# ALASKA MEDICAID
# PHARMACY AND THERAPEUTICS COMMITTEE
# (TELECONFERENCE)

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

## MINUTES OF MEETING
**April 17, 2020**
**8:00 a.m.**

**Committee Members Present:**
Jenna Hiestand, Chair, MD
Robert Carlson, MD
Diane Liljegren, MD
Vincent Greear, R.Ph.
Charles Ryan, MD
John Riley, PA
Ryan Ruggles, PharmD
Trish White, R.Ph.

**Committee Members Absent:**
Sarah Doran-Atchison, PharmD
Claudia Phillips, MD

**Others Present:**
Erin Narus, PharmD, R.Ph., State of Alaska
Charles Semling, PharmD, R.Ph.
Marti Padilla, R.Ph., Magellan Medical Administration
Umang Patel, Pharm D, R.Ph., Magellan Medical Administration
Betty Caudle, Kron Associates

### 1. Call to Order – Chair

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

### 2. Roll Call

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

### 3. Public Comments - Local Public/Health Practitioners

There were no public comments.

## 4. Class Review, Discussion & Vote

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

***Public Comments for Hereditary Angioedema (Blue Class)***

There were no public comments.

Dr. Umang Patel noted that all information shared and distributed in the course of this meeting is confidential and should be treated accordingly.

Dr. Umang Patel gave the Magellan presentation on Hereditary Angioedema Agents. Hereditary angioedema (HAE) is a rare dominant, autosomal genetic disorder that affects between 6,000 and 30,000 individuals in the United States. It is characterized by recurrent episodes of nonpruritic, nonpitting, subcutaneous or submucosal edema involving the skin or mucosal tissues of the upper respiratory and GI tracts. Although swelling can resolve spontaneously in a few days without treatment, laryngeal edema may be fatal, and the pain of GI attacks can be incapacitating. Symptoms can begin as early as 2 years of age and persist throughout life with unpredictable severity and frequency of attacks. It is thought that minor trauma and stress can lead to an attack. However, many attacks can occur without any apparent trigger. There are two types of C1-INH deficient HAE. Type I is the most common and occurs in about 85% of patients. In Type I, the body does not produce enough C1-INH. Type II is characterized by the presence of normal or high levels of a dysfunctional C1-INH. Prophylaxis is needed to reduce potential edema caused by a stressor or procedures likely to precipitate an attack or decrease the number of severities of angioedema attacks.

Changes in the treatment guidelines were reviewed.

The drugs in the class are stratified by prophylaxis and treatment. For prophylaxis, there is Cinryze, Haegarda and Takhzyro. For treatment, there is Kalbitor, Firazyr, Berinert, and Ruconest.

In July 2019, Icatibant Acetate became the first generic FDA-approved for Shire's Firazyr. It is indicated for the treatment of acute HAE attacks in ages 18 years of age and older. Following treatment of laryngeal attacks with treatment, patients should be advised to seek immediate medication attention. Dosage recommendations were reviewed. It is available as an injection.

The utilization report was reviewed, and 7% were for preferred products. At the last review, a motion of therapeutic alternatives to include at least one prophylaxis formulation and one treatment formulation passed unanimously.

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

***Public Comments for Hemophilia (Blue Class)***

**KEN LIU**, a representative of Sanofi, discussed Eloctate. Please refer to the full prescribing information for additional details. Eloctate or Recombinant is an antihemophilic factor, Fc fusion

protein. It is FDA approved in adults and children with Hemophilia A for control and prevention of bleeding episodes, perioperative management, and routine prophylaxis to reduce the frequency of bleeding episodes. It is not indicated for the treatment of vonWillebrand. Dosed in duration of treatments depend on the severity of the Factor VIII deficiency, the location and extensive bleeding, and the patient's clinical condition. Calculation of the required dose of Factor VIII is based on the finding that one IU of Factor VIII per kilogram of body weight raises the plasma factor A level by two IUs per deciliter. Dosing recommendations were reviewed. Several clinical studies and their outcomes were reviewed. Eloctate is contraindicated in patients who have had life-threatening hypersensitivity reactions to Eloctate, including anaphylaxis. Hypersensitivity reactions have been reported with Eloctate. The formation of neutralizing antibodies or inhibitors to Factor VIII has been reported following the administration of Eloctate, including in previously untreated patients. The most frequently occurring adverse reaction were arthralgia, malaise, myalgia, headaches, and rash. Eloctate was demonstrated as an effective on-demand treatment for the control of bleeding episodes and an effective prophylactic treatment that can result in low ABR in Hemophilia A patients.

**JIGNESH PATEL**, a representative of Novo Nordisk, discussed multiple medication. Novoeight is a recombinant Factor VIII product indicated for the entire gamut of the indications on-demand. It is a room-stable temperature product which reduces the amount of waste. Esperoct is an extended half-life treatment for adults and children with Hemophilia A for on-demand treatment and control of bleeding episodes, perioperative management of bleeding, and routine prophylaxis to reduce the frequency of bleeding episodes. It has a fixed-dosing nature, which is unique compared to some of the other extended half-life products on the market, which allows for a more predictable utilization. Several studies and their outcomes were reviewed. Rebinyn is an extended half-life Factor IX product. It is indicated in adults and children with Hemophilia B for on-demand and perioperative management. It also has fixed dosing, which is unique compared to the other products and allows for better product utilization, monitoring and product category budgeting.

**KYLE DOWNEY**, a representative of Genentech, discussed Hemlibra. Please refer to the information provided for safety and indications. Hemlibra is indicated for prophylaxis to prevent bleeding episodes in both adults and pediatrics with Hemophilia A. It is administered subcutaneously and has a dosing schedule of twice every other week and then once every four weeks. Several clinical trials and their outcomes were reviewed. Hemlibra offers a unique and important alternative of subcutaneous therapy. The overall goal is to reduce joint bleeds.

Dr. Umang Patel gave the Magellan presentation on Hemophilia, a rare, inherited bleeding disorder where the blood does not clot properly due to an absence of one of the coagulation factors present in normal blood. It is identified as an X-linked congenital bleeding disorder that has an estimated frequency of 1 in 5,000 to 10,000 births. It typically affects males on the maternal side due to X-linked inheritance; however, females may also rarely be affected. Up to 30% of newly diagnosed cases occur with no prior family history and are attributed to spontaneous mutations in either the F8 or F9 gene. The World Federation of Hemophilia estimates the global prevalence of hemophilia is around 400,000 persons. It is estimated that there are approximately 17,000 to 20,000 people in the United States that are afflicted with hemophilia. There are two main types of hemophilia, type A and type B. Type A is also known as Factor VIII deficiency, classical hemophilia, or standard hemophilia. It is far more common than type B and presents in 80-85 percent of all hemophilia patients. Patients with type A hemophilia exhibit low or missing levels of clotting Factor VIII. Type B, also known as Factor IX deficiency or Christmas disease. Those with type B have low or missing levels of clotting Factor IX.

Hemophilia also encompasses a number of other rare factor deficiencies. These disorders include deficiencies involving the following factors: Factor I, fibrinogen deficiency; Factor II, prothrombin deficiency; Factor V, proconvertin deficiency; Factor X, Stuart-Prower deficiency; Factor XI, hemophilia C or plasma thromboplastin deficiency; Factor XII, Hageman factor deficiency; and Factor XIII, fibrin stabilizing deficiency. These disorders are far less common than hemophilia A and B, exemplified by Factor XIII deficiency which is estimated to occur in 1 in 5 million persons.

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

Guidelines from the World Federation of Hemophilia and the National Hemophilia Foundation Medical and Safety Advisory Committee were provided.

Wilate, a von Willebrand factor/coagulation Factor VIII complex, was approved by the FDA in October 2019 for a new indication for adults and adolescents with hemophilia A for routine prophylaxis to reduce the frequency of bleeding episodes and on-demand treatment and control of bleeding episodes.

An FDA communication for Humate-P came out in October 2019. Customers were altered to misalignment/incorrect position of strength on packaging of Humate-P that could confuse the user; although incorrectly aligned, the printed strengths are correct.

Kogenate FS was recalled by the FDA in July 2019. Bayer issued a patient-level voluntary recall of two lots of Kogenate FS because certain vials in the lots were labeled Kogenate FS but contained Jivi antihemophilic factor, which is a recombinant. Affected lots were distributed from February 5, 2019 to July 15, 2019, from Bayer's distribution sites in Berkeley, California, and Shawnee, Kansas.

The utilization report was reviewed, and 86% were for preferred products. At the last review, a motion for therapeutic alternatives passed unanimously.

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

**4-B. Cardiovascular:** ACE Inhibitor & Renin Inhibitors (Green Class); Angiotensin Receptor Blockers (ARB) (Blue Class); Angiotensin Modulator/CCB Combinations (Green Class); Antianginal and Anti-ischemic Agents (Green Class); Anticoagulants (Blue Class); Beta-

Blockers (Green Class); Calcium Channel Blockers (Blue Class); Erythropoiesis Stimulating Agents (Blue Class); Lipotropics, Other (Blue Class); PCSK-9 Inhibitors (Blue Class);Platelet Aggregation Inhibitors (Red Class); Pulmonary Arterial Hypertension (Blue Class)

Dr. Umang Patel noted that the Cardiovascular class would be presented together. At the last review, the motion was bundled together.

***Cardiovascular: ACE Inhibitors and Renin Inhibitors (Green Class)***

Dr. Umang Patel gave the Magellan presentation on ACE Inhibitors and Renin Inhibitors. The utilization report was reviewed, and 99% were for preferred products. There was no individual motion at the last review.

***Public Comments for Cardiovascular: Angiotensin Receptor Blockers (ARB) (Blue Class)***

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Angiotensin Receptor Blockers (ARB). Hypertension was reviewed. Approximately 116 million, or almost 50%, of adults in the United States have high blood pressure, along with 1 in 3 Americans having prehypertension. The highest prevalence is among African American men and women. Approximately 58.6% and 56% of African American men and women, respectively, are likely to develop high blood pressure by 55 years of age. It is estimated that hypertension is controlled in only 54% of patients with the condition.

Guidelines from the American Heart Association and the American College of Cardiology were provided and/or reviewed.

The FDA approved a new indication for Estresto, a combination of Sacubitril and Valsartan, in October 2019 for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients 1 year of age or older. ACE inhibitors and ARBs are pregnancy Category X as they can cause fetal damage. Dosing and availability are stratified by indication and are weight based.

