

**ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE**

**Location of Meeting
Frontier Building, 3601 C Street, Room 890/896**

**MINUTES OF MEETING
April 19, 2019
8:00 a.m.**

Committee Members Present:

Jenna Hiestand, MD, Chair
Robert Carlson, MD (telephonic)
Sarah Doran-Atchison, Pharm D (telephonic)
Vincent Greear, MD (telephonic)
Diane Liljegren, MD (telephonic)
Claudia Phillips, MD (telephonic)
John Riley, PA (telephonic)
Charles Ryan, MD
Ryan Ruggles, PharmD
Trish White, R.Ph. (telephonic)

Committee Members Absent:

Others Present:

Erin Narus, PharmD, State of Alaska
Charles Semling, PharmD, R.Ph.
Umang Patel, PharmD, R.Ph., Magellan Medicaid Administration
Marti Padilla, R.Ph., Magellan Medicaid Administration
Colette Grower, Kron Associates

1. Call to Order – Chair

Dr. Hiestand called the meeting to order at 8:02 a.m.

2. Roll Call

The roll call was taken, and a quorum was present.

3. Public Comments - Local Public/Health Practitioners

There were no local public/health practitioner comments.

4. Class Review, Discussion & Vote

4-A. Single Class Review: Hereditary Angioedema (Red Class); Hemophilia (Red Class)

Public Comments for Single Class Review: Hereditary Angioedema (Red Class)

HEIDI MEMMOTT, a representative of Shire, discussed Takhzyro. Hereditary angioedema is characterized by recurrent, unpredictable episodes of swelling in the hands and feet, throat and larynx. Hereditary angioedema carries the risks of life-threatening asphyxiation. Recent guidelines for the treatment of hereditary angioedema were reviewed. Takhzyro is a fully human monoclonal antibody indicated for prophylaxis to prevent HAE attacks in patients 12 and older. It is in a ready-to-use, single-dose vial. It is administered as a subcutaneous injection and intended for self-administration or administration by a caregiver after training by a healthcare professional. Several trials and their outcomes were reviewed. The most common adverse reactions were injection site reactions consisting of pain, erythema, and bruising. Other adverse reactions observed in more than 10% of patients were upper respiratory tract infections, headaches, rashes, and diarrhea. Other adverse reactions that occurred when compared to placebo include hypersensitivity (1% versus 0%), increased aspartate transaminase (2% versus 0%), and increased alanine transaminase (2% versus 0%).

Dr. Umang Patel gave the Magellan presentation on Hereditary Angioedema, a rare, dominant autosomal genetic disorder that affects approximately 6,000 to 30,000 individuals in the United States. It is characterized by recurrent episodes of nonpruritic, nonpitting, subcutaneous or submucosal edema involving the skin or mucosal tissues of the upper respiratory and GI tracts. Although swelling can resolve spontaneously in several days without treatment, laryngeal edema may be fatal, and the pain of GI attacks can be incapacitating. Symptoms can begin as early as 2 years of age and persist throughout life with unpredictable severity and frequency of attacks. It is thought that minor trauma and stress can lead to an attack; however, many attacks can occur without any apparent trigger.

There are two types of C1-INH deficient HAE. The most common type, Type I, is where the body does not produce enough C1-INH, which occurs in about 80% of patients with the condition. Type II HAE is characterized by the presence of normal or high levels of a dysfunctional C1-INH. Prophylaxis is needed to reduce potential edema caused by a stressor or procedure likely to precipitate an attack or decrease the number and severity of angioedema attacks.

Guidelines from the U.S. Hereditary Angioedema Association, the Hereditary Angioedema International Work Group and World Allergy Organization, and the International Consensus Group were reviewed.

In June 2017, a subcutaneous C1-esterase inhibitor (Haegarda) formulation was approved for routine prophylaxis prevention of HAE attacks in adolescent and adult patients. In June 2018, the FDA expanded the indication for Cinryze for routine prophylaxis against angioedema attacks to include pediatric patients ages 6 to 11 years of age with HAE. In August 2018, the FDA approved Takhzyro, a plasma kallikrein inhibitor, to treat patients 12 years of age and older with Type I and II HAE.

The following medications are included in the class. Prophylaxis: Cinryze, Haegarda, and Takhzyro. Treatment: Kalbitor, Firazyf, Berinert, and Roconest. Dosing recommendations and dosage availability was reviewed.

The utilization report was reviewed. As this is a new class, 100% of the prescriptions were for non-PDL drugs and there was no previous motion.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE PROPHYLAXIS FORMULATION AND ONE TREATMENT FORMULATION. SECONDED BY DR. GREAR. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Single Class Review: Hemophilia (Red Class)

Dr. Narus noted this was the first review of the Hemophilia class, partially because only factor replacement products have been available in the past. This is a narrow class with very few treatment options. With the approval of Hemlibra, alternative products are now available. Hemophilia impacts a very small population in Alaska. We work closely with the Hemophilia Treatment Center to promote individualized treatment, which makes utilization of the PDL challenging. When the FDA approved Hemlibra, they outlined specific post-marketing studies that are anticipated, so information will continue to evolve. To address any concerns of the hemophilia community, Medicaid does not intend to switch individual's medications or prefer any bispecific products. However, we will work with the Hemophilia Treatment Center to identify individuals who may benefit from moving over to the newly approved products.

JESSICA CHARLET, a representative of Bayer, discussed Jivi. It is a B-domain deleted recombinant factor VIII variant that is site-specifically pegylated with a single 60KDa branched polyethylene glycol moiety. It is a third generation recombinant factor VIII product indicated for use in previously treated hemophilia A patients 12 years of age and older for on-demand treatment and control of bleeding, for perioperative management of bleeding, and for routine prophylaxis to reduce the frequency of bleeding episodes. Jivi is not indicated for the use in hemophilia A patients younger than 12 years of age, in previously untreated patients, or for the treatment of Von Willebrand disease. Jivi is a new extended half-life recombinant factor VIII treatment with a unique stepwise prophylaxis dosing regimen. Dosing recommendations were reviewed. Several studies and their outcomes were reviewed. The most frequently reported adverse reactions in clinical trials were headache, cough, nausea, and fever.

SHARON CAHOON METZGER, a representative of Sanofi, advocated for continued individualized treatment for hemophilia. Sanofi's new product is an extended half-life product called Eloctate. Since the new products have come to the marketplace, we have seen increased prophylaxis, increased adherence in terms of MPR, and better clinical outcomes in terms of joint health in patients. On behalf of all new hemophilia products coming to the market, we advocate for continued access for patients as their health continues to improve as the products become something they can tolerate and are willing to stay adherent on.

SHIRLEY QUACH, a representative of Genentech, discussed Hemlibra. Hemophilia is a very rare and debilitating disease that affects patient quality of life and physical motions. Currently there is no cure for hemophilia. It can also lead to long-term complications such as arthritis and decreased mobility. Hemlibra was FDA-approved in 2017 for patients with hemophilia A with inhibitors, and it was line extended to non-inhibitor patients in 2018. Hemlibra is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients ages newborn and

older with hemophilia A with or without FVIII inhibitors. Several trials/studies and their outcomes were reviewed. There is a boxed warning regarding thrombotic microangiopathy and thromboembolism, but these were seen when Hemlibra was given concomitantly with a high dose of aPCC for long periods of time. Safety is an area that we are continuing to review. The introduction of Hemlibra into the market has changed the standard of care for patients with hemophilia A and allows patients to live a more normal life. Hemlibra should be available to patients if it is something that fits them and that they want.

Dr. Umang Patel gave the Magellan presentation on Single Class Review: Hemophilia. Hemophilia is a rare, inherited bleeding disorder where the blood does not clot properly due to an absence of one of the coagulation factors present in normal blood. It is identified as an X-lined congenital bleeding disorder that has an estimated frequency of 1 in 5,000 to 10,000 births. It typically affects males on the maternal side due to X-lined inheritance; however, females may also rarely be affected but are more commonly carriers of the disease. Up to 30% of newly diagnosed cases occur with no prior family history and are attributed to spontaneous mutations in either the F8 or F9 gene.

The World Federation of Hemophilia estimates the global prevalence of hemophilia at around 400,000 people. It is estimated that there are approximately 17,000 to 20,000 people in the U.S. afflicted with hemophilia. The two main types are type A and type B. Type A is also known as Factor VIII deficiency, classical hemophilia, or standard hemophilia. It is far more common than hemophilia B, with hemophilia A presenting in 80% to 85% of all hemophilia patients. Patients with type A hemophilia exhibit low or missing levels of clotting Factor VIII. Type B is also known as Factor IX deficiency or Christmas disease. Those with type B have low or missing levels of clotting factor IX. Hemophilia can also encompass a number of other rare factor deficiencies. These disorders are far less common than hemophilia A and B, exemplified by factor XIII deficiency which is estimated to occur in 1 in 5 million people.

Von Willebrand disease is similar to hemophilia A. This is a group of inherited bleeding disorders related to the absence or defects of the Von Willebrand Factor, a clotting protein needed to achieve hemostasis. It binds to Factor VIII and platelets to generate a platelet plug during the clotting process. The disease leads to bleeding from impaired platelet adhesion and aggregation, which may be accompanied by reduced levels of Factor VIII. The prevalence of this is between 1 in 100 to 10,000 individuals and is equal in males and females. There are three major subtypes of Von Willebrand disease. Type 1 is a partial quantitative deficiency that accounts for 75% of all patients. Type 2 is a more pronounced qualitative deficiency and accounts for about 25% of patients. Type 2 is further divided into four variants on the basis of identified phenotypes. Type 3 is characterized as a complete Von Willebrand Factor deficiency and occurs very rarely. For these patients, their inherent Factor VIII levels are typically very low.

Guidelines for the World Federation of Hemophilia and the National Hemophilia Foundation Medical and Safety Advisory Committee were reviewed.

In February 2019, the FDA approved Esperoct, a recombinant coagulation factor VIII product indicated in adults and children with hemophilia A for routine prophylaxis to reduce frequency of bleeding episodes, on-demand treatment and control of bleeding episodes, and perioperative management of bleeding. It is not indicated for Von Willebrand disease. The U.S. launch is not expected before 2020. Warnings and precautions include hypersensitivity reactions, including

anaphylaxis. Dosage recommendations were reviewed. It is available as a lyophilized powder in single-dose vials.

In October 2018, the FDA approved Hemlibra, a bispecific factor iXa- and factor X-directed antibody, for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and all pediatric patients (including newborns) with hemophilia A with or without factor VIII inhibitors. Previously, it was approved only for those with factor VIII inhibitors. There is a black box warning for potential development of thrombotic microangiopathy and thromboembolism. Dosage recommendations were reviewed. It is available as single-dose vials. Storage instructions for the medication can be found on the package insert.

In August 2018, the FDA approved Jivi, an antihemophilic factor indicated for use in previously treated adults and adolescents (12 years of age and greater) with hemophilia A for on-demand treatment and control of bleeding episodes, perioperative management of bleeding, and routine prophylaxis to reduce the frequency of bleeding episodes. It is not indicated for use in previously untreated patients or those with Von Willebrand disease. Warnings and precautions include a history of hypersensitivity reactions to the active substance, polyethylene glycol, mouse and hamster proteins, or other constituents of the product. Dosing recommendations were reviewed. It is available in single-use glass vials.

In May 2017, the FDA approved Rebinyn, a recombinant glycopegylated factor IX product. It is indicated for the prevention and control of bleeding episodes in patients with hemophilia B and perioperative management in patients with hemophilia B. It is not indicated for routine prophylaxis or for induction of immune tolerance therapy in patients with hemophilia B. Dosing recommendations were reviewed. It is available as a single-use vial.

The utilization report was reviewed. As this is a new class, 100% of the prescriptions were for non-preferred drugs and there was no previous motion.

In response to Dr. Phillips, Dr. Narus said the State's recommended motion would be therapeutic alternatives in recognition of the variety and uniqueness of the products, including differences in their indications and mechanisms of action. There is no need to further subdivide the class.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.

4-B. Cardiovascular: ACE Inhibitors & Renin Inhibitors (Green Class); Angiotensin Receptor Blockers (ARB) (Green Class); Angiotensin Modulators/CCB Combinations (Green Class); Antianginal and Anti-ischemic Agents (Green Class); Anticoagulants (Blue Class); Beta-Blockers (Blue Class); Calcium Channel Blockers (Blue Class); Erythropoiesis Stimulating Agents (Red Class); Lipotropics, Other (Blue Class); PCSK-9 Inhibitors (Green Class); Platelet Aggregation Inhibitors (Green Class); Pulmonary Arterial Hypertension (Blue Class)

Cardiovascular: ACE Inhibitors & Renin Inhibitors (Green Class)

Cardiovascular: Angiotensin Receptor Blockers (ARB) (Green Class)

Cardiovascular: Angiotensin Modulator/CCB Combinations (Green Class)

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: ACE Inhibitors & Renin Inhibitors, Angiotensin Receptor Blockers (ARB), and Angiotensin Modulator/CCB Combinations together. Approximately 75 million adults in the United States have high blood pressure along with 1 of 3 American adults having prehypertension. The highest prevalence is among African American men and women. Approximately 70% of African American men and women are likely to develop high blood pressure by 55 years of age compared to about 55% of white men and 40% of white women. It is estimated that hypertension is controlled in 54% of patients with the condition. A 2018 guideline update from the AHA, the scientific statement on resistant hypertension, was reviewed.

The utilization report was reviewed. For ACE Inhibitors and Renin Inhibitors, there were 7,238 prescriptions with 99.1% being for preferred products. For Angiotensin Receptor Blockers, there were 2,860 prescriptions with 92.1% being for preferred products. For Angiotensin Modulator/CCB Combinations, there were 223 prescriptions with 78.9% being for preferred products.

At the last review, a motion that the drugs in all three subgroups were therapeutic alternatives to include at least one ACE Inhibitor, one ARB, and one ARNI agent, passed unanimously.

DR. RILEY MOVED THE DRUGS IN ALL THREE CLASSES WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE ACE INHIBITOR, ONE ARB, AND ONE ARNI AGENT. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Cardiovascular: Antianginal and Anti-ischemic Agents (Green Class)

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Antianginal and Anti-ischemic Agents. The utilization report was reviewed. There were 34 prescriptions, 100% for preferred products. At the last review, a motion for class effect passed unanimously.

DR. RYAN MOVED A CLASS EFFECT. SECONDED BY DR. RUGGLES. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Cardiovascular: Anticoagulants (Blue Class)

MAE KWONG, a representative of Janssen, discussed Xarelto, a direct oral anticoagulant. It was recently approved for a new indication, the reduction in cardiovascular events including cardiovascular death, myocardial infarction and stroke in patients with chronic coronary artery disease or peripheral artery disease. Several studies and their outcomes were reviewed. The AHA/ACC/HRS guidelines were updated in 2019 and now prefer NOACs over Warfarin to reduce stroke risk in atrial fibrillation patients, unless patients have moderate to severe mitral stenosis or a mechanical heart valve. Real-world evidence continues to support the safety and effectiveness of Xarelto. In December, a supplemental new drug application was submitted to the FDA for Rivaroxaban to prevent venous thromboembolism in acute medically ill patients. If approved, this will add to the existing indications for Xarelto, further differentiating it as a must-have option as it is the most studied anticoagulant available to the most groups of patients. We request that Xarelto remain available to Alaska Medicaid patients for all approved indications, as well as access to potential future indications.

DAVID GROSS, a representative of Pfizer, discussed Eliquis. It is FDA approved to reduce the risk of stroke and systemic embolism in patients with nonvalvular in atrial fibrillation. It is also indicated for

the treatment of DVT and PE to prevent reoccurrence following initial therapy, and for the prophylaxis of DVT in patients who have undergone hip or knee replacement surgery. There is a black box warning regarding increased risk of thromboembolic events in patients who prematurely discontinue, and risk of spinal hematoma in patients undergoing neuraxial anesthesia or spinal puncture. Use in patients with prosthetic heart valves is not recommended. Please refer to the package insert for more detailed safety information. Several trials and studies and their outcomes were reviewed.

Dr. Umang Patel read an email from Teresa Hall (ph) at the Alaska Heart and Vascular Institute advocating for Xarelto on the PDL.

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Anticoagulants. Venous thromboembolism (VTE) manifests as deep vein thrombosis (DVT) and pulmonary embolism (PE) and is a major consequence of various surgical procedures and medical conditions. DVT occurs when a thrombus composed of cellular material is bound together with fibrin strands and forms in the deep venous portion of the extremities, most commonly in the legs. The exact number of patients impacted is unknown; however, it is estimated these conditions affect between 300,000 and 600,000 people in the U.S. every year. If left untreated, approximately 30% of patients who develop PE will die within the first few hours of the event. Generally, the risk of VTE increases with the number of risk factors present, major traumas, and age. Due to the risk of morbidity and fatal PE associated with DVT, prophylaxis has become the standard of care for patients at high work for thrombosis.

Coronary artery disease (CAD) and peripheral artery disease (PAD) was discussed. Approximately 14 million Americans have CAD, and 8.5 million over the age of 40 have PAD. Prevention and treatment of atherosclerosis focus on modifiable risk factors. Therapy includes lifestyle changes and the medical treatment of hypertension, hyperlipidemia, and diabetes mellitus. Antiplatelet medications are indicated for reduction of thrombotic CV events in patients with established CAD or PAD.

Atrial fibrillation (AF) is a common arrhythmia ranging in prevalence from 2% in patients under 65 years of age to 9% for those 65 or older. The prevalence is higher in men than women and increases with age. More than a third of patients with AF are 80 years of age or older. Patients with AF can have a reduction in cardiac output resulting in pooling of blood in the heart, atrial thrombus formation, and potential systemic embolization. Ischemic stroke is the most frequent clinical manifestation of AF associated embolization. AF increases the risk of stroke five-fold. In patients with AF, the ACCP recommends measuring the risk using the CHA₂DS₂-VASc score, which considers risk factors such as gender, age, history of stroke, TIA, or thromboembolism, as well as history of congestive heart failure, hypertension, diabetes mellitus, or vascular disease. The score ranges from 0 to 9, with higher numbers indicating more risk.

Guidelines from the American College of Chest Physicians and AHA/ACC/HRS were reviewed.

In October 2018, Xarelto became the first oral anticoagulant approved for use in combination with low-dose aspirin to reduce the risk of major CV events in patients with chronic CAD or PAD. To reduce the risk of stroke and systemic embolism in patients with NVAF; treatment of PE; reduction in the risk of recurrence of DVT and of P for patients at continued risk for recurrent DVT and/or PE following initial six-months treatment for DVT and/or PE. Xarelto should not be used in patients with end-stage CKD or receiving hemodialysis due to lack of evidence regarding the balance between risks and benefits. Dosage recommendations were reviewed. It is available in tablets and as a starter pack.

The utilization report was reviewed. There were 1,827 prescriptions with 97.5% being for preferred products.

At the last review, a motion for therapeutic alternatives to include one oral agent, one injectable agent, one NOAC that can be used for PE, and Warfarin passed unanimously.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE ORAL AGENT, ONE INJECTABLE AGENT, ONE NOAC THAT CAN BE USED FOR PE, AND WARFARIN. SECONDED BY DR. WHITE.

Dr. Riley felt cardiovascular prophylaxis should be added to the motion. Dr. Liljegren noted that NOAC was now called DOAC.

DR. PHILLIPS AMENDED THE MOTION AND MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE ORAL AGENT, ONE INJECTABLE AGENT, ONE DOAC THAT CAN BE USED FOR PE AND CV PROPHYLAXIS, AND WARFARIN. SECONDED BY DR. GREAR. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Cardiovascular: Beta-Blockers (Blue Class)

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Beta-Blockers. The treatment guidelines from the American Academy of Pediatrics include the management of infantile hemangiomas, which occurs in as many as 5% of infants, making them the most common benign tumor in infancy. Most are small, innocuous, self-resolving, and require no treatment. However, because of their size or location, a significant minority can be problematic. For infants with potentially problematic hemangiomas, early intervention and/or referral is recommended, and Propranolol is preferred for at least six months when systemic treatment is indicated. Select cases may be treated with topical Timolol. Surgery and/or laser treatment are most useful for the treatment of residual skin changes after involution and, less commonly, may be considered early to treat infantile hemangiomas.

The utilization report was reviewed. There were 8,097 prescriptions with 85.9% being for preferred products.

At the last review, a motion for class effect to include both Carvedilol and Metoprolol Succinate passed unanimously.

DR. RUGGLES MOVED A CLASS EFFECT TO INCLUDE BOTH CARVEDILOL AND METOPROLOL SUCCINATE. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Cardiovascular: Calcium Channel Blockers (Blue Class)

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Calcium Channel Blockers. The new drug in the class is Consensi. It is indicated for patients for whom treatment with Amlodipine for hypertension and Celecoxib for osteoarthritis are appropriate. Consensi is contraindicated in the setting of coronary artery bypass surgery. NSAIDs can cause an increased risk of serious CV thrombotic events and an increased risk of serious GI adverse events. Consensi should be discontinued if abnormal liver tests persist or worsen. Dosage recommendations were reviewed. It is available as a tablet.

The utilization was reviewed. There were 3,646 prescriptions with 99.2% being for preferred products.

At the last review, a motion for therapeutic alternatives to include at least one short acting agent, one extended release agent, and one nondihydropyridine agent passed unanimously.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE SHORT ACTING AGENT, ONE EXTENDED RELEASE AGENT, AND ONE NONDIHYDROPYRIDINE AGENT. SECONDED BY DR. RUGGLES. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Cardiovascular: Erythropoiesis Stimulating Agents (Red Class)

AMY STANFORD, a representative of Pfizer, discussed Retacrit, which was FDA approved in May 2018. It is an erythropoiesis stimulating agent indicated for anemia due to chronic kidney disease in patients on dialysis and not on dialysis, zidovudine in patients with HIV infections, the effects of concomitant myelosuppressive chemotherapy, and reduction of allogenic RBC transfusion in patients undergoing elective non-cardiac, non-vascular surgery. The clinical development program for Retacrit was reviewed. Several studies and their outcomes were reviewed. Retacrit is labeled with the same warnings and precautions as Epogen and Procrit, including the boxed warning that states in controlled trials in CKD, patients experience greater risk for death, serious adverse cardiovascular reactions, and stroke when administered erythropoiesis stimulating agents to target a hemoglobin level of greater than 11 grams per deciliter. No trial has identified a hemoglobin target level, ESA dose, or dosing strategy that does not increase these risks. Use the lowest Retacrit dose sufficient to reduce the need for transfusions.

Erin Narus asked Ms. Stanford to provide the State of Alaska with any information available on Retacrit studies that looked at switch studies and their outcomes.

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Erythropoiesis Stimulating Agents. Anemia is a frequent complication, affecting over 3 million Americans. It is associated with serious diseases such as chronic kidney disease, diabetes, heart disease, and cancer, as well as chronic inflammatory conditions like rheumatoid arthritis or inflammatory bowel disease. Erythropoietin is glycoprotein produced in the kidneys that stimulates red blood cell production from the bone marrow. It acts on the erythroid progenitor cells in the bone marrow to cause late differentiation and maturity of red blood cells. Endogenous production of erythropoietin by the kidney is normally regulated by the levels of tissue oxygenation. Hypoxia and anemia generally increase the production of erythropoietin, which in turn stimulates erythropoiesis. In normal subjects, plasma erythropoietin levels range from 0.01 to 0.03 units per milliliter and may increase 100- to 1,000-fold during hypoxia or anemia.

However, patients with CKD have impaired production of erythropoietin, which is the primary cause of their anemia.

Treatment guidelines from the National Comprehensive Cancer Network and the American Society of Clinical Oncology and American Society of Hematology were reviewed.

In June 2018, the FDA expanded the indication for Mircera to treat anemia associated with CKD in patients 5 to 17 years of age on hemodialysis who are converting from another ESA after their hemoglobin level was stabilized. It is indicated for the treatment of anemia associated with CKD in adult patients on dialysis and adult patients not on dialysis, pediatric patients 5 to 17 years of age on hemodialysis who are converting from another ESA after their Hgb level was stabilized with an ESA. Warnings and precautions include Micera is contraindicated in patients with uncontrolled hypertension. It is not indicated for the treatment of anemia due to cancer chemotherapy. Patients experienced greater risks and serious CV events when administered ESAs to target higher versus lower Hgb levels. Individualize dosing to achieve and maintain Hgb levels within the range of 10-12 g/dL. Dosing recommendations were reviewed. It is available in single-dose prefilled syringes.

In May 2018, the FDA approved Retacrit, the first FDA-approved biosimilar to Epogen and Procrit. It is indicated for the treatment of anemia due to CKD in patients on dialysis and not on dialysis; myelosuppressive chemotherapy, and upon initiation, there is at least two additional months of planning chemotherapy; zidovudine in patients with HIV-1 infection and endogenous serum erythropoietin levels less or equal to 500 milliunits per milliliter; reduction of allogenic RBC transfusion in patients with perioperative hemoglobin between 10-13 grams per deciliter who are at risk for perioperative blood loss from elective noncardiac, nonvascular surgery. It is not indicated in patients who are willing to donate autologous blood pre-operatively. There are boxed warnings for increased risk of death, myocardial infarction, stroke, VTE, thrombosis, and tumor progression or recurrence. It is contraindicated in patients with uncontrolled hypertension. It is available in single-dose preservative-free vials.

The utilization report was reviewed. There were 213 prescriptions with 99.4% being for preferred products.

At the last review, a motion for therapeutic alternatives passed unanimously.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RUGGLES. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Cardiovascular: Lipotropics, Other (Blue Class)

Public Comments for Cardiovascular: PCSK-9 Inhibitors (Green Class)

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Lipotropics, Other and PCSK-9 Inhibitors. The National Health and Nutrition Examination Survey reported that in 2015 and 2016 approximately 12.4% of adults had high total cholesterol and 18.4% had low HDL-C. It is higher in women (13.7%) compared to men (11.2%). Many clinical trials have demonstrated that high serum

concentration of low-density lipoprotein cholesterol and low levels of high-density lipoprotein cholesterol are major risk factors for coronary heart disease.

Treatment guidelines from the American Association of Clinical Endocrinologists and the American College of Endocrinology, the American Diabetes Association, and the American Heart Association and American College of Cardiology were reviewed.

The utilization reports were reviewed for Lipotropics, Other was reviewed. There were 1,149 prescriptions with 80.4% being for preferred products.

At the last review, a motion for therapeutic alternatives to include at least one drug from each subclass passed unanimously.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE DRUG FROM EACH SUBCLASS. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

The utilization report for PCSK-9 Inhibitors was reviewed. There were 6 prescriptions with 100% being for non-preferred products.

At the last review, a motion for class effect passed unanimously.

DR. RYAN MOVED A CLASS EFFECT. SECONDED BY DR. RUGGLES. THE MOTION PASSED UNANIMOUSLY.

Cardiovascular: Platelet Aggregation Inhibitors (Green Class)

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Platelet Aggregation Inhibitors. The utilization report was reviewed. There were 885 prescriptions with 98.5% being for preferred products.

At the last review, a motion of therapeutic alternatives to include at least Clopidogrel passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST CLOPIDOGREL. SECONDED BY DR. RUGGLES. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Cardiovascular: Pulmonary Arterial Hypertension (Blue Class)

JOHN HARTNEY, a representative of Actelion, discussed Opsumit, which is indicated to delay disease progression and reduce hospitalization for pulmonary arterial hypertension (PAH). Opsumit is the only endothelin receptor antagonist indicated to delay disease progression and reduce PAH related hospitalization as both monotherapy and combination therapy with phosphodiesterase-5 inhibitors or inhaled prostanoids. Several studies and their outcomes were reviewed. There are boxed warnings for embryo-fetal toxicity for which there is a REMS Program. ERAs have caused elevations of aminotransferases, hepatotoxicity, liver failure, and decreases in hemoglobin concentrations. Obtain liver

enzyme tests prior to initiation and repeat during treatment as clinically indicated. Peripheral edema and fluid retention are known consequences of PAH and ERAs. Monitor for signs of fluid tension after Opsumit initiation. Opsumit is indicated to delay disease progression and reduce hospitalization. The optimum dose is 10 milligrams once daily and can be used as monotherapy or in combination therapy with PD-5 inhibitors or inhaled prostanoids. We request that Opsumit be included on the Alaska Medicaid preferred drug list.

ELIZABETH ESTERL, a representative of United Therapeutics, discussed Orenitram. Pulmonary arterial hypertension is a rare chronic illness with an estimated prevalence of 5 to 50 cases per million people. Life expectancy has improved from 2.8 years in the early 1980s to a medium survival of 7 years in this modern era. Despite advancements such as new medication mechanisms of action and evidence supporting the combination of therapies, PAH remains a rapidly progressing disease without a cure. Orenitram was FDA approved in December 2013 and is indicated to improve exercise capacity in patients with PAH. We continue to build upon efficacy and safety data sets post approval. The FREEDOM-EV trial and its outcomes was reviewed.

Dr. Umang Patel gave the Magellan presentation on Cardiovascular: Pulmonary Arterial Hypertension. The prevalence varies substantially depending on the type, etiology, and underlying conditions. It is estimated in approximately 15 per million people. Pulmonary hypertension (PH) is characterized by an increase in pulmonary arterial pressure and secondary right ventricular failure. This is defined as a resting mean pulmonary arterial pressure as greater or equal to 25 millimeters of mercury. Symptoms can include dyspnea, dizziness, syncope, fatigue, edema, angina, palpitations, and other symptoms, all of which are exacerbated by exertion. PH does not have a cure and, if left untreated, it is a life-threatening disease with poor prognosis. Management of PH should be limited to specialized centers where clinicians are experienced in the evaluation and treatment of patients with PH. Although a number of approved therapies for PAH has grown in the past years, the prognosis is still poor, with approximately 50% mortality within the first five years after diagnosis. There are many causes of PAH including idiopathic or underlying disease and hereditary causes. Cellular changes in the walls of pulmonary arteries, and it appears that mutations in the bone morphogenetic protein receptor type 2 gene, plays a key role in the pathogenesis of heritable PAH. Other etiologies in PAH include drugs and toxins, collagen vascular resistance, HIV, portal hypertension, chronic thromboembolism, and congenital heart disease. The World Health Organization classifies PH patients into five groups based on etiology. Group I refers to pulmonary arterial hypertension; Group II refers to PH due to left heart disease; Group III refers to PH due to lung disease; Group IV refers to PH due to blood clots in the lungs; and Group V refers to PH due to blood and other rare disorders. In 2013, clinical classifications were updated to provide the same PH classifications for adult and pediatric patients. In addition, the individual categorization of the persistent PH of neonates was included.

Treatment guidelines from the European Society of Cardiology and the European Respiratory Society, the American College of Chest Physicians were reviewed.

The utilization report was reviewed. There were 79 prescriptions with 86.1% being for preferred products.

At the last review, a motion for therapeutic alternatives to include one from each class plus one inhaled product passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE FROM EACH CLASS PLUS ONE INHALED PRODUCT. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Break from 9:55 a.m. to 10:06 a.m.

4-C. Anti-Infective: Antifungals, Oral (Blue Class); Antifungals, Topical (Blue Class); Antivirals, Influenza (Red Class); Fluoroquinolones, Oral (Blue Class); Hepatitis B Agents (Blue Class); Hepatitis C Agents (Red Class); Optic Antibiotics (Green Class)

Public Comments for Anti-Infective: Antifungals, Oral (Blue Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Antifungals, Oral and Antifungals, Topical. Invasive infection from candida is a major cause of morbidity and mortality in healthcare. Significant infections due to these organisms are generally referred to as invasive candidiasis. They can be associated with candidemia and metastatic organ involvement. Candidemia is one of the most common bloodstream infections in U.S. hospitals, typically ranking as the third or fourth most common cause of healthcare-associated bloodstream infection. Over 90% of invasive disease is caused by the five most common pathogens: *C. albicans*, *C. glabrata*, *C. tropicalis*, *C. parvosa*, and *C. krusei*. Mucosal candida infections (such as oropharynx, esophagus or vaginal) are not considered invasive. Onychomycosis is a fungal infection of the nails that causes thickening, discoloration, and separation from the nail bed. It occurs in 10% of the general population: 20% in persons less than 60 years of age, and 50% in those greater than 70 years of age. It is most often caused by dermatophytes. The recurrence rate of onychomycosis is 10% to 50%.

Guidelines from the Infectious Diseases Society of America, the American Family Physician, and the British Association of Dermatologists were provided, but none have changed since last year.

The new drugs in the class were reviewed. Tolsura is indicated for treatment in immunocompromised and non-immunocompromised patients with pulmonary and extrapulmonary blastomycosis; histoplasmosis, including chronic cavitary pulmonary disease and disseminated and non-meningeal histoplasmosis; or aspergillosis, if the patient is intolerant of, or refractory to, Amphotericin B. Tolsura is not indicated for the treatment of onychomycosis and is not interchangeable or substitutable with other Itraconazole products. There is a boxed warning for congestive heart failure and drug interactions. Dosage recommendations were reviewed. It is available in a capsule.

In February 2019, the FDA expanded the indication for Vfend to include patients as young as 2 years of age. It is indicated for the treatment of the following infections in those 12 years of age and older: invasive aspergillosis; serious infections caused by *Scedosporium apiospermum* and *Fusarium* species including *Fusarium solani*, in patients intolerant of, or refractory to, other therapy; esophageal candidiasis; and candidemia in non-neutropenic patients and disseminated candidiasis in skin, abdomen, kidney, bladder wall, and wounds. Dosage recommendations were reviewed. It is available as tablet and suspension formulations.

The utilization report was reviewed. There were 1,908 prescriptions with 97.6% being for preferred products.

At the last review, a motion for therapeutic alternatives to include at least one Fluconazole tablet, one oral Terbinafine preparation, and one pediatric preparation passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE FLUCONAZOLE TABLET, ONE ORAL TERBINAFINE PREPARATION, AND ONE PEDIATRIC PREPARATION. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Anti-Infective: Antifungals, Topical (Blue Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Antifungals, Topical. Tinea infections are caused by dermatophytes and are classified by the sites involved: tinea pedis, tinea cruris, tinea capitis, tinea versicolor, tinea corporis, and tinea unguium. Dermatophytes are usually limited to involvement of hair, nails and stratum corneum. There are three genera: Trichophyton, Microsporum and Epidermophyton. Prepubertal children most often have tinea corporis or tinea capitis. Adolescents/adults most often have tinea cruris, tinea pedis, or tinea unguium. Tinea is often misdiagnosed based on appearance. Lifetime risk of acquiring tinea infections is 10% to 20%.

Guidelines from the Centers for Disease Control and Prevention, and the American Family Physicians were reviewed.

In August 2018, the safety and efficacy of Kerydin was established in patients 6 years of age and older. It is indicated for topical treatment of onychomycosis of toenails due to Trichophyton rubrum or Trichophyton mentagrophytes. Dosing recommendations were reviewed. It is available as a solution.

Janssen announced the discontinuation of Nizoral 2% shampoo. The last production was in October 2018 with an expiry date of September 2020. Other ketoconazole shampoo products remain on the market.

The utilization report was reviewed. There were 1,588 prescriptions with 96.6% being for preferred products.

At the last review, a motion for therapeutic alternatives to include at least one solution, one shampoo, and one topical cream or ointment passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE SOLUTION, ONE SHAMPOO, AND ONE TOPICAL CREAM OR OINTMENT. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Dr. Narus notes that continued stewardship of our antifungal products is a critical piece in ensuring the appropriate utilization and efficacy of these agents.

Public Comments for Anti-Infective: Antivirals, Influenza (Red Class)

SHIRLEY QUACH, a representative of Genentech, discussed Xofluza. It is indicated for the treatment of acute, uncomplicated influenza in patients 12 years of age and older who have been symptomatic for no more than 48 hours. Based on data from 2010 through 2018, the Centers for Disease Control and Prevention estimates a range of 9.3 to 49 million illnesses, 140,000 to 960,000 hospitalizations, and 12,000 to 79,000 deaths due to influenza annually in the United States. According to the Infectious Disease Society of America guidelines, early treatment of influenza with antivirals may reduce severity and duration of symptoms, hospitalization, complications, the use of out-patient services and antibiotics, expense and quantity of viral shedding, and mortality in certain populations. Xofluza is one of four antivirals the CDC recommends for the treatment of influenza in the 2018/2019 season. Several studies and their outcomes were reviewed. Xofluza represents another treatment option for influenza with a novel mechanism of action and a convenient one-time dose.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Antivirals, Influenza. Influenza is a common illness affecting most people at least once in their lifetime. It is an uncomplicated illness that typically resolves after three to seven days. It is often self-limiting. Persons at higher risk for influenza complications are those less than 2 years of age, those over 65 years of age, immunocompromised patients, pregnant/postpartum patients, those less than 19 years of age with long-term ASA therapy, American Indians or Alaska Natives, extremely obese patients, nursing homes or chronic care facility patients, and patients with specific chronic disease states. Influenza vaccination is the primary method of preventing influenza. For the 2018/2019 season, inactivated influenza vaccines, recombinant influenza vaccines, and live attenuated influenza vaccines are available. Inactivated influenza vaccines are available in quadrivalent and trivalent formulations, while recombinant influenza vaccine and LAIV4 are available in quadrivalent formulations. There is also a high-dose inactivated influenza vaccine and adjuvanted inactivated influenza vaccine available in trivalent formulations. For the 2018/2019 season, the ACIP voted to recommend that providers may administer any licensed, age-appropriate influenza vaccine, including LAIV4 when appropriate. Virus strains included in the 2018/2019 U.S. trivalent vaccines were reviewed.

Guidelines from the Centers for Disease Prevention and the Infectious Diseases Society of America were reviewed.

In October 2018, the FDA approved Xofluza for the treatment of acute, uncomplicated influenza in patients 12 years of age or older who have been symptomatic for less than 48 hours. Warnings and precautions include a risk of serious bacterial infections may coexist with, or occur as, a complication of influenza. Xofluza and Oseltamivir have not been shown to prevent these complications, including bacterial infection. There is no evidence of efficacy of Xofluza, oseltamivir, zanamivir in any illness due to pathogens other than influenza viruses. Co-administration of Xofluza with polyvalent cation-containing laxatives, antacids, or oral supplements (calcium iron, magnesium, selenium, or zinc) should be avoided. Dosing recommendations were reviewed. It is available as a tablet.

The utilization report was reviewed. There were 1,751 prescriptions with 97.7% being for preferred products.

At the last review, a motion for therapeutic alternatives to include Oseltamivir passed unanimously.

In response to Dr. Phillips, Dr. Semling said Rimantadine could be removed from the PDL, but since it had no utilization, it would fall out of category. Tamiflu was included in last year's motion because it had just gone generic and there were no similar medications at the time to treat influenza.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE OSELTAMIVIR. SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Anti-Infective: Fluoroquinolones, Oral (Blue Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Fluoroquinolones, Oral. Oral fluoroquinolones vary in the spectrum of antimicrobial activity. Older fluoroquinolones have a gram-negative spectrum of activity, whereas newer fluoroquinolones have broad spectrums of activity covering both gram-negative and gram-positive bacteria. Fluoroquinolones are indicated for disease states ranging from acute bronchitis to UTIs.

In December 2018, the FDA published a safety alert regarding increased risk of rare but serious aortic ruptures with systemic fluoroquinolone antibiotics in patients with a history of blockage or aneurysm of blood vessels, including the aorta, hypertension, select genetic disorders, and advanced age. Use of fluoroquinolones should be avoided in these patients unless no other treatment options are available. Stop treatment immediately if symptoms of aortic aneurysm or dissection occur. The warning is based on cases reported to the FDA Adverse Event Reporting System and four published observational studies. While the exact cause could not be determined, patients on fluoroquinolones with these risk factors were twice as likely to experience an aortic aneurysm or dissection.

In July 2018, the FDA announced a requirement of strengthening PI warnings for fluoroquinolones as they may cause significant decreases in blood sugar, potentially resulting in serious adverse events (coma or death), and certain mental health side effects. Healthcare practitioners should alert patients to these adverse effects and should use agents in the class only when clinically indicated.

In June 2018, the Centers for Disease Control and Prevention published a Health Update with current recommendations on management and reporting of Shigella infections that have been treated with Ciprofloxacin or Azithromycin and resulted in possible clinical treatment failure. The CDC continues to identify an increasing number of Shigella isolates that harbor resistance mechanisms to Ciprofloxacin and has also identified strains with resistance to Azithromycin. It is unclear if fluoroquinolone treatment of a Shigella infection with Ciprofloxacin is associated with a worse clinical outcome or whether such treatment increases the risk of transmission. The CDC recommends careful monitoring of antibiotic treatment. For patients with Shigella infection and possible fluoroquinolones or Azithromycin failure, consider consulting an infectious disease specialist, collect stool samples for cultures, and report cases to local/state health departments.

The utilization report was reviewed. There were 887 prescriptions with 98.6% being for preferred products.

At the last review, a motion for class effect passed unanimously.

DR. PHILLIPS MOVED A CLASS EFFECT. SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Anti-Infective: Hepatitis B Agents (Blue Class)

COLEEN FONG, a representative of Gilead Sciences, discussed Vemlidy. It has been approved for the use of adult patients with chronic hepatitis B who are compensated. In February 2019, the FDA provided updated labeling regarding the use of Vemlidy, 25 milligrams, in a patient population who is on end-stage renal disease and/or hemodialysis. In the adult population with compensated hepatic disease, you can use Vemlidy without alterations and/or changes in the dose. Several trials and their outcomes were reviewed. We see continued viral suppression as well as improvement over time with improvement in ALT normalization. For the side effect profile, we see comparable adverse events with no resistance to date out to three years. We request Vemlidy be included on the PDL for adult patients who are living with compensated chronic hepatitis B.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Hepatitis B Agents. Chronic hepatitis B virus (HBV) affects an estimated 850,000 to 2.2 million people in the U.S. In 2016, the number of acute HBV cases reported to the CDC was 3,218, although the CDC estimates the actual number of new infections to be approximately 20,900. Some communities report that newly diagnosed HBV infections are most often found in adult immigrants to the U.S. Outside the U.S., many chronic infections result from vertical transmission (mother-to-infant), with a high prevalence of chronic infections in Asia. From 1990 to 2014, the rate of new HBV infections as declined. The greatest decline was been among children born since 1991 due to routine vaccinations. Since 2014, there has been an increase in the rate of new HBV infections, likely due to increased injection drug use. During 2011 to 2012, there were about 847,000 noninstitutionalized people in the U.S. with chronic HBV infection. In 2015, there were about 1,700 deaths related to HBV, which is underestimated. The CDC estimates the annual deaths due to HBV to be about 14,000. Chronic infection develops in about 90% of infants, 25% to 50% of children ages 1-5, and 5% in adults.

In December 2018, the FDA approved an expanded indication for Viread for the use of chronic hepatitis B in pediatric patients 2 years of age and older weighing at least 10 kilograms. Previously, it was only approved only for patients at least 12 years of age for hepatitis B. Warnings and precautions include severe acute exacerbations of hepatitis B virus have been reported in HBV-infected patients who have discontinued therapy. Hepatic function should be monitored closely in HBV-infected patients who discontinue Viread. New onset or worsening renal impairment can include acute renal failure and Fanconi syndrome. Avoid administering Viread with concurrent or recent use of nephrotoxic drugs. Dosage recommendations were reviewed. It is available as a tablet.

The drug utilization report was reviewed. There were 60 prescriptions with 88.3% being for preferred products.

At the last review, a motion for therapeutic alternatives passed unanimously.

DR. RUGGLES MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Anti-Infective: Hepatitis C Agents (Red Class)

MARGARET OLMON, a representative of AbbVie, discussed Mavyret. It is a treatment option for HCV patients without cirrhosis or with compensated cirrhosis. It is the only once-daily pan-genotypic Rivobirin-free regimen FDA-approved to treat patients with chronic hepatitis C virus across all genotypes, 1 through 6. This includes those who do and do not have cirrhosis, have treatment experience, have HIV, or have chronic kidney disease. Mavyret can also be used in patients after a kidney or liver transplant regardless of baseline renal disease. Up to 95% of patients with HCV can be treated with this Mavyret. The vast majority of patients who are awaiting treatment in Alaska are eligible for an eight-week treatment course. Mavyret carries a boxed warning regarding the risk of hepatitis B reactivation in patients co-infected with HCV and HBV, as do all direct acting antivirals. Mavyret has two contraindications, one for patients with severe hepatic impairment and one for patients taking concomitant Atomizvir (ph) or Refampin (ph). The most common adverse reactions were headache and fatigue. Mavyret is well tolerated and requires no liver monitoring or baseline resistance testing. No dosage or duration adjustments are needed for patients with HIV coinfection or for any level of renal impairment, including dialysis. Please refer to the online prescribing information at rxabbvie.com. We request that Mavyret remain available as a preferred medication on the PDL.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Hepatitis C Agents. HCV infection is the most common chronic blood-borne infection in the U.S. In approximately 15% to 25% of patients who become infected, the virus is eliminated during the acute phase of the infection by T cell-mediated antiviral mechanisms; however, in the other 75% to 85% of patients, the virus persists for decades. An estimated 23,000-46,000 children in the U.S. have HCV. Approximately 2.7 million people in the U.S. are chronically infected, although it is estimated that nearly 75% of these people may be unaware. HCV accounts for 40% of chronic liver disease in the U.S. In patients with chronic HCV infection followed for 20 years, disease progression to cirrhosis occurs in about 20% to 25%. Of those who develop cirrhosis, approximately 30% will develop end-stage liver disease over the next 10 years and 1% to 2% per year will develop hepatocellular carcinoma. HCV infection is the most common reason for liver transplantation and results in an estimated 8,000 to 10,000 deaths per year in the U.S. The most important risk for HCV infection is injection drug use, which account for at least 60% of acute HCV infections in the U.S. Other modes of transmission include mother-to-infant, receiving a blood or organ donation prior to 1992, occupational exposures, chronic hemodialysis, and contaminated devices shared for non-injection drug use, such as intranasal illicit drug use. Sexual transmission also occurs but generally seems to be inefficient except among HIV infected men who have unprotected sex with men. Other risk factors include incarceration and receiving a tattoo in an unregulated setting. It is estimated that 29% of incarcerated persons in North America are anti-HCV positive. Hepatitis C viral genotype is an important factor in selecting the optimal treatment planning, dictating drugs selection, dose, and duration of treatment. There are six HCV genotypes and more than 50 subtypes, and the distribution of HCV genotypes varies across the world, which were reviewed.

Guidelines from the American Association for Liver Diseases and the Infectious Disease Society of America were reviewed.

The updates in the class were reviewed. Janssen voluntarily withdrawing the NDA for Olysio effective May 25, 2018, due to significant marketplace changes and availability of effective therapies for HCV infection, resulting in declined use and no longer an unmet need; the decision was not driven by any

safety, efficacy, or quality issues. AbbVie announced the voluntary discontinuation of Viekira XR and Technivie in the U.S. due to changes in HCV treatment practices. Bristol Myer Squibb will stop distribution of remaining strengths of Daklinza tablets effective June 2019. Gilead announced plans to launch authorized generic versions of Epclusa and Harvoni in the U.S. through a newly created subsidiary, Asegua Therapeutics. The authorized generics were available effective January 2019.

The utilization report was reviewed. There were 63 prescriptions with 96.3% being for preferred products.

At the last review, a motion for therapeutic alternatives to ensure all genotypes have coverage passed unanimously.

Dr. Phillips suggested considering not including medications that are going to be discontinued, as well as making sure that there are drugs available that will treat genotypes 1, 2 and 3. The others are rare enough that we could use the medically necessary clause.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Anti-Infective: Otic Antibiotics (Green Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Anti-Infective: Otic Antibiotics. Otitis externa is an acute inflammation of the external auditory canal. It is commonly referred to as “swimmer’s ear” or “tropical ear.” This condition is often precipitated by water exposure to trauma. Common pathogens implicated in otitis externa are pseudomonas aeruginosa and staphylococcus aureus, often occurring as a polymicrobial infection. Patients will typically complain of otalgia and otorrhea, and the ear canal may appear erythematous and swollen. It is imperative that the ear canal be cleared of any discharge or debris that can occlude the canal since the presence of such material can keep the canal moist and interfere with topical treatment. All ages are affected, with a peak incidence in children 7 to 12 years of age. The standard treatment for acute otitis media has been the use of systematic antibiotics, while topical therapy antibiotics is generally used for otitis externa. Topical antibiotics may help to decrease adverse reactions and reduce the potential for antibiotic resistance when used in patients with acute otitis media and with tympanostomy tubes.

Treatment guidelines from the American Academy of Otolaryngology-Head and Neck Surgery Foundation were reviewed.

The utilization report was reviewed. There were 947 prescriptions with 97.4% being for preferred products. There was no previous motion.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

4-C. Genitourinary: Benign Prostatic Hyperplasia (BPH) Agents (Green Class); Bladder Relaxant Preparations (Blue Class); Vaginal Antibiotics (Blue Class)

Public Comments for Genitourinary: Benign Prostatic Hyperplasia (BPH) Agents (Green Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Genitourinary: Benign Prostatic Hyperplasia (BPH) Agents. The utilization report was reviewed. There were 1,612 prescriptions with 96.5% being for preferred products.

At the last review, a motion for therapeutic alternatives to include one alpha blocker and one androgen hormone inhibitor passed unanimously.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE ALPHA BLOCKER AND ONE ANDROGEN HORMONE INHIBITOR. SECONDED BY DR. GREAR. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Genitourinary: Bladder Relaxant Preparations (Blue Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Genitourinary: Bladder Relaxant Preparations. Overactive bladder (OAB) is a chronic and debilitating syndrome that is characterized by urinary urgency with or without urge incontinence, usually in combination with urinary frequency (8 or more voiding episodes per 24 hours) and nocturia (awakening one or more times per night to void). It is prevalent in 16% of men and 17% of women; 20% of those older than 60 years of age. First line therapy is behavioral therapy. Second line therapy is oral antimuscarinics including Darifenacin, Fesoterodine, Oxybutynin, Solifenacin, Tolterodine, or Trospium. Surgery is reserved for patients with severe refractory OAB symptoms or those who are not candidates for oral therapy.

The updated information in the class was reviewed. In May 2018, the FDA approved a new indication for Myrbetriq. It was already indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency. The new indication is for the treatment of overactive bladder with symptoms or urge urinary incontinence, urgency, and urinary frequency in combination with Solifenacin. Dosing recommendations were reviewed. It is available as a tablet.

The utilization report was reviewed. There were 1,064 prescriptions with 81.7% being for preferred products.

At the last review, a motion of therapeutic alternatives passed unanimously.

In response to Dr. Phillips, Dr. Narus discussed the 18% of the prescriptions that were for non-preferred products on the PDL. If this is due to low efficacy as monotherapy or changing utilization trends, we may want to send this down to the DUR Committee for review.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, WITH THE UNDERSTANDING THAT THE DUR COMMITTEE WILL REVIEW THIS CLASS. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Genitourinary: Vaginal Antibiotics (Blue Class)

There were no public testimonies.

Dr. Umang Patel gave the Magellan presentation on Genitourinary: Vaginal Antibiotics. Polymicrobial clinical syndrome resulting from replacement *Lacobucillus* sp. With anaerobic bacteria, *G. vaginalis*, *Ureaplasma*, *Mycoplasma*, and numerous fastidious or uncultivated anaerobes. Symptoms include vaginal discharge, pain, itching, or malodor and can be asymptomatic. It is associated with STDs and female genital tract infections. A diagnosis requires three of four Amsel's criteria: abnormal gray discharge, vaginal pH less than 4.5, a positive amine test, or less than 20% of the epithelial cells being clue cells. A Nugent score is considered the standard for diagnosing bacterial vaginosis. Culture and sensitivity testing of bacteria are not routinely performed. Bacterial vaginosis may recur in up to 30% of women within three months after treatment.

Treatment guidelines from the Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists were reviewed.

Updated information in the class was reviewed. In August 2018, the FDA approved Nuessa for the treatment of bacterial vaginosis in females 12 years of age and older. It had previously only been approved for adults. It is indicated for the treatment of bacterial vaginosis in non-pregnant women 12 years of age and older. Contraindications include a history of hypersensitivity to metronidazole, parabens, other ingredients of the formulation or other nitroimidazole derivatives; concomitant use of disulfiram or within two weeks of disulfiram; and concomitant use of alcohol. Dosage recommendations were reviewed. It is available with a single-dose, prefilled, disposable applicator.

The utilization report was reviewed. There were 358 prescriptions with 72.9% being for preferred products.

At the last review, a motion of class effect passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. GREAR. THE MOTION PASSED UNANIMOUSLY.

The committee moved into a closed session.

5. **Review Minutes from January 2019 Meeting**
6. **Comments from Committee Members or Chair**
7. **Adjourn**

The public portion of the meeting adjourned at 11:13 a.m.