

MAY 23, 2017



PHARMACY AND THERAPEUTICS (P&T) COMMITTEE MEETING

CHAIRLED BY IRA PROTAS, DIRECTOR OF PHARMACY BENEFITS

NORTH CAROLINA STATE HEALTH PLAN

3200 ATLANTIC AVENUE, RALEIGH, NC 27604



## Pharmacy and Therapeutics (P&T) Committee Meeting Tuesday, May 23<sup>rd</sup> 2017, 6:00 p.m. to 8:00 p.m.

### Agenda

<u>Topic:</u>	<u>Presenter:</u>
<b>I. Welcome</b>	Ira Protas, Chair
• Call to Order	
<b>II. Conflict of Interest Statement</b>	Lotta Crabtree, JD
<b>III. Minutes from March, 21<sup>st</sup> 2017 Meeting*</b>	Jamilah Brunson, PharmD
<b>IV. Old Business</b>	Jamilah Brunson, PharmD
• Formulary Development and Management at CVS Caremark®	
<b>V. Light Meal</b>	
<b>VI. 2017 Q3 Formulary Updates*</b>	Jamilah Brunson, PharmD
• Specialty Exclusions	
○ Otrexup Injection	Joseph Shanahan, MD
○ Berinert Injection	John Anderson, MD
• Hyperinflation Exclusions	Carl Antolick III, PharmD
• Tier Changes	Carl Antolick III, PharmD
○ Negative	
○ Positive	
• Formulary Additions	
○ Rytary capsules	David Konanc, MD
○ Ocrevus injection	David Konanc, MD
○ Namzaric capsules	David Konanc, MD
○ Dupixent injection	Matthew Flynn, MD
○ Eucrisa ointment	Matthew Flynn, MD
○ Bavencio injection	Michael Spiritos, MD
○ Zejula capsules	Michael Spiritos, MD
○ Ruconest injection	John Anderson, MD
<b>VII. Utilization Management Policy Review*</b>	Jamilah Brunson, PharmD
• Rasuvo Specialty Guideline	Joseph Shanahan, MD
• Enbrel Specialty Guideline	Joseph Shanahan, MD
• Humira Specialty Guideline	Joseph Shanahan, MD

\*Requires a vote by the P&T Committee

- Cinryze Specialty Guideline
- H.P. Acthar Specialty Guideline
- Topical antifungals Coverage Authorization Criteria
- Noxafil Coverage Authorization Criteria
- Vfend Coverage Authorization Criteria
- Glumetza / Fortamet Coverage Authorization Criteria
- Saxenda Coverage Authorization Criteria
- Contrave Coverage Authorization Criteria
- Belviq Coverage Authorization Criteria
- Short-Acting Anti-Obesity Coverage Authorization Criteria
- Topical Acne Coverage Authorization Criteria
- Differin Coverage Authorization Criteria
- Tazorac Coverage Authorization Criteria
- Tretinoin Coverage Authorization Criteria
- Isotretinoin Coverage Authorization Criteria

John Anderson, MD

John Anderson, MD

John Engemann, MD

John Engemann, MD

John Engemann, MD

Jennifer Burch, PharmD, CDE

Matthew Flynn, MD

Jamilah Brunson, PharmD

**VIII. Other Topics\*****IX. Next Meeting Date**

Ira Protas, Chair

- Tuesday, August 22<sup>nd</sup> 2017
- Directions



## STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

### ETHICS AWARENESS & CONFLICT OF INTEREST REMINDER

*(to be read by the Chair of the P&T Committee or his or her designee at the beginning of each meeting)*

In accordance with the NC State Health Plan for Teachers and State Employees' ethics policy, it is the duty of every member of the Pharmacy and Therapeutics whether serving in a vote casting or advisory capacity, to avoid both conflicts of interest and appearances of conflict.

Does any Committee member have any known conflict of interest or the appearance of any conflict with respect to any manufacturers of any medication to be discussed at today's meeting?

Or, if during the course of the evaluation process if you identify a conflict of interest or the appearance of a conflict.

If so, please identify the conflict or appearance of conflict and refrain from any undue participation<sup>1</sup> in the particular matter involved.

<sup>1</sup> *"A public servant shall take appropriate steps, under the particular circumstances and considering the type of proceeding involved, to remove himself or herself to the extent necessary, to protect the public interest and comply with this Chapter, from any proceeding in which the public servant's impartiality might reasonably be questioned due to the public servant's familial, personal, or financial relationship with a participant in the proceeding." See N.C.G.S. §138A-36 (c). If necessary, the Chairman or individual member involved should consult with his ethics liaison, legal counsel, or the State Ethics Commission to help determine the appropriate response in a given situation. Rev. 1-16-07*



**Pharmacy and Therapeutics (P&T) Committee Meeting**  
**March 21, 2017**  
**6:00 PM – 8:00 PM**  
**MINUTES**

**P&T Committee Members**

*Voting Members:*

Randy Grigg, MD  
 Jennifer Burch, PharmD  
 Paul Cunningham, MD  
 Michael Spiritos, MD  
 John Engemann, MD  
 David Konanc, MD  
 Patti Forest, MD

*Non-Voting Members:*

Lotta Crabtree, JD  
 Ira Protas, RPh (Chair)  
 Jamilah Brunson, PharmD (Secretary)  
 Carl Antolick III, PharmD  
 B. Steven Bentsen, MD (Beacon Health Options)  
 Anuradah Rao-Patel, MD (BCBSNC)  
 Connie Rominger (BCBSNC)  
 Renee Jarnigan, RPh (CVS Caremark)

**State Health Plan (SHP) Staff**

Natasha Davis  
 Neha Zadoo  
 Lucy Barreto  
 Margaret Balogun  
 Robbie Wallace (CVS Health)

**Guests**

Mike Laraway (NovoNordisk)  
 Angela Furniss (NovoNordisk)  
 Kim Turk (GSK)  
 Edward Turner (UCB)

**I. Welcome**

Ira Protas welcomed committee members and guests.

**II. Introductions**

New committee chair Ira Protas, R.Ph. introduced himself as Director of Pharmacy Benefits for the Plan. Ira also introduced new committee member Carl Antolick III, PharmD Clinical Pharmacist for the Plan.

**III. Conflict of Interest**

Lotta Crabtree, JD ensured there were no conflicts of interest for members with any of the items for discussion.

**IV. Minutes from December, 13<sup>th</sup> 2016 Meeting**

The committee members reviewed and approved the December 13, 2016 minutes.

## V. Old Business

Dr. Brunson shared information pertaining to the State Health Plan's **Formulary Customization Decision** relative to the nonformulary status of Farydak, Tasigna, Belsomra and Alecensa. Due to limited utilization, grandfathered status, formulary alternative and clinical rationale for the exclusion it was the recommendation of the Plan's clinical team to maintain the nonformulary of these products. Dr. Konanc questioned the cost of Emflaza's sky-rocketing price even though it's available in Europe at a fraction of the cost. Chair Protas explained that the Plan nor the PBM vendor has much influence in that instance, and that we are required to follow FDA and governmental standards.

Chairman Protas provided updates on the implementation of new PBM vendor CVS Caremark. He noted that the implementation has gone well and issues are readily addressed.

Dr. Brunson reviewed the 2017 formulary management strategy of CVS Caremark. These include the removal of hyperinflation products, embrace of biosimilars & follow-on biologic and indication-based formulary options.

Chair Protas made a motion to move to a **closed** session. The motion was seconded, approved and guests not part of the closed session vacated the conference room.

## VI. 2017 Q2 Formulary Updates

### A. Formulary Removals

Dr. Antolick reviewed shared the 2017 hyperinflation medications slated for removal. All the products are brand name medications with bioequivalent generics or low-cost generic formulary alternatives. Dr. Antolick shared the Plan's cost inflation data for each product from 2014 to present.

Chair Protas requested a motion to approve the formulary removal of the hyperinflation products: E.E.S.® suspension, ERYPED® suspension, MACRODANTIN® capsules, BETAPACE® and BETAPACE AF® tablets, LANOXIN® tablets, DYRENIUM® capsules, ZONEGRAN® capsules, CAFERGOT® tablets, MIACALCIN® injection and spray, UROXATRAL® 10 mg tablets and VANOXIDE-HC® lotion.

Dr. Engemann made a motion to approve and it was seconded by Dr. Burch. The motion was unanimously approved by committee members.

### B. Formulary Additions

Dr. Brunson reviewed oncology products:

Cabometyx™ (cabozantinib) is an oral kinase inhibitor that provided an additional subsequent treatment option to advanced renal cell carcinoma patients that have progressed on prior antiangiogenic therapy. The medication is proposed as an addition at a Tier 6 with specialty guideline management. The *Cabometyx™ (cabozantinib) Specialty Guideline Management Criteria* content was also reviewed.

Cotellic® (cobimetinib) is a mitogen-activated extracellular signal-regulated kinase inhibitor that, when used in combination with vemurafenib, offers an additional treatment option to patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. The medication is proposed as an addition at a Tier 6 with specialty guideline management. The *Cotellic® (cobimetinib) Specialty Guideline Management Criteria* content was also reviewed.

Emend® (apripitant) suspension is a substance P/neurokinin 1 receptor antagonist used in combination therapy to treat chemotherapy induced nausea and vomiting in patient greater than or equal to 6 months old. The medication is proposed as an addition at a Tier 3 with quantity limits and prior authorization. The *Emend® - Varubi® Quantity Limit Criteria* and *Emend® - Varubi® Prior Authorization*

*Criteria* were also reviewed, and Dr. Spiritos agreed that the quantity limits were within normal dosing guidelines.

Lartruvo™ (olaratumab) is a platelet-derived growth factor receptor alpha blocking antibody used in combination with doxorubicin to treat soft tissue carcinoma in patients with a subtype which is not amenable to curative surgery or radiotherapy treatment. The medication is proposed as an addition at a Tier 6 with specialty guideline management. The *Lartruvo™ (olaratumab) Specialty Guideline Management Criteria* content was also reviewed.

Kyprolis® (carfilzomib) is a proteasome inhibitor used in combination therapy to treat relapsed or refractory multiple myeloma in patients who have received one to three lines of therapy. The medication is proposed as an addition at a Tier 6 with specialty guideline management. The *Kyprolis® (carfilzomib) Specialty Guideline Management Criteria* content was also reviewed.

Dr. Brunson asked for any questions or concerns regarding presented oncology medications and criteria specifically soliciting Dr. Spiritos (Oncology). There were no clinical concerns expressed.

Dr. Brunson reviewed infectious disease products:

Impavido® (miltefosine) is an oral alkylphosphocholine agent used to treat leishmaniasis in adults and adolescent patients greater than or equal to twelve years old. The medication is proposed as an addition at a Tier 3 with no utilization management program.

Vemlidy® (tenofovir alafenamide) is a prodrug of tenofovir used to treat chronic hepatitis B virus infection in adult patient with compensated liver disease. The medication is proposed as an addition at a Tier 3 with no utilization management program.

Dr. Brunson asked for any questions or concerns regarding presented oncology medications and criteria specifically soliciting Dr. Engemann (Infectious Disease). There were no clinical concerns expressed.

Dr. Brunson reviewed neurology products:

Adzenys XR- ODT® (amphetamine ext rel) and QuilliChew ER® (methylphenidate ext rel) were presented as additional formulations of stimulant chemical entities already on the formulary. For Attention Deficit Hyperactivity Disorder patients Adzenys XR provides an orally disintegrating tablet option and Quillichew ER provides a chewable tablet option. Both medications are proposed as additions at Tier 3 with quantity limits and prior authorization.

The *Attention Deficit Hyperactivity Disorder Coverage Authorization Criteria* was also reviewed. Dr. Grigg noted outdated diagnosis and symptom presentation language from DSM-IV. Criteria needs updates from DSM-V specifically regarding the presence of symptoms before age 12. Dr. Grigg and Dr. Konanc expressed concern regarding requiring prior authorization on patients greater than 19 years old. Recommendations were made to change the criteria to apply after age 26. Dr. Konanc expressed clinical concern regarding removal of multiple sclerosis related fatigue as a compendia supported used for this class. Dr. Brunson agreed to take concerns back to clinical team for analysis.

Onzentra Xsail® (sumatriptan nas pow) and Zembrace® SymTouch (sumatriptan injector) were presented as additional formulations of sumatriptan already on the formulary. Both medications are proposed as additions at Tier 3 with generic step therapy, quantity limit and prior authorization programs.

The *Anti-migraine 5-HT<sub>1</sub> Agonists Coverage Authorization Criteria* was also reviewed.

Keveyis® (dichlorphenamide) is an oral carbonic anhydrase inhibitor used to treat primary hyperkalemic or hypokalemic periodic paralysis. The medication is proposed as an addition at a Tier 3 with no utilization management program.

Exondys 51™ (eteplirsen) is a new molecular entity FDA approved with accelerated orphan drug designation for Duchenne muscular dystrophy. The medication is proposed as an addition at a Tier 6 with specialty guideline management. The *Exondys 51™ (eteplirsen) Specialty Guideline Management Criteria* content was also reviewed.

Belsomra® (suvorexant) is an orexin B receptor antagonist used to treat insomnia. The medication is proposed as an addition at a Tier 3 with prior authorization and step therapy programs. The *Belsomra® (suvorexant) Coverage Authorization Criteria* content was also reviewed.

Dr. Brunson asked for any questions or concerns regarding presented neurology medications and criteria specifically soliciting Dr. Grigg (Psychiatry) and Dr. Konanc (Neurology). There were further no clinical concerns expressed.

Dr. Brunson also reviewed these additional proposed formulary additions:

Royaldee® (calcifediol ext rel) was presented as an additional formulation of vitamin D<sub>3</sub> analogs. This product provides an extended release option and is proposed for addition at Tier 3 with no utilization management.

Veltassa® (patiomer) is a non-absorbed cation polymer used as adjunctive therapy in treatment of chronic unstable hyperkalemia refractory to other treatment options. This product is proposed for addition at Tier 2 with no utilization management.

Corlanor® (ivabradine) is a selective hyperpolarization-activated cyclic nucleotide-gated channel inhibitor agent. It is used to reduce the risk of hospitalization for worsening heart failure in patients on maximum tolerate doses or a contraindication to beta blockers. The medication is proposed as an addition at a Tier 2 with prior authorization criteria. The *Corlanor Coverage Authorization Criteria* content was also reviewed.

Linzess® (linaclotide) 72mcg capsule was presented as an additional strength of the Linzess capsules already on formulary. This product is proposed for addition at Tier 3 with no utilization management.

Obredon® (hydrocodone/ guaifenesin) was presented as an additional formulation of opioid antitussive combinations already on formulary. This product is proposed for addition at Tier 3 with no utilization management.

Dr. Brunson asked for any questions or concerns and no further clinical concerns were expressed.

### **C. Formulary Omissions**

Chairman Protas reviewed medications that were previously omitted from the formulary secondary to coding issues during the PBM vendor transition. Corrections were made and applied to more than 1,500 products and all products with applicable tiering were reviewed with the committee.

Chairman Protas asked for a motion to approve the formulary additions as presented with exception of clinical concerns expressed regarding the *Attention Deficit Hyperactivity Disorder Coverage Authorization Criteria*. Dr. Engemann made a motion to approve and it was seconded by Dr. Burch. The motion was unanimously approved by committee members.

**D. Tier Changes**

Dr. Antolick reviewed medications proposed to change tier placement. For the products moving to a non-preferred tier all have a bioequivalent generic or low-cost formulary options. Six medications are proposed to move to preferred tiers to provide additional options on the formulary. Dr. Burch made a motion to approve and it was seconded by Dr. Engemann. The motion was unanimously approved by committee members.

**VII. Utilization Management Criteria**

Dr. Brunson reviewed the content of the *Narcolepsy Agent Coverage Authorization Criteria*. Dr. Konanc expressed clinical concern regarding removal of multiple sclerosis related fatigue and idiopathic hyper somnolence as a compendia supported uses for this class. Dr. Brunson agreed to take concerns back to clinical team for analysis.

Dr. Forest reviewed the content of the *Short Acting Beta<sub>2</sub>-Adrenergic Agonist Coverage Authorization Criteria* and *Long-Acting Beta<sub>2</sub>-Adrenergic Agonist Coverage Authorization Criteria*. The programs include only quantity limits. There were no clinical concerns expressed.

Chairman Protas asked for a motion to approve the formulary tier changes and utilization programs as presented with exception of clinical concerns expressed regarding the *Narcolepsy Agent Coverage Authorization Criteria*. Dr. Engemann made a motion to approve and it was seconded by Dr. Burch. The motion was unanimously approved by committee members.

**IX. Next Meeting Date**

Chairman Protas announced that the next P&T committee meeting will be held on Tuesday May 23<sup>rd</sup> 2017 and that a new charter for the P&T Committee will be presented for vote.



## **Formulary Development and Management at CVS Caremark®**

Development and management of drug formularies are integral components in the pharmacy benefit management (PBM) services CVS Caremark provides to health plans and plan sponsors. Formularies have two primary functions: 1) to help the PBM provide pharmacy care that is clinically sound and affordable for plans and their plan members; and 2) to help manage drug spend through the appropriate selection and use of drug therapy.

Underlying principles of the CVS Caremark Formulary Development and Management Process include the following:

- CVS Caremark is committed to providing a clinically appropriate formulary.
- Decisions on formulary are made by a committee of independent, unaffiliated clinical pharmacists and physicians.
- The physician always makes the ultimate prescribing determination as to the most appropriate course of therapy.

The CVS Caremark formulary development process is based on nearly two decades of experience as well as extensive clinical pharmaceutical management resources. The formulary is developed and managed through the activities of the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee and Formulary Review Committee.

### **CVS Caremark National Pharmacy and Therapeutics Committee**

The CVS Caremark National P&T Committee is foundational in the process. The P&T Committee is an external advisory body of experts from across the United States, composed of 22 independent health care professionals including 18 physicians and four pharmacists, all of whom have broad clinical backgrounds and/or academic expertise regarding prescription drugs. A majority of the CVS Caremark National P&T Committee members are actively practicing pharmacists and physicians. Two physicians and two pharmacists are experts in the care of the elderly or disabled. One of the physicians is a medical ethicist. The role of the medical ethicist is to assist in the decision-making process by facilitating the discussion, as needed, and to provide unbiased feedback with respect to the logic and appropriateness of the conclusions drawn and the decisions reached. The composition of the CVS Caremark National P&T Committee exceeds the Centers for Medicare and Medicaid Services (CMS) P&T committee requirements for Medicare Part D sponsors and also exceeds URAC standards.

<b>CVS Caremark National Pharmacy and Therapeutics Committee Membership</b>		
4 pharmacists, including	18 physicians, representing	
1 academic pharmacist	Allergy	Internal medicine
1 hospital pharmacist	Cardiology	Infectious disease
2 geriatric pharmacists	Clinical pharmacology	Pediatrics
	Endocrinology	Neurology
	Family practice	Medical ethics
	Gastroenterology	Pharmacoeconomics
	Gerontology	Pharmacology
	Hematology/oncology	Psychiatry-adult/ pediatric/adolescent
		Rheumatology

The regular voting members on the CVS Caremark National P&T Committee are not employees of CVS Caremark. The CVS Caremark National P&T Committee is charged with reviewing all drugs, including generics that are represented on the CVS Caremark approved drug lists. The approvals made are non-biased, quality driven and evidence based. The clinical merit of the drug, not the cost, is the primary consideration of the CVS Caremark National P&T Committee.

New members are included on the current CVS Caremark National P&T Committee on the basis of: active involvement in clinical practice (patient care), whether in the academic, hospital, or community setting; national recognition in their specialty; contributions to medical and/or pharmacy literature; and previous experience with pharmacy and therapeutics committees. The CVS Caremark National P&T Committee members are compensated for their participation with an appropriate honorarium and any travel/hotel expenses incurred in the process of serving on the P&T Committee.

The CVS Caremark National P&T Committee meets face-to-face on a quarterly basis and, as needed, on an ad hoc basis. CVS Caremark has a stringent conflict of interest policy for CVS Caremark P&T Committee members. CVS Caremark requires each P&T Committee member to complete a Conflict of Interest Disclosure Statement annually. Completed Conflict of Interest Statements are carefully scrutinized by the CVS Caremark Chief Health Officer and Vice President of Clinical Affairs responsible for formulary development and maintenance. An objective party in the CVS Caremark Compliance Department verifies that conflict of interest requirements have been met. Through this careful review, CVS Caremark helps ensure that the P&T Committee meets or exceeds all federal and state regulatory requirements for conflict of interest, including CMS, and all industry accreditation standards, including URAC and the National Committee for Quality Assurance (NCQA).

#### **Clinical Formulary Department**

The CVS Caremark National P&T Committee functions are supported by the CVS Caremark Clinical Formulary Department. Clinical pharmacists in the Formulary Department prepare individual Drug Monographs and Therapeutic Class Reviews following a comprehensive review of available clinical literature. Numerous references and information resources are used to assist in the evaluation and review of the medications under consideration for formulary addition. These peer-reviewed resources are selected based on being accurate, reliable, current, comprehensive and well respected.

#### **Formulary Development and Maintenance Process**

The CVS Caremark National P&T Committee bases decisions on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information. The CVS Caremark P&T Committee reviews medications from a purely clinical perspective; it does not have access to nor does it consider any information on rebates, negotiated discounts or net costs. In alignment with this clinical perspective, the CVS Caremark National P&T Committee also reviews new drug evaluations, new FDA-approved indications, new clinical line extensions and publications on new clinical practice trends.

In evaluating new drugs for formulary inclusion, the CVS Caremark P&T Committee reviews the individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews prepared by the Clinical Formulary Department. CVS Caremark National P&T Committee members share insights based on their clinical practice and the quality of published literature. FDA-approved drugs products<sup>1</sup> are reviewed and considered for inclusion on the CVS Caremark National Formulary and standard formularies/drug lists by the CVS Caremark National P&T Committee. The CVS Caremark National P&T Committee also reviews and approves all utilization management (UM) criteria (i.e., prior authorization, step therapy and quantity limits outside of FDA-approved labeling).

The CVS Caremark National P&T Committee reviews all standard formularies annually. The review is conducted by drug class to assure that the formulary recommendations previously established are maintained and to recommend additional changes for clinical appropriateness if advisable based on newly available pharmaceutical information. In addition, the CVS Caremark National P&T Committee reviews all UM criteria annually.

Review of new drugs or new indications for drugs in six classes is expedited. These classes include the immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals and antineoplastics. For drugs in these classes, the CVS Caremark National P&T Committee makes a National Formulary and Medicare Part D Drug List status decision within 90 days of launch/ market availability. For drugs outside of these classes, the CVS Caremark National P&T Committee makes a National Formulary decision within 90 days of launch/market availability and a Medicare Part D Drug List status decision within 180 days of launch/market availability. In addition, the CVS Caremark National P&T Committee will make a formulary status decision for the Managed Medicaid Drug List within 90 days of launch/market availability of newly FDA-approved drugs, or will provide a clinical justification if this timeframe is not met.

### **Formulary Review Committee**

The Formulary Review Committee (FRC) is an internal CVS Caremark committee that evaluates additional factors that may affect the formulary. For example, when two or more drugs produce similar clinical results, the FRC may evaluate factors such as:

- Utilization trends
- Impact of generic drugs or drugs designated to become available over-the-counter
- Brand and generic pipeline
- Line of business
- Plan sponsor cost
- Applicable manufacturer agreement
- Potential impact on members

The FRC makes business recommendations based on such factors to the CVS Caremark P&T Committee. It is important to note that any drug product must first be deemed safe and effective by the P&T Committee before it is considered eligible for inclusion on a CVS Caremark Formulary or Drug List, and that any recommendations made by the FRC must be approved by the CVS Caremark National P&T Committee before implementation.

### **Formulary Management**

The formulary is a dynamic tool that may be responsive to changes in the marketplace. It is intended to offer savings to clients while ensuring clinically appropriate products are available for members to use. Clients may choose to utilize CVS Caremark formularies for their plans or use them as the foundation for custom formularies.

Most drug classes have multiple generic and low-cost brand-name options that cover the same indications as more costly brand-name options in the same class. The generic and low-cost brand-name options offer similar efficacy and safety. Since many brand-name drugs do not provide clear clinical and/or financial advantages when compared to available drug options within the therapeutic class, several strategies are available to promote cost-effective use of medications ranging from tiered copayments, excluding products from coverage or having a closed plan design.

- Tiered copayments encourage members to use preferred formulary drugs. A three-tier formulary—typically with generics in the first, lowest cost tier; preferred brand-name drugs at second tier; and non-preferred brand-name drugs at the highest-cost third tier—is the option chosen by the vast majority of plan sponsors working with CVS Caremark.
- Many of our standard formularies also exclude certain products from coverage. The excluded products have alternatives available that will deliver cost savings to plan sponsors.
- Closed formularies will cover a set number of products and the others are not covered unless the claim goes through an override process.

Within these plan designs, clients may opt to implement a formulary exception process where members, after meeting certain criteria, could have an excluded product covered, or could receive a third-tier product at a second-tier copay.

All formularies include generic drugs, and generics are typically in the lowest tier of pricing for members. Brand-name products may be considered preferred or non-preferred in the common three-tier plan design. Preferred brand-name drugs are encouraged with a lower copay than non-preferred brand-name products.

### **Formulary Compliance**

Plan design, as noted above, is primary in achieving formulary compliance. CVS Caremark also provides plan sponsors with a range of solutions that encourage the use of generics and preferred brand-name drugs. Many CVS Caremark clients choose a plan that requires that a cost-effective generic be used before a single-source brand in the same therapeutic class.

**Promotion of generics.** When an A-rated generic becomes available, it is considered preferred and proactively encouraged. At that point, significant efforts are made to transition utilization to the lower-cost generic product. Client plan design will direct the effort and can be very aggressive and only cover the generic, or be more moderate and require the member to pay the difference between the brand-name drug and the generic if the brand-name product is chosen. Some clients may no longer cover the brand-name drug if a generic is available.

**Member-directed formulary education.** Members are notified when a new brand-name or generic product replaces a product they are using on the formulary. They are also notified if a product they are using is removed from the drug list, which could occur due to withdrawal from the market for safety reasons. If a non-preferred product has been dispensed at a retail pharmacy due to a prescription marked "Dispense As Written," the member may also be alerted via mail about alternative formulary product(s) that could be available at a lower copayment.

Members can also learn about the formulary through mailings such as the Prescriptions Savings Guide® report, which provides a personalized analysis of their prescription utilization and any opportunity they may have to save money. Such opportunities could include the use of a generic or preferred brand-name product in place of a non-preferred product, or accessing prescriptions through the CVS Caremark Mail Service Pharmacy. The website Caremark.com, in addition to providing a simple way to order prescription refills, allows the member to access information about their specific drug list, pricing information and generic availability, as well as general drug and health information.

### **Improving Member Experience and Outcomes**

CVS Caremark is focused on helping members achieve their health and wellness goals through proper understanding and utilization of their medications. There are a number of strategies used to support members in their desire for positive outcomes including:

- Helping them become knowledgeable about their plan, benefit structure and drug therapy management options
- Helping them understand and comply with their prescribed therapies by providing:
  - Adherence counseling with all new prescriptions (face-to-face at CVS Pharmacy® locations, by letter through mail service and retail network)
  - Refill reminders (letters, Interactive Voice Response (IVR), Internet) and non-adherent prompts (letters and phone calls)
  - Availability of automatic prescription renewals and refills
  - Information about ways to save on prescriptions by using lower-cost alternatives or lower-cost channels
- Coordinating with plan sponsors to promote enrollment in wellness and health management programs and offering appropriate and timely immunizations
- Making formularies readily available on Caremark.com.

1. All drugs that are legally marketed under the Federal Food Drug and Cosmetic Act (e.g., "grandfathered" drugs).



## 1. EXCLUSIONS:

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Hematologic/Hereditary/Angioedema	BERINERT® (C1 inhibitor [human]) INJ 500 UNIT	Tier 3--> Not Covered/ ACSF	Availability of another option for the treatment hereditary angioedema attacks.	RUCONEST® (C1 inhibitor [recombinant]) INJ 2100UNIT	Exclusion - ACSF	Y	Tier 6-->NC
Immunologic Agents/Disease-Modifying Anti-rheumatic Drugs (DMARDs)	OTREXUP® (methotrexate) INJ	Tier 3--> Not Covered/ ACSF	Availability of another methotrexate auto-injector.	RASUVO® (methotrexate) INJ	Exclusion - ACSF	Y	Tier 6-->NC
Endocrine & Metabolic/Androgens	testosterone gel 1%(50MG)	1--> Not covered	Additional NDC as part of existing formulary exclusion	testosterone 2 % gel or ANDRODERM®, AXIRON®	Exclusion - NDC Update to Existing Formulary Exclusion	N	NC

# OTREXUP<sup>®</sup>

(methotrexate) [solution auto-injector]

<b>P&amp;T Consideration</b>	Drug is being removed from formulary; coverage would require an approved formulary exception
<b>Proposed Tier Placement</b>	NC-Non Formulary
<b>Formulary Alternatives</b>	Rasuvo <sup>®</sup> (methotrexate) [solution auto-injector]
<b>FDA Approval</b>	October 11, 2013 (drug entity: 1953)
<b>Therapeutic Class</b>	Disease-Modifying Antirheumatic Drug (DMARD)
<b>Indications and Usage</b>	For patients with severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) who are intolerant of or had an inadequate response to first-line therapy; For symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not responsive to other forms of therapy  Otrexup <sup>®</sup> is not indicated for neoplastic diseases
<b>Dosing</b>	<b><u>Forms &amp; Strengths:</u></b> Solution auto-injector: methotrexate 10mg/0.4mL, 12.5mg/0.4mL, 15mg/0.4mL, 17.5mg/0.4mL, 20mg/0.4mL, 22.5mg/0.4mL & 25mg/0.4mL  <b><u>Administration:</u></b> Administer once weekly subcutaneously in abdomen or thigh; RA: 7.5 mg once weekly; pJIA: 10mg/m <sup>2</sup> once weekly; Psoriasis: 10 to 25 mg once weekly  <b><u>Adjustments:</u></b> Use of another formulation of methotrexate in patients requiring doses less than 10mg or doses above 25 mg per week, dose adjustment of < 5mg increments, high-dose regimens or oral, intramuscular, intravenous, intra-arterial or intrathecal dosing
<b>Safety</b>	<b><u>Contraindications:</u></b> Pregnancy, nursing mothers, hepatic disease, immunodeficiency syndromes, preexisting blood dyscrasias, hypersensitivity  <b><u>Warnings:</u></b> Organ system toxicity, embryo-fetal Toxicity, effects on reproduction, risk of improper dosing, impaired renal function, dizziness & fatigue, malignant lymphomas, tumor lysis syndrome and concomitant radiation treatment
<b>Key Points</b>	Novel auto-injection mechanism in device
<b>Treatment Guidelines</b>	Rheumatoid arthritis: Treatment initiation with a disease-modifying antirheumatic drug (DMARD) is recommended in DMARD-naïve patients with either early rheumatoid arthritis (RA) (disease duration <6 months) or established RA (disease duration ≥6 months). Methotrexate is the preferred initial DMARD for most early or established RA patients (ACR 2016).
<b>Place in Therapy</b>	Alternative treatment option for patients unable to use manual injection device

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use OTREXUP™ safely and effectively. See full prescribing information for OTREXUP.

OTREXUP (methotrexate) injection, for subcutaneous use

Initial U.S. Approval: 1953

**WARNING: SEVERE TOXIC REACTIONS, INCLUDING EMBRYO-FETAL TOXICITY AND DEATH**

See full prescribing information for complete boxed warning.

- Serious toxic reactions and death have been reported with the use of methotrexate. Patients should be closely monitored for bone marrow, liver, lung, skin, and kidney toxicities (5.1).
- Methotrexate has been reported to cause fetal death and/or congenital anomalies and is contraindicated in pregnancy (4, 5.2).
- Unexpectedly severe (sometimes fatal) bone marrow suppression, aplastic anemia, and gastrointestinal toxicity have been reported with concomitant administration of methotrexate (usually in high dosage) along with some nonsteroidal anti-inflammatory drugs (NSAIDs) (5.1).
- Hepatotoxicity, fibrosis, and cirrhosis may occur after prolonged use (5.1).
- Methotrexate may cause interstitial pneumonitis at any time during therapy and has been reported at low doses. Pulmonary symptoms (especially a dry, nonproductive cough) may require interruption of treatment and careful investigation (5.1).
- Diarrhea, ulcerative stomatitis, hemorrhagic enteritis, and death from intestinal perforation may occur (5.1).
- Severe, occasionally fatal, skin reactions have been reported (5.1).
- Potentially fatal opportunistic infections may occur (5.1).

-----**RECENT MAJOR CHANGES**-----

Dosage and Administration (2)

12/2016

-----**INDICATIONS AND USAGE**-----

Otrexup is a folate analog metabolic inhibitor indicated for the:

- Management of patients with severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA), who are intolerant of or had an inadequate response to first-line therapy (1.1)
- Symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy (1.2)

Limitation of Use

Otrexup is not indicated for the treatment of neoplastic diseases (1.3).

-----**DOSAGE AND ADMINISTRATION**-----

- Otrexup is for once weekly subcutaneous use only. Administer Otrexup in the abdomen or thigh. (2.1)
- Use another formulation of methotrexate for patients requiring oral, intramuscular, intravenous, intra-arterial, or intrathecal dosing, doses less than 10 mg per week, doses above 25 mg per week, high-dose regimens, or dose adjustments of less than 5 mg increments (2.1)
- Starting doses of methotrexate:
  - RA: 7.5 mg once weekly (2.2)
  - pJIA: 10 mg/m<sup>2</sup> once weekly (2.2)
  - Psoriasis: 10 to 25 mg once weekly of an oral, intramuscular, subcutaneous, or intravenous formulation (2.3)
- Adjust dose gradually to achieve an optimal response (2.2, 2.3)

**FULL PRESCRIBING INFORMATION: CONTENTS\***

**WARNING: SEVERE TOXIC REACTIONS, INCLUDING EMBRYO-FETAL TOXICITY AND DEATH**

**1 INDICATIONS AND USAGE**

- 1.1 Rheumatoid Arthritis including Polyarticular Juvenile Idiopathic Arthritis
- 1.2 Psoriasis
- 1.3 Limitation of Use

**2 DOSAGE AND ADMINISTRATION**

- 2.1 Important Dosing Information
- 2.2 Rheumatoid Arthritis including Polyarticular Juvenile Idiopathic Arthritis
- 2.3 Psoriasis
- 2.4 Administration and Handling

**3 DOSAGE FORMS AND STRENGTHS**

**4 CONTRAINDICATIONS**

-----**DOSAGE FORMS AND STRENGTHS**-----

Injection: Single-dose auto-injector delivering 0.4 mL of methotrexate in the following dosage strengths: 10 mg, 12.5 mg, 15 mg, 17.5 mg, 20mg, 22.5 mg and 25 mg (3).

-----**CONTRAINDICATIONS**-----

- Pregnancy (4)
- Nursing mothers (4)
- Alcoholism or liver disease (4)
- Immunodeficiency syndromes (4)
- Preexisting blood dyscrasias (4)
- Hypersensitivity to methotrexate (4)

-----**WARNINGS AND PRECAUTIONS**-----

- Organ system toxicity: Potential for serious toxicity. Only for use by physicians experienced in antimetabolite therapy (5.1).
- Embryo-fetal toxicity: Exclude pregnancy before treatment. Avoid pregnancy if either partner is receiving Otrexup. Advise males to avoid pregnancy for a minimum of three months after therapy and females to avoid pregnancy for at least one ovulatory cycle after therapy (5.2).
- Effects on reproduction: May cause impairment of fertility, oligospermia and menstrual dysfunction (5.3)
- Laboratory tests: Monitor complete blood counts, renal function and liver function tests (5.4).
- Risks from improper dosing: Mistaken daily use has led to fatal toxicity (5.5)
- Patients with impaired renal function, ascites, or pleural effusions: Elimination is reduced (5.6).
- Dizziness and fatigue: May impair ability to drive or operate machinery (5.7)

-----**ADVERSE REACTIONS**-----

Common adverse reactions are: nausea, abdominal pain, dyspepsia, stomatitis/mouth sores, rash, nasopharyngitis, diarrhea, liver function test abnormalities, vomiting, headache, bronchitis, thrombocytopenia, alopecia, leucopenia, pancytopenia, dizziness, photosensitivity, and "burning of skin lesions" (6).

**To report SUSPECTED ADVERSE REACTIONS, contact Antares at 1-855-Otrexup (1-855-687-3987) or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

-----**DRUG INTERACTIONS**-----

- Aspirin, NSAIDs, and steroids: concomitant use may elevate and prolong serum methotrexate levels and cause increased toxicity (7.1)
- Proton pump inhibitors: concomitant use may elevate and prolong serum methotrexate levels and cause increased toxicity (7.2)

-----**USE IN SPECIFIC POPULATIONS**-----

- Pediatric use: Safety and efficacy of methotrexate, including Otrexup, have not been established in pediatric patients with psoriasis. Safety and efficacy of Otrexup have not been established in pediatric patients with malignancy (8.4)
- Geriatric use: Use caution in dose selection (8.5)

**See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.**

**Revised: 12/2016**

**5 WARNINGS AND PRECAUTIONS**

- 5.1 Organ System Toxicity
- 5.2 Embryo-Fetal Toxicity
- 5.3 Effects on Reproduction
- 5.4 Laboratory Tests
- 5.5 Risks from Improper Dosing
- 5.6 Patients with Impaired Renal Function, Ascites, or Pleural Effusions
- 5.7 Dizziness and Fatigue
- 5.8 Malignant Lymphomas
- 5.9 Tumor Lysis Syndrome
- 5.10 Concomitant Radiation Therapy

**6 ADVERSE REACTIONS**

- 6.1 Clinical Trials Experience
- 6.2 Other Adverse Reactions

**7 DRUG INTERACTIONS**

- 7.1 Aspirin, Nonsteroidal Anti-Inflammatory Drugs, and Steroids

# BERINERT®

(C1 inhibitor, human) [Intravenous kit]

<b>P&amp;T Consideration</b>	Drug is being removed from formulary; coverage would require an approved formulary exception
<b>Proposed Tier Placement</b>	NC-Non Formulary
<b>Formulary Alternatives</b>	Ruconest®(C1 inhibitor, recombinant)
<b>FDA Approval</b>	July 2016 (drug entity: 2009)
<b>Therapeutic Class</b>	C1 esterase inhibitor (Human); blood derived product
<b>Indications and Usage</b>	For treatment of acute abdominal, facial or laryngeal attacks of hereditary angioedema (HAE) in adult and pediatric patients
<b>Dosing</b>	<p><b>Forms &amp; Strengths:</b> Dosage kit: single-use 500 IU lyophilized concentrate for reconstitution vial, 10 mL sterile water for injection vial, Mix2Vial filter transfer set, alcohol swab</p> <p><b>Administration:</b> Administer 20IU per kg by intravenous injection. Patients may self-administer only after training &amp; instruction from healthcare provider.</p> <p><b>Adjustments:</b> Compared to adults, when adjusted for baseline, the half-life of Berinert was shorter and clearance (on per kg basis) was faster in children. The clinical implication of this difference is not known.</p>
<b>Safety</b>	<p><b>Contraindications:</b> known hypersensitivity to C1 esterase inhibitor</p> <p><b>Warnings:</b> hypersensitivity reaction, arterial &amp; venous thromboembolic events, exposure to human-derived infectious agents</p>
<b>Key Points</b>	Human plasma-derived option for acute HAE attack
<b>Treatment Guidelines</b>	C1INH acts at several points in the pathways important in the generation of angioedema. Plasma-derived C1INH is the best studied first-line therapy for acute episodes of angioedema in patients with HAE.
<b>Place in Therapy</b>	Human derived treatment option for HAE acute attack

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use Berinert safely and effectively. See full prescribing information for Berinert.

**Berinert® [C1 Esterase Inhibitor (Human)]**

**For intravenous use. Freeze-Dried Powder for Reconstitution.**

**Initial U.S. Approval: 2009**

**RECENT MAJOR CHANGES**

Indications and Usage (1) 07/2016  
Warnings and Precautions (5.3) 09/2016

**INDICATIONS AND USAGE**

Berinert is a plasma-derived C1 Esterase Inhibitor (Human) indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients (1).

The safety and efficacy of Berinert for prophylactic therapy have not been established (1).

**DOSAGE AND ADMINISTRATION****For intravenous use only.**

- Store the vial in the original carton in order to protect from light. Store at 2-25°C (36-77°F). Do not freeze.(2)
- Administer 20 International Units per kg body weight.(2)
- Reconstitute Berinert prior to use using the Sterile Water for Injection, USP provided.(2.1)
- Use a silicone-free syringe for reconstitution and administration.(2.1)
- Administer at room temperature within 8 hours of reconstitution.(2.1)
- Inject at a rate of approximately 4 mL per minute.(2.2)
- Do not mix Berinert with other medicinal products or solutions.(2.2)
- Appropriately trained patients may self-administer upon recognition of an HAE attack.(2.2)

**DOSAGE FORMS AND STRENGTHS**

- 500 International Units lyophilized concentrate in a single-use vial for reconstitution with 10 mL of Sterile Water for Injection, USP (3).

**CONTRAINDICATIONS**

- Do not use in patients with a history of life-threatening immediate hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor preparations (4).

**WARNINGS AND PRECAUTIONS**

- Hypersensitivity reactions may occur. Epinephrine should be immediately available to treat any acute severe hypersensitivity reactions following discontinuation of administration.(5.1)
- Serious arterial and venous thromboembolic (TE) events have been reported at the recommended dose of C1 Esterase Inhibitor (Human) products, including Berinert, following administration in patients with HAE. Risk factors may include the presence of an indwelling venous catheter/access device, prior history of thrombosis, underlying atherosclerosis, use of oral contraceptives or certain androgens, morbid obesity, and immobility. Benefits of treatment of HAE attacks should be weighed against the risks of TE events in patients with underlying risk factors. Monitor patients with known risk factors for TE events during and after Berinert administration. TE events have also been reported following administration of a C1 Esterase Inhibitor (Human) product when used for unapproved indications at higher than recommended doses.<sup>1</sup>(5.2)
- Berinert is made from human plasma and may contain infectious agents, eg, viruses the variant Creutzfeldt-Jakob disease (vCJD) agent and, theoretically, the Creutzfeldt-Jakob disease (CJD) agent.(5.3)
- Laryngeal HAE attacks: Following self-administration of Berinert for laryngeal HAE attacks, advise patients to immediately seek medical attention.(5.4)

**ADVERSE REACTIONS**

- The most serious adverse reaction reported in subjects who received Berinert was an increase in the severity of pain associated with HAE.(6.1)
- The most common adverse reaction reported in greater than 4% of the subjects and greater than placebo among subjects who received Berinert in the placebo-controlled clinical trial was dysgeusia.(6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact the CSL Behring Pharmacovigilance Department at 1-866-915-6958 or to the FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

**USE IN SPECIFIC POPULATIONS**

- Pregnancy: Use only if clearly needed.(8.1)
- Compared to adults, when adjusted for baseline, the half-life of Berinert was shorter and clearance (on per kg basis) was faster in children. The clinical implication of this difference is not known.(12.3)

**See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.**

**Revised: September 2016**

**FULL PRESCRIBING INFORMATION: CONTENTS\***

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\*Sections or subsections omitted from the full prescribing information are not listed

## 2. HYPERINFLATION:

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Central Nervous System/ Antipsychotics/ Atypicals	FANAPT® (Iloperidone)	3--> Not Covered	Availability of additional options for the treatment of schizophrenia.	generics, LATUDA® (lurasidone), SEROQUEL XR® (quetiapine XR)	Hyperinflation Exclusion	N	Tier 3-->NC
Gastrointestinal/ Inflammatory Bowel Disease	COLAZAL® (balsalazide) CAP 750MG	3--> Not Covered	Availability of additional options for the treatment of mildly to moderately active ulcerative colitis.	generic balsalazide	Hyperinflation Exclusion	N	Tier 3-->NC
Topical/ Dermatology/ Miscellaneous Skin Conditions	BENSAL HP® (salicylic acid) OIN	3--> Not Covered	Availability of additional options for the treatment of skin inflammation and irritation caused by certain conditions.	hydrocortisone, desonide	Hyperinflation Exclusion	N	Tier 3-->NC
Topical/ Ophthalmic/ Anti-inflammatories/Steroidal	FML FORTE® (fluorometholone) SUS 0.25% OP	3--> Not Covered	Availability of additional options for the treatment steroid-responsive inflammation of the eye.	generics, DUREZOL® (difluprednate), LOTEMAX® (loteprednol)	Hyperinflation Exclusion	N	Tier 3-->NC
Topical/ Ophthalmic/ Anti-inflammatories/Steroidal	FML LIQUIFILM® (fluorometholone) SUS 0.1% OP	3--> Not Covered	Availability of additional options for the treatment steroid-responsive inflammation of the eye.	generics, DUREZOL® (difluprednate), LOTEMAX® (loteprednol)	Hyperinflation Exclusion	N	Tier 3-->NC

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Topical/ Ophthalmic/ Anti- inflammatories/Steroidal	FML® (fluorometholone) OIN 0.1% OP	3--> Not Covered	Availability of additional options for the treatment steroid-responsive inflammation of the eye.	generics, DUREZOL® (difluprednate), LOTEMAX® (loteprednol)	Hyperinflation Exclusion	N	Tier 3-->NC
Anti-Infectives/ Antibacterials/ Tetracyclines	MINOCIN® (minocycline) CAP	3--> Not Covered	Availability of a generic option.	generic minocycline	Hyperinflation Exclusion	N	Tier 3-->NC
Topical/ Ophthalmic/ Anti- inflammatories/Steroidal	PRED FORTE® (prednisolone) SUS 1% OP	3--> Not Covered	Availability of additional options for the treatment steroid-responsive inflammation of the eye.	generics, DUREZOL® (difluprednate), LOTEMAX® (loteprednol)	Hyperinflation Exclusion	N	Tier 3-->NC
Topical/ Ophthalmic/ Anti- inflammatories/Steroidal	PRED MILD® (prednisolone) SUS 0.12% OP	3--> Not Covered	Availability of additional options for the treatment of noninfectious allergic and inflammation of the eye.	generics, DUREZOL® (difluprednate), LOTEMAX® (loteprednol)	Hyperinflation Exclusion	N	Tier 3-->NC

## 3. TIER CHANGES:

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Anti-infectives/ Antiretroviral Agents/ Protease Inhibitors	KALETRA® (lopinavir/ritonavir) SOL	Tier 2/ACSF--> Tier 3/ACSF	Availability of a generic option. Currently all HIV brands fall at tier 2 and generics at tier 1 per NC SHP customization	generics	Negative Tier Change	Y	Tier 2-->Tier 3
Anti-infectives/ Antiretroviral Agents/ Antiretroviral Combinations	EPZICOM® (abacavir/lamivudine) TAB	Tier 2--> Tier 3/ACSF	Availability of a generic option. Currently all HIV brands fall at tier 2 and generics at tier 1 per NC SHP customization	generic or preferred brands TRUVADA®, DESCOVY® (emtricitabine/ tenofovir)	Negative Tier Change	Y	Tier 2-->Tier 3
Gastrointestinal/ Laxatives	MOVIPREP® (PEG-3350) SOL	2--> 3	Availability of additional options for the preparation for a colonoscopy.	generics, SUPREP® (Na, K, Mg sulfate)	Negative Tier Change	N	Tier 2-->Tier 3
Cardiovascular/ Antilipemics/ Cholesterol Absorption Inhibitors	ZETIA® (ezetimibe) TAB 10MG	2--> 3	Availability of a generic option.	generics	Negative Tier Change	N	Tier 2-->Tier 3
Anti-Infectives/ Miscellaneous	ALBENZA® (albendazole) TAB 200MG	2--> 3	Availability of additional anti-infective options for the treatment of worms.	generic mebendazole	Negative Tier Change	N	Tier 2-->Tier 3
Antineoplastic Agents/Kinase Inhibitors	CABOMETYX™ (cabozantinib) TAB	Tier 3-> Tier 2/ ACSF	To provide an additional option for the treatment of renal cell carcinoma.	NA	Positive Tier Change	Y	Tier 6-->Tier 5
Topical/Dermato logy/Atopic Dermatitis	DUPIXENT® (dupilumab) SYN 300/2ML	Tier 3--> T2/ACSF	To provide an additional option for the treatment of atopic dermatitis.	NA	Positive Tier Change	Y	NTM Block --> Tier 6-->Tier 5
Anti-Infectives/ Miscellaneous	EMVERM™ (mebendazole) CHW 100MG	3--> 2	To provide an additional option for the treatment of worms.	NA	Positive Tier Change	N	Tier 3-->Tier 2
Cardiovascular/ Antiarrhythmics	MULTAQ® (dronedarone) TAB 400MG	3--> 2	To provide an additional option for the treatment of atrial fibrillation.	NA	Positive Tier Change	N	Tier 3-->Tier 2

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Central Nervous System/ Antipsychotics/ Atypicals	ABILIFY® (aripiprazole) MAINTENA SDV	3--> 2	To provide an additional option for the treatment of schizophrenia.	NA	Positive Tier Change	N	Tier 3-->Tier 2
Central Nervous System/ Hypnotics/ Nonbenzodiazepines	BELSOMRA® (suvorexant) TAB	3--> 2	To provide an additional nonbenzodiazepine option for the treatment of insomnia.	NA	Positive Tier Change	N	Tier 3-->Tier 2
Central Nervous System/ Migraine/ Selective Serotonin Agonists	ONZETRA™ (sumatriptan) EXHA PWD 11MG	3--> 2	To provide an additional option for the treatment of migraines.	NA	Positive Tier Change	N	Tier 3-->Tier 2
Central Nervous System/ Migraine/ Selective Serotonin Agonists	ZEMBRACE™ (sumatriptan) SYM INJ 3/0.5ML	3--> 2	To provide an additional option for the treatment of migraines.	NA	Positive Tier Change	N	Tier 3-->Tier 2
Central Nervous System/ Postherpetic Neuralgia	HORIZANT® (gabapentin) TAB	3--> 2	To provide an additional option for the treatment of postherpetic neuralgia and restless leg syndrome.	NA	Positive Tier Change	N	Tier 3-->Tier 2
Central Nervous System/ Psychotherapeutic- Miscellaneous/ Pseudobulbar Affect Agents	NUEDEXTA® (dextromethorphan/ quinidine) CAP 20- 10MG	3--> 2	To provide an option for the treatment of pseudobulbar affect.	NA	Positive Tier Change	N	Tier 3-->Tier 2

## 4. FORMULARY ADDITIONS:

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Hematologic/ Hereditary/ Angioedema	RUCONEST® (C1 esterase inhibitor [recombinant]) INJ 2100UNIT	NTM Block--> Tier 2/ACSF	To provide an option for the treatment of acute attacks in patients with hereditary angioedema.	NA	NTM Block Removal	Y	NTM Block--> Tier 5
Central Nervous System/ Antidementia	NAMZARIC® (memantine/donepezil) CAP	Blocked--> 2	To provide an additional option for the treatment of moderate to severe dementia of Alzheimer's disease.	NA	NTM Block Removal	N	NTM Block--> Tier 2
Central Nervous System/ Antiparkinsonian Agents	RYTARY™ (carbidopa/levodopa) 23.75 CAP 95	NTM Block--> Tier 3	To provide an additional option for the treatment of moderate to severe Parkinson's disease.	NA	NTM Block Removal	N	NTM Block--> Tier 3
Central Nervous System/ Antiparkinsonian Agents	RYTARY™ (carbidopa/levodopa) 36.25 CAP 145	NTM Block--> Tier 3	To provide an additional option for the treatment of moderate to severe Parkinson's disease.	NA	NTM Block Removal	N	NTM Block--> Tier 3
Central Nervous System/ Antiparkinsonian Agents	RYTARY™ (carbidopa/levodopa) 48.75 CAP 195	NTM Block--> Tier 3	To provide an additional option for the treatment of moderate to severe Parkinson's disease.	NA	NTM Block Removal	N	NTM Block--> Tier 3
Central Nervous System/ Antiparkinsonian Agents	RYTARY™ (carbidopa/levodopa) 61.25 CAP 245	NTM Block--> Tier 3	To provide an additional option for the treatment of moderate to severe Parkinson's disease.	NA	NTM Block Removal	N	NTM Block--> Tier 3
Anti-Infectives/ Miscellaneous	VANCOMYCIN INJ 1.75/500	NTM Block--> Tier 1	Additional NDC as part of existing formulary product	NA	NTM Block Removal	N	NTM Block--> Tier 1
Anti-Infectives/ Miscellaneous	VANCOMYCIN INJ 500/50	NTM Block--> Tier 1	Additional NDC as part of existing formulary product	NA	NTM Block Removal	N	NTM Block--> Tier 1
Anti-Infectives/ Miscellaneous	VANCOMY/NACL INJ 2/500ML	NTM Block--> Tier 1	Additional NDC as part of existing formulary product	NA	NTM Block Removal	N	NTM Block--> Tier 1

Therapeutic Category	Drug Name	CVS Status Change	Rationale	Alternatives	Change Type	Specialty Flag	Proposed NC Status/Tier
Anti-Infectives/ Miscellaneous	VANCOMY/NACL INJ 2.5/500	NTM Block--> Tier 1	Additional NDC as part of existing formulary product	NA	NTM Block Removal	N	NTM Block--> Tier 1
Anti-Infectives/ Miscellaneous	VANCOMYC/D5W INJ 1.25/250	NTM Block--> Tier 1	Additional NDC as part of existing formulary product	NA	NTM Block Removal	N	NTM Block--> Tier 1
Anti-Infectives/ Miscellaneous	VANCOMYC/D5W INJ 1.75/500	NTM Block--> Tier 1	Additional NDC as part of existing formulary product	NA	NTM Block Removal	N	NTM Block--> Tier 1
Topical/ Dermatology/ Atopic Dermatitis	DUPIXENT® (dupilumab) INJ 300/2ML	NTM Block--> Tier 3/ACSF	To provide an additional option for the treatment of moderate to severe atopic dermatitis.	NA	NTM Block Removal	Y	NTM Block--> Tier 6
Central Nervous System/Multiple Sclerosis Agents	OCREVUS™ (ocrelizumab) INJ 300/10ML	NTM Block--> Tier 3/ACSF	To provide an option for the treatment of primary progressive multiple sclerosis	NA	NTM Block Removal	Y	NTM Block--> Tier 6
Topical/ Dermatology/ Atopic Dermatitis	EUCRISA™ (crisaborole) OIN 2%	NTM Block--> Tier 3	To provide an additional option for the treatment of atopic dermatitis.	NA	NTM Block Removal	N	NTM Block--> Tier 3
Antineoplastic Agents/ Antineoplastic Antibodies	BAVENCIO® (avelumab) INJ 20MG/ML	NTM Block--> Tier 3/ACSF	To provide an additional option for the treatment of metastatic Merkel cell carcinoma.	NA	NTM Block Removal	Y	NTM Block--> Tier 6
Antineoplastic Agents/ Mitotic Inhibitors	ZEJULA™ (niraparib) CAP 100MG	NTM Block--> Tier 3/ACSF	To provide an additional option for the treatment of recurrent ovarian carcinoma.	NA	NTM Block Removal	N	NTM Block--> Tier 6
Anti-infectives/ Vaccines	STAMARIL® (yellow fever vaccine [live]) INJ	NTM Block--> Tier 3	To provide an option for yellow fever vaccination.	NA	NTM Block Removal	N	NTM Block--> Tier 3

# RYTARY®

(carbidopa and levodopa) [extended-release capsules]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	3 – Non-preferred brand
<b>Formulary Alternatives</b>	SINEMET CR® (carbidopa/levodopa CR), STALEVO® (carbidopa/levodopa/entacapone), SINEMET® (carbidopa/levodopa)
<b>FDA Approval</b>	January 8, 2015 (drug entity: 1975)
<b>Therapeutic Class</b>	Anti-Parkinson Agent, Decarboxylase inhibitor and dopamine precursor combination
<b>Indications and Usage</b>	Treatment of Parkinson's disease, post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication
<b>Dosing</b>	<p><b>Forms &amp; Strengths:</b> extended-release capsules: Carbidopa and levodopa 23.75 mg / 95 mg, 36.25 mg / 145 mg, 48.75 mg / 195 mg, &amp; 61.25 mg / 245 mg</p> <p><b>Administration:</b> three times daily with or without food, do not crush/chew; max total daily dose of 612.5 mg / 2450 mg; high-fat, high calorie meal may delay the absorption of levodopa by about 2 hours; may sprinkle contents of capsule on applesauce (1 to 2 tablespoons) and consume immediately</p> <p><b>Adjustments:</b> dosages of other carbidopa and levodopa products are not interchangeable on a 1:1 basis with the dosages of RYTARY®.</p>
<b>Safety</b>	<p><b>Contraindications:</b> nonselective MAO inhibitors</p> <p><b>Warnings:</b> sleepiness and dizziness, suicide ideation, hallucinations/psychosis, impulse control disorders, dyskinesia, cardiovascular events, avoid sudden discontinuation or rapid dose reduction to reduce the risk of withdrawal-emergent hyperpyrexia and confusion.</p>
<b>Key Points</b>	Combines the fast onset of immediate-release (works within an hour) with the longer duration of sustained-release (lasts about 6 hours). May reduce "off-time," when the drug wears off and symptoms worsen, by 70 minutes per day compared to the IR.
<b>Treatment Guidelines</b>	<b>Parkinson's:</b> carbidopa/levodopa is the most effective pharmacologic agent and remains the primary treatment for symptomatic patients. There is no standard treatment algorithm, patients are treated based on symptoms. With functional impairment: immediate-release carbidopa/levodopa or dopamine agonist or combination of the two. Anticholinergics can be useful for symptomatic control, but are associated with more adverse effects. Motor complications: consider MAO-B inhibitor, or COMT inhibitor. Severe dyskinesia: reduce carbidopa/levodopa, consider amantadine. Brain surgery can also be considered.
<b>Place in Therapy</b>	Save for advanced Parkinson's. Alternative for patients taking both the IR and CR or in those still having problems with off-time despite taking the IR or CR $\geq$ 4 times/day.

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use RYTARY safely and effectively. See full prescribing information for RYTARY.

**RYTARY (carbidopa and levodopa) extended-release capsules, for oral use**

**Initial U.S. Approval: 1975**

**RECENT MAJOR CHANGES**

Dosage and Administration, (2.2, 2.4) 10/2016

**INDICATIONS AND USAGE**

RYTARY is a combination of carbidopa (an aromatic amino acid decarboxylation inhibitor) and levodopa (an aromatic amino acid) indicated for the treatment of Parkinson's disease, post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication (1)

**DOSAGE AND ADMINISTRATION**

- Levodopa-naïve patients: Starting dose is 23.75 mg / 95 mg three times daily; may increase to 36.25 mg / 145 mg three times daily on the fourth day of treatment (2.1)
- See Table 1 for instructions for converting patients taking immediate-release carbidopa-levodopa to an initial dose of RYTARY. Dosages of RYTARY are not interchangeable with other carbidopa-levodopa products (2.2)
- The maximum recommended daily dose of RYTARY is 612.5 mg / 2450 mg (2.1, 2.2)
- RYTARY may be taken with or without food; do not chew, divide or crush (2.4, 12.3)

**DOSAGE FORMS AND STRENGTHS**

Extended-release capsules: Carbidopa and levodopa 23.75 mg / 95 mg, 36.25 mg / 145 mg, 48.75 mg / 195 mg, 61.25 mg / 245 mg (3)

**CONTRAINDICATIONS**

- Nonselective MAO inhibitors (4)

**WARNINGS AND PRECAUTIONS**

- May cause falling asleep during activities of daily living (5.1)
- Avoid sudden discontinuation or rapid dose reduction to reduce the risk of withdrawal-emergent hyperpyrexia and confusion (5.2)
- Cardiovascular Events: Monitor patients with a history of cardiovascular disease (5.3)
- Hallucinations/Psychosis may occur (5.4)
- Impulse Control Disorders: Consider dose reduction or stopping RYTARY if occurs (5.5)
- May cause or exacerbate dyskinesia: Consider dose reduction (5.6)

**ADVERSE REACTIONS**

- Early Parkinson's disease: Most common adverse reactions (incidence  $\geq 5\%$  and greater than placebo) are nausea, dizziness, headache, insomnia, abnormal dreams, dry mouth, dyskinesia, anxiety, constipation, vomiting, and orthostatic hypotension (6.1)
- Advanced Parkinson's disease: Most common adverse reactions (incidence  $\geq 5\%$  and greater than oral immediate-release carbidopa-levodopa) are nausea and headache (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Impax Laboratories at 1-877-99-IMPAX or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**DRUG INTERACTIONS**

Iron salts and dopamine D2 antagonists including metoclopramide: May reduce the effectiveness of RYTARY (7.2, 7.3)

**USE IN SPECIFIC POPULATIONS**

Pregnancy: Based on animal data, may cause fetal harm (8.1)

See 17 for PATIENT COUNSELING INFORMATION

Revised: 10/2016

**FULL PRESCRIBING INFORMATION: CONTENTS\*****1 INDICATIONS AND USAGE****2 DOSAGE AND ADMINISTRATION**

- Dosage in Patients Naïve to Levodopa Therapy
- Converting from Immediate-Release Carbidopa-Levodopa to RYTARY
- Discontinuation of RYTARY
- Administration Information

**3 DOSAGE FORMS AND STRENGTHS****4 CONTRAINDICATIONS****5 WARNINGS AND PRECAUTIONS**

- Falling Asleep During Activities of Daily Living and Somnolence
- Withdrawal-Emergent Hyperpyrexia and Confusion
- Cardiovascular Ischemic Events
- Hallucinations/Psychosis
- Impulse Control/Compulsive Behaviors
- Dyskinesia
- Peptic Ulcer Disease
- Glaucoma
- Melanoma

**6 ADVERSE REACTIONS**

- Clinical Trials Experience
- Postmarketing Experience

**7 DRUG INTERACTIONS**

- Monoamine Oxidase (MAO) Inhibitors
- Dopamine D2 Receptor Antagonists and Isoniazid

7.3 Iron Salts

**8 USE IN SPECIFIC POPULATIONS**

- Pregnancy
- Nursing Mothers
- Pediatric Use
- Geriatric Use

**10 OVERDOSAGE****11 DESCRIPTION****12 CLINICAL PHARMACOLOGY**

- Mechanism of Action
- Pharmacodynamics
- Pharmacokinetics

**13 NONCLINICAL TOXICOLOGY**

- Carcinogenesis, Mutagenesis, Impairment of Fertility

**14 CLINICAL STUDIES**

- Patients with Early Parkinson's Disease
- Patients with Advanced Parkinson's Disease

**16 HOW SUPPLIED/STORAGE AND HANDLING**

- How Supplied
- Storage and Handling

**17 PATIENT COUNSELING INFORMATION**

\*Sections or subsections omitted from the full prescribing information are not listed.

# OCREVUS<sup>®</sup>

(ocrelizumab) [injection for IV]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	6 – Non-preferred Specialty
<b>Formulary Alternatives</b>	<i>For RRMS only:</i> TYSABRI <sup>®</sup> (natalizumab), BETASERON <sup>®</sup> , REBIF <sup>®</sup> (interferon beta-1b), COPAXONE <sup>®</sup> , GLATOPA <sup>®</sup> (glatiramer acetate)
<b>FDA Approval</b>	March 28, 2017
<b>Therapeutic Class</b>	Monoclonal Antibody (Anti-CD20)
<b>Indications and Usage</b>	Treatment of patients with relapsing or primary progressive forms of multiple sclerosis
<b>Dosing</b>	<p><b><u>Forms &amp; Strengths:</u></b> Injection: 300 mg/10 mL in a single-dose vial</p> <p><b><u>Administration:</u></b> Hep B screening required; pre-med with corticosteroid and antihistamine and give IV; Starting dose is 300 mg, followed 2 weeks later with a second 300 mg infusion; Subsequent doses are 600 mg every 6 months; monitor for 1 hour after infusion</p> <p><b><u>Adjustments:</u></b> For mild to moderate infusion reactions reduce the infusion rate to half for at least 30 minutes. If tolerated, increase rate per instructions.</p>
<b>Safety</b>	<p><b><u>Contraindications:</u></b> Active hepatitis B virus infection; history of life-threatening infusion reaction to OCREVUS<sup>®</sup></p> <p><b><u>Warnings:</u></b> Infusion reactions; Delay treatment with active infections; Delay live-attenuated or live vaccines during and after treatment until B-cell repletion; Increased risk of malignancy, including breast cancer, may exist</p>
<b>Key Points</b>	First FDA-approved therapy specifically approved to treat primary progressive multiple sclerosis (PPMS), and a new option for treating relapsing MS (RRMS)
<b>Treatment Guidelines</b>	OCREVUS <sup>®</sup> , symptom management (many medications) and rehabilitation (physical therapy)
<b>Place in Therapy</b>	First-line treatment for primary progressive MS

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use OCREVUS safely and effectively. See full prescribing information for OCREVUS.

**OCREVUS™ (ocrelizumab) injection, for intravenous use**  
**Initial U.S. Approval: 2017**

**INDICATIONS AND USAGE**

OCREVUS is a CD20-directed cytolytic antibody indicated for the treatment of patients with relapsing or primary progressive forms of multiple sclerosis (1)

**DOSAGE AND ADMINISTRATION**

- Hepatitis B virus screening is required before the first dose (2.1)
- Pre-medicate with methylprednisolone (or an equivalent corticosteroid) and an antihistamine (e.g., diphenhydramine) prior to each infusion (2.2)
- Administer OCREVUS by intravenous infusion
  - Start dose: 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion (2.3)
  - Subsequent doses: 600 mg intravenous infusion every 6 months (2.3)
- Must be diluted prior to administration (2.3, 2.6)
- Monitor patients closely during and for at least one hour after infusion (2.3, 2.5)

**DOSAGE FORMS AND STRENGTHS**

- Injection: 300 mg/10 mL (30 mg/mL) in a single-dose vial. (3)

**CONTRAINDICATIONS**

- Active hepatitis B virus infection (4)
- History of life-threatening infusion reaction to OCREVUS (4)

**WARNINGS AND PRECAUTIONS**

- Infusion reactions: Management recommendations for infusion reactions depend on the type and severity of the reaction. Permanently discontinue OCREVUS if a life-threatening or disabling infusion reaction occurs (2.3, 5.1)
- Infections: Delay OCREVUS administration in patients with an active infection until the infection is resolved. Vaccination with live-attenuated or live vaccines is not recommended during treatment with OCREVUS and after discontinuation, until B-cell repletion (5.2)
- Malignancies: An increased risk of malignancy, including breast cancer, may exist with OCREVUS (5.3)

**ADVERSE REACTIONS**

The most common adverse reactions were:

- RMS (incidence  $\geq 10\%$  and  $>$  REBIF): upper respiratory tract infections and infusion reactions (6.1)
- PPMS (incidence  $\geq 10\%$  and  $>$  placebo): upper respiratory tract infections, infusion reactions, skin infections, and lower respiratory tract infections (6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact Genentech at 1-888-835-2555 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

**USE IN SPECIFIC POPULATIONS**

- Pregnancy: Based on animal data, may cause fetal harm. (8.1)

**See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.**

**Revised: 3/2017**

**FULL PRESCRIBING INFORMATION: CONTENTS\*****1 INDICATIONS AND USAGE****2 DOSAGE AND ADMINISTRATION**

- 2.1 Assessments Prior to First Dose of OCREVUS
- 2.2 Preparation Before Every Infusion
- 2.3 Recommended Dosage and Dose Administration
- 2.4 Delayed or Missed Doses
- 2.5 Dose Modifications Because of Infusion Reactions
- 2.6 Preparation and Storage of the Dilute Solution for Infusion

**3 DOSAGE FORMS AND STRENGTHS****4 CONTRAINDICATIONS****5 WARNINGS AND PRECAUTIONS**

- 5.1 Infusion Reactions
- 5.2 Infections
- 5.3 Malignancies

**6 ADVERSE REACTIONS**

- 6.1 Clinical Trials Experience
- 6.2 Immunogenicity

**7 DRUG INTERACTIONS**

- 7.1 Immunosuppressive or Immune-Modulating Therapies

**8 USE IN SPECIFIC POPULATIONS**

- 8.1 Pregnancy
- 8.2 Lactation
- 8.3 Females and Males of Reproductive Potential
- 8.4 Pediatric Use
- 8.5 Geriatric Use

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- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
- 12.3 Pharmacokinetics

**13 NONCLINICAL TOXICOLOGY**

- 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

**14 CLINICAL STUDIES**

- 14.1 Relapsing Forms of Multiple Sclerosis (RMS)
- 14.2 Primary Progressive Multiple Sclerosis (PPMS)

**16 HOW SUPPLIED/STORAGE AND HANDLING****17 PATIENT COUNSELING INFORMATION**

\*Sections or subsections omitted from the full prescribing information are not listed



## SPECIALTY GUIDELINE MANAGEMENT

### OCREVUS (ocrelizumab)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

##### FDA-Approved Indications

Ocrevus is indicated for the treatment of adult patients with relapsing or primary progressive forms of multiple sclerosis (MS).

All other indications are considered experimental/investigational and are not covered benefits.

##### II. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a neurologist.

##### III. CRITERIA FOR INITIAL APPROVAL

###### A. Relapsing Forms of Multiple Sclerosis

Authorization of 12 months may be granted to members who are 18 years of age or older for the treatment of relapsing forms of MS when at least ONE of the following criteria is met:

1. The member is newly diagnosed with MS.
2. The member is new to treatment with disease modifying therapy.
3. For members who have previously received or are currently receiving disease modifying therapy: The member's disease is not currently stabilized on existing disease modifying therapy as evidenced by disease progression or occurrence of an intolerable adverse event.

###### B. Primary Progressive Multiple Sclerosis

Authorization of 12 months may be granted to members who are 18 years of age or older for the treatment of primary progressive MS.

##### IV. CONTINUATION OF THERAPY

###### A. Relapsing Forms of Multiple Sclerosis

Authorization of 12 months may be granted to members requesting continuation of therapy for the treatment of relapsing forms of MS when the member has experienced disease improvement or slowing of disease progression (eg, decrease in the number of relapses, improvement or no decline in Kurtzke

Expanded Disability Status Scale [EDSS] or in MRI findings) since initiating Ocrevus therapy.

**B. Primary Progressive Multiple Sclerosis**

Authorization of 12 months may be granted to members requesting continuation of therapy for the treatment of primary progressive MS when the member has experienced slowing of disease progression (eg, no decline in EDSS or MRI findings) since initiating Ocrevus therapy.

**V. REFERENCES**

1. Ocrevus [package insert]. South San Francisco, CA: Genentech, Inc.; March 2017.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

Prior Authorization

Original Implementation Date:

Revision Information	
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# NAMZARIC®

(memantine HCl & donepezil HCl) [extended-release capsules]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	Tier 2 – Preferred Brand
<b>Formulary Alternatives</b>	Generic donepezil, generic memantine
<b>FDA Approval</b>	December 23, 2014
<b>Therapeutic Class</b>	N-Methyl-D-Aspartate (NMDA) receptor antagonist & acetylcholinesterase inhibitor (ChEI)
<b>Indications and Usage</b>	Treatment of moderate to severe dementia of the Alzheimer's type in patient stabilized on 10 mg of donepezil HCl once daily
<b>Dosing</b>	<p><b><u>Forms &amp; Strengths:</u></b> Extended-release capsules: 7, 14, 21, 28 mg memantine &amp; 10 mg donepezil</p> <p><b><u>Administration:</u></b> patient not on memantine should start with 7 mg/10 mg once daily in the evening and increase by 7 mg increments at least weekly to 28 mg/10 mg. Patients currently taking memantine can be switched to 28 mg/10 mg once daily in the evening; take with or without food, whole or sprinkled on applesauce; do not divide, crush or chew</p> <p><b><u>Adjustments:</u></b> severe renal impairment: 14 mg/10 mg once daily in the evening</p>
<b>Safety</b>	<p><b><u>Contraindications:</u></b> hypersensitivity</p> <p><b><u>Warnings:</u></b> exaggerate succinylcholine-type muscle relaxation during anesthesia, vagotonic effects on the sinoatrial and atrioventricular nodes manifesting as bradycardia or heart block, active or occult gastrointestinal bleeding, can cause diarrhea, nausea, and vomiting, may cause bladder outflow obstructions, Conditions that raise urine pH may decrease the urinary elimination of memantine, resulting in increased plasma levels of memantine</p>
<b>Key Points</b>	Reduces patients pill burden
<b>Treatment Guidelines</b>	ChEI treatment titrate if tolerability permits, with adverse events or disease progression consider switching ChEI or adding memantine; treat behavioral and psychological symptoms of dementia as required
<b>Place in Therapy</b>	Provides a single capsule, once a day treatment option for moderate-to-severe Alzheimer's patient currently being treated with donepezil

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use NAMZARIC capsules safely and effectively. See full prescribing information for NAMZARIC capsules.

**NAMZARIC (memantine and donepezil hydrochlorides) extended-release capsules, for oral use**  
Initial U.S. Approval: 2014

**RECENT MAJOR CHANGES**

Indications and Usage (1) 07/2016  
Dosage and Administration (2.1, 2.3) 07/2016

**INDICATIONS AND USAGE**

NAMZARIC is a combination of memantine hydrochloride, an NMDA receptor antagonist, and donepezil hydrochloride, an acetylcholinesterase inhibitor, indicated for the treatment of moderate to severe dementia of the Alzheimer's type in patients stabilized on 10 mg of donepezil hydrochloride once daily. (1)

**DOSAGE AND ADMINISTRATION**

- For patients on donepezil hydrochloride 10 mg only, the recommended starting dose of NAMZARIC is 7 mg/10 mg, taken once daily in the evening. The dose should be increased in 7 mg increments to the recommended maintenance dose of 28 mg/10 mg. The minimum recommended interval between dose increases is one week. (2.1)
- Patients on memantine hydrochloride (10 mg twice daily or 28 mg extended-release once daily) and donepezil hydrochloride 10 mg once daily can be switched to NAMZARIC 28 mg/10 mg, taken once daily in the evening. (2.1)
- NAMZARIC can be taken with or without food, whole or sprinkled on applesauce; do not divide, chew, or crush. (2.2)
- Severe renal impairment: the recommended maintenance dose for NAMZARIC is 14 mg/10 mg once daily in the evening. (2.3)

**DOSAGE FORMS AND STRENGTHS**

Extended-Release Capsules:

- 7 mg memantine hydrochloride and 10 mg donepezil hydrochloride (3)
- 14 mg memantine hydrochloride and 10 mg donepezil hydrochloride (3)
- 21 mg memantine hydrochloride and 10 mg donepezil hydrochloride (3)
- 28 mg memantine hydrochloride and 10 mg donepezil hydrochloride (3)

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- INDICATIONS AND USAGE**
- DOSAGE AND ADMINISTRATION**
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  - Administration Information
  - Dosing in Patients with Severe Renal Impairment
- DOSAGE FORMS AND STRENGTHS**
- CONTRAINDICATIONS**
- WARNINGS AND PRECAUTIONS**
  - Anesthesia
  - Cardiovascular Conditions
  - Peptic Ulcer Disease and Gastrointestinal Bleeding
  - Nausea and Vomiting
  - Genitourinary Conditions
  - Seizures
  - Pulmonary Conditions
- ADVERSE REACTIONS**
  - Clinical Trials Experience
  - Postmarketing Experience
- DRUG INTERACTIONS**
  - Use of Memantine with Drugs That Make the Urine Alkaline
  - Use of Memantine with Other N-methyl-D-aspartate (NMDA) Antagonists
  - Effect of Other Drugs on the Metabolism of Donepezil
  - Use of Donepezil with Anticholinergics
  - Use of Donepezil with Cholinomimetics and Other Cholinesterase Inhibitors
- USE IN SPECIFIC POPULATIONS**
  - Pregnancy
  - Lactation
  - Pediatric Use
  - Geriatric Use
  - Renal Impairment
  - Hepatic Impairment

**CONTRAINDICATIONS**

NAMZARIC is contraindicated in patients with known hypersensitivity to memantine hydrochloride, donepezil hydrochloride, piperidine derivatives, or to any excipients used in the formulation. (4)

**WARNINGS AND PRECAUTIONS**

- NAMZARIC is likely to exaggerate succinylcholine-type muscle relaxation during anesthesia. (5.1)
- NAMZARIC may have vagotonic effects on the sinoatrial and atrioventricular nodes manifesting as bradycardia or heart block. (5.2)
- Monitor patients for symptoms of active or occult gastrointestinal bleeding, especially those at increased risk for developing ulcers. (5.3)
- NAMZARIC can cause diarrhea, nausea, and vomiting. (5.4)
- NAMZARIC may cause bladder outflow obstructions. (5.5)
- Conditions that raise urine pH may decrease the urinary elimination of memantine, resulting in increased plasma levels of memantine. (5.5, 7.1)

**ADVERSE REACTIONS**

- The most common adverse reactions, occurring at a frequency of at least 5% and greater than placebo with memantine hydrochloride extended-release 28 mg/day, were headache, diarrhea, and dizziness. (6.1)
- The most common adverse reactions, occurring at a frequency of at least 5% in patients receiving donepezil hydrochloride and at twice or more the placebo rate, include diarrhea, anorexia, vomiting, nausea, and ecchymosis. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Allergan at 1-800-433-8871 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**DRUG INTERACTIONS**

- Combined use with NMDA antagonists: use with caution. (7.2)
- NAMZARIC may interfere with anticholinergic medications. (7.4)
- Concomitant administration of succinylcholine, similar neuromuscular blocking agents, or cholinergic agonists may lead to synergistic effect. (7.5)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 09/ 2016

- OVERDOSAGE**
- DESCRIPTION**
- CLINICAL PHARMACOLOGY**
  - Mechanism of Action
  - Pharmacokinetics
- NONCLINICAL TOXICOLOGY**
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  - Animal Toxicology and/or Pharmacology
- CLINICAL STUDIES**
- HOW SUPPLIED/STORAGE AND HANDLING**
  - How Supplied
  - Storage and Handling
- PATIENT COUNSELING INFORMATION**

\*Sections or subsections omitted from the full prescribing information are not listed.

# DUPIXENT<sup>®</sup>

(dupilumab) [injection, for subcutaneous use]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	Tier 6 – Non-preferred Specialty
<b>Formulary Alternatives</b>	Cyclosporine, azathioprine, methotrexate
<b>FDA Approval</b>	March 28, 2017 – Breakthrough therapy
<b>Therapeutic Class</b>	Human monoclonal antibody; Interleukin-4 receptor alpha antagonist
<b>Indications and Usage</b>	Treatment of adult patients with moderate to severe atopic dermatitis (AD) whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable; Can be used with or without topical corticosteroids
<b>Dosing</b>	<p><b>Forms &amp; Strengths:</b> Injection: 300 mg/2 mL solution in a single-dose pre-filled syringe with needle shield</p> <p><b>Administration:</b> Subcutaneous initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week</p> <p><b>Adjustments:</b> Avoid use with live vaccines</p>
<b>Safety</b>	<p><b>Contraindications:</b> Known hypersensitivity to DUPIXENT<sup>®</sup> (dupilumab) or any of its excipients</p> <p><b>Warnings:</b> Discontinue if systemic hypersensitivity reaction occurs, Patients should report worsening eye conditions (conjunctivitis and keratitis), Patients with comorbid asthma should not adjust or stop their asthma treatment without consultation with their physicians</p>
<b>Key Points</b>	First and only systemic biologic approved for the treatment of moderate to severe AD; May gain approval for other indications, most notable for refractory asthma
<b>Treatment Guidelines</b>	Stepped approach based on severity: emollients, mild, moderate, or potent topical corticosteroids, topical phosphodiesterase 4 inhibitor, topical calcineurin inhibitors, bandages, phototherapy, monoclonal antibodies, systemic therapy
<b>Place in Therapy</b>	Alternative option to systemic immunosuppressant therapy in the treatment of moderate to severe atopic dermatitis after the failure or contraindication to topical agents

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use DUPIXENT safely and effectively. See full prescribing information for DUPIXENT.

**DUPIXENT® (dupilumab) injection, for subcutaneous use**

Initial U.S. Approval: 2017

**INDICATIONS AND USAGE**

DUPIXENT is an interleukin-4 receptor alpha antagonist indicated for the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids. (1)

**DOSAGE AND ADMINISTRATION**

- Administer by subcutaneous injection. (2.1)
- The recommended dose is an initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week. (2.1)

**DOSAGE FORMS AND STRENGTHS**

- Injection: 300 mg/2 mL solution in a single-dose pre-filled syringe with needle shield (3)

**CONTRAINDICATIONS**

Known hypersensitivity to DUPIXENT or any of its excipients. (4)

**WARNINGS AND PRECAUTIONS**

- **Hypersensitivity:** If a systemic hypersensitivity reaction occurs, discontinue DUPIXENT immediately and initiate appropriate therapy. (5.1)
- **Conjunctivitis and Keratitis:** Patients should report new onset or worsening eye symptoms to their healthcare provider. (5.2)
- **Comorbid Asthma:** Advise patients with comorbid asthma not to adjust or stop their asthma treatment without consultation with their physicians. (5.3)

**ADVERSE REACTIONS**

Most common adverse reactions (incidence  $\geq 1\%$ ) are injection site reactions, conjunctivitis, blepharitis, oral herpes, keratitis, eye pruritus, other herpes simplex virus infection, and dry eye. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Regeneron at 1-855-395-3248 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**DRUG INTERACTIONS**

**Live Vaccines:** Avoid use of live vaccines with DUPIXENT. (7.1)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 03/2017

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- 1 INDICATIONS AND USAGE
- 2 DOSAGE AND ADMINISTRATION
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- 3 DOSAGE FORMS AND STRENGTHS
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- 5 WARNINGS AND PRECAUTIONS
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- 6 ADVERSE REACTIONS
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- 8.2 Lactation
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- 8.5 Geriatric Use

**10 OVERDOSE****11 DESCRIPTION****12 CLINICAL PHARMACOLOGY**

- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
- 12.3 Pharmacokinetics

**13 NONCLINICAL TOXICOLOGY**

- 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

**14 CLINICAL STUDIES****16 HOW SUPPLIED/STORAGE AND HANDLING**

- 16.1 How Supplied
- 16.2 Storage and Handling

**17 PATIENT COUNSELING INFORMATION**

\* Sections or subsections omitted from the full prescribing information are not listed.

**FULL PRESCRIBING INFORMATION****1 INDICATIONS AND USAGE**

DUPIXENT is indicated for the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.

**2 DOSAGE AND ADMINISTRATION****2.1 Dosage**

DUPIXENT is administered by subcutaneous injection.

The recommended dose of DUPIXENT for adult patients is an initial dose of 600 mg (two 300 mg injections), followed by 300 mg given every other week.

DUPIXENT can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, such as the face, neck, intertriginous and genital areas.

If a dose is missed, instruct the patient to administer the injection within 7 days from the missed dose and then resume the patient's original schedule. If the missed dose is not administered within 7 days, instruct the patient to wait until the next dose on the original schedule.

**2.2 Important Administration Instructions**

DUPIXENT is intended for use under the guidance of a healthcare provider. A patient may self-inject DUPIXENT after training in subcutaneous injection technique using the pre-filled syringe. Provide proper training to patients and/or caregivers on the preparation and administration of DUPIXENT prior to use according to the "Instructions for Use".

For the initial 600 mg dose, administer each of the two DUPIXENT 300 mg injections at different injection sites.

Administer subcutaneous injection into the thigh or abdomen, except for the 2 inches (5 cm) around the navel. The upper arm can also be used if a caregiver administers the injection.

Rotate the injection site with each injection. DO NOT inject DUPIXENT into skin that is tender, damaged, bruised, or scarred.

The DUPIXENT "Instructions for Use" contains more detailed instructions on the preparation and administration of DUPIXENT [see *Instructions for Use*].

**2.3 Preparation for Use of DUPIXENT Pre-filled Syringe With Needle Shield**

Before injection, remove DUPIXENT pre-filled syringe from the refrigerator and allow DUPIXENT to reach room temperature (45 minutes) without removing the needle cap.

Inspect DUPIXENT visually for particulate matter and discoloration prior to administration. DUPIXENT is a clear to slightly opalescent, colorless to pale yellow solution. Do not use if the liquid contains visible particulate matter, is discolored or cloudy (other than clear to slightly opalescent, colorless to pale yellow). DUPIXENT does not contain preservatives; therefore, discard any unused product remaining in the pre-filled syringe.

**3 DOSAGE FORMS AND STRENGTHS**

DUPIXENT is a clear to slightly opalescent, colorless to pale yellow solution available as:

- Injection: 300 mg/2 mL in a single-dose pre-filled syringe with needle shield

**4 CONTRAINDICATIONS**

DUPIXENT is contraindicated in patients who have known hypersensitivity to dupilumab or any of its excipients [see *Warnings and Precautions* (5.1)].

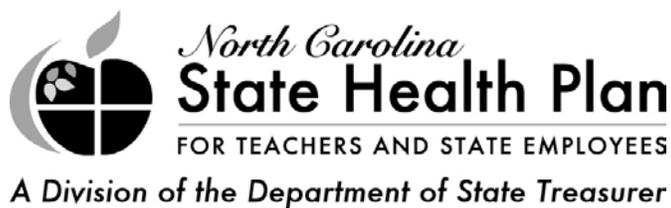
**5 WARNINGS AND PRECAUTIONS****5.1 Hypersensitivity**

Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions, were reported in less than 1% of subjects who received DUPIXENT in clinical trials. Two subjects experienced serum sickness or serum sickness-like reactions that were associated with high titers of antibodies to dupilumab [see *Adverse Reactions* (6.2)]. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue DUPIXENT [see *Adverse Reactions* (6.1, 6.2)].

**5.2 Conjunctivitis and Keratitis**

Conjunctivitis and keratitis occurred more frequently in subjects who received DUPIXENT. Conjunctivitis was the most frequently reported eye disorder. Most subjects with conjunctivitis recovered or were recovering during the treatment period [see *Adverse Reactions* (6.1)].

Keratitis was reported in <1% of the DUPIXENT group (1 per 100 subject-years) and in 0% of the placebo group (0 per 100 subject-years) in the 16-week monotherapy trials. In the 52-week



## SPECIALTY GUIDELINE MANAGEMENT

### DUPIXENT (dupilumab)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

##### FDA-Approved Indication

Dupilumab is indicated for the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Dupilumab can be used with or without topical corticosteroids.

All other indications are considered experimental/investigational and are not a covered benefit.

##### II. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a dermatologist or an allergist/immunologist.

##### III. CRITERIA FOR INITIAL APPROVAL

Authorization of 4 months may be granted for treatment of moderate-to-severe atopic dermatitis in members 18 years of age or older when either of the following criteria is met:

1. Member has had an inadequate treatment response to a topical corticosteroid or a topical calcineurin inhibitor in the past 180 days.
2. The use of topical corticosteroids and topical calcineurin inhibitors is not advisable for the member (e.g., due to contraindications or prior intolerances).

##### IV. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for members 18 years of age or older who achieve or maintain positive clinical response with Dupilumab therapy for moderate-to-severe atopic dermatitis as evidenced by low disease activity or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting).

##### V. REFERENCES

1. Dupilumab [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; March 2017.
2. Eichenfield LF, Tom WL, et al. Guidelines of care for the management of atopic dermatitis: Section 2. Management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol*. 2014;71:116-32.
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**POLICY IMPLEMENTATION/REVISION INFORMATION**

Prior Authorization

Original Implementation Date:

Revision Information	
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# EUCRISA<sup>®</sup>

(crisaborole) [ointment 2%, for topical use]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	Tier 3 – Non-preferred Brand
<b>Formulary Alternatives</b>	Generic topical corticosteroids (hydrocortisone, betamethasone, desonide, etc), and topical calcineurin inhibitors such as ELIDEL <sup>®</sup> (pimecrolimus) or PROTOPIC <sup>®</sup> (tacrolimus)
<b>FDA Approval</b>	December 14, 2016
<b>Therapeutic Class</b>	Dermatological – Phosphodiesterase 4 inhibitor
<b>Indications and Usage</b>	Topical treatment of mild to moderate atopic dermatitis in patients 2 years of age and older
<b>Dosing</b>	<p><b><u>Forms &amp; Strengths:</u></b> Ointment, 2%</p> <p><b><u>Administration:</u></b> Apply a thin layer twice daily to affected areas; for topical use only, not for ophthalmic, oral, or intravaginal use</p> <p><b><u>Adjustments:</u></b> None</p>
<b>Safety</b>	<p><b><u>Contraindications:</u></b> Hypersensitivity to crisaborole or any component of the formulation</p> <p><b><u>Warnings:</u></b> Discontinue if signs and symptoms of hypersensitivity occur</p>
<b>Key Points</b>	First and only topical PDE4 inhibitor on the market; First nonsteroidal medication approved for the treatment of atopic dermatitis in over a decade
<b>Treatment Guidelines</b>	Stepped approach based on severity: emollients, mild, moderate, or potent topical corticosteroids, topical phosphodiesterase 4 inhibitor, topical calcineurin inhibitors, bandages, phototherapy, monoclonal antibodies, systemic therapy
<b>Place in Therapy</b>	Second-line topical treatment option after failure or contraindication to a topical corticosteroid or topical calcineurin inhibitors for patients with mild to moderate atopic dermatitis age 2 years and older

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use EUCRISA safely and effectively. See full prescribing information for EUCRISA.

**EUCRISA™ (crisaborole) ointment, 2%, for topical use**  
**Initial U.S. Approval: 2016**

**INDICATIONS AND USAGE**

EUCRISA is a phosphodiesterase 4 inhibitor indicated for topical treatment of mild to moderate atopic dermatitis in patients 2 years of age and older. (1)

**DOSAGE AND ADMINISTRATION**

- Apply a thin layer twice daily to affected areas. (2)
- For topical use only. (2)
- Not for ophthalmic, oral, or intravaginal use. (2)

**DOSAGE FORMS AND STRENGTHS**

Ointment, 2%. (3)

**CONTRAINDICATIONS**

Known hypersensitivity to crisaborole or any component of the formulation. (4)

**WARNINGS AND PRECAUTIONS**

*Hypersensitivity reactions:* If signs and symptoms of hypersensitivity occur, discontinue EUCRISA immediately and initiate appropriate therapy. (5.1)

**ADVERSE REACTIONS**

The most common adverse reaction occurring in  $\geq 1\%$  in subjects is application site pain. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Anacor Pharmaceuticals at 1-844-4ANACOR [1-844-426-2267] or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 12/2016

**FULL PRESCRIBING INFORMATION: CONTENTS\***

- 1 **INDICATIONS AND USAGE**
- 2 **DOSAGE AND ADMINISTRATION**
- 3 **DOSAGE FORMS AND STRENGTHS**
- 4 **CONTRAINDICATIONS**
- 5 **WARNINGS AND PRECAUTIONS**
  - 5.1 Hypersensitivity Reactions
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  - 6.1 Clinical Trials Experience
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  - 8.1 Pregnancy
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- 11 **DESCRIPTION**

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- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
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**13 NONCLINICAL TOXICOLOGY**

- 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

**14 CLINICAL STUDIES****16 HOW SUPPLIED/STORAGE AND HANDLING**

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- 16.2 Storage and Handling

**17 PATIENT COUNSELING INFORMATION**

\* Sections or subsections omitted from the full prescribing information are not listed.



## PRIOR AUTHORIZATION CRITERIA

**BRAND NAME**  
(generic)

**EUCRISA**  
(crisaborole)

**Type: Initial Step Therapy; Post Step Therapy Prior Authorization; Initial Prior Authorization**

### POLICY

#### FDA-APPROVED INDICATIONS

Eucrisa (crisaborole) is indicated for topical treatment of mild to moderate atopic dermatitis in patients 2 years of age and older.

#### INITIAL STEP THERAPY

If the patient has filled a prescription for a topical calcineurin inhibitor AND a medium or higher potency topical corticosteroid within the past 180 days (see Table 1) under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

If the patient meets the initial step therapy criteria, then a quantity limit will apply. If the patient is requesting more than the quantity limit, the claim will reject with a message indicating that a PA is required.

#### INITIAL LIMIT CRITERIA

Drug	1 Month Limit*	3 Month Limit*
Eucrisa (crisaborole)	60 grams (1 tube) per 25 days	180 grams (3 tubes) per 75 days

\* The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

#### COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for a patient 2 years of age or older for mild to moderate atopic dermatitis
  - AND**
    - The requested drug is being prescribed for use on sensitive skin areas (e.g., face, body skin folds, genital area, armpit, or around the eyes)
    - AND**
    - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor
  - OR**
    - The requested drug is being prescribed for use on non-sensitive (or remaining) skin areas
    - AND**
    - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor and a medium or higher potency topical corticosteroid

- Coverage Duration for initial therapy is 3 months with a quantity limit not to exceed 60 gm per 30 days. Coverage for 120 gm per 30 days will be provided when 5% or greater body surface area is affected

#### OR

- The requested drug is being prescribed for continuation of therapy, and the patient achieved or maintained positive clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), exudation (oozing and crusting), excoriation (evidence of scratching), induration (hardening)/papulation (formation of papules), lichenification (epidermal thickening), OR pruritus (itching)].
- Coverage Duration for continuation of therapy is 12 months with a quantity limit not to exceed 60 gm per 30 days. Coverage for 120 gm per 30 days will be provided when 5% or greater body surface area is affected

#### REFERENCES

1. Crisaborole [package insert]. New York, NY: Pfizer Inc.; December 2016.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed December 2016.
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4. Eichenfield LF, Tom WL, et. al. Guidelines of care for the management of atopic dermatitis: Section 2. management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol* 2014;71:116-32.
5. Paller AS, Tom WL, et. al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. *J Am Acad Dermatol*. 2016 Jul 11; 75 (3) 494-503.e4.
6. Berke R, Singh A, et al. Atopic Dermatitis: An Overview. *American Family Physician*. July 2012; 86(1): 35-42.
7. Topical Corticosteroids. *Facts and Comparisons*. Facts & Comparisons [database online]. St. Louis, MO: Wolters Kluwer Health Inc; 2014. Accessed December 2016.
8. Pfizer receives FDA Approval for Eucrisa (crisaborole), a Novel Non-Steroidal Topical Ointment for Mild to Moderate Atopic Dermatitis (Eczema). Pfizer Press Release. December 14, 2016.
9. Dermatologic Therapies-Basic Dermatology Curriculum. American Academy of Dermatology. June 8, 2011. <https://www.aad.org/File%20Library/Global%20navigation/Education%20and%20quality%20care/Basic%20Dermatology%20Curriculum/Dermatologic-Therapies.pptx>

# BAVENCIO<sup>®</sup>

(avelumab) [injection, for intravenous use]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	Tier 6 – Non-preferred Specialty
<b>Formulary Alternatives</b>	<i>Off-label only:</i> KEYTRUDA <sup>®</sup> (pembrolizumab), YERVOY <sup>®</sup> (ipilimumab), OPDIVO <sup>®</sup> (nivolumab), TECENTRIQ <sup>®</sup> (atezolizumab)
<b>FDA Approval</b>	March 23, 2017 – Accelerated Approval; Orphan drug; Breakthrough therapy
<b>Therapeutic Class</b>	Antineoplastic agent, Programmed death ligand-1 (PD-L1) blocking monoclonal antibody (immune checkpoint inhibitor)
<b>Indications and Usage</b>	Treatment of adults and pediatric patients 12 years and older with metastatic Merkel cell carcinoma (MCC)
<b>Dosing</b>	<p><b><u>Forms &amp; Strengths:</u></b> Injection: 200 mg/10 mL solution in single-dose vial</p> <p><b><u>Administration:</u></b> Premedicate with acetaminophen and an antihistamine for the first 4 infusions and subsequently as needed; Give 10 mg/kg IV infusion over 60 minutes every 2 weeks</p> <p><b><u>Adjustments:</u></b> Hold for immune-mediated conditions; Slow infusion rate or stop for infusion-related reactions</p>
<b>Safety</b>	<p><b><u>Contraindications:</u></b> None</p> <p><b><u>Warnings:</u></b> Immune-mediated pneumonitis, hepatitis, colitis, endocrinopathies, nephritis and renal dysfunction; infusion-related reactions; embryo-fetal toxicity</p>
<b>Key Points</b>	First and only FDA-approved anti-PD-L1 immunotherapy for MCC; JAVELIN Merkel 200 trial studied 88 patients with confirmed mMCC whose disease had progressed on or after chemotherapy, it is currently being investigated in patients with mMCC that have not been previously treated with chemotherapy; Accelerated approval mandates further clinical trials to confirm clinical benefit and are currently being conducted
<b>Treatment Guidelines</b>	Surgery to remove localized tumors; radiation therapy; immune checkpoint inhibitor (avelumab); chemotherapy (etoposide and carboplatin); VOTRIENT <sup>®</sup> (pazopanib) with or without Sandostatin
<b>Place in Therapy</b>	First-line therapy in patients with advanced mMCC, such as those with distant metastases (stage IV) or MCC that cannot be removed surgically.

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use BAVENCIO safely and effectively. See full prescribing information for BAVENCIO.

**BAVENCIO® (avelumab) injection, for intravenous use**

Initial U.S. Approval: 2017

**INDICATIONS AND USAGE**

BAVENCIO is a programmed death ligand-1 (PD-L1) blocking antibody indicated for the treatment of adults and pediatric patients 12 years and older with metastatic Merkel cell carcinoma (MCC). (1)

This indication is approved under accelerated approval. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. (1, 14)

**DOSAGE AND ADMINISTRATION**

- Administer 10 mg/kg as an intravenous infusion over 60 minutes every 2 weeks. (2.1)
- Premedicate with acetaminophen and an antihistamine for the first 4 infusions and subsequently as needed. (2.2)

**DOSAGE FORMS AND STRENGTHS**

Injection: 200 mg/10 mL (20 mg/mL) solution in single-dose vial. (3)

**CONTRAINDICATIONS**

None. (4)

**WARNINGS AND PRECAUTIONS**

- Immune-mediated pneumonitis: Withhold for moderate pneumonitis; permanently discontinue for severe, life-threatening or recurrent moderate pneumonitis. (5.1)

- Immune-mediated hepatitis: Monitor for changes in liver function. Withhold for moderate hepatitis; permanently discontinue for severe or life-threatening hepatitis. (5.2)
- Immune-mediated colitis: Withhold for moderate or severe colitis; permanently discontinue for life-threatening or recurrent severe colitis. (5.3)
- Immune-mediated endocrinopathies: Withhold for severe or life-threatening endocrinopathies (5.4)
- Immune-mediated nephritis and renal dysfunction: Withhold for moderate or severe nephritis and renal dysfunction; permanently discontinue for life-threatening nephritis or renal dysfunction. (5.5)
- Infusion-related reactions: Interrupt or slow the rate of infusion for mild or moderate infusion-related reactions. Stop the infusion and permanently discontinue BAVENCIO for severe or life-threatening infusion-related reactions. (5.7)
- Embryo-fetal toxicity: BAVENCIO can cause fetal harm. Advise of potential risk to a fetus and use of effective contraception. (5.8, 8.1, 8.3)

**ADVERSE REACTIONS**

Most common adverse reactions (reported in  $\geq 20\%$  of patients) were fatigue, musculoskeletal pain, diarrhea, nausea, infusion-related reaction, rash, decreased appetite, and peripheral edema. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact EMD Serono at 1-800-283-8088 ext. 5563 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**USE IN SPECIFIC POPULATIONS**

Lactation: Advise not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 3/2017

**FULL PRESCRIBING INFORMATION: CONTENTS\*****1 INDICATIONS AND USAGE****2 DOSAGE AND ADMINISTRATION**

2.1 Recommended Dosage

2.2 Premedication

2.3 Dose Modifications

2.4 Preparation and Administration

**3 DOSAGE FORMS AND STRENGTHS****4 CONTRAINDICATIONS****5 WARNINGS AND PRECAUTIONS**

5.1 Immune-Mediated Pneumonitis

5.2 Immune-Mediated Hepatitis

5.3 Immune-Mediated Colitis

5.4 Immune-Mediated Endocrinopathies

5.5 Immune-Mediated Nephritis and Renal Dysfunction

5.6 Other Immune-Mediated Adverse Reactions

5.7 Infusion-Related Reactions

5.8 Embryo-Fetal Toxicity

**6 ADVERSE REACTIONS**

6.1 Clinical Trials Experience

6.2 Immunogenicity

**8 USE IN SPECIFIC POPULATIONS**

8.1 Pregnancy

8.2 Lactation

8.3 Females and Males of Reproductive Potential

8.4 Pediatric Use

8.5 Geriatric Use

**10 OVERDOSAGE****11 DESCRIPTION****12 CLINICAL PHARMACOLOGY**

12.1 Mechanism of Action

12.3 Pharmacokinetics

**13 NONCLINICAL TOXICOLOGY**

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

13.2 Animal Toxicology and/or Pharmacology

**14 CLINICAL STUDIES****16 HOW SUPPLIED/STORAGE AND HANDLING****17 PATIENT COUNSELING INFORMATION**

\*Sections or subsections omitted from the full prescribing information are not listed



## SPECIALTY GUIDELINE MANAGEMENT

### BAVENCIO (avelumab)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Treatment of adults and pediatric patients 12 years and older with metastatic Merkle cell carcinoma

All other indications are considered experimental/investigational and are not a covered benefit.

##### II. CRITERIA FOR APPROVAL

**Merkle Cell Carcinoma**

Authorization of 12 months may be granted for members prescribed Bavencio for the treatment of metastatic Merkle cell carcinoma.

##### III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

##### IV. REFERENCES

1. Bavencio [package insert]. New York, NY: Pfizer Inc.; March 2017.

#### POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date:

Revision Information	
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# ZEJULA<sup>®</sup>

(niraparib) [formulation]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	Tier 6 – Non-preferred Specialty
<b>Formulary Alternatives</b>	LYNPARZA <sup>®</sup> (olaparib), RUBRACA <sup>®</sup> (rucaparib)
<b>FDA Approval</b>	March 27, 2017
<b>Therapeutic Class</b>	Antineoplastic agent; poly(ADP-ribose) polymerase (PARP) Inhibitor
<b>Indications and Usage</b>	Maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy
<b>Dosing</b>	<p><b><u>Forms &amp; Strengths:</u></b> Capsules: 100 mg</p> <p><b><u>Administration:</u></b> 300 mg once daily with or without food, continue until disease progression or unacceptable adverse reaction</p> <p><b><u>Adjustments:</u></b> For adverse reactions, consider interruption of treatment, dose reduction, or dose discontinuation</p>
<b>Safety</b>	<p><b><u>Contraindications:</u></b> None</p> <p><b><u>Warnings:</u></b> Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML); Bone Marrow Suppression; Cardiovascular Effects; Embryo-Fetal Toxicity</p>
<b>Key Points</b>	ZEJULA is the only PARP inhibitor that has demonstrated a clinically meaningful increase in progression-free survival (PFS) in women with recurrent ovarian cancer, regardless of BRCA mutation or biomarker status
<b>Treatment Guidelines</b>	Surgery (USO, hysterectomy, cytoreductive), chemotherapy (taxane and platinum doublet), targeted therapy (bevacizumab, olaparib, pazopanib), hormone therapy (tamoxifen, anastrozole, leuprolide), clinical trials
<b>Place in Therapy</b>	New treatment option for patients who have responded positively to a primary treatment that may help delay relapse

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use ZEJULA safely and effectively. See full prescribing information for ZEJULA.

**ZEJULA™ (niraparib) capsules, for oral use**

Initial U.S. Approval: 2017

**INDICATIONS AND USAGE**

ZEJULA is a poly(ADP-ribose) polymerase (PARP) inhibitor indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. (1)

**DOSAGE AND ADMINISTRATION**

- Recommended dose is 300 mg taken once daily with or without food. (2.1)
- Continue treatment until disease progression or unacceptable adverse reaction. (2.1, 2.2)
- For adverse reactions, consider interruption of treatment, dose reduction, or dose discontinuation. (2.2)

**DOSAGE FORMS AND STRENGTHS**

Capsules: 100 mg (3)

**CONTRAINDICATIONS**

None.

**WARNINGS AND PRECAUTIONS**

- Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML): MDS/AML occurred in patients exposed to ZEJULA, and some cases were fatal. Monitor patients for hematological toxicity and discontinue if MDS/AML is confirmed (5.1)

- Bone Marrow Suppression: Test complete blood counts weekly for the first month, monthly for the next 11 months and periodically thereafter for clinically significant changes. (5.2)
- Cardiovascular Effects: Monitor blood pressure and heart rate monthly for the first year and periodically thereafter during treatment with ZEJULA. Manage with antihypertensive medications as well as adjustment of the ZEJULA dose, if necessary. (5.3)
- Embryo-Fetal Toxicity: ZEJULA can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception. (5.4, 8.1, 8.3)

**ADVERSE REACTIONS**

Most common adverse reactions (incidence  $\geq 10\%$ ) are thrombocytopenia, anemia, neutropenia, leukopenia, palpitations, nausea, constipation, vomiting, abdominal pain/distention, mucositis/stomatitis, diarrhea, dyspepsia, dry mouth, fatigue/asthenia, decreased appetite, urinary tract infection, AST/ALT elevation, myalgia, back pain, arthralgia, headache, dizziness, dysgeusia, insomnia, anxiety, nasopharyngitis, dyspnea, cough, rash, and hypertension. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact TESARO at 1-844-4-tesaro or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**USE IN SPECIFIC POPULATIONS**

- Lactation: Advise women not to breastfeed during treatment and for 1 month after receiving the final dose. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 3/2017

**FULL PRESCRIBING INFORMATION: CONTENTS\*****1 INDICATIONS AND USAGE****2 DOSAGE AND ADMINISTRATION**

- 2.1 Recommended Dosage
- 2.2 Dose Adjustments for Adverse Reactions

**3 DOSAGE FORMS AND STRENGTHS****4 CONTRAINDICATIONS****5 WARNINGS AND PRECAUTIONS**

- 5.1 Myelodysplastic Syndrome/Acute Myeloid Leukemia
- 5.2 Bone Marrow Suppression
- 5.3 Cardiovascular Effects
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**6 ADVERSE REACTIONS**

- 6.1 Clinical Trials Experience

**8 USE IN SPECIFIC POPULATIONS**

- 8.1 Pregnancy
- 8.2 Lactation
- 8.3 Females and Males of Reproductive Potential
- 8.4 Pediatric Use
- 8.5 Geriatric Use
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## SPECIALTY GUIDELINE MANAGEMENT

### ZEJULA (niraparib)

**POLICY**

**I. INDICATIONS**

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

ZeJula indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy

All other indications are considered experimental/investigational and are not a covered benefit.

**II. CRITERIA FOR INITIAL APPROVAL**

Authorization of 12 months may be granted for maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer when all of the following criteria are met:

- A. The member is in a complete or partial response to platinum-based chemotherapy.
- B. Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

**III. CONTINUATION OF THERAPY**

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

**IV. REFERENCES**

- 1. Zejula [package insert]. Waltham, MA: Tesaro, Inc.; March 2017.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

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# RUCONEST<sup>®</sup>

(C1 esterase inhibitor [recombinant]) [intravenous use]

<b>P&amp;T Consideration</b>	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
<b>Proposed Tier Placement</b>	Tier 5 – Preferred Specialty
<b>Formulary Alternatives</b>	CINRYZE <sup>®</sup> (C1 esterase inhibitor [human]), FIRAZYR <sup>®</sup> (icatibant), KALBITOR <sup>®</sup> (ecallantide)
<b>FDA Approval</b>	July 16, 2014
<b>Therapeutic Class</b>	C1 Esterase Inhibitor (C1-INH)
<b>Indications and Usage</b>	Treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE); Limitation of use: effectiveness was not established in HAE patients with laryngeal attacks
<b>Dosing</b>	<p><b><u>Forms &amp; Strengths:</u></b> 2100 IU Lyophilized powder for reconstitution for injection in a single-use vial.</p> <p><b><u>Administration:</u></b> reconstitute and administer as a slow intravenous injection over 5 minutes; &lt; 84 kg = 50 IU per kg; ≥ 84 kg = 4200 IU (2 vials)</p> <p><b><u>Adjustments:</u></b> None</p>
<b>Safety</b>	<p><b><u>Contraindications:</u></b> allergy to rabbits and rabbit-derived products; hypersensitivity to C1-INH preparations</p> <p><b><u>Warnings:</u></b> Hypersensitivity reactions, including anaphylaxis; Arterial and venous thromboembolic (TE) events</p>
<b>Key Points</b>	As a recombinant C1-INH there is no known risk of human viral transmission; is approved for acute attacks
<b>Treatment Guidelines</b>	Acute attacks: C1-INH or kallikrein inhibitor, or if those are unavailable, fresh frozen plasma; In HAE with normal C1 inhibitor levels, infusion of C1-INH has proven to be ineffective
<b>Place in Therapy</b>	Treatment of choice in acute HAE types I and II

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use RUCONEST® safely and effectively. See full prescribing information for RUCONEST.

**RUCONEST (C1 esterase inhibitor [recombinant])**  
**For Intravenous Use, Lyophilized Powder For Reconstitution**  
**Initial U.S. Approval: [year]**

**INDICATIONS AND USAGE**

RUCONEST is a C1 esterase inhibitor [recombinant] indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE). (1)

Limitation of Use: Effectiveness was not established in HAE patients with laryngeal attacks.

**DOSAGE AND ADMINISTRATION**

For Intravenous Use Only.

- Reconstitute each vial (2100 IU) by adding 14 mL sterile Water for Injection per vial to obtain a solution of 150 IU per mL.
- Administer the reconstituted solution at room temperature as a slow intravenous injection over approximately 5 minutes.
- Appropriately trained patients may self-administer upon recognition of an HAE attack. (2.3)

Recommended dose of RUCONEST for an acute attack

Body weight	RUCONEST Dose for Intravenous Injection	Volume (mL) of Reconstituted Solution (150 IU/mL) to be Administered
< 84 kg	50 IU per kg	Body weight in kg divided by 3
≥ 84 kg	4200 IU (2 vials)	28 mL

If the attack symptoms persist, an additional (second) dose can be administered at the recommended dose level. Do not exceed 4200 IU per

dose. No more than two doses should be administered within a 24 hour period.

**DOSAGE FORMS AND STRENGTHS**

2100 IU Lyophilized powder for reconstitution for injection in a single-use vial. (3)

**CONTRAINDICATIONS**

- Known or suspected allergy to rabbits and rabbit-derived products.
- History of immediate hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor preparations. (4)

**WARNINGS AND PRECAUTIONS**

- Hypersensitivity reactions, including anaphylaxis may occur. Should symptoms occur, discontinue RUCONEST and administer appropriate treatment. (5.1)
- Serious arterial and venous thromboembolic (TE) events have been reported at the recommended dose of plasma derived C1 esterase inhibitor products in patients with risk factors. Monitor patients with known risk factors for TE events during and after RUCONEST administration. (5.2)

**ADVERSE REACTIONS**

- The serious adverse reaction reported in clinical trials is anaphylactic reaction. (6.1)
- The common adverse reactions (≥ 2%) reported in clinical trials were headache, nausea, and diarrhea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Salix Pharmaceuticals, Inc. at 1-800-508-0024 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**USE IN SPECIFIC POPULATIONS**

Pregnancy: Limited animal data. No human data. Use only if clearly needed. (8.1)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: [XX/20XX]

**FULL PRESCRIBING INFORMATION: CONTENTS\***

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- Carcinogenesis, Mutagenesis, Impairment of Fertility
- Animal Toxicology and/or Pharmacology

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\*Sections or subsections omitted from the full prescribing information are not listed.



## **SPECIALTY GUIDELINE MANAGEMENT**

### **RUCONEST (recombinant C1 esterase inhibitor)**

#### **POLICY**

##### **I. INDICATIONS**

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Treatment of acute attacks in adults and adolescent patients with hereditary angioedema (HAE)

All other indications are considered experimental/investigational and are not a covered benefit.

##### **II. REQUIRED DOCUMENTATION**

The following information is necessary to initiate the prior authorization review: C4 levels and C1 inhibitor functional and antigenic protein levels.

##### **III. CRITERIA FOR INITIAL APPROVAL**

Indefinite authorization may be granted for treatment of acute HAE attacks when all of the following criteria are met:

1. Diagnostic laboratory testing for HAE has been performed (eg, C4 levels, C1 inhibitor functional and antigenic protein levels).
2. With C1 inhibitor deficiency: C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test.
3. With normal C1 inhibitor: Other causes of angioedema have been ruled out (eg, drug-induced) and either of the following criteria are met:
  - a. Member has tested positive for the F12 gene mutation or
  - b. The member has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (e.g., cetirizine) for at least one month.

##### **IV. CONTINUATION OF THERAPY**

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

##### **V. DOSAGE AND ADMINISTRATION**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

## VI. REFERENCES

1. Ruconest [package insert]. Raleigh, NC: Santarus, Inc.; February 2015.
2. Bowen T, Cicardi M, Farkas H, et al. 2010 International consensus algorithm for the diagnosis, therapy, and management of hereditary angioedema. *Allergy Asthma Clin Immunol.* 2010;6(1):24.
3. Cicardi M, Bork K, Caballero T, et al. Hereditary Angioedema International Working Group. Evidence-based recommendations for the therapeutic management of angioedema owing to hereditary C1 inhibitor deficiency: consensus report of an International Working Group. *Allergy.* 2012;67:147-157.
4. Zuraw BL, Banerji A, Bernstein JA, et al. US Hereditary Angioedema Association Medical Advisory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. *J Allergy Clin Immunol: In Practice.* 2013; 1(5): 458-467.
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6. Craig T, Pursun EA, Bork K, et al. WAO guideline for the management of hereditary angioedema. *WAO Journal.* 2012; 5:182-199.
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8. Cicardi M, Aberer W, Banerji A, et al. Classification, diagnosis, and approach to treatment for angioedema: consensus report from the Hereditary Angioedema International Working Group. *Allergy.* 2014;69: 602-616.
9. Bowen T. Hereditary angioedema: beyond international consensus – circa December 2010 – The Canadian Society of Allergy and Clinical Immunology Dr. David McCourtie Lecture. *Allergy Asthma Clin Immunol.* 2011;7(1):1.
10. Bernstein J. Update on angioedema: Evaluation, diagnosis, and treatment. *Allergy and Asthma Proceedings.* 2011;32(6):408-412.
11. Longhurst H, Cicardi M. Hereditary angio-edema. *Lancet.* 2012;379:474-481.

## POLICY IMPLEMENTATION/REVISION INFORMATION

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## BINDER DIVIDER

“Utilization Management”





A Division of the Department of State Treasurer

## SPECIALTY GUIDELINE MANAGEMENT

### RASUVO (methotrexate injection)

#### POLICY

##### A. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

##### FDA-Approved Indications

- **Rheumatoid Arthritis including Polyarticular Juvenile Idiopathic Arthritis**  
Rasuvo is indicated in the management of selected adults with severe, active rheumatoid arthritis (RA) or children with active polyarticular juvenile idiopathic arthritis, who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs).
- **Psoriasis**  
Rasuvo is indicated in adults for the symptomatic control of severe, recalcitrant, disabling psoriasis that is not adequately responsive to other forms of therapy, but only when the diagnosis has been established, as by biopsy and/or after dermatologic consultation. It is important to ensure that a psoriasis “flare” is not due to an undiagnosed concomitant disease affecting immune responses.

All other indications are considered experimental/investigational and are not a covered benefit.

##### B. CRITERIA FOR APPROVAL

###### 1. RA and pJIA

Authorization of 24 months may be granted for members who meet ANY of the following criteria:

- a. Member has tried and had an inadequate response or intolerance to generic methotrexate.
- b. Member has an inability to prepare and administer generic injectable methotrexate.

###### 2. Psoriasis

Authorizations of 24 months may be granted for members who meet BOTH of the following criteria:

- a. Member has tried and had an inadequate response or intolerance to generic methotrexate.
- b. Member has tried and had an insufficient response to another form of therapy (e.g., topical therapy, phototherapy [e.g., UVB, PUVA], other systemic agents [e.g., cyclosporine, acitretin]).

##### C. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet ALL initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Rasuvo as evidenced by low disease activity or improvement in signs and symptoms of the condition.

##### D. DOSAGE AND ADMINISTRATION

###### 1. Dosing Limits

The following dosing limits apply:

- 30 mg per week

##### REFERENCES

1. Rasuvo [package insert]. Chicago, IL: Medac Pharma Inc.; July 2014.
2. Singh JA, Furst DE, Bharat A, et al. 2012 Update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res.* 2012;64(5):625-639.

3. Smolen JS, Landewe R, Breedveld FC, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2013 update. *Ann Rheum Dis*. Published Online First: [October 25, 2013].
4. Beukelman T, Patkar NM, Saag KG, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. *Arthritis Care Res*. 2011;63(4):465-482.
5. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 4: Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. *J Am Acad Dermatol*. 2009;61:451-485.

#### **POLICY IMPLEMENTATION/REVISION INFORMATION**

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Original Implementation Date: 1/1/2017

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## SPECIALTY GUIDELINE MANAGEMENT

### ENBREL (etanercept)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

###### A. FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis (RA)
2. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
3. Active psoriatic arthritis (PsA)
4. Active ankylosing spondylitis (AS)
5. Moderate to severe chronic plaque psoriasis (PsO)

###### B. Compendial Uses

1. Axial spondyloarthritis
2. Reactive arthritis

All other indications are considered experimental/investigational and are not a covered benefit.

##### II. EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions:

- A. Untreated latent TB infection (treatment must be initiated prior to starting Enbrel)
- B. Active tuberculosis infection (treatment must be completed prior to starting Enbrel)

##### III. CRITERIA FOR INITIAL APPROVAL

###### A. **Moderately to severely active rheumatoid arthritis (RA)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Enbrel, any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Enbrel.
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 25 mg/week).
  - b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

###### B. **Active polyarticular juvenile idiopathic arthritis (pJIA)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Enbrel or any other biologic DMARD indicated for active polyarticular juvenile idiopathic arthritis in a

paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Enbrel.

2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate.
  - b. Member has intolerance or contraindication to methotrexate (see Appendix A).

**C. Active psoriatic arthritis (PsA)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Enbrel or any other biologic DMARD indicated for active psoriatic arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Enbrel.
2. Authorization of 24 months may be granted for treatment of active PsA when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate, sulfasalazine, or leflunomide.
  - b. Member has intolerance or contraindication to methotrexate, sulfasalazine, or leflunomide (see Appendix A and Appendix B).
  - c. Member has active enthesitis and/or dactylitis (i.e., sausage digit).
  - d. Member has predominant axial disease (i.e., extensive spinal involvement).

**D. Active ankylosing spondylitis (AS) and axial spondyloarthritis**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Enbrel or any other biologic DMARD indicated for active ankylosing spondylitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Enbrel.
2. Authorizations of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.
  - b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix C).

**E. Moderate to severe chronic plaque psoriasis**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Enbrel or any other biologic DMARD indicated for the treatment of moderate to severe chronic plaque psoriasis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Enbrel.
2. Authorization of 24 months may be granted for treatment of moderate to severe chronic plaque psoriasis when all of the following criteria are met:
  - a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
  - b. Member meets any of the following criteria:
    - i. Member has had an insufficient response to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin despite adequate dosing and duration (see Appendix D).
    - ii. Member has had an intolerance or adverse event to a trial of phototherapy or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
    - iii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix E).
    - iv. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

**F. Reactive arthritis**

Authorization of 24 months may be granted for treatment of reactive arthritis.

**IV. CONTINUATION OF THERAPY**

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Enbrel as evidenced by low disease activity or improvement in signs and symptoms of the condition.

## V. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The following dosing limits apply:

- A. Plaque psoriasis
  1. Initial loading dose for the initial 3 months: 100 mg per week; 1200 mg total for 3 months.
  2. Maintenance dose: 50 mg per week
- B. All other indications
  1. 50 mg per week

## VI. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received at least a 28-day supply of Enbrel, any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit within the previous 120 days of the continuation request are exempted from all requirements related to TB screening and treatment in this Policy.

## VII. APPENDICES

### Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

### Appendix B: Examples of Contraindications to Sulfasalazine and/or Leflunomide

1. History of intolerance or adverse event
2. Hypersensitivity
3. Intestinal obstruction
4. Porphyria
5. Pregnancy
6. Significant drug interaction
7. Urinary obstruction

### Appendix C: Examples of Contraindications to the Use of NSAIDs

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

**Appendix D: Time to Clinical Efficacy and Dose for Treatment of Plaque Psoriasis with Phototherapy, Methotrexate, Cyclosporine and Acitretin.**

1. Phototherapy: at least 4 weeks or 10 sessions
2. Methotrexate: at least 1 month following a titration to the maximum tolerated dose. The maximum titrated dose must be 10 mg/week or higher.
3. Cyclosporine: 2.5 mg/kg/day or higher for at least 2 months
4. Acitretin: 25 mg/day or higher for at least 3 months

**Appendix E: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.**

1. Alcohol intake / alcoholic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

**VIII. REFERENCES**

1. Enbrel [package insert]. Thousand Oaks, CA: Immunex Corporation; March 2015.
2. van der Heijde D, Sieper J, Maksymowych WP, et al. 2010 Update of the international ASAS recommendations for the use of anti-TNF agents in patients with axial spondyloarthritis. *Ann Rheum Dis*. 2011;70:905-908.
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4. Smolen JS, Landewé R, Breedveld FC, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2013 update. *Ann Rheum Dis*. 2014;73:492-509.
5. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
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8. Menter A, Gottlieb A, Feldman SR, et al. Guidelines for the management of psoriasis and psoriatic arthritis. Section 1: Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2008;58(5):826-850.
9. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
10. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies; 2015 update. *Ann Rheum Dis*. 2016;75(3):499-510.
11. Gladman DD, Antoni C, P Mease, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis*. 2005;64(Suppl II):ii14–ii17.
12. Braun J, van den Berg R, Baraliakos X, et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis* 2011;70:896–904.
13. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol*. 2015: 10.1002/art.39298. [Epub ahead of print].

**POLICY IMPLEMENTATION/REVISION INFORMATION**

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## SPECIALTY GUIDELINE MANAGEMENT

### HUMIRA (adalimumab)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

###### A. FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis (RA)
2. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
3. Active psoriatic arthritis (PsA)
4. Active ankylosing spondylitis (AS)
5. Moderately to severely active Crohn's disease (CD)
6. Moderate to severely active ulcerative colitis (UC)
7. Moderate to severe chronic plaque psoriasis (PsO)
8. Moderate to severe Hidradenitis Suppurativa
9. Non-infectious intermediate, posterior and panuveitis

###### B. Compendial Uses

Axial spondyloarthritis

All other indications are considered experimental/investigational and are not a covered benefit.

##### II. EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions:

- A. Untreated latent TB infection (treatment must be initiated prior to starting Humira)
- B. Active tuberculosis infection (treatment must be completed prior to starting Humira)

##### III. CRITERIA FOR INITIAL APPROVAL

###### A. **Moderately to severely active rheumatoid arthritis (RA)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira, any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 25 mg/week).
  - b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

###### B. **Active polyarticular juvenile idiopathic arthritis (pJIA)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira or any other biologic DMARD indicated for active polyarticular juvenile idiopathic arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate.
  - b. Member has intolerance or contraindication to methotrexate (see Appendix A).

**C. Active psoriatic arthritis (PsA)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira or any other biologic DMARD indicated for active psoriatic arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
2. Authorization of 24 months may be granted for treatment of active PsA when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate, sulfasalazine, or leflunomide.
  - b. Member has intolerance or contraindication to methotrexate, sulfasalazine, or leflunomide (see Appendix A and Appendix B).
  - c. Member has active enthesitis and/or dactylitis (i.e., sausage digit).
  - d. Member has predominant axial disease (i.e., extensive spinal involvement).

**D. Active ankylosing spondylitis (AS) and axial spondyloarthritis**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira or any other biologic DMARD indicated for active ankylosing spondylitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
2. Authorizations of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
  - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.
  - b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix C).

**E. Moderately to severely active Crohn's disease (CD)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira or any other biologic DMARD indicated for the treatment of Crohn's disease in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
2. Authorization of 24 months may be granted for treatment of moderately to severely active CD when the following criteria is met:
  - a. Member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix D).

**F. Moderately to severely active ulcerative colitis (UC)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira or any other biologic DMARD indicated for moderately to severely active ulcerative colitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
  - a. Members who are currently receiving or have received a biologic DMARD other than Humira must have lost response to a previous TNF inhibitor therapy due to antibody formation.
2. Authorization of 24 months may be granted for treatment of moderately to severely active UC when all of the following criteria are met:
  - a. Member is naïve to TNF inhibitor therapy or has lost response to previous TNF inhibitor therapy due to antibody formation.

- b. Member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix E)

**G. Moderate to severe chronic plaque psoriasis (PsO)**

1. Authorization of 24 months may be granted for members who have received at least a 28-day supply of Humira or any other biologic DMARD indicated for the treatment of moderate to severe chronic plaque psoriasis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Humira.
2. Authorization of 24 months may be granted for treatment of moderate to severe chronic plaque psoriasis when all of the following criteria are met:
  - a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
  - b. Member meets any of the following criteria:
    - i. Member has had an insufficient response to either phototherapy (e.g., UVB, PUVA) or a pharmacologic treatment with methotrexate, cyclosporine or acitretin despite adequate dosing and duration (see Appendix F).
    - ii. Member has had an intolerance or adverse event to a trial of phototherapy or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
    - iii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix G).
    - iv. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

**H. Moderate to severe hidradenitis suppurativa**

Authorization of 24 months may be granted for treatment of moderate to severe hidradenitis suppurativa.

**I. Uveitis (non-infectious intermediate, posterior and panuveitis)**

Authorization of 24 months may be granted for treatment of non-infectious intermediate, posterior and panuveitis.

**IV. CONTINUATION OF THERAPY**

**A. For ulcerative colitis:**

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve clinical remission by treatment day 56 (week 8) and maintain positive clinical response with Humira thereafter as evidenced by low disease activity or improvement in signs and symptoms of ulcerative colitis.

**B. For all other indications:**

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Humira as evidenced by low disease activity or improvement in signs and symptoms of the condition.

**V. DOSAGE AND ADMINISTRATION**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The following dosing limits apply:

- A. Rheumatoid arthritis
  1. 40 mg per 2 weeks
  2. Without methotrexate due to intolerance or contraindication: 40 mg per week
- B. Psoriatic arthritis and ankylosing spondylitis
  1. 40 mg per 2 weeks
- C. Polyarticular juvenile idiopathic arthritis
  1. The dosing limit is determined based on the member's weight.
    - a. Less than 15 kg (33 lbs): 10 mg per 2 weeks
    - b. 15 kg (33 lbs) to 30 kg (66 lbs): 20 mg per 2 weeks

- c. 30 kg (66 lbs) or greater: 40 mg per 2 weeks
- D. Pediatric Crohn's disease
  - 1. The dosing limit is determined based on the member's weight.
    - a. Less than 40 kg (88 lbs)
      - Initial loading dose for the initial 15 days: 120 mg total
      - Maintenance dose: 20 mg per 2 weeks
    - b. 40 kg (88 lbs) or greater
      - Initial loading dose for the initial 15 days: 240 mg total
      - Maintenance dose: 40 mg per 2 weeks
- E. Adult Crohn's disease
  - 1. Initial loading dose for the initial 15 days: 240 mg total
  - 2. Maintenance dose: 40 mg per 2 weeks
- F. Ulcerative colitis
  - 1. Initial loading dose for the initial 15 days: 240 mg total
  - 2. Maintenance dose: 40 mg per 2 weeks
- G. Plaque psoriasis
  - 1. Initial loading dose for the initial 7 days: 80 mg once on day 1 only
  - 2. Maintenance dose: 40 mg per 2 weeks
- H. Hidradenitis suppurativa
  - 1. Initial loading dose for the initial 15 days: 240 mg total
  - 2. Maintenance dose: 40 mg per week

## VI. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)

Note: Members who have received at least a 28-day supply of Humira, any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit within the previous 120 days of the continuation request are exempted from requirements related to TB screening and treatment in this Policy.

## VII. APPENDICES

### Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

### Appendix B: Examples of Contraindications to Sulfasalazine and/or Leflunomide

1. History of intolerance or adverse event
2. Hypersensitivity
3. Intestinal obstruction
4. Porphyria
5. Pregnancy
6. Significant drug interaction
7. Urinary obstruction

### **Appendix C: Examples of Contraindications to the Use of NSAIDs**

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

### **Appendix D: Examples of Conventional Therapy Options for CD**

1. Mild to moderate disease – induction of remission:
  - a. Oral budesonide, oral mesalamine
  - b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
  - a. Azathioprine, mercaptopurine
  - b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
  - a. Prednisone, methylprednisolone intravenously (IV)
  - b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
  - a. Azathioprine, mercaptopurine
  - b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission
  - a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission
  - a. Azathioprine, mercaptopurine
  - b. Alternative: methotrexate IM

### **Appendix E: Examples of Conventional Therapy Options for UC**

1. Mild to moderate disease – induction of remission:
  - a. Oral mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa), balsalazide, olsalazine
  - b. Rectal mesalamine (e.g., Canasa, Rowasa)
  - c. Rectal hydrocortisone (e.g., Colocort, Cortifoam)
  - d. Alternatives: prednisone, azathioprine, mercaptopurine, sulfasalazine
2. Mild to moderate disease – maintenance of remission:
  - a. Oral mesalamine, balsalazide, olsalazine, rectal mesalamine
  - b. Alternatives: azathioprine, mercaptopurine, sulfasalazine
3. Severe disease – induction of remission:
  - a. Prednisone, hydrocortisone IV, methylprednisolone IV
  - b. Alternatives: cyclosporine IV, tacrolimus, sulfasalazine
4. Severe disease – maintenance of remission:
  - a. Azathioprine, mercaptopurine
  - b. Alternative: sulfasalazine
5. Pouchitis: Metronidazole, ciprofloxacin
  - a. Alternative: rectal mesalamine

### **Appendix F: Time to Clinical Efficacy and Dose for Treatment of Plaque Psoriasis with Phototherapy, Methotrexate, Cyclosporine and Acitretin.**

1. Phototherapy: at least 4 weeks or 10 sessions
2. Methotrexate: at least 1 month following a titration to the maximum tolerated dose. The maximum titrated dose must be 10 mg/week or higher.
3. Cyclosporine: 2.5 mg/kg/day or higher for at least 2 months
4. Acitretin: 25 mg/day or higher for at least 3 months

### **Appendix G: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.**

1. Alcohol intake / alcoholic liver disease
2. Breastfeeding
3. Drug interaction

4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

## VIII. REFERENCES

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## POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2017

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## SPECIALTY GUIDELINE MANAGEMENT

### CINRYZE (C1 esterase inhibitor)

#### POLICY

##### A. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

##### FDA-Approved Indication

- Routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema (HAE)

##### Compendial Use

- Treatment of acute HAE attacks

All other indications are considered experimental/investigational and are not covered benefits.

##### B. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review:

- C4 levels and C1 inhibitor functional and antigenic protein levels

##### C. CRITERIA FOR APPROVAL

###### 1. Hereditary Angioedema (HAE)

Indefinite authorization may be granted to members who meet ALL of the following criteria:

- Diagnostic laboratory testing for HAE has been performed (eg, C4 levels, C1 inhibitor functional and antigenic protein levels).
- For members with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test.
- For members with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug-induced) and the member meets EITHER of the following criteria:
  - Member tested positive for the F12 gene mutation.
  - Member has a family history of angioedema.

##### D. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

#### REFERENCES

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## INDICATION- SPECIFIC SPECIALTY GUIDELINE MANAGEMENT

### H.P. ACTHAR GEL (repository corticotropin injection)

#### POLICY

##### I. INDICATIONS

The indication-specific Specialty Guideline Management (SGM) program provides coverage for specific, but not all FDA labeled or compendial supported drug use based on plan design and the scope of the pharmacy benefit. This program provides coverage for H.P. Acthar Gel for the treatment of infantile spasms and exacerbations of multiple sclerosis if all of the approval criteria are met.

- A. **Infantile spasms:** as monotherapy for the treatment of infantile spasms in infants and children under 2 years of age
- B. **Multiple Sclerosis:** treatment of acute exacerbations of multiple sclerosis in adults

The use of H.P. Acthar for the treatment of all other indications listed in the FDA product labeling has not been proven to be superior to conventional therapies (e.g., corticosteroids, immunosuppressive agents) and has a significantly higher cost than the standard of care agents. Use of H. P. Acthar for these conditions is considered not medically necessary and is not a covered benefit.

- A. **Rheumatic Disorders:** as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: psoriatic arthritis; rheumatoid arthritis, including juvenile rheumatoid arthritis, ankylosing spondylitis
- B. **Collagen Diseases:** during an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, systemic dermatomyositis (polymyositis)
- C. **Dermatologic Diseases:** severe erythema multiforme, Stevens-Johnson syndrome
- D. **Allergic States:** serum sickness
- E. **Ophthalmic Diseases:** severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation
- F. **Respiratory Diseases:** symptomatic sarcoidosis
- G. **Edematous State:** to induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus

##### II. REQUIRED DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review for requests for treatment of multiple sclerosis exacerbations: chart notes detailing the outcomes of the most recent trial with IV methylprednisolone, including dosage and duration of treatment.

##### III. CRITERIA FOR INITIAL APPROVAL

###### A. Infantile Spasms

Authorization of 4 weeks may be granted to members who are less than 2 years of age for the treatment of infantile spasms.

**B. Multiple Sclerosis**

Authorization of 3 weeks may be granted to members for the treatment of acute exacerbations of multiple sclerosis when the member has had an inadequate response to a trial of IV methylprednisolone (for the current exacerbation).

**IV. CONTINUATION OF THERAPY****A. Infantile Spasms**

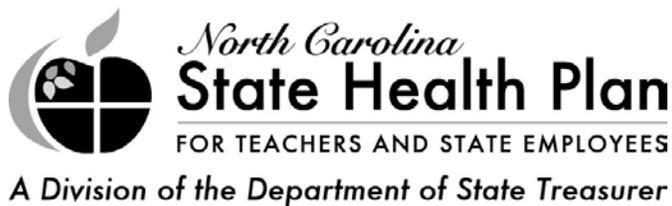
Authorization of 4 weeks may be granted to members requesting H.P. Acthar Gel for continuation of therapy when the member has shown substantial clinical benefit from therapy.

**B. Multiple sclerosis**

Authorization of 3 weeks may be granted for members requesting re-authorization for H.P. Acthar therapy when ALL initial authorization criteria are met.

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<b>DRUG CLASS</b>	<b>TOPICAL ANTIFUNGALS</b>
<b>BRAND NAME (generic)</b>	<b>JUBLIA (efinaconazole topical solution)</b>
	<b>KERYDIN (tavaborole topical solution)</b>
<b>Type: Initial Prior Authorization</b>	

### POLICY

#### FDA-APPROVED INDICATIONS

Jublia and Kerydin are indicated for the treatment of onychomycosis of the toenails due to *Trichophyton rubrum* or *Trichophyton mentagrophytes*.

#### COVERAGE CRITERIA

Jullia and Kerydin will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of onychomycosis of the toenail(s) confirmed by KOH preparation, fungal culture, or nail biopsy
- AND**
- The patient meets one of the following criteria:
    - Immunocompromised
    - Diabetes mellitus
    - Peripheral vascular disease
    - Swelling and/or redness surrounding nail
- AND**
- The patient had a treatment failure, intolerance, or contraindication to at least TWO of the following agents:
    - Oral terbinafine
    - Oral itraconazole
    - Topical ciclopirox

Quantity Limit may apply.

#### REFERENCES

1. NCSHP Prior Authorization Approval Policy.

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<b>DRUG CLASS</b>	<b>ANTIFUNGALS</b>
<b>BRAND NAME (generic)</b>	<b>NOXAFIL (posaconazole)</b>
<b>Type: Initial Prior Authorization</b>	

**POLICY**

**FDA-APPROVED INDICATIONS**

Noxafil is indicated for prophylaxis of invasive *Aspergillus* and *Candida* infections in patient who are at high risk of developing these infections.

Noxafil oral suspension is indicated for the treatment of oropharyngeal candidiasis, including oropharyngeal candidiasis refractory to itraconazole and/or fluconazole.

**COVERAGE CRITERIA**

Noxafil will be covered with prior authorization when the following criteria are met:

- The drug is being prescribed for the prophylaxis or treatment of invasive *Aspergillus*
- OR**
- The drug is being prescribed for use in the prophylaxis or treatment of a *Candida* infection that is refractory to fluconazole or itraconazole

Quantity Limit may apply.

**REFERENCES**

1. NCSHP Prior Authorization Approval Policy.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

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**DRUG CLASS**                      **ANTIFUNGAL**

**BRAND NAME**                      **VFEND**  
**(generic)**                              **(voriconazole)**

**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Vfend is indicated for use in patients 12 years of age and older in the treatment of the following fungal infections:

- Invasive aspergillosis. In clinical trials, the majority of isolates recovered were *Aspergillus fumigatus*. There were a small number of cases of culture-proven disease due to species of *Aspergillus* other than *A. fumigatus*.
- Candidemia in non-neutropenic patients and the following *Candida* infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds.
- Esophageal candidiasis.
- Serious fungal infections caused by *Scedosporium apiospermum* (asexual form of *Pseudallescheria boydii*) and *Fusarium* spp. including *Fusarium solani*, in patients intolerant of, or refractory to, other therapy.

Specimens for fungal culture and other relevant laboratory studies (including histopathology) should be obtained prior to therapy to isolate and identify causative organism(s). Therapy may be instituted before the results of the cultures and other laboratory studies are known. However, once these results become available, antifungal therapy should be adjusted accordingly.

### COVERAGE CRITERIA

Vfend will be covered with prior authorization when the following criteria are met:

- Voriconazole (Vfend) is being prescribed for a diagnosis of invasive aspergillosis infection OR salvage therapy (failure, intolerance or contraindications of other therapies) to treat a fungal infection caused by *Fusarium* or *Scedosporium* species

**OR**

- The patient has been diagnosed with candidemia, esophageal candidiasis, a disseminated (widespread) *Candida* infection in the skin, or a *Candida* infection in the abdomen, kidney, bladder wall, or wounds

**AND**

- The patient has experienced an inadequate treatment response, intolerance, or contraindication to fluconazole or itraconazole

### REFERENCES

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5. Walsh TJ, Anaissie EJ, Denning DW, et al. Treatment of Aspergillosis: Clinical Practice Guidelines of the Infectious Diseases Society of America. *Clinical Infectious Diseases* 2008; 46: 327-360.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

Prior Authorization

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## PRIOR AUTHORIZATION CRITERIA

### BRAND NAME (generic)

**FORTAMET**  
(metformin extended-release)

**GLUMETZA**  
(metformin extended-release)

***Type: Initial Prior Authorization***

### POLICY

#### FDA-APPROVED INDICATIONS

##### **Fortamet**

Fortamet is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

##### **Glumetza**

Glumetza is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

##### Important Limitations of Use

Glumetza should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

#### COVERAGE CRITERIA

Fortamet (metformin extended-release) and Glumetza (metformin extended-release) will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)
- AND**
- The patient has experienced an intolerance to generic Glucophage XR

#### REFERENCES

1. Fortamet [package insert]. Florham Park, NJ: Shionogi, Inc.; April 2012.
2. Glumetza [package insert]. Bridgewater, NJ: Salix Pharmaceuticals; April 2016.
3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed September 2016.
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<b>BRAND NAME (generic)</b>	<b>SAXENDA (liraglutide injection)</b>
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**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Saxenda is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial body mass index (BMI) of

- 30 kg/m<sup>2</sup> or greater (obese), or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, or dyslipidemia)

### Limitations of Use

- Saxenda is not indicated for the treatment of type 2 diabetes mellitus.
- Saxenda and Victoza both contain the same active ingredient, liraglutide, and therefore should not be used together. Saxenda should not be used in combination with any other GLP-1 receptor agonist.
- Saxenda has not been studied in patients taking insulin. Saxenda and insulin should not be used together.
- The effects of Saxenda on cardiovascular morbidity and mortality have not been established.
- The safety and effectiveness of Saxenda in combination with other products intended for weight loss, including prescription drugs, over-the-counter drugs, and herbal preparations, have not been established.
- Saxenda has not been studied in patients with a history of pancreatitis.

### COVERAGE CRITERIA

Saxenda will be covered with prior authorization when the following criteria are met:

- The patient has been receiving the requested drug for at least 16 weeks and the patient lost at least 4 percent of baseline body weight or has continued to maintain their weight loss
- OR**
- The requested medication will be used with a reduced calorie diet and increased physical activity **AND**
    - The patient has a body mass index (BMI) greater than or equal to 30 kg per square meter
- OR**
- The patient has a body mass index (BMI) greater than or equal to 27 kg per square meter **AND** has additional risk factors

### REFERENCES

1. Saxenda [package insert]. Plainsboro, NJ: Novo Nordisk Inc; January 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed July 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. [www.micromedexsolutions.com](http://www.micromedexsolutions.com) [available with subscription]. Accessed July 2016.
4. Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. National Heart, Lung, and Blood Institute. NIH Publication No. 12-7486. October 2012. [http://www.nhlbi.nih.gov/guidelines/cvd\\_ped/peds\\_guidelines\\_full.pdf](http://www.nhlbi.nih.gov/guidelines/cvd_ped/peds_guidelines_full.pdf). 141-159. Accessed July 2016.
5. Obesity. World Gastroenterology Organization Global Guideline. 2011. <http://www.worldgastroenterology.org/assets/export/userfiles/Obesity-Master%20Document%20for%20Website.pdf>. Accessed July 2016.
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7. Jensen MD, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation*. 2013;00:000–000.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

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<b>BRAND NAME (generic)</b>	<b>CONTRAVE (naltrexone HCl and bupropion HCl extended release)</b>
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**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Contrave is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial body mass index (BMI) of:

- 30 kg/m<sup>2</sup> or greater (obese), or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes)

### Limitations of Use:

- The effect of Contrave on cardiovascular morbidity and mortality has not been established.
- The safety and effectiveness of Contrave in combination with other products intended for weight loss, including prescription drugs, over-the-counter drugs, and herbal preparations, have not been established.

### COVERAGE CRITERIA

- Contrave will be covered with initial prior authorization for 4 months when the following criteria are met:
  - The requested medication will be used with a reduced calorie diet and increased physical activity **AND**
    - The patient has a body mass index (BMI) greater than or equal to 30 kg per square meter. **OR**
    - The patient has a body mass index (BMI) greater than or equal to 27 kg per square meter **AND** has additional risk factors.
- Contrave will be covered with renewal prior authorization for 36 months when the following criteria are met:
  - The patient has completed at least 4 months of Contrave therapy and lost at least 5 percent of baseline body weight or has continued to maintain their weight loss.

### REFERENCES

1. Contrave [package insert]. La Jolla, CA: Orexigen Therapeutics, Inc.; September 2014.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed July 2016.
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6. Fitch A, Everling L, Fox C, et al. Institute for Clinical Systems Improvement. Prevention and Management of Obesity for Adults. Updated May 2013. [https://www.icsi.org/\\_asset/s935hy/ObesityAdults.pdf](https://www.icsi.org/_asset/s935hy/ObesityAdults.pdf). Accessed July 2016.
7. Jensen MD, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation*. 2013;00:000–000.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

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<b>BRAND NAME (generic)</b>	<b>BELVIQ (lorcaserin)</b>
	<b>BELVIQ XR (lorcaserin) extended-release</b>

**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Belviq and Belviq XR are indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial body mass index (BMI) of:

- 30 kg/m<sup>2</sup> or greater (obese), or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes)

### Limitations of Use:

- The safety and efficacy of coadministration with other products intended for weight loss including prescription drugs (e.g., phentermine), over-the-counter drugs, and herbal preparations have not been established
- The effect on cardiovascular morbidity and mortality has not been established

### COVERAGE CRITERIA

Belviq and Belviq XR will be covered with prior authorization when the following criteria are met:

- The patient has completed at least 3 months of therapy with the requested drug **AND**
  - The patient has lost at least 5 percent of baseline body weight or has continued to maintain their weight loss

#### **OR**

- The requested medication will be used with a reduced calorie diet and increased physical activity **AND**
    - The patient has a body mass index (BMI) greater than or equal to 30 kg per square meter
- OR**
- The patient has a body mass index (BMI) greater than or equal to 27 kg per square meter **AND** has additional risk factors

### REFERENCES

1. Belviq [package insert]. Woodcliff Lake, NJ: Eisai Inc; December 2014.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed July 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. [www.micromedexsolutions.com](http://www.micromedexsolutions.com) [available with subscription]. Accessed July 2016.
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7. Jensen MD, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation*. 2013;00:000–000.

8. Belviq XR [package insert]. Woodcliff Lake, NJ: Eisai Inc; July 2016.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

Prior Authorization

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**DRUG CLASS****ANTI OBESITY AGENTS****BRAND NAME  
(generic)****benzphetamine products****diethylpropion products****phendimetrazine products****phentermine products (including SUPRENZA)*****Type: Initial Prior Authorization*****POLICY****FDA-APPROVED INDICATIONS****Benzphetamine**

Benzphetamine is indicated in the management of exogenous obesity as a short term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction in patients with an initial body mass index (BMI) of 30 kg/m<sup>2</sup> or higher who have not responded to appropriate weight reducing regimen (diet and/or exercise) alone. The limited usefulness of agents of this class should be weighed against possible risks inherent in their use. Benzphetamine is indicated for use as monotherapy only.

**Diethylpropion**

Diethylpropion is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction in patients with an initial body mass index of 30 kg/m<sup>2</sup> or higher and who have not responded to an appropriate weight reducing regimen (diet and/or exercise) alone. The usefulness of agents of this class should be measured against possible risk factors inherent in their use. Diethylpropion is indicated for use as monotherapy only.

**Phendimetrazine**

Phendimetrazine tartrate extended-release capsules are indicated in the management of exogenous obesity as a short term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction in patients with an initial body mass index (BMI) of greater than or equal to 30 kg/m<sup>2</sup> or greater than or equal to 27 kg/m<sup>2</sup> in the presence of other risk factors (e.g., controlled hypertension, diabetes, hyperlipidemia) who have not responded to appropriate weight reducing regimen (diet and/or exercise) alone.

Phendimetrazine tartrate (PDM) is indicated in the management of exogenous obesity as a short term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction in patients with an initial body mass index (BMI) of 30 kg/m<sup>2</sup> or higher who have not responded to appropriate weight reducing regimen (diet and/or exercise) alone. Phendimetrazine tartrate is indicated for use as monotherapy only.

**Phentermine**

Phentermine is indicated as a short-term (a few weeks) adjunct in a regimen of weight reduction based on exercise, behavioral modification, and caloric restriction, in the management of exogenous obesity for patients with an initial body mass index  $\geq 30$  kg/m<sup>2</sup>, or  $\geq 27$  kg/m<sup>2</sup> in the presence of other risk factors (e.g., controlled hypertension, diabetes, hyperlipidemia). The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use.

**COVERAGE CRITERIA**

Antiobesity agents will be covered with prior authorization when the following criteria are met:

- The patient has not received approval for 3 months of therapy within the past 365 days  
**AND**
- The requested medication will be used with a reduced calorie diet and increased physical activity **AND**
  - The patient has a body mass index (BMI) greater than or equal to 30 kg per square meter  
**OR**
  - The patient has a body mass index (BMI) greater than or equal to 27 kg per square meter **AND** has additional risk factors

**REFERENCES**

1. Adipex-P [package insert]. Horsham, PA: Teva Select Brands; July 2014.
2. Didrex [package insert]. New York, NY: Pharmacia and Upjohn Company; August 2010.
3. Diethylpropion [package insert]. Parsippany, NJ: Actavis Pharma, Inc.; March 2014.
4. Phendimetrazine [package insert]. Atlanta, GA: Mikart, Inc.; August 2013.
5. Phendimetrazine extended-release [package insert]. Princeton, NJ: Sandoz Inc.; February 2012.
6. Suprenza [package insert]. Cranford, NJ: Akrimax Pharmaceuticals, LLC; June 2013.
7. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed July 2016.
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11. Jensen MD, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation*. 2013;00:000–000.

**POLICY IMPLEMENTATION/REVISION INFORMATION**

Prior Authorization

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<b>DRUG CLASS</b>	<b>ACNE MEDICATIONS</b>
<b>BRAND NAME</b>	ACANYA
	ACZONE
	AKNE-MYCIN
	AZELEX
	CLINDAGEL
	EPIDUO
	FABIOR
	INVOA EASY PAD
	ONEXTON
	RIAX
	ROSAC
	ROSANIL
	SUMADAN
	SUMAXIN
	TRETIN-X
	VELTIN
	ZIANA

***Type: Post Step Therapy Prior Authorization***

**INITIAL STEP THERAPY**

If the patient has filled a prescription for at least a 1 day supply of any of the following generic products: benzoyl peroxide, clindamycin/benzoyl peroxide, clindamycin topical, erythromycin topical, erythromycin/benzoyl peroxide, sodium sulfacetamide, or sodium sulfacetamide/sulfur or generic tretinoin product within the past 30 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

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<b>DRUG CLASS</b>	<b>RETINOIDS (TOPICAL)</b>
<b>BRAND NAME (generic)</b>	<b>DIFFERIN (ALL TOPICAL) (adapalene)</b>

**Type: Initial Prior Authorization**

### POLICY

#### **FDA-APPROVED INDICATIONS**

Differin Gel 0.1% and Cream are indicated for the topical treatment of acne vulgaris.

Differin Gel 0.3% and Lotion are indicated for the topical treatment of acne vulgaris in patients 12 years of age and older.

#### **COVERAGE CRITERIA**

Prior Authorization will be required for all patients greater than 35 years old to ensure appropriate use.

Differin will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of acne vulgaris

#### **REFERENCES**

1. Differin Cream [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; November 2009.
2. Differin Gel 0.1% [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; April 2011.
3. Differin Gel 0.3% [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; December 2013.
4. Differin Lotion 0.1% [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; April 2013.
5. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. [www.micromedexsolutions.com](http://www.micromedexsolutions.com) [available with subscription]. Accessed June 2015.
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7. Strauss J, Krowchuk D, Leyden J, et al. Guidelines of Care for Acne Vulgaris Management. *J Am Acad Dermatol*. 2007;56:651-663.
8. Thiboutot D, Gollnick H, Bettoli V, et al. New Insights into the Management of Acne: An update from the Global Alliance to Improve Outcomes in Acne Group. *J Am Acad Dermatol*. 2009;60;S1-50.

#### **POLICY IMPLEMENTATION/REVISION INFORMATION**

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<b>DRUG CLASS</b>	<b>RETINOID (TOPICAL)</b>
<b>BRAND NAME (generic)</b>	<b>TAZORAC (ALL TOPICAL) (tazarotene)</b>

**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

#### **Tazorac (tazarotene) Cream**

Tazorac Cream 0.05% and 0.1% are indicated for the topical treatment of patients with plaque psoriasis.

Tazorac Cream 0.1% is also indicated for the topical treatment of patients with acne vulgaris.

#### **Tazorac (tazarotene) Gel**

Tazorac Gel 0.05% and 0.1% are indicated for the topical treatment of patients with stable plaque psoriasis of up to 20% body surface area involvement.

Tazorac Gel 0.1% is also indicated for the topical treatment of patients with facial acne vulgaris of mild to moderate severity.

The efficacy of Tazorac Gel in the treatment of acne previously treated with other retinoids or resistant to oral antibiotics has not been established.

### COVERAGE CRITERIA

Prior Authorization will be required for all patients greater than 35 years old to ensure appropriate use.

Tazorac will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for acne vulgaris  
**OR**
- The requested drug is being prescribed for plaque psoriasis AND it will be applied to less than 20 percent of the patient's body surface area  
**AND**
  - Patient has tried at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) OR the patient has experienced an adverse event, intolerance, or contraindication to topical corticosteroids  
[Note: The patient may still be using a corticosteroid product IN ADDITION TO Tazorac.]
- AND**
- Patient is NOT able to bear children  
**OR**
- Patient is able to bear children AND the pregnancy status of the patient has been evaluated, and the patient is aware of the potential risks of fetal harm and importance of birth control while using the requested drug

### REFERENCES

1. Tazorac Cream [package insert]. Irvine, CA: Allergan, Inc; December 2013.
2. Tazorac Gel [package insert]. Irvine, CA: Allergan, Inc; July 2014.
3. Avage [package insert]. Irvine, CA: Allergan, Inc; January 2012.

- 4. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed March 2016.
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- 7. Zaenglein A, Pathy A, Schlosser B, et al. Guidelines of Care for the Management of Acne Vulgaris. *J Am Acad Dermatol*. 2016; In Press Corrected Proof. [http://www.jaad.org/article/S0190-9622\(15\)02614-6/pdf](http://www.jaad.org/article/S0190-9622(15)02614-6/pdf). Accessed March 2016.

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<b>DRUG CLASS</b>	<b>RETINOIDS (TOPICAL)</b>
<b>BRAND NAME (generic)</b>	<b>ATRALIN (ALL TOPICAL) (tretinoin)</b>
	<b>AVITA (ALL TOPICAL) (tretinoin)</b>
	<b>RETIN-A (ALL TOPICAL) (tretinoin)</b>
	<b>RETIN-A MICRO (ALL TOPICAL) (tretinoin gel, microsphere)</b>
	<b>TRETIN-X (ALL TOPICAL) (tretinoin)</b>
	<b>VELTIN (ALL TOPICAL) (clindamycin/tretinoin gel)</b>
	<b>ZIANA (ALL TOPICAL) (clindamycin/tretinoin gel)</b>

**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X gel and Tretin-X cream are indicated for topical application in the treatment of acne vulgaris. The safety and efficacy of these products in the treatment of other disorders have not been established.

Veltin and Ziana are indicated for the topical treatment of acne vulgaris in patients 12 years or older.

### Compendial Use

Keratosis follicularis (Darier's disease, Darier-White disease) <sup>12,15,16</sup>

### COVERAGE CRITERIA

Prior Authorization will be required for all patients greater than 35 years old to ensure appropriate use.

Tretin-X, Veltin, Ziana will be covered with prior authorization when the following criteria are met:

- The patient has filled a prescription for at least a 1 day supply of any of the following generic products: benzoyl peroxide, clindamycin/benzoyl peroxide, clindamycin topical, erythromycin topical, erythromycin/benzoyl peroxide, sodium sulfacetamide, or sodium sulfacetamide/sulfur or generic tretinoin product within the past 30 days under a prescription benefit administered by CVS Caremark

#### **AND**

- The patient has the diagnosis of acne vulgaris or keratosis follicularis (Darier's disease, Darier-White disease)



### **COVERAGE CRITERIA**

The other listed Topical Tretinoin will be covered with prior authorization when the following criteria are met:

- The patient has the diagnosis of acne vulgaris or keratosis follicularis (Darier's disease, Darier-White disease)

### **REFERENCES**

1. Atralin [package insert]. Bridgewater, NJ: Coria Laboratories, Ltd; August 2014.
2. Avita Cream [package insert]. Research Triangle Park, NC: Mylan Pharmaceuticals Inc; November 2013.
3. Avita Gel [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; November 2013.
4. Refissa [package insert]. San Diego, CA: Suneva Medical, Inc.; January 2014.
5. Renova [package insert]. Los Angeles, CA: Ortho-McNeil-Janssen Pharmaceuticals, Inc.; August 2015.
6. Retin-A [package insert]. Los Angeles, CA: Ortho-McNeil-Janssen Pharmaceuticals, Inc.; October 2011.
7. Retin-A Micro [package insert]. Los Angeles, CA: Ortho-McNeil-Janssen Pharmaceuticals, Inc.; May 2013.
8. Tretin-X [package insert]. Cumberland, RI: Onset Dermatologics, LLC; May 2013.
9. Veltin [package insert]. Research Triangle Park, NC: Stiefel Laboratories, Inc; March 2014.
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<b>DRUG CLASS</b>	<b>ISOTRETINOINS (ALL ORAL)</b>
<b>BRAND NAME (generic)</b>	<b>ABSORICA (isotretinoin)</b>
	<b>AMNESTEEM (isotretinoin)</b>
	<b>CLARAVIS (isotretinoin)</b>
	<b>MYORISAN (isotretinoin)</b>
	<b>SOTRET (isotretinoin)</b>
	<b>ZENATANE (isotretinoin)</b>

**Type: Initial Prior Authorization**

## POLICY

### FDA-APPROVED INDICATIONS

Isotretinoin is indicated for the treatment of severe recalcitrant nodular acne. Nodules are inflammatory lesions with a diameter of 5 mm or greater. The nodules may become suppurative or hemorrhagic. "Severe," by definition, means "many" as opposed to "few or several" nodules. Because of significant adverse effects associated with its use, isotretinoin should be reserved for patients with severe nodular acne who are unresponsive to conventional therapy, including systemic antibiotics. In addition, isotretinoin is indicated only for those female patients who are not pregnant, because isotretinoin can cause severe birth defects.

A single course of therapy for 15 to 20 weeks has been shown to result in complete and prolonged remission of disease in many patients. If a second course of therapy is needed, it should not be initiated until at least 8 weeks after completion of the first course, because experience has shown that patients may continue to improve while off isotretinoin. The optimal interval before retreatment has not been defined for patients who have not completed skeletal growth.

### Compendial Uses

Acne – refractory<sup>8</sup>

Cutaneous T-cell Lymphoma (CTCL) (e.g., mycosis fungoides, Sézary syndrome)<sup>7</sup>

Keratosis follicularis (Darier Disease) – severe<sup>8</sup>

Lamellar ichthyosis – severe skin involvement<sup>7</sup>

Neuroblastoma<sup>8</sup>

Pityriasis rubra pilaris<sup>7</sup>

Rosacea – severe refractory<sup>8</sup>

Squamous Cell Cancers – to reduce the development of precancers and skin cancers in high risk patients<sup>8</sup>

Transient acantholytic dermatosis (Grover Disease) – severe<sup>8</sup>

## **COVERAGE CRITERIA**

Isotretinoin will be covered with prior authorization when the following criteria are met:

- The patient has the diagnosis of acne vulgaris (severe recalcitrant nodular or refractory) OR severe refractory rosacea AND
  - The patient has tried and had inadequate treatment responses to any topical acne product AND an oral antibiotic
- **AND**
- Treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course

**OR**

- The patient has neuroblastoma, OR cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), OR is at high risk for developing skin cancer (squamous cell cancers)

**OR**

- The requested drug is being prescribed for any of the following: A) transient acantholytic dermatosis (Grover Disease), B) keratosis follicularis (Darier Disease), C) lamellar ichthyosis, D) pityriasis rubra pilaris

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**POLICY IMPLEMENTATION/REVISION INFORMATION**

Prior Authorization

Original Implementation Date: 1/1/2017

Revision Information	
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## Pharmacy and Therapeutics (P&T) Committee Meeting Tuesday, May 23<sup>rd</sup> 2017, 6:00 p.m. to 8:00 p.m.

### Agenda

<u>Topic:</u>	<u>Presenter:</u>
<b>I. Welcome</b>	Ira Protas, Chair
<ul style="list-style-type: none"> <li>• Call to Order</li> </ul>	
<b>II. Conflict of Interest Statement</b>	Lotta Crabtree, JD
<b>III. Minutes from March, 21<sup>st</sup> 2017 Meeting*</b>	Jamilah Brunson, PharmD
<b>IV. Old Business</b>	Jamilah Brunson, PharmD
<ul style="list-style-type: none"> <li>• Formulary Development and Management at CVS Caremark®</li> </ul>	
<b>V. Light Meal</b>	
<b>VI. 2017 Q3 Formulary Updates*</b>	Jamilah Brunson, PharmD
<ul style="list-style-type: none"> <li>• Specialty Exclusions               <ul style="list-style-type: none"> <li>○ Otrexup Injection</li> <li>○ Berinert Injection</li> </ul> </li> <li>• Hyperinflation Exclusions</li> <li>• Tier Changes               <ul style="list-style-type: none"> <li>○ Negative</li> <li>○ Positive</li> </ul> </li> <li>• Formulary Additions               <ul style="list-style-type: none"> <li>○ Rytary capsules</li> <li>○ Ocrevus injection</li> <li>○ Namzaric capsules</li> <li>○ Dupixent injection</li> <li>○ Eucrisa ointment</li> <li>○ Bavencio injection</li> <li>○ Zejula capsules</li> <li>○ Ruconest injection</li> </ul> </li> </ul>	Joseph Shanahan, MD John Anderson, MD Carl Antolick III, PharmD Carl Antolick III, PharmD  David Konanc, MD David Konanc, MD David Konanc, MD Matthew Flynn, MD Matthew Flynn, MD Michael Spiritos, MD Michael Spiritos, MD John Anderson, MD
<b>VII. Utilization Management Policy Review*</b>	Jamilah Brunson, PharmD
<ul style="list-style-type: none"> <li>• Rasuvo Specialty Guideline</li> <li>• Enbrel Specialty Guideline</li> <li>• Humira Specialty Guideline</li> </ul>	Joseph Shanahan, MD Joseph Shanahan, MD Joseph Shanahan, MD

\*Requires a vote by the P&T Committee

- Cinryze Specialty Guideline John Anderson, MD
- H.P. Acthar Specialty Guideline John Anderson, MD
- Topical antifungals Coverage Authorization Criteria John Engemann, MD
- Noxafil Coverage Authorization Criteria John Engemann, MD
- Vfend Coverage Authorization Criteria John Engemann, MD
- Glumetza / Fortamet Coverage Authorization Criteria Jennifer Burch, PharmD, CDE
- Saxenda Coverage Authorization Criteria Jennifer Burch, PharmD, CDE
- Contrave Coverage Authorization Criteria Jennifer Burch, PharmD, CDE
- Belviq Coverage Authorization Criteria Jennifer Burch, PharmD, CDE
- Short-Acting Anti-Obesity Coverage Authorization Criteria Jennifer Burch, PharmD, CDE
- Topical Acne Coverage Authorization Criteria Matthew Flynn, MD
- Differin Coverage Authorization Criteria Matthew Flynn, MD
- Tazorac Coverage Authorization Criteria Matthew Flynn, MD
- Tretinoin Coverage Authorization Criteria Matthew Flynn, MD
- Isotretinoin Coverage Authorization Criteria Matthew Flynn, MD
- SSRI Step Therapy Criteria Randy Grigg, MD

**VIII. Other Topics\***

Jamilah Brunson, PharmD

**IX. Next Meeting Date**

Ira Protas, Chair

- Tuesday, August 22<sup>nd</sup> 2017
- Directions



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**THE NC STATE HEALTH PLAN IS LOCATED IN THE LONGLEAF BUILDING**

**Directions to the State Health Plan from Downtown Raleigh**

Take US-401 N / S. McDowell Street

Take the Wake Forest Road exit toward Atlantic Ave

Use the left 2 lanes to turn left onto Wake Forest Rd

Continue onto Atlantic Avenue

Cross Highwoods Boulevard and take the first or second right into the office complex.

Follow the signs to the Longleaf Building.

Street level/handicapped parking can be found on the opposite side of the building from where the flags are flying.

**Directions to the State Health Plan from RDU Airport**

Take I-40 East

Use the right 2 lanes to take exit 289 for Wade Avenue toward I-440/US-1 N

Continue onto Wade Avenue

Take exit onto I-440E/US-1 N toward Wake Forest/Rocky Mt/Wilson

Take exit 11 to merge onto US-1 N/US-401 N/Capital Boulevard toward Wake Forest/Louisburg

Stay in the left lane and turn left at Highwoods Boulevard

Turn right on Atlantic Avenue and take the first or second right into the office complex.

Follow the signs to the Longleaf Building

Street level/handicapped parking can be found on the opposite side of the building from where the flags are flying