There are two new generics. Aliskiren was released in March 2019. BioPharma and Prasco announced the launch of an authorized generic for Tekturna, 150 and 300 milligram tablets. Noden will continue to distribute Tekturna and Tekturna HCT. Valsartan was released in March 2019 and the FDA approved Alkem's Valsartan, another generic formulation of Diovan. The FDA also issued a press release noting that they are prioritizing ARB applications to mitigate shortages related to multiple recalls.

Recalls were reviewed. For Losartan, there were four major recalls last year. In May 2019, Vivimed Life Sciences issued a recall of 19 lots of Losartan potassium due to the detection of NMBA above the FDA's acceptable exposure limit. Based on the available information, the risk of developing cancer in a few patients following long-term use of the product containing high levels of the impurity NMBA cannot be ruled out. In June 2019, Macleod Pharmaceuticals issued a voluntary recall of one lot of Losartan/HCTZ combination for a similar reason. In June 2019, Teva initiated a voluntary recall of 35

lots of bulk Losartan potassium. In September 2019, Torrent expanded its voluntary recall from two lots of Losartan potassium tablets to a total of 10 lots.

FDA communications were reviewed. In March 2019, the FDA issued a press release regarding the ongoing investigation of the recent voluntary recalls of multiple generic ARBs. The most recent recall involving Camber Pharmaceuticals detected NMBA, which is a known animal and potential human carcinogen. It was the first ARB recall resulting from the presence of NMBA, which is the third type of nitrosamine impurity detected in ARB medicines. While recent FDA analyses of NDMA and NDEA in recalled Valsartan found that overall the risk to individual patients was very low, the agency continues to evaluate the risk to patients and will continue to test all ARBs for impurities. The FDA will continue to work with companies to remove affected products from the market. In June 2019, the online pharmacy Valisure detected solvent N-dimethylformamide in select lots of Valsartan. Valisure considered levels high and submitted a citizen petition to the FDA on June 13 asking the FDA to take action. The FDA acknowledged receipt and will evaluate and respond directly to the petitioner. IN August 2019, the FDA issued a statement regarding ARB recalls and ARB safety. The statement clarifies the risks of exposure and summarizes the current analysis status on manufacturing data.

The utilization report was reviewed, and 92.6% were for preferred products. There was no individual motion at the last review.

***Cardiovascular: Angiotensin Modulator/CCB Combinations (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Angiotensin Modulator/CCB Combinations. The utilization report was reviewed, and 87.5% were for preferred products. At the last review, a motion that all three subgroups were therapeutic alternatives to include at least one ACE inhibitor, one ARB, and one ARNI agent, passed unanimously.

**MR. RILEY MOVED THAT ALL THREE SUBGROUPS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE ACE INHIBITOR, ONE ARB, AND ONE ARNI AGENT. SECONDED BY MS. LILJEGREN. THE MOTION PASSED UNANIMOUSLY.**

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

Dr. Umang Patel gave the Magellan presentation on Antianginal and Anti-ischemic Agents. The utilization report was reviewed, and 39.5% were for preferred products. At the last review, a motion for class effect passed unanimously.

In response to Ms. Liljegren, Dr. Umang Patel referenced the utilization sheet on the web portal and noted that one of the medications had not been reviewed and was divvied up into the non-PDL function.

**DR. RYAN MOVED A CLASS EFFECT. SECONDED BY MS. WHITE. THE MOTION PASSED UNANIMOUSLY.**

***Public Comments for Cardiovascular: Anticoagulants (Blue Class)***

**MAE KWONG**, a representative of Janssen, discussed Xarelto (Rivaroxaban). We request that the committee consider adding Xarelto 2.5 milligram dose to the PDL. It is given twice daily, which makes it the only agent approved for the reduction and risk of major cardiovascular events, including cardiovascular death, MI and stroke in patients with CAD or PAD. Xarelto 2.5 milligrams given twice daily in combination with aspirin yielded a 24% reduction in events versus placebo as demonstrated in the COMPASS trial, which was stopped a year early due to efficacy. Several studies and their outcomes were reviewed. The 2019 AHA, ACC, HRS guidelines for the management of patients with HR fibrillation now prefer NOAC as the recommended drug class over Warfarin to reduce stroke risk in appropriate atrial fibrillation patients, unless patients have moderate to severe mitral stenosis or a mechanical heart valve. Xarelto is a NOAC with the most FDA approved indications to treat and help protect against thrombotic events, further differentiating Xarelto as a must-have option as it is the most studied anticoagulant available to a broad group of patients. We thank the committee for making Xarelto available to Medicaid patients and request that the 2.5 milligram dose be added to the PDL.

**DAVE GROSS**, a representative of Pfizer, discussed Eliquis. It is FDA approved to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. It is indicated for the treatment of deep vein thrombosis, pulmonary embolism, to prevent recurrence following initial therapy, and for the prophylaxis of deep vein thrombosis in patients who have undergone hip or knee replacement surgery. There is a black box warning regarding an increased risk of thrombotic events in people who prematurely discontinue the drug, and risk of spinal/epidural hematoma in patients undergoing neuraxial anesthesia or spinal puncture. For complete safety information, please refer to the full product and labeling information. Several trials and their outcomes were reviewed. We request that Eliquis be maintained on the Alaska Medicaid PDL.

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

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

Atrial fibrillation (AF) is a common arrhythmia ranging in prevalence from 2% in patients under 65 years of age to 9% for those 65 and older. The prevalence is higher in men than in women and increases with age. More than a third of patients with AF are 80 years of age or older. Patients with AF can have a reduction in cardiac output resulting in pooling of blood in the heart, atrial thrombus formation, and potential systemic embolization. Ischemic stroke is the most frequent clinical

manifestation of AF associated with embolization. AF increases the risk of stroke five-fold. In patients with AF, ACCP recommends measuring thromboembolism risk using the $CHA_2DS_2$-VASc score, which considers risk factors such as gender, age, history of stroke, TIA, or thromboembolism, as well as history of congestive heart failure, hypertension, diabetes mellitus, or vascular disease (prior MI, peripheral artery disease, or aortic plaque). The score ranges from 0 to 9 with higher numbers indicating more risk.

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

Fragmin received an expanded indication from the FDA in May 2019 to reduce the recurrence of symptomatic venous thromboembolism (VTE) in pediatric patients 1 month of age or older. There are black box warnings for patients anticoagulated with low molecular weight heparins or heparinoids who receive neuraxial anesthesia or undergo a spinal puncture for the risk of epidural or spinal hematomas, which may result in long-term or permanent paralysis.

Xarelto received an expanded indication from the FDA in October 2019 for the prophylaxis of VTE and VTE-related death during hospitalization and post hospital discharge in adult patients admitted for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE and not at high risk of bleeding. Black box warnings include premature discontinuation or an oral anticoagulant and patients anticoagulated with Xarelto who receive neuraxial anesthesia or undergo a spinal puncture are at risk for epidural or spinal hematomas, which may result in long-term or permanent paralysis.

In January 2020, the FDA approved the first generic of Eliquis from Mylan and Micro Labs.

The utilization report was reviewed, and 98% were for preferred products. At the last review, a motion of therapeutic alternatives to include one oral agent, one injectable agent, one DOAC that can be used for PE and CV prophylaxis, and Warfarin passed unanimously.

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

***Cardiovascular: Beta-Blockers (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Beta-Blockers. The utilization report was reviewed, and 81.4% were for preferred products. At the last review, a motion of class effect to include both Carvedilol and Metoprolol Succinate passed unanimously.

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

***Public Comments for Cardiovascular: Calcium Channel Blockers (Red Class)***

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Calcium Channel Blockers. No background was necessary as hypertension was reviewed earlier in the meeting.

In December 2019, the FDA approved a new drug, Conjupri. It may be used alone or in combination with other antihypertensive agents for the treatment of hypertension to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal CV events, primarily strokes and MIs. Warnings and precautions were reviewed. Symptomatic hypotension is possible, particularly in patients with severe aortic stenosis. However, acute hypotension is unlikely. Worsening angina and acute MI can develop after starting or increasing the dose of Amlodipine, particularly in patients with severe obstructive coronary artery disease. Titrate slowly in patients with severe hepatic impairment. Dosing recommendations were reviewed. It is available in a tablet formulation. There is limited available data for patients who are pregnant to inform a drug associated risk. Dosage reductions are recommended for geriatric and pediatric patients. Patients with renal failure may receive the usual initial dose.

In July 2019, the FDA approved Katerzia oral suspension. It is indicated for the treatment of hypertension in adults and children 6 years of age and older to lower blood pressure. It is indicated for coronary artery disease for chronic stable angina, vasospastic angina, and Angiographically Documented Coronary Artery Disease in patients without heart failure or an ejection fraction of less than 40%. All calcium channel blockers have similar warnings and precautions. Dosage recommendations were reviewed. It is available in an oral suspension.

The utilization report was reviewed, and 99.3% were for preferred products. At the last review, a motion of therapeutic alternatives to includes at least one short-acting agent, one extended release agent, and one non-dihydropyridine agent passed unanimously.

**DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE SHORT-ACTING AGENT, ONE EXTENDED RELEASE AGENT, AND ONE NON-DIHYDROPYRIDINE AGENT. SECONDED BY DR. CARLSON. THE MOTION PASSED UNANIMOUSLY.**

***Public Comments for Cardiovascular: Erythropoiesis Stimulating Agents (Blue Class)***

There were no public comments.

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

Another subclass of anemia is beta thalassemia. It is a rare inherited blood disorder marked by the reduction of functional hemoglobin levels and has an incidence of approximately 1 in 100,000 individuals in the general population. There are three subtypes of beta thalassemia which are characterized by the severity of symptoms: minor, intermediate and major. Individuals with beta thalassemia major require regular blood transfusions, as often as once every two to four weeks, and are dependent on medical care for survival. Treatment for beta thalassemia is highly dependent on the type, progression and severity of disease, and the presence or absence of certain symptoms. Treatment options may include regular blood transfusions, chelation therapy, folic acid treatment, removal of the spleen and/or gallbladder, and bone marrow transplantation.

Reblozyl is the first FDA-approved erythroid maturation agent that reduces patient transfusion burden by regulating late-stage RBC maturation. It is approved for the treatment of anemia in adult patients with beta thalassemia who require regular red blood cell transfusions.

Guidelines from the National Comprehensive Cancer Network and the American Society of Clinical Oncology and American Society of Hematology were provided and/or reviewed.

In November 2019, the FDA approved Reblozyl, an erythroid maturation agent indicated for the treatment of anemia in adult patients and beta thalassemia who require regular red blood cell transfusions. Warnings and precautions were reviewed. For thrombosis/thromboembolism, there is an increased risk in patients with beta thalassemia. Patients should be monitored for signs and symptoms of thromboembolic events and treatment instituted promptly. For hypertension, monitor blood pressure during treatment and initiate anti-hypertensive treatment as necessary. For embryo-fetal toxicity, female patients of reproductive potential should be advised of potential fetus risk and use of effective contraception. Dosage recommendations were reviewed. It is available as single-dose injections.

The utilization report was reviewed, and 90.2% were for preferred products. At the last review, a motion of therapeutic alternatives passed unanimously.

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

***Public Comments for Cardiovascular: Lipotropics, Other, and PCSK-9 Inhibitors (Blue Classes)***

There were no public comments for Lipotropics, Other, but there were public comments for PCSK-9 Inhibitors.

**BEN DROESE**, a representative of Amgen, discussed Repatha, a self-administered, subcutaneous PCSK-9 inhibitor that is approved to reduce MI, stroke, and coronary revascularization in patients with establish cardiovascular disease, as well as approval for LDL reduction in patients with primary hypolipidemia and homozygous familial hypercholesterolemia. Please refer to the FDA-approved prescribing information for full details. Several trials and their outcomes were reviewed. Two substantial changes since the publication of the guidelines that affect the cost of PCSK-9 class recommendations based on the underlying value assessments were reviewed.

**SCOTT ANDERSON**, a representative of Regeneron, discussed Praluent, a PCSK-9 inhibiting monoclonal antibody that has demonstrated the ability to significantly lower LDL cholesterol. It is indicated as an adjunct to diet, alone or in combination with other lipid-lowering therapies for the treatment of adults with primary hyperlipidemia, including patients with heterozygous familial hypercholesterolemia. It is also indicated to reduce the risk of myocardial infarctions, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease. Several studies and their outcomes were reviewed. The most commonly occurring adverse events included nasal pharyngitis, injection site reactions, and influenza. The starting dosage of Praluent is 75 milligrams every two weeks, administered subcutaneously. If additional LDL cholesterol lowering is needed, the dose can be titrated to 150 milligrams every other week. Praluent as demonstrated to be well tolerated and has a favorable adverse event profile. Most importantly, it has also demonstrated the ability to lower major adverse cardiovascular events in very high-risk patients with atherosclerotic cardiovascular disease.

Dr. Umang Patel gave the Magellan presentation on Lipotropics, Other. The National Health and Nutrition Examination Survey reported that in 2015 to 2016 approximately 12.4% of adults had high total cholesterol, and 18.4% had low HDL-C. This is higher in women (13.7%) when compared to men (11.2%). Many clinical trials have demonstrated that a high serum concentration of low-density lipoprotein cholesterol (LDL-C) and low levels of high-density lipoprotein cholesterol (HDL-C) are major risk factors for coronary heart disease.

Guidelines from the American Association of Clinical Endocrinologists and the American College of Endocrinology, the American Diabetes Association, the American Heart Association and American College of Cardiology, the American Heart Association, the American Diabetes Association-Standards of Medical Care in Diabetes, and the National Lipid Association were provided and/or reviewed.

In April 2019, the FDA approved the new formulation, the Welchol chewable bar. It is indicated as an adjunct to diet and exercise to reduce elevated LDL-C in adults with primary hyperlipidemia, reduce LDL-C levels in boys and postmenarchal girls, 10 to 17 years of age, with heterozygous familial hypercholesterolemia, and improve glycemic control in adults with T2DM.

In October 2019, the FDA approved Livalo as an adjunctive therapy to diet in pediatric patients ages 8 years of age or older with HeFH to reduce total cholesterol, LDL-C, and Apo B. It was already approved in adults with primary hyperlipidemia or mixed dyslipidemia.

In December 2019, the FDA approved a new indication for Vascepa based on result of the REDUCE-IT trial. It is indicated as an adjunct to maximally tolerated statin therapy to reduce the risk of MI, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated triglycerides of 150 mg/dL or greater, and an established cardiovascular disease or diabetes, and two or more additional risk factors for cardiovascular disease.

In February 2020, the FDA approved Nexletol as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease who require additional lowering of low-density LDL-C. The effect of Nexletol on cardiovascular morbidity and mortality has not been determined. Warnings and precautions include hyperuricemia and tendon rupture. Dosing recommendations were reviewed. It is available in tablet formulation.

In February 2020, the FDA approved Nexlizet, a Bempedoic acid and Ezetimibe combination. It is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease who require additional lower of LDL-C. Drug interactions were reviewed. With Simvastatin, avoid concomitant use with Simvastatin greater than 20 milligrams. With Pravastatin, avoid concomitant use with Pravastatin greater than 40 milligrams.

In July 2019, the FDA approved an expanded indication for Praluent to reduce the risk of MI, stroke, and unstable angina requiring hospitalization in adults with established CVD and as an adjunct to diet, alone or in combination with other lipid-lowering therapies for the treatment of adults with primary hyperlipidemia to reduce LDL-C. The safety and efficacy have not been established in pediatric patients. For renal dose adjustment, there is no data for severely impaired renal patients or hepatic impairment, but there are no dose adjustments needed for mild to moderate.

The utilization report was reviewed, and 0% were for preferred products. At the last review, a motion for therapeutic alternatives to include at least one drug from each subclass passed unanimously.

**MR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RYAN.**

In response to Dr. Ryan, the committee discussed why there were no preferred medications on the PDL. After a review, Dr. Umang Patel said his files did not indicate a preferred product for this class. Dr. Erin Narus said there was no preferred product in this class based on the current PDL. Some of the medications will require a prior authorization. The other products would be prescribed utilizing the medically necessary clause. Mr. Greear said he did not believe that the PDL reflected the committee's motion at the previous meeting. Dr. Erin Narus said this was the first review since the original motion.

**THE MOTION PASSED UNANIMOUSLY.**

Dr. Umang Patel gave the Magellan presentation on PCSK-9 Inhibitors. The overview was done with the Lipotropic, Other, class. The utilization report was reviewed, and 0% were for preferred products. At the last review, a motion of class effect passed unanimously.

**MR. GREEAR MOVED A CLASS EFFECT. SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.**

***Public Comments for Cardiovascular: Platelet Aggregation Inhibitors (Red Class)***

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Platelet Aggregation Inhibitors. In 2018, the Heart Disease and Stroke Statistics update cites cardiovascular disease as the leading cause of all deaths in the United States in 2015, with coronary heart disease (43.8%) being the leading cause of CV death, followed by stroke (16.8%), among CV deaths. Stroke also causes significant morbidity and mortality in the United States and is the fifth leading cause of death behind heart disease, cancer, chronic lower respiratory disease, and accidents. Inhibitory effects on platelet aggregation have led to a significant

decrease in the rate of vascular events for both primary and secondary CV prevention trials. A small percentage of patients with CV disease have aspirin resistance, and therefore may be at higher risk for CV events. The definition of aspirin resistance is quite variable in the literature and has been described as the failure to prevent a thrombotic event, the inability to inhibit platelet thromboxane formation, or the inability to cause prolongation of bleeding time. Other antithrombotic drugs have been developed to improve the platelet aggregation inhibition and to improve the safety profile of platelet aggregation inhibitor therapy. Clopidogrel (Plavix), aspirin/dipyridamole ER (Aggrenox), and ticlopidine are platelet aggregation inhibitors and are useful in treatment and prevention of CV and cerebrovascular thrombotic events. Prasugrel (Effient) has shown better efficacy compared to clopidogrel in preventing MI and stent thrombosis in ACS patients undergoing percutaneous coronary intervention. While long-term safety information is still limited with the use of prasugrel, it has been associated with significantly more major bleeding episodes when compared to clopidogrel-treated patients. Studies have shown ticagrelor (Brilinta) to be favored over clopidogrel in preventing deaths from CV causes, MI, or stroke.

Guidelines from the American College of Cardiology/American Heart Association were reviewed.

In April 2019, Yosprala, which was discontinued by Aralez for business reasons, has been relaunched. The aspirin component of Yosprala is indicated for reducing the combined risk of death and nonfatal stroke in patients who have had ischemic stroke or transient ischemia of the brain due to fibrin platelet emboli, reducing the combined risk of death and nonfatal MI in patients with a previous MI or unstable angina pectoris, reducing the combined risk of MI and sudden death in patients with chronic stable angina pectoris, and for use in patients who have undergone revascularization procedures or percutaneous transluminal coronary angioplasty when there is a preexisting condition for which aspirin is already indicated. The omeprazole component of Yosprala is indicated for decreasing the risk of developing aspirin-associated gastric ulcers in patients at risk for developing aspirin-associated gastric ulcers due to age (55 years and older) or documented history of gastric ulcers. Yosprala is not for use as an initial dose of aspirin therapy during onset of acute coronary syndrome, acute MI, or before percutaneous coronary intervention. It has not been shown to reduce the risk of GI bleeds due to aspirin. Do not substitute Yosprala with the single-ingredient products of aspirin and omeprazole. Dosing recommendations were reviewed. It is available as a delayed-release tablet. Safety and efficacy of Yosprala has not been established for pediatric patients. Patients with severe renal impairment should not use this medication, but there are no dose adjustments needed for patients with mild to moderate renal impairment. This medication should not be used for patients with any degree of hepatic impairment. Patients of Asian ancestry with unknown CYP2C19 genotype or known poor metabolizers should avoid use of this medication.

The utilization report was reviewed, and 98.3% were for preferred products. At the last review, a motion of therapeutic alternatives to include at least Clopidogrel passed unanimously.

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

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

**AMY HYGANRICE (ph)**, a representative of United Therapeutics, discussed Orenitram. United Therapeutics was started by our founders after their daughter was diagnosed with pulmonary arterial hypertension (PAH) and they realized how few treatment options were available. Our first PAH medication, Remodulin injection, was approved in 2002. We continued to develop and commercialize new therapies. We also continue our pursuit to find a cure for PAH and end-stage one disease. Orenitram was FDA approved in December 2013 with the indication to improve exercise capacity in patients with PAH. Several clinical trials/studies and their outcomes, which resulted in the additional indication of delaying disease progression, were reviewed. We that you retain Orenitram on the Alaska Medicaid PDL.

**JOHN HARTNEY**, a representative of Actelion Pharmaceuticals, discussed Uptravi, a selective prostacyclin receptor agonist indicated for the treatment of pulmonary arterial hypertension to delay disease progression and reduce the risk of hospitalization. Several studies and their outcomes were reviewed. The most frequent side effects included headache, diarrhea, jaw pain, nausea, myalgia, vomiting, pain in extremity, and flushing. We request that Uptravi be added to the Alaska Medicaid PDL.

Dr. Umang Patel gave the Magellan presentation on Pulmonary Arterial Hypertension. The prevalence varies substantially depending on the type, etiology, and underlying conditions. It is estimated to be roughly 15 per million people. Pulmonary hypertension (PH) is characterized by an increase in pulmonary arterial pressure and secondary right ventricular failure. This is defined as a resting mean pulmonary arterial pressure of 25 millimeters of mercury or greater. Symptoms include dyspnea, dizziness, syncope, fatigue, edema (peripheral), angina, palpitations, and other symptoms, all of which are exacerbated by exertion. PH does not have a cure. If left untreated, it is a life-threatening disease with poor prognosis. Management should be limited to specialized centers where clinicians are experienced in the evaluation and treatment. Although the number of approved therapies has grown in the past years, the prognosis is still poor, with approximately 50% mortality within the first 5 years after diagnosis. There are many causes of PAH including idiopathic or underlying disease and hereditary causes. Cellular changes in the walls of pulmonary arteries, and it appears that mutations in the bone morphogenetic protein receptor type 2 gene plays a key role in the pathogenesis of heritable PAH. Other etiologies in PAH include drugs and toxins, collagen vascular resistance, HIV, portal hypertension, chronic thromboembolism, and congenital heart disease. The World Health Organization classifies these patients into five groups based on etiology. Group 1 refers to pulmonary arterial hypertension. Group II refers to PH due to left heart disease. Group III refers to PH due to lung disease. Group IV refers to PH due to blood blots in the lungs. Group V refers to PH due to blood and other rare disorders. In 2013, clinical classifications were updated to provide the same PH classifications for adult and pediatric patients. In addition, the individual categorization of the persistent PH of neonates was included.

Guidelines from the European Society of Cardiology and the European Respiratory Society, and the American College of Chest Physicians were provided and/or reviewed.

In October 2019, the FDA approved Orenitram to delay disease progression in the treatment of pulmonary arterial hypertension (PAH). Previously, it was only approved to improve exercise capacity. It is contraindicated in severe hepatic impairment. Abrupt discontinuation is not recommended. In patients with diverticulosis, tablets can become lodged in the diverticulum.

In February 2019, the FDA approved Alyq, a new generic, for the treatment of PAH to improve exercise ability. It is the first generic for Adcirca. Teva announced they have launched this product.

In June 2019, the FDA approved Revatio, the first generic for Pfizer's Revatio oral suspension. The launch has already been initiated.

In April 2019, the FDA updated the REMS for Tracleer to include generics of Ambrisentan. The new name is Ambrisentan REMS program.

In May 2019, the FDA approved modifications to the REMS for Tracleer to establish a Single Shared System REMS for brand and generic Bosentan products.

In May 2019, Opsumit REMS was updated to require the inpatient pharmacy Authorized Representative (AR) to notify the Opsumit REMS when the AR changes.

The utilization report was reviewed, and 39.3% were for preferred products. At the last review, a motion of therapeutic alternatives to include one from each class plus one inhaled product passed unanimously.

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

*(Break from 10:00 a.m. to 10:14 a.m.)*

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

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

There were no public comments.

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

In February 2019, the FDA expanded the indication for Vfend to include patients as young as 2 years of age. Previously, it was only approved in patients 12 years of age and older. It is indicated for the treatment of invasive aspergillosis, candidemia in non-neutropenics and other deep tissue Candida infections, esophageal candidiasis, and serious fungal infections cause by Scedosporium apiospermum and Fusarium species including Fusarium solani, in patients intolerant of, or refractory to, other therapy.

The utilization report was reviewed, and 98.5% were for preferred products. At the last review, a motion for therapeutic alternatives to include at least one Fluconazole tablet, one oral Terbinafine preparation, and one pediatric preparation passed unanimously.

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

***Anti-Infective: Antifungals, Topical (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Antifungals, Topical. The utilization report was reviewed, and 86.9% were for preferred products. At the last review, a motion of therapeutic alternatives to include at least one solution, one shampoo, and one topical cream or ointment passed unanimously.

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

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

**KYLE DOWNEY**, a representative for Genentech, discussed Xofluza. Please refer to the full prescribing information for the full efficacy and safety data. The CDC treatment guidelines are updated on an annual basis and have now included Xofluza, among other antiviral medication, for the treatment of the flu. The flu is an epidemic on an annual basis, normally affecting one in eight people. Due of the variable nature of the flu, many current regiments are not sufficient and only about 45% of patients were vaccinated in the 2018/2019 flu season. Xofluza was introduced to the U.S. market in October 2018 for the acute, uncomplicated influenza patients, ages 12 and older, who have been symptomatic for no longer than 48 hours. In October 2019, the FDA also granted approval for Xofluza for the use of acute, uncomplicated influenza treatment in patients who are also at a high risk of developing complications to influenza, again within that 48-hour timeframe. In March 2020, the FDA accepted a new drug application for two supplemental indications for Xofluza for the late 2020/2021 timeframe for the indication of a one-time oral suspension for children, ages 1 through 12, again treated within the 48-hour timeframe. The FDA has also recently accepted a new drug application for post exposure prophylaxis to influenza in people 1 year of age or older with the oral suspension and/or the tablet formulation. We expect that review to be completed in November 2020. Xofluza currently covers the flu treatment in a single dose for patients current age 12 and older who have been symptomatic for no longer than 48 hours. Xofluza patients saw roughly a one-day or 33% reduction in symptoms

compared to that of placebo. Adverse invents occurred in less than 1% of patients. The most common adverse events were diarrhea, bronchitis, nausea, sinusitis, and headache. Currently, oseltamivir is the only approved antiviral agent on the Alaska PDL. Based on the evolving clinical evidence, the one-time dosing, and the CDC flu guidelines, we request that Xofluza be added to the Alaska PDL.

Dr. Umang Patel gave the Magellan presentation on Antivirals, Influenza. Influenza is a common illness affecting most people at least once in their lifetime. An uncomplicated illness typically resolves after three to seven days. It is often self-limiting. Persons at higher risk for influenza complications, patients less than 2 years or over 65 years of age, immunocompromised patients, pregnant and postpartum patients, less than 19 years of age plus long-term ASA therapy, American Indians/Alaska Natives, extremely obese patients, nursing homes and other chronic care facility patients, and patients with specific chronic disease states. Influenza vaccination is the primary method for preventing influenza. Inactivated influenza vaccines are available in quadrivalent and trivalent formulations, while recombinant influenza vaccines and LAIV4 are available in quadrivalent formulations. There is also a high-dose inactivated influenza vaccine and adjuvanted inactivated influenza vaccine available in trivalent formulation. For the 2018-2019 season, the ACIP voted to recommend that providers may administer any licensed, age-appropriate influenza vaccine, including LAIV4 when appropriate. This was a change from the previous two seasons during which time the ACIP recommended that LAIVA4 not be used. Virus strains included in the 2019-2020 U.S. trivalent influenza vaccine contain hemagglutinin derived from an A/Brisbane/02/2018 (H1N1)pdm09-like virus, an A/Kansas/14/2017 (H3N2)-like virus and a B/Colorado/06/2017-like virus (Victoria lineage). Quadrivalent influenza vaccines contain HA derived from the three viruses contained in the trivalent vaccine plus a B/Phuket/3073/2013-like virus (Yamagata lineage).

Treatment guidelines from the Centers for Disease Control and Prevention and the Infectious Diseases Society of America were provided and/or reviewed.

In October 2019, the FDA approved an expanded indication for Xofluza (baloxavir marboxil). It is now indicated for the treatment of acute, uncomplicated influenza in patients 12 years of age or older who have been symptomatic for less than 48 hours and who are otherwise healthy or at high risk of developing influenza-related complications. A risk of serious bacterial infections may coexist with, or occur, as a complication of influenza. It has not been shown to prevent these complications, including bacterial infection. There is no evidence of efficacy for baloxavir marboxil, oseltamivir, zanamivir in any illness due to pathogens other than influenza viruses. Co-administration of Xofluza with polyvalent cation-containing laxatives, antacids, or oral supplements should be avoided. Dosing recommendations were reviewed. It is available in tablet formulation.

The utilization report was reviewed, and 93% were for preferred products. At the last review, a motion for therapeutic alternatives to include Oseltamivir passed unanimously.

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

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

There were no public comments.

Dr. Umang Patel gave the Magellan presentation on Fluoroquinolones, Oral. Oral fluoroquinolones vary in the spectrum of antimicrobial activity. Older fluoroquinolones have a gram-negative spectrum of activity. Newer fluoroquinolones have broad spectrums of activity covering both gram-negative and gram-positive bacteria. Fluoroquinolones are indicated for a huge variety of disease states.

Guidelines from the FDA Safety Alert and the Centers for Disease Control and Prevention were provided and/or reviewed.

In October 2019, the FDA approved Baxdela for the treatment of adults with community-acquired bacterial pneumonia caused by designated susceptible bacteria. It had already been approved for acute bacterial skin and skin structure infections. Warnings and precautions include clostridium difficile-associated diarrhea can occur. Dosing recommendations were reviewed. It is available as an injection or oral tablets.

In May 2019, the FDA issued a safety alert regarding increased risk of rare, but serious, aortic ruptures with systemic fluoroquinolone antibiotics in patients with a history of blockages or aneurysm of blood vessels, including the aorta, hypertension, select genetic disorders and advanced age. The use of fluoroquinolones should be avoided in these patient populations unless no other treatment options are available. Stop fluoroquinolone treatment immediately if symptoms of aortic aneurysm or dissection occur. This warning is based on cases reported to the FDA Adverse Event Reporting System and four published observational studies. While the exact cause could not be determined, patients on fluoroquinolones with these risk factors were twice as likely to experience aortic aneurysm/dissection.

In February 2019, Bayer discontinued marketing Avelox tablets in the United States.

The utilization report was reviewed, and 97.9% were for preferred products. At the last review, a motion of class effect passed unanimