ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

Location of Meeting
Frontier Building, 3601 C Street, Room 880/890

MINUTES OF MEETING
September 15, 2017
8:00 a.m.

Committee Members Present:
Jeffrey Demain, MD, Chair
Robert Carlson, MD (telephonic)
Jenna Hiestand, MD
Claudia Phillips, MD (telephonic)
John Riley, PA-C, (telephonic)
Ryan Ruggles, PharmD
Trish White, R.Ph. (telephonic)

Committee Members Absent:
Vincent Greear, MD
Diane Liljegren, MD (excused)
Charles (Chuck) Semling, R.Ph. (excused)

Others Present:
John McCall, R.Ph., Magellan Medicaid Administration
Erin Narus, PharmD, State of Alaska
Sally Fullerton, Kron Associates

1. Call to Order – Chair

Dr. Demain called the meeting to order at 8:07 a.m. He noted that industry comments would be taken on red classes only and limited to three minutes.

2. Roll Call

The roll call was taken and a quorum was present.

3. Public Comments - Local Public/Health Practitioners

Dr. Nolan, representing himself and six other endocrinologists, spoke about insulin Degludec. Letters from several other physicians were distributed. Insulin Degludec has been a substantial addition to diabetes care in Alaska. With the use of insulin Degludec, we have seen a decline in hypoglycemic episodes and nocturnal hypoglycemia; pediatric physicians have noticed a significant decline in hypoglycemic episodes and hospitalizations in patients 1 year of age and older; and patients have noticed less tenderness and pain associated with the injection site. Dr. Kerford Lescher's letter lists the

literature available on insulin Degludec, as well as why physicians like this medicine and its apparent benefits for patients with both type 1 and type 2 diabetes.

In response to Dr. Demain, Dr. Nolan said there appeared to be immediate control benefits when using insulin Degludec. Patients with type 1 diabetes may not need insulin pumps and have fewer hospitalizations, which is particularly valuable in bush Alaska. Pediatric physicians using insulin Degludec have seen a substantial decline in DKA. Dr. Nolan's opinion was that insulin Degludec appeared to be cost beneficial and risk beneficial.

4. Class Review, Discussion & Vote

4-A. SPECIALTY: Hepatitis C (Red Class)

Public Comments for Specialty: Hepatitis C (Red Class)

Colleen Fong, a representative of Gilead, discussed the hepatitis C virus (HCV). Gilead has a broad range of products that meet the needs of many types of patients, including those who are compensated/decompensated with HIV and/or a post-transplant with SVR rates that range from 95 to 99 percent. Gilead's newest agent, Vosevi, is not only for patients using a Sofosbuvir agent, but also an NS5A inhibitor or any product that is solely Sofosbuvir-based and in combination with older DAA agents. Several trials and their outcomes were reviewed. The safety profile for Vosevi is comparable to the other agents in this class. The most commonly reported incidents include nausea and diarrhea. Overall, Sofosbuvir-based regimens are for patients of all genotypes. Vosevi has a pediatric indication and a profile that is both safe and tolerable.

Margaret Olman, a representative of Abbie, discussed Mavyret, which was recently approved as a once-daily Ribavirin-free treatment for patients with chronic hepatitis C infection. It is indicated to treat across all genotypes for adults without cirrhosis or with compensated cirrhosis. It is also indicated for those with genotype 1 who have previously been treated with an NS5A inhibitor or a protease inhibitor, but not both. This includes patients with genotype 1 who failed regimens such as Harvoni, Epclusa, or Sofosbuvir plus Daclatasir. Mavyret can treat up to 95 percent of HCV patients. Several trials and their outcomes were reviewed. Mavyret carries a boxed warning regarding the risk of hepatitis B reactivation, as do all drugs in this class. Mavyret is contraindicated in patients with severe hepatic impairment or when administered concomitantly with Rifampin or Atazanavir. The most common adverse reactions were headaches and fatigue. Adverse events were comparable among patients who had compensated cirrhosis or without cirrhosis. Overall discontinuation rates due to adverse events were 0.1 percent. Compete safety information and full prescribing information can be found at www.rxabbie.com.

In response to Dr. Demain, Margaret Olman said 95 percent of HCV patients should have Mavyret available to treat their infection. The expectation is that 15 percent of patients can be treated with a 12-week regimen and 80 percent can be treated with an 8-week regimen of Mavyret.

Mr. McCall gave the Magellan presentation on Hepatitis C Agents. According to the CDC, the hepatitis C virus infection is the most common chronic blood-borne infection in the U.S. The CDC estimates that 2.7 to 3.9 million people are living with HCV. Sixty percent of acute HCV infections in the U.S. are due to the use of illicit injectable drugs. If left untreated, 15-25 percent of HCV patients

will clear the virus, 75-85 percent will develop chronic infections, 60-70 percent will develop chronic liver disease, 5-20 percent will develop cirrhosis in the next 20 to 30 years, and 1-5 percent will die from the consequences of chronic infection. There are six HCV genotypes and more than 50 subtypes. The distribution of HCV genotypes varies across the world, with the most common worldwide being genotype 1. However, genotype 3 is the most difficult to treat. The Cohort study, by ANMC in collaboration with the CDC, gives us a glimpse of the most common genotypes in Alaska compared to other states, with genotypes 2 and 3 being higher when compared to the rest of the country. The agents available for the treatment of HCV were reviewed. There are now single agents that cover all genotypes with SVR rates in the 90s. We have better options for resistance for comorbidities, as well as for younger patients. There are now more convenient dosages and shorter intervals. The emergence of multiple options is driving down cost in a drug class that has been successful, but very costly to patients and benefit programs. The AASLD/ISDA updated their hepatitis C treatment guidelines in April 2017. A key update was to shorten the duration of Harvoni in patients without cirrhosis to eight weeks. For non-African Americans without cirrhosis and not infected with HIV, patients with HCR RNA is less than six million when used for initial treatment. The FDA approved Sovaldi and Harvoni to treat HCV in children 12 years of age and older. The new boxed warnings include the potential for reactivating the hepatitis B virus for all the DAAs and Peginterferons. The FDA approved Technivie for compensated cirrhosis, which was previously only approved in patients without cirrhosis. However, with the newer options, we are moving away from Ribavirin. The new drugs in the class are Vosevi and Mavyret. Vosevi is approved as a salvage therapy after DAA failure for patients who previously received treatment containing an NS5A inhibitor like Harvoni. It is approved for genotype 1a or 3 patients who have been treated with Sofosbuvir without an NS5A inhibitor. It can be used in patients without cirrhosis or with compensated cirrhosis. It can be used as salvage therapy across all genotypes. POLARIS-1 and POLARIS-4, two studies on Vosevi, were reviewed. Mavyret is an NS3/4A protease inhibitor and an NS5A inhibitor. It is indicated for the treatment of patients with chronic HCV genotypes 1-6 without cirrhosis and with compensated cirrhosis. It can be used for genotype 1 patients previously treated with an NS5A inhibitor or an NS3/4A protease inhibitor containing regimen, but not both. It can also be used in the presence of severe renal impairment including dialysis. The duration of treatment for Mavyret varies from 8 to 16 weeks. Several trials on Mavyret and the resulting SVR rates were reviewed. Utilization indicates the preferred agents are being used, but non-preferred Epclusa also has a lot of usage. The use of the traditional drugs, Ribavirin and Peginterferon, reflect the guideline update that moves away from Peginterferons due to the efficacy of the newer agents without the addition of Ribavirin. At the last review, a motion for therapeutic alternatives with treatment coverage for each genotype passed unanimously.

In response to Dr. Demain, Erin Narus said there has recently been studies that indicate an increased elasticity or softening of the liver in patients on these drugs, but the clinical significance is not fully understood on the actual cirrhosis itself. There may be structural changes as the virus is eradicated, but it is too early to be conclusive. As far as which product that has better long-term outcomes other than viral elimination or achieving SVR, it is too early to tell. According to the AASLD and ISDA, comparing SVR rates is determination of clinical efficacy.

In response to Dr. Hiestand, Erin Narus explained the criteria that went into effect in July 2016 for potential candidates for hepatitis C treatment. Treatment is available for individuals who can demonstrate abstinence from illegal drug use or individuals participating in a treatment program. The goal is to move people toward wellness. Newly proposed criteria will be reviewed by the DUR

Committee later today that take an additional step toward a patient-centered model and the idea of patient readiness.

In response to Dr. Demain, Erin Narus said Epclusa and Mavyret were indicated for naive patients who have not previously failed and do not need salvage therapy. Other products in the class are indicated for a range of genotypes. If the committee were to select a more selective product, consideration should be given to different genotypes.

Dr. Demain advised the new member, Dr. Hiestand, about the medically necessary clause. In this case, the prescription for a non-preferred agent would probably have to go through the DUR Committee.

The committee discussed a potential motion. Bob Carlson suggested a class effect for naive genotype 1 patients, which would cover most of the patients, and then using the medically necessary clause for the remaining patients. In response to Dr. Phillips, John McCall said genotype 3 appears to be prevalent in Alaska according to the Cohort Study, but genotype 1 was still the most common in the U.S. and Alaska. Erin Narus felt it was reasonable to consider a class effect, because that would bring all the players into the mix. There would still need to be criteria for use and identification of specific products, because the supplemental rebate negotiations come as a package. In response to Dr. Carlson, Erin Narus said last year's motion of therapeutic alternatives with coverage for each genotype, would fit within the recommendations being made to the DUR Committee later this afternoon. In terms of preferred products, the state will need to select products that cover all genotypes. The committee discussed the difference between class effect and therapeutic alternatives.

DR. RUGGLES MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO ENSURE ALL GENOTYPES HAVE COVERAGE. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

Erin Narus asked if the committee wanted to continue the inclusion of Peginterferons and Ribavirin in the class as they are no longer the standard of care for hepatitis C. In response to Dr. Demain, John McCall said the 79 claims for Ribavirin was included in the utilization report that began in July 2016, before the newer medications were available. Erin Narus said the newer DAs could operate in the absence of Ribavirin, which used to help boost the activity of the DAs. There could be still be situations where Ribavirin would be used. Dr. Demain said Interferons and Ribavirin would eventually come off the formulary, but could still be utilized with the medically necessary clause. Erin Narus said a motion was not necessary, but the background conversation was helpful. In response to Dr. Hiestand, Erin Narus said including Interferons and Ribavirin on the PDL could imply the promotion of those products, but the state can make the necessary adjustments with the current motion.

4-B. GASTROINTESTINAL: Antiemetic-Antivertigo Agents (Red Class); GI Motility & Irritable Bowel Syndrome, Chronic (Red Class); Ulcerative Colitis (Green Class); Cytokine & Cell-Adhesion Molecules (CAM) Antagonist - GI Indicated (Red Class)

Public Comments for Gastrointestinal: Antiemetic-Antivertigo Agents (Red Class)

There were no public comments.

Mr. McCall gave the Magellan presentation on Gastrointestinal: Antiemetic-Antivertigo Agents. This group includes several classes of drugs and applies to several indications. For Alaska, the drug chosen for review is the 5-HT_3 antagonists, which are indicated for nausea and vomiting, and prevention of chemotherapy-induced nausea and vomiting. The side effects of chemotherapy-induced nausea and vomiting has a detrimental effect on the quality of life of patients with cancer. Both ASCO and NCNN state 5-HT_3 receptor antagonists are the backbone of first line emesis prevention in chemotherapy. The administration of a 5-HT_3 receptor antagonist typically reduces or prevents emesis in 50 percent of patients, increases to 70 percent in combination with Dexamethasone, and increases to 84 percent when an NK_1 receptor antagonist is added. The goal is to prevent both acute and delayed nausea and vomiting. The utilization report indicates 99 percent of the prescriptions were for preferred agents. At the last review, a motion for therapeutic alternatives passed unanimously.

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

Gastrointestinal: GI Motility and Irritable Bowel Syndrome, Chronic (Red Class)

Taylor Bradshaw, a representative of Allergan, discussed Viberzi. Irritable Bowel Syndrome (IBS-D) is a functional GI disorder with symptoms attributed to the lower GI tract that can be persistent, occur expectantly, and tend to last and wane over time, causing anxiety for IBS-D patients. There is an unmet need for IBS-D treatment that affects both the bowel and abdominal symptoms, which is why Viberzi is unique and first in class. It has a mixed opioid activity and works locally in the GI tract. Several studies and their outcomes were reviewed. The most commonly reported side effect was constipation. Severe constipation is reported in less than 1 percent of patients and there were no complications of constipation reported. Sphincter release spasm and pancreatitis occurred in less than 1 percent of patients. Viberzi is available in two dosages: 100 milligrams twice daily with food or 75 milligrams twice daily with food for patients unable to tolerate the 100-milligram dose, if they are taking concomitant OATP1B1 inhibitors, or if a patient has mild to moderate hepatic impairment. Viberzi is contraindicated for patients without a gallbladder due to an increased risk of pancreatitis. We respectfully request unrestricted access to Viberzi on the PDL.

Jeanette Thompson, a representative of Synergy, discussed Trulance, which was approved by the FDA in January 2017 for the treatment of adults with chronic idiopathic constipation or CIC. Occasional constipation is common and can occur for various reasons. However, over 33 million adults in the U.S. suffer from daily or chronic symptoms associated with constipation without a known cause. Studies have consistently demonstrated that CIC patients have an impaired quality of life. Patients most likely attempt to manage their symptoms with improved diet, over-the-counter laxatives, and currently available prescription medications. However, these options can fail to provide relief and may be associated with poor tolerability. Therefore, Trulance offers a new treatment option. The approved dose for Trulance is 3 milligrams taken once daily with or without food. Several trials and their outcomes on the efficacy and safety of Trulance were reviewed. The most common adverse event reported was diarrhea, which was reported in 5 percent of patients. Trulance is contraindicated in patients less than 6 years of age and patients with mechanical gastrointestinal obstruction. The use of Trulance should be avoided in patients 6 to 18 years of age. The pharmacology of Trulance was reviewed. Trulance offers patients with CIC a new option with proven efficacy and safety. We request that you add Trulance to the Alaska PDL.

In response to Dr. Demain, Jeanette Thompson said Trulance did not regulate PH. It works in a PH-sensitive manner like uroguanylin, a naturally occurring human gastrointestinal peptide.

Jesse Hoag, a representative of Shionogi, discussed Symproic, an opioid antagonist indicated for the treatment of opioid-induced constipation in adults with chronic non-cancer pain. This includes patients with chronic pain related to prior cancer or treatment. It is contraindicated in patients with known or suspected GI obstructions, those with increased risk of recurrent obstruction, and those with a history of hypersensitivity reaction to Naldemedine Tosylate. Reactions reported include bronchospasm and rash. Warnings associated with Symproic include GI perforation and opioid withdrawal. The recommended dose is 0.2 milligrams orally, once a day, with or without food. Patients receiving opioids for less than four weeks may be less responsive to Symproic. Symproic should be discontinued if treatment or opioid medication is discontinued. The pharmacology of Symproic was reviewed. Several trails and their outcomes were reviewed. The most common adverse events were abdominal pain, diarrhea and nausea. We request that Symproic be added to the PDL.

Mr. McCall gave the Magellan presentation on Gastrointestinal: GI Motility and Irritable Bowel Syndrome, Chronic. With IBS, patients have a combination of symptoms that include GI pain and discomfort, which are typically either constipation predominant, diarrhea predominant and/or alternates between the two. Patients with mild symptoms often respond to dietary changes. Pharmacological intervention is reserved for patients with moderate to severe symptoms. Women are two and a half times more likely to suffer from IBS-D than men. Chronic idiopathic constipation is a condition in which bowel movements are infrequent, typically less than three per week. Opioid induced constipation is a common adverse effect of opioid therapy. There have been no updates to the guidelines for IBS-D, which states preferring one agent over another is difficult due to the lack of head-to-head trials. The guidelines recommend Rifaximin, an antibacterial indicated for IBS-D. The new agents in the class, which were discussed by the industry representatives, were reviewed. The utilization reports were reviewed. At the last review, a motion for therapeutic alternatives to include one formulation for diarrhea and one for constipation passed unanimously.

The committee discussed the abuse potential of Viberzi, a schedule-4 narcotic, which Dr. Hiestand noted was often abused on the streets. Erin Narus said there had also been reports of abuse for Loperamide, the over-the-counter formulation that eventually resulted in deaths. Although staff is aware of the issue, they would appreciation the committee's feedback. Taylor Bradshaw, the representative for Viberzi, said a fair amount of abuse testing had been done including cost comparisons between Viberzi versus Oxycodone and heroin. If an abuser wanted to inject Viberzi, its lack being water soluble makes it difficult to inject. If an abuser wants to shoot or inject Viberzi, its formation of a yellow crust when heated makes it difficult to inject. Therefore, we do not believe that Viberzi has a very high abuse potential.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE FORMATION FOR DIARRHEA AND ONE FOR CONSTIPATION. SECONDED BY DR. CARLSON.

In response to Dr. Hiestand, who felt Viberzi should require a prior authorization and should not be considered a first-line agent, Erin Narus said Dr. Hiestand could vote no or abstain from voting. If she abstained from voting, the DUR Committee could address her concerns.

THE MOTION PASSED WITH DR. HIESTAND ABSTAINING.

Dr. Hiestand explained her opposition to having open access to Viberzi, an opioid agonist, when there was already an opioid epidemic. Alternatives that are not scheduled or controlled substances are available. If it was determined that Viberzi was a necessary medication, there should at least be a prior authorization requirement upon first fill.

Gastrointestinal: Cytokine and Cell-Adhesion Molecules (CAM) Antagonists - GI Indicated (Red Class)

Chioma Ezenduka, a representative of UCB Pharma, discussed Cimzia, a recombinant, humanized anti-TNF biologic that is FDA approved for reducing the signs and symptoms of Crohn's Disease and maintaining clinical response in adult patients with moderate to severe active disease who have had an inadequate response to conventional therapy. It is also effective for extra intestinal manifestations that many with Crohn's experience such as rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis. With several anti-inflammatory biologics approved for the management of Crohn's Disease, Cimzia possess a unique structure, which was reviewed. Several studies and their outcomes were reviewed. Studies have shown that Crohn's Disease typically affects women in their peak reproductive years with about 50 percent of patients under 35 years of age at time of diagnosis. About 25 percent of these women conceive for the first time during this period. This population of women requires optimal disease management, thus UCB has made a commitment to women of child-bearing age who suffer from inflammatory conditions. Because of that commitment, UCB became the first pharmaceutical company to sponsor a study that measured the Cimzia concentrations in breast milk. A second study was also conducted to evaluate the concentration of Cimzia that crosses the placenta in pregnant women. Both studies found minimal to undetectable levels of Cimzia in both breast milk and in newborn babies, which allows for uninterrupted treatment throughout pregnancy and lactation where necessary. Cimzia is currently a non-preferred agent in the state of Alaska. We ask that Cimzia be added to the PDL in cases of pregnancy and lactation, or for those who would like to start a family.

Margaret Olman, a representative of Abbie, discussed Humira. Please review the full prescribing information if you have any questions about Humira. Humira is indicated for the treatment of adult Crohn's Disease, pediatric Crohn's Disease, and ulcerative colitis, among others. It is indicated to reduce the signs and symptoms, and inducing and maintaining clinical remission in adult patients with moderate to severe active Crohn's Disease who have had inadequate response to conventional therapy, or if they've lost response to or intolerant to Infliximab. Several trials and their outcomes were reviewed. With longstanding safety data, 71 global trials, 14 years on-market experience and over 1 million patients exposed, Humira has a well-defined, published benefit-to-risk database. We request the committee main the preferred status of Humira on the PDL for the people of Alaska.

In response to Dr. Demain, Margaret Olman said patients have become pregnancy while using Humira, but it was not recommended. That should be a doctor/patient decision.

John McCall gave the Magellan presentation on Gastrointestinal: Cytokine and Cell-Adhesion Molecules (CAM) Antagonist - GI Indicated. Ulcerative colitis and Crohn's Disease, both related to inflammatory bowel disease, are both treated by these agents. Symptoms for both include diarrhea, fever, malaise, abdominal pains, cramping, reduced appetite and unintended weight loss. Ulcerative

colitis is inflammation in the large intestine and rectum, and it affects only the inner lining of the GI tract. It does not go beyond the mucosa and submucosa. The onset of ulcerative colitis is most common between 15 and 40 years of age, with a second peak between 50 and 80 years of age. Crohn's Disease is an inflammation that can appear anywhere in the digestive tract, but it goes beyond the inner layers of the GI tract and affects all the layers of the bowel walls. It can occur at any age, but is more prevalent among adolescents and young adults between the age of 15 and 35. Smoking is a modifiable risk factor in Crohn's Disease. Complications associated with ulcerative colitis and Crohn's Disease were reviewed. The committee is only reviewing the biologicals in their use for GI indications. Renflexis is a biosimilar for Infliximab. It is given as an IV infusion in an office. It is a TNF alpha blocker and has the same warnings as Remicade. The TNF alpha blockers were the first biologicals in the guidelines, but newer biologicals have emerged on the market. The formulation, indication and recommended doses of the agents in this class were reviewed. At the last review, the motion was therapeutic alternative to include Humira.

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

Gastrointestinal: Ulcerative Colitis (Green Class) (Taken out of order)

John McCall gave the Magellan presentation on Gastrointestinal: Ulcerative Colitis. These drugs are local GI agents for ulcerated colitis. They are used in patients with a low risk for colectomy. They have an advantage of low systemic side effects. Each of these agents are designed to get through the rest of the GI tract and reach the colon for local effect. Patients should not be immediately switched from systemic steroids, but should be tapered off. There is a low usage of these agents. At the last review, the motion was therapeutic alternatives, to include at least one delayed-release agent, one prodrug short-acting agents, and one rectal preparation.

DR. RUGGLES MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE DELAYED-RELEASE AGENT, ONE PRODRUG SHORT-ACTING AGENT, AND ONE RECTAL PREPARATION. THE MOTION PASSED UNANIMOUSLY.

Break from 9:41 a.m. to 9:59 a.m.

Dr. Demain did a roll call and all members were present.

4-C. ENDOCRINE/METABOLIC: Antihyperuricemics (Green Class); Progestins for Cachexia (Green Class); Growth Hormone (Green Class); Androgenic Agents, Topical (Green Class); Bone Resorption Inhibitors (Red Class); Hypoglycemics, Metformin (Green Class); Hypoglycemics, Alpha-Glucosidase (Green Class); Hypoglycemics, SGLT2 (Red Class); Hypoglycemics, Meglitinides (Green Class); Hypoglycemics, Thiazolidinedione (TZD) and Combinations (Green Class); Hypoglycemics, Amylin Analogues (Green Class); Hypoglycemics, Dipeptidyl Peptidase-4 Inhibitor (DPP-4) and Combinations (Red Class); Hypoglycemics, Glucagon-like Peptide-1 (GLP-1) and Combinations (Red Class); Rapid-Acting Insulins (Green Class); Regular Insulins (Green Class); Intermediate Insulins (Green

Class); Rapid/Intermediate-Acting Insulins (Green Class); Regular/Intermediate-Acting Combination Insulins (Green Class); Long-Acting Insulins (Red Class)

Public Comments for Endocrine/Metabolic: Bone Resorption Inhibitors (Red Class) (Taken out of order)

Erin Narus read a letter from Dr. John Botson advocating for the inclusion of Teriparatide for patients with osteoporosis. It is the only antibiotic agent on the market for bone health. It is the only agent shown to improve bone density and build bone.

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Bone Resorption Inhibitors. Osteoporosis is characterized by decreasing bone mass and deterioration often leading to fracture. The primary goal of osteoporosis management is to reduce risk fracture. The hip, spine and wrist are most likely to be affected. Risk factors include increasing age, menopause for women, vitamin D deficiency, and chronic use of certain drugs. Non-pharmacological prevention and treatment methods include changes in social habits, dietary changes, exercise, fall prevention, and calcium and vitamin D replacement. The American College of Physicians guidelines recommend Alendronate, Risedronate, injectable Zoledronic Acid, and Prolia as first-line therapy. The AACE guidelines recommend bisphosphonates for first-line therapy for postmenopausal women. The ACB guidelines recommend a treatment duration for five years for women and bisphosphonates as first-line therapy for men with osteoporosis. They recommend against the use of estrogen products or Raloxifene for the treatment of osteoporosis in postmenopausal women due to increased cardiovascular risk. The American College of Rheumatology guidance of managing glucocorticoid-induced osteoporosis in adults and children. For patients on a systemic steroid, fracture risk should be assessed within six months after starting long-term glucocorticoid treatment. All patients should have optimal calcium and vitamin D, as well as making lifestyle changes. Oral bisphosphonates are recommended as first-line therapy. Second-line agents included IV bisphosphonates and Prolia. The new drug in the class is Tymlos, a parathyroid hormone receptor agonist, is indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture. It comes as a daily subcutaneous injection in prefilled syringes that can be kept at room temperate for up to 30 days. It is limited to a two-year treatment. Its approval was based on findings from a placebo controlled trial, which was reviewed. It carries a boxed warning regarding the risk of osteosarcoma. The utilization report was reviewed. At the last review, the motion was therapeutic alternatives to include at least one non-daily bisphosphonate.

The committee discussed the fact that one of the generic calcitonin agents, which was not preferred but was predominantly used, was probably due to its cost advantage. It was noted that the brand-name equivalent was no longer available. Erin Narus said the PDL would be updated.

DR. RUGGLES MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE NON-DAILY BISPHOSPHONATE AND ONE INJECTION MEDICATION.

In response to Dr. Demain, Dr. Ruggles said the injection medication would include either Forteo or Prolia. The usage of Forteo on the utilization report was 63 percent so one of the injectables should be included on the PDL. Dr. Demain recommended amending the motion to include one parathyroid hormone analog.

DR. RUGGLES AMENDED THE MOTION TO THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE NON-DAILY BISPHOSPHONATE AND ONE PARATHYROID HORMONE ANALOG. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

Endocrine/Metabolic: Antihyperuricemics (Green Class)

Erin Narus read a letter from Dr. John Botson expressing his support for the addition of Pegloticase to the PDL for the treatment of gout. This agent is not on the Alaska PDL or covered by Alaska Medicaid, but it is included on most of the other state Medicaid programs.

In response to Dr. Demain, Erin Narus said Pegloticase was under the category of physician administered drugs. The PDL is geared toward outpatient self-administered drugs. The line between products dispensed from a pharmacy and those dispensed from a clinic are starting to blur. Medications that started out as being physician administered are moving to outpatient self-administration, such as Stelara. This item can be reviewed by staff and the DUR Committee. Other physician administered drugs are managed through the DUR process due to situations such as this one.

Dr. Demain said a reasonable step-by-step process needed to be created so doctors did not have barriers utilizing certain medications. When physician administered drugs are addressed, staff should get clinical input from physicians and not just rely on the literature.

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Antihyperuricemics. Gout is a type of inflammatory arthritis associated with hyperuricemia. While gout is always associated with hyperuricemia, hyperuricemia is not always associated with gout. In one Cohort Study, gout developed in only 22 percent of subjects with urate levels of more than 9 milligrams per deciliter during a five-year period. Risk factors for gout are obesity, hypertension, alcoholic intake, diuretics, a diet rich in meat, seafood and high fructose drinks. Poor kidney function is another risk factor. About 3.9 percent of U.S. adults older than 20 years of age report being told at some point that they've had gout. The most recent guidelines by the American College of Physicians recommend non-steroidal anti-inflammatory drugs or Colchicine to treat patients with acute gout based on cost, or if oral steroids and NSAIDs cannot be tolerated. They recommend against initiating long-term urate lowering therapy in most patients after a first gout attack or in patients with infrequency attacks. The utilization report was reviewed. At the last review, the motion was therapeutic alternatives.

In response to Dr. Hiestand, Erin Narus discussed the utilization report. The generic version of Colchicine had not been available for a period of time, so according to the Medicaid rules there was a natural shift to the brand-name product until the generic became available again.

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

Endocrine/Metabolic: Progestins for Cachexia (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Progestins for Cachexia. The only drug available in this class is Megace. It is a synthetic derivative of Progesterone. It is an appetite

enhancing agent in cachexia. It is associated with increased appetite and an improved overall sense of wellbeing in AIDS patients with cachexia. While the drug is very effective in increasing total body weight, a good percentage of that weight is fat versus lean body mass. The NCCN guidelines recommend Megace, 400 to 800 milligrams a day, for end-stage cancer patients as a first-line therapy. Both medications are pregnancy category X. The utilization report was reviewed. At the last review, the motion was class effect.

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

Endocrine/Metabolic: Growth Hormones (Green Class)

Mr. McCall gave the Magellan presentation on Endocrine/Metabolic: Growth Hormones. All of these products are formulations of Somatropin. The choice of drug is based on FDA-approved indications and patient preferences related to administration and administration device. The utilization report was reviewed. At the last review, the motion was class effect.

DR. RILEY MOVED A CLASS EFFECT. SECONDED BY DR. WHITE. THE MOTION PASSED UNANIMOUSLY.

Dr. Carlson, who did not answer the roll call for the vote, left the meeting. Dr. Demain noted a quorum was still present.

Endocrine/Metabolic: Androgenic Agents, Topical (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Androgenic Agents, Topical. Oral administration of testosterone is ineffective due to first past metabolism in the liver. Injectable and transdermal methods of delivery are the dosage forms. Transdermal delivery of testosterone is more appealing to most patients compared to injectables. Causes of hypogonadism are classified as primary, due to failure of the testes, or secondary, due to failure of the hypothalamus and pituitary gland. Treatment goals are continuation of normal life and activities, and decreased risk of secondary complications such as infertility, osteoporosis, fatigue and mood disturbances. The first generic formulation of Axiron is now on the market, which the state will review based on cost and availability. Patients need to be careful with the transdermal gels to ensure it is not transferred to other people. Potential adverse reactions with the transdermal formulation is skin reactions. At the last review, the motion was class effect.

DR. CARLSON MOVED A CLASS EFFECT. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Endocrine/Metabolic: Hypoglycemics, SGLT2 (Red Class) (Taken out of order)

Erin Narus read three letters into the record. Dr. Ross Tanner advocated for the inclusion of Jardiance on the PDL. Dr. Cydney Fenton and Dr. Muhammad Ahmed advocated for the inclusion of Tresiba on the PDL. There were two other letters, from Dr. Rachel Kerford Lescher and Dr. Jeffrey Medland, both advocating for Tresiba on the PDL.

Mae Kwong, a representative of Janssen, discussed Invokana. Janssen's cardiovascular trial for Invokana, known as the CANVAS program, and its outcomes were reviewed. Invokana sustains positive effects of glycemic and blood pressure control, as well as weight reduction. Overall adverse effects were generally consistent with previous findings. An increased risk of lower limb amputation, mostly of the toe, with Invokana was seen in the completed CANVAS program, which was consistent with the observation made by the Independent Data Monitoring Committee in 2016. The highest risk of amputation occurred in patients with a prior history of amputation or vascular disease. No increase in incidence of amputation was observed across the other 12 completed phase-three or phase-four trials. In summary, the Canvass Program results add to the clinical differentiation benefit already seen with Invokana as the only SGLT2 that's been proven superior to Glimepiride and Januvia in clinical trials, as well as a superiority to Januvia in real-world studies. The Credence Study and its outcomes were reviewed. We request that Invokana be added to the Alaska PDL.

Steve Hall, a representative of Boehringer Ingelheim, discussed Jardiance (Empagliflozin). New information has become available on Jardiance since the last review of this class. It is the first agent, and it's still the only oral agent, indicated to reduce the risk of cardiovascular death in adults with Type 2 diabetes and established cardiovascular disease. A study and its outcomes were reviewed. A recently FDA safety communication regarding another SGL2 inhibitor showed an increased risk of leg and foot amputations. The FDA is requiring new warnings to be added to that agent's label to describe this risk. In this context, we would like to keep you updated with information on this class to ensure that you are aware of the safety profiles. Based on a comprehensive review of available data, there is no evidence to suggest an increased risk of amputations with Empagliflozin. Several trials and their outcomes were reviewed. After conclusion of the FDA's review, which includes post marketing spontaneous reports, the FDA has not required a label update of Empagliflozin products.

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, SGLT2. SGLT2s inhibitors reduce renal glucose reabsorption in the proximal convoluted tubule, leading to increased urinary glucose excretion. Adverse effects related to the class are increased urination, UTIs, fungal infection, and dehydration. There is a warning about diabetic ketoacidosis. In the ADA guidelines, this class if listed as second-line therapy. The new drug in this class is Synjardy XR, a combination of Jardiance and Metformin. The FDA published a drug safety communication, based on the CANVAS and CANVAS R studies, that concluded certain medications caused an increased risk of leg and foot amputations and required a boxed warning to those products. However, those products also reduced cardiovascular events by 14 percent and had a reduced rate of renal decline by 40 percent of patients. The utilization report was reviewed. At the last review, the motion was class effect, but that was related to a larger market basket.

Dr. Demain noted that if a primary drug is approved, the combination product will be included on the PDL provided it is not cost prohibitive compared to using two agents.

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

Endocrine/Metabolic: Hypoglycemics, Metformin (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, Metformin. Diabetes mellitus is a simple Type 1 autoimmune disease affecting the beta cells of the pancreas. About 5 percent of patients with diabetes have Type 1 diabetes. The onset of Type 1 diabetes generally occurs in childhood or as young adults. Type 2 diabetes is a metabolic disorder with an onset usually at adulthood, although we are now seeing it in children more than we have in the past. Resistance to insulin leads to beta cell burnout relates to it. Morbidity and mortality related to diabetes is divided into two categories: microvascular events and macrovascular events. Microvascular events include diabetic retinopathy, nephropathy, and neuropathy. There has been quite a bit of focus on macrovascular events, because cardiovascular disease is the leading cause of morbidity and mortality with diabetes. Hypertension and dyslipidemia are also risk factors for cardiovascular disease and commonly co-exhibit with it. Large benefits are seen when these three risk factors are addressed simultaneously. The ADA guidelines have recommendations for treating hypertension, dyslipidemia, and diabetes, in addition to glucose control. In 2008, the FDA mandated that new drugs for Type 2 diabetes should provide evidence that the drug will not result in unacceptable increases in major adverse cardiovascular events.

Metformin is first-line therapy for the treatment of Type 2 diabetes according to the American Diabetes Association Guidelines. If Metformin is contraindicated or a second agent is needed, guidelines recommend multiple other options as second-line therapy. For patients with long-standing, sub-optimally controlled Type 2 diabetes and cardiovascular disease, the ADA recommends the SGLT2 inhibitor Jardiance or the GLP-1 receptor agonist Victoza, because both have shown to have benefits in cardiovascular trials. The utilization report was reviewed. At the last review, the motion was class effect.

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

Endocrine/Metabolic: Hypoglycemics, Alpha-Glucosidase (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, Alpha-Glucosidase. There is very low usage in this class. They are taken with meals. They have a modest effect on lowering the A1C by about .4 to .7 percent. They have GI side effects including bloating, gas and diarrhea. These agents are not listed as first- or second-line therapies by the ADA. At the last review, the motion was class effect.

The committee discussed whether this class of drugs should remain on the PDL.

DR. (UNIDENTIFIED) MOVED A CLASS EFFECT. SECONDED BY DR. (UNIDENTIFIED). THE MOTION PASSED UNANIMOUSLY.

Endocrine/Metabolic: Hypoglycemics, Thiazolidinedione (TZD) and Combinations (Green Class) (Taken out of order)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, Thiazolidinedione (TZD) and Combinations. Thiazolidinedione increases sensitivity of muscles and liver to insulin. The utilization report was reviewed. Warnings are related to increased risk of bone fractures, edema, and weight gain. These should be avoided in patients with heart failure or liver diseases. The use of

Pioglitazone for more than one year may be associated with an increased risk of bladder cancer, which was not seen with Rosiglitazone. At the last review, the motion as class effect.

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

Endocrine/Metabolic: Hypoglycemics, Meglitinides (Green Class)

Mr. McCall gave the Magellan presentation on Endocrine/Metabolic: Hypoglycemics, Meglitinides. Meglitinides increase beta cell secretions. They are administered before meals to stimulate mealtime insulin release. They have a very low utilization. At the last review, the motion was class effect.

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

Endocrine/Metabolic: Hypoglycemics, Amylin Analogues (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, Amylin Analogues. These products can be used in Type 1 diabetes as an analogue that acts on the pancreas. It is used for type glucose control and is secreted by the beta pilot cells. The utilization report indicates one prescription.

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

Public Comments for Endocrine/Metabolic: Hypoglycemics, Dipeptidyl Peptidase-4 Inhibitors (DPP-4) and Combinations (Red Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, Dipeptidyl Peptidase-4 Inhibitors (DPP-4) on Combinations. These agents are stimulated by the presence of glucose in the gut. These cause an increase in insulin synthesis and a decrease in hepatic glucose production. They also slow gastric emptying. The DPP-4 inhibitors and combinations slow the inactivation of both intestinal hormones GLP-1 and GIP. Side effects and risks are increased hypoglycemia and reports of joint pain. Pancreatitis was found in one recent meta-analysis. Qtern, a combination of Dapagliflozin and Saxagliptin, is approved for Type 2 diabetes in adults. Warnings and adverse effects are similar to those for the individual products. There were no head-to-head trials done for Qtern. At the last review, the motion was class effect.

Dr. Demain noted this class had significant utilization and the preferred agents received 90 to 100 percent of the prescriptions.

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

Public Comments for Endocrine/Metabolic: Hypoglycemics, Glucagon-like Peptide-1 (GLP-1) and Combinations (Red Class)

Anthony Wheeler, a representative of Eli Lilly, discussed Trulicity. This drug is administered weekly. There are now eight completed randomized controlled trials on Trulicity, which looked at Trulicity as monotherapy and in combination with other diabetes medications. Several studies and their outcomes were reviewed. Patients who received Trulicity were significantly more likely to be adherent and persistent to their medication after six months from starting it when compared to patients who received Victoza or Bydureon. Trulicity has a proven safety and tolerability profile similar to other medications in this class. It is available as a once-weekly injection. It is delivered by using a single-use device that has a hidden pre-attached and self-retracting needle. There is no mixing or reconstitution required to use the drug. We request that Trulicity be included on the PDL.

Anthony Hoovler, a representative of Novo Nordisk, discussed Victoza. It is a GLP-1 receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adult patients with Type 2 diabetes. Victoza is now also approved in the U.S. as the only Type 2 diabetes treatment to reduce the risk of adverse cardiovascular events in adults with Type 2 diabetes and established cardiovascular disease. The LEADER trial and its outcomes were reviewed. The LEADER trial is not the only GLP-1 cardiovascular outcomes trial to be completed and reported, but Victoza is the only GLP-1 that is currently available to show this benefit. Although Victoza was not previously recommended as first-line therapy for Type 2 diabetes, its limitation and use has been removed from the label. Victoza is not insulin and should not be used with patients with Type 1 diabetes. Similar to other longer-acting GLP-1 agonists, there is a boxed warning regarding risk of Larry C-cell tumors. Similar to other GLP-1 agonists, the Victoza label includes warnings and precautions regarding pancreatitis. Although Victoza should be used with caution with patients with renal impairment, based on clinical study of Victoza in patients with renal impairment, no dose adjustment of Victoza is recommended in patients with renal impairment. Please see the complete PI for additional safety information. Victoza is the most commonly prescribed GLP-1 in the U.S. We request that Victoza be included on the PDL.

Anthony Hoovler, a representative of Norvo Nordisk, discussed Xultophy. It is a combination of insulin Degludec and Liraglutide. It is indicated as an adjunct to diet and exercise to improve glycemic control in adult patients with Type 2 diabetes inadequately controlled on basal insulin, less than 50 units a day, or on Liraglutide, 1.8 milligrams or less daily. There is a REMS in place for Xultophy to inform health care providers of potential risks of medullary thyroid carcinoma and acute pancreatitis. There is a boxed warning of Larry C-cell tumors in patients with a personal family history of medullary thyroid carcinoma and they should not use Xultophy. Please refer to the complete PI for additional safety information. Several studies and their incomes were reviewed. Xultophy is dosed subcutaneously, once a day at the same time, with or without food, and should be titrated by two units upwards or downwards as needed every three or four days. The maximum dose of Xultophy is 50 units. It is applied in a pre-filled disposable pen. After the first use, the pen can be stored for up to 21 days. The concurrent use of basal insulin and GLP-1 receptor agonists are an established treatment regimen and is included in the most recent 2017 ADA position statement on the management of hyperglycemia patients with Type 2 diabetes. We request that Xultophy be added to the Alaska PDL.

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Hypoglycemics, Glucagon-like Peptide-1 (GLP-1) and Combinations. The GLP-1 receptor agonist stimulates the GLP-1 receptors leading to an increase in insulin secretion and a decrease in glucose production. It also slows gastric emptying. Two of the new drugs were reviewed by industry representatives. Another new drug is Adlyxin or Lixisenatide, which is indicated for adults with Type 2 diabetes. It has similar side effects compared to the other drugs in the class. The other new drug is Soliqua, a combination of Lixisenatide

and Insulin Glargine. Trulicity now has an added indication and can be used with basal insulin. The utilization report was reviewed, which shows a shift toward Victoza. Victoza is recommended for patients with cardiovascular disease. These drugs are known for causing weight loss. There is a warning for pancreatitis. There is a boxed warning for thyroid cancer. At the last review, the motion was class effect.

In response to Dr. Demain, John McCall said the shift away from Byetta to Victoza was probably related to Victoza's new indication and once-daily or weekly administration.

The committee discussed the motion in relation to those agents that demonstrate a decrease in cardiac events. They all cause weight loss, but only the Victoza has evidence of reduced cardiovascular events.

DR. RILEY MOVED A CLASS EFFECT TO CONSIDER THE CARDIO PROTECTIVE ASPECT, AND TO INCLUDE AT LEAST ONE WEEKLY PREPARATION. SECONDED BY DR. HIESTAND. THE MOTION PASSED UNANIMOUSLY.

Public Comments for Long-Acting Insulins (Red Class) (Taken out of order)

Anthony Hoovler, a representative of Nova Nordisk, discussed Tresiba. Tresiba is a long-acting basal insulin that is indicated to improve glycemic control in patients with Type 1 and Type 2 diabetes from age 1 through adulthood. It is the only basal insulin approved for both Type 1 and Type 2 diabetes in patients as young as 1 year old. The only two basal insulin analogues that are approved for pediatric Type 2 diabetes are Tresiba and Levemir. Tresiba is available in two formulations. There is a U-100 pen and U-200 pen. The U-100 pen can provide from 1 to 80 units in a single injection. The U-200 pen can provide from 2 to 160 units in a single injection. The option to provide 160 units in a single injection is unique to Tresiba. The formulations in both pens are bioequivalent. After being open, the Tresiba flex-touch pen can be used up to 56 days, which is two weeks longer than any other insulin. We request that Tresiba be maintained on the Alaska PDL.

Erin Narus referenced letters read earlier in the meeting that requested insulin Degledec be included on the Alaska PDL.

Mr. McCall gave the Magellan presentation Long-Acting Insulins. Tresiba has a new indication for patients 1 years of age and older. The DEVOTE trial showed a statistically significant risk reduction for hypoglycemia for Tresiba. Basaglar is a new agent. It is called a follow-on biologic for Lantus. At the last review, the motion was therapeutic alternatives to include at least Tresiba and grandfather-in previous long-acting regimens.

DR. RUGGLES MOVED A CLASS EFFECT TO INCLUDE TRESIBA. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

The committee decided to review the remaining insulins as a group.

Endocrine/Metabolic: Rapid-Acting Insulins (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Rapid-Acting Insulins. At the last review, the motion was class effect to include a pen delivery system.

Endocrine/Metabolic: Regular Insulins (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Regular Insulins. At the last review, the motion was class effect.

Endocrine/Metabolic: Intermediate Insulins (Green Class)

Mr. McCall gave the Magellan presentation Endocrine/Metabolic: Intermediate Insulins. At the last review, the motion was class effect.

Endocrine/Metabolic: Rapid/Intermediate-Acting Combination Insulins (Green Class)

Mr. McCall gave the Magellan presentation on Endocrine/Metabolic: Rapid/Intermediate-Acting Combination Insulins. At the last review, the motion was class effect.

Endocrine/Metabolic: Regular/Intermediate-Acting Combination Insulins (Green Class)

Mr. McCall gave the Magellan presentation on Endocrine/Metabolic: Regular/Intermediate-Acting Combination Insulins. At the last review, the motion was class effect.

DR. HIESTAND MOVED ACCEPT LAST YEAR'S MOTIONS: CLASS EFFECT TO INCLUDE A PEN FOR THE RAPID-ACTING INSULINS. SECONDED BY DR. RUGGLES. THE MOTION PASSED UNANIMOUSLY.

5. Review Minutes from April 2017 Meeting

This item was not addressed.

6. Comments from Committee Members or Chair

This item was not address.

7. Adjourn

The meeting adjourned at 11:42 a.m.