of numerous other cost-effective stimulants and non-stimulants for treating ADHD.

For children, updates were made to allow pediatric patients with swallowing difficulties to bypass the requirement for a trial of a different non-stimulant first, since Qelbree capsules can be opened up and mixed with applesauce. The other non-stimulants cannot be crushed or chewed.

The PA criteria is as follows:

Updates from the August 2022 meeting are in bold
Manual PA criteria apply to all new users of Qelbree.

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

For Adults:

- **Patient is 18 years of age or older**
- **Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)**
- **Patient has tried and failed, had an inadequate response, OR contraindication to amphetamine salts XR (Adderall XR, generic) or other long acting amphetamine or derivative drug**
- **Patient has tried and failed, had an inadequate response, OR contraindication to methylphenidate OROS and other (Concerta, generic) or other long acting methylphenidate or derivative drug**
- **Patient has tried and failed, had an inadequate response, OR contraindication to atomoxetine (generic Strattera)**
- **Patient has tried and failed, had an inadequate response, OR contraindication to at least one other non-stimulant ADHD medication (generic formulations of Kapvay or Intuniv)**

For children and adolescents:

- Patient is 6 to 17 years of age
- Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
- Patient has tried and failed, had an inadequate response, OR contraindication to amphetamine salts XR (Adderall XR, generic) or other long acting amphetamine or derivative drug

- Patient has tried and failed, had an inadequate response, OR contraindication to methylphenidate OROS and other (Concerta, generic) or other long acting methylphenidate or derivative drug
- Patient has tried and failed, had an inadequate response, OR contraindication to at least one non-stimulant ADHD medication (generic formulations of Strattera, Kapvay, or Intuniv)
- **OR if patient is under the age of 18 and cannot swallow due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis, autism spectrum disorder, etc.) and not convenience, then a trial of one non-stimulant ADHD medication (generic formulations of Strattera, Kapvay, or Intuniv) is not required**

Non-FDA-approved uses are not approved (to include depression and anxiety).

Prior authorization does not expire.

5. **Miscellaneous Metabolic Agents—setmelanotide injection (Imcivree)**—The PA was updated for the new indication of chronic weight management in adults and pediatric patients 6 years of age and older with monogenic or syndromic obesity due to Bardet-Beidl syndrome was added to the PA.

The PA criteria is as follows:

Updates from the August 2022 meeting are in bold and ~~striketrough~~

Manual PA criteria apply to 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) OR
- **The patient has monogenic or syndromic obesity due to Bardet-Beidl syndrome (BBS)**
- 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 for **POMC-, PCSK1-, or LEPR-deficiency or BBS** 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.

B. Prior Authorization Criteria—Updated PA Criteria for New FDA-Approved Indications Implementation Plan

The P&T Committee recommended an effective the first Wednesday 60 days after signing of the minutes.

XIII. PRIOR AUTHORIZATION CRITERIA—UPDATED PA CRITERIA FOR NEW FDA-APPROVED INDICATIONS

BAP Comments

A. Prior Authorization Criteria—Updated PA Criteria for New FDA-Approved Indications

The P&T Committee evaluated updates to the PA criteria for several drugs, due to new FDA-approved indications, as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Prior Authorization Criteria—Updated PA Criteria for New FDA-Approved Indications Implementation Plan

The P&T Committee recommend effective date the first Wednesday 60 days after signing of the minutes.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XIV. PRIOR AUTHORIZATION CRITERIA—REMOVAL OF PRIOR AUTHORIZATION

P & T Comments

A. Prior Authorization Criteria—Removal of Prior Authorization

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) removing the PA criteria for azelaic acid 15% gel and Auvi-Q auto-injector.

1. Topical Acne and Rosacea Agents: azelaic acid 15% (Finacea, generics)

The P&T Committee evaluated an MTF request to remove the PA criteria for Finacea. Azelaic acid 15% gel is approved for treating rosacea, but is commonly used for acne. Step therapy requires a trial of topical metronidazole first for rosacea. Finacea is now available in cost-effective generic formulations.

There is high quality evidence that topical azelaic acid decreases inflammatory lesions and erythema in rosacea. Additionally, for acne the 2016 American Academy of Dermatology guidelines give azelaic acid a class A recommendation with level 1 evidence. Azelaic acid is also rated as pregnancy category B.

The P&T Committee recommended removing the PA criteria for azelaic acid 15% gel; it remains on the UF, but will not be added to the BCF. Note that the current PA criteria for azelaic acid 20% cream (Azelex), which is approved for acne, will remain in place.

2. Respiratory Agents Miscellaneous: epinephrine Auto-Injector (Auvi-Q)

PA criteria for the Auvi-Q talking epinephrine auto-injector device were re-instated in February 2020, due to the resolution of the national shortage of EpiPen. Since 2020, the price of Auvi-Q has dropped significantly, and the nationwide supply of epinephrine auto-injectors appears stable. The P&T Committee recommended removing the Auvi-Q PA.

B. Prior Authorization Criteria—Removal of Prior Authorization Implementation Plan

The P&T Committee recommended an effective the first Wednesday 2 weeks after signing of the minutes.

XV. PRIOR AUTHORIZATION CRITERIA—REMOVAL OF PRIOR AUTHORIZATION

BAP Comments

A. Prior Authorization Criteria—Removal of Prior Authorization

The P&T Committee recommended removing the PA criteria for azelaic acid 15% gel and Auvi-Q auto-injector.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Prior Authorization Criteria—Removal of Prior Authorization Implementation Plan

The P&T Committee recommended an effective date the first Wednesday 2 weeks after signing of the minutes.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XVI. PRIOR AUTHORIZATION CRITERIA—REMOVAL OF AN INDICATION

P & T Comments

A. Prior Authorization Criteria—Removal of Indications

Over the past several months, the FDA has removed certain indications from some oncology drugs due to safety issues. The P&T Committee recommended updates to the PAs below, based on recent FDA action.

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) to remove the Rubraca indication for BRCA-mutated ovarian cancer after at least two prior chemotherapies. If any updates are made to the Copiktra label, the corresponding PA criteria will be updated accordingly, as described below.

1. Oncologic Agents - Poly Adenosine Diphosphate Ribose Polymerase- (PARP) Inhibitor: rucaparib (Rubraca)

The indication for BRCA-mutated ovarian cancer after at least two prior chemotherapies has been removed, due to increased risk of death compared to chemotherapy in the third-line ovarian cancer treatment setting. The indications remain for ovarian cancer as second-line maintenance treatment in chemotherapy responders and also for previously treated BRCA-mutant metastatic castration-resistant prostate cancer.

2. Oncologic Agents - Non-Bruton Tyrosine Kinase Inhibitors for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (non-BTKIs for CLL/SLL): duvelisib (Copiktra)

A recent clinical trial reported a possible increased risk of death with Copiktra compared to another medication for leukemia and lymphoma. Additionally there was a higher risk of serious side effects with Copiktra, including infections, diarrhea, inflammation of the intestines and lungs, skin reactions, and elevated liver enzyme levels. Although the FDA has not yet formally removed the indications for CLL/SLL, the P&T Committee will continue to monitor FDA actions and respond accordingly with updating the PA if needed.

B. Prior Authorization Criteria—Removal of Prior Authorization Implementation Plan

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) an effective date of the first Wednesday 60 days after signing of the minutes.

XVII. PRIOR AUTHORIZATION CRITERIA—REMOVAL OF AN INDICATION

BAP Comments

A. Prior Authorization Criteria—Removal of Prior Authorization

The P&T Committee recommended removal of the indications for the oncology drugs Rubraca and Copiktra, as discussed above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Prior Authorization Criteria—Removal of Prior Authorization Implementation Plan

The P&T Committee recommended an effective date the first Wednesday 60 days after signing of the minutes.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XVIII. BRAND OVER GENERIC AUTHORIZATION FOR FLUTICASONE PROPIONATE HYDROFLUOROALKANE (FLOVENT HFA) AND TIER 1 COPAY

P & T Comments

A. Fluticasone propionate hydrofluoroalkane (Flovent HFA) brand over generic authorization and Tier 1 Copay

The Inhaled Corticosteroids (ICS) subclass was reviewed in May 2014, and Flovent dry powder inhaler (DPI) and hydrofluoroalkane (HFA) inhalers were designated as BCF and step-preferred. A generic fluticasone propionate HFA formulation has entered the market, however this product is less cost-effective compared to brand Flovent HFA. Therefore, the branded Flovent HFA/Flovent DPI product will continue to be dispensed at all three points of service, and the generic will only be available with prior authorization (i.e., the reverse of the current brand to generic policy).

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) requiring brand Flovent HFA or Flovent DPI in all new and current users at all three points of service, based on cost effectiveness. The prescriber will provide patient-specific justification as to why brand Flovent HFA or Flovent DPI cannot be used. The Tier 1 (generic) copayment will apply to both brand Flovent HFA and DPI.

The authority for the Tier 1 copayment is codified in 32 CFR 199.21(j)(3): 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 P&T Committee may also designate that the drug be cost-shared at the generic rate.

B. Fluticasone propionate hydrofluoroalkane (Flovent HFA) brand over generic authorization and Tier 1 Copay Implementation Plan

The P&T Committee recommended (14 for, 0 opposed, 0 abstained, 2 absent) an effective of 2 weeks after signing of the minutes. The “brand over generic” requirement will be removed administratively when it is no longer cost-effective compared to the AB-rated generics.

XIX. BRAND OVER GENERIC AUTHORIZATION FOR FLUTICASONE PROPIONATE HYDROFLUOROALKANE (FLOVENT HFA) AND TIER 1 COPAY

BAP Comments

A. Fluticasone propionate hydrofluoroalkane (Flovent HFA) brand over generic authorization and Tier 1 Copay

The P&T Committee recommended fluticasone propionate hydrofluoroalkane (Flovent HFA) brand over generic authorization, as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Fluticasone propionate hydrofluoroalkane (Flovent HFA) brand over generic authorization and Tier 1 Copay Implementation Plan

The P&T Committee recommended an effective date of 2 weeks after signing of the minutes, as discussed above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XX. BRAND OVER GENERIC AUTHORIZATION FOR MESALAMINE 1.2 gm (LIALDA)

P & T Comments

A. Removal of Lialda Brand over Generic Requirement

Brand over generic PA requirements originally applied to mesalamine 1.2 gram tablets (Lialda) in September 2017, due to cost effectiveness. In April 2020, cost-effective generic mesalamine formulations were available at the Mail Order and MTFs, however, generic prices at Retail pharmacies were not cost effective. On May 20, 2020, the brand over generic requirements were administratively removed at the Mail Order and MTF points of service, but remained at Retail pharmacies. The cost of generic mesalamine 1.2 gram tablets has now fallen at the Retail POS.

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent), to remove the brand Lialda over generic PA requirement at the Retail Network. The co-pay for brand Lialda at Retail pharmacies will increase back to the Tier 2 copay.

B. Removal of Lialda Brand over Generic Requirement Implementation Plan

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent), and effective date of 2 weeks after signing of the minutes.

XXI. BRAND OVER GENERIC AUTHORIZATION FOR MESALAMINE 1.2 gm (LIALDA)

BAP Comments

A. Removal of Lialda Brand over Generic Requirement

The P&T Committee recommended removal of Liala brand over generic requirement as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Removal of Lialda Brand over Generic Requirement Implementation Plan

The P&T Committee recommended an effective date of 2 weeks after signing of the minutes, as discussed above

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XXII. NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) 2017 PILOT PROGRAM: INCORPORATION OF VALUE-BASED HEALTH CARE IN PURCHASED CARE COMPONENT OF TRICARE AND MEDICATION ADHERENCE

P & T Comments

Background—A pilot program outlined in the NDAA 2017 required identification of high-value medications where copayments or cost shares would be reduced for targeted populations of covered beneficiaries. The P&T Committee identified rosuvastatin (Crestor generics) and insulin glargine pens (Lantus pens) as candidates for inclusion in the pilot, which was intended to assess the effects of copayment reduction or elimination on medication adherence rates. Additionally,

the amount of any reduced or eliminated copay would be credited towards the patient's deductible/catastrophic cap. Implementation occurred on January 1, 2018, to align with recommended regulatory language. (*See the November 2017 and August 2017 DoD P&T Committee minutes*)

Pilot results showed there was no meaningful change in adherence, positive or negative, for patients receiving Lantus pens or rosuvastatin following a reduction in copay.

Following termination of the pilot on December 31, 2022, the following changes will occur:

- Because rosuvastatin is a generic, the copay will increase from the current \$0 co-pay back to the Tier 1 copay at the Mail Order and Retail network pharmacies, as generic co-pays are statutorily required, and absent statutory authority to exclude a specific item or service from otherwise required co-pays, they cannot be waived. Patients will be notified of the copay change via letter.
- The catastrophic cap credit for the reduced/eliminated copays will end.
- These changes will occur on January 1, 2023.

The Committee also discussed the copays for Lantus, a branded drug. At the August 2017 Basal Insulin drug class review, the Lantus pens and vials were both designated as BCF, based on provider opinion, clinical and cost effectiveness, and MHS utilization patterns. The conclusion at the time was that the majority of MHS patients could be treated with Lantus, as there was a lack of compelling advantages of the newer basal insulin analogs.

The P&T Committee recommended (15 for, 0 against, 0 abstained, 1 absent) the following:

- Insulin glargine pens (Lantus pens): Maintaining the Tier 1 copay at the Mail Order and Retail Network
- Insulin glargine vials (Lantus vials): Applying the Tier 1 copay at the Mail Order and Retail Network
- Implementation will occur on January 1, 2023.

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 Lantus pens and vials will provide a greater incentive for beneficiaries to use the most cost-effective basal insulin product in the purchased care points of service.

XXIII. NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) 2017 PILOT PROGRAM: INCORPORATION OF VALUE-BASED HEALTH CARE IN

PURCHASED CARE COMPONENT OF TRICARE AND MEDICATION ADHERENCE

BAP Comments

The P&T Committee recommended the Tier 1 copay for Lantus pens and vials, with an implementation of January 1, 2023, due to termination of the pilot program, as stated above.

BAP Comments

Concur: Non-Concur: Abstain: Absent: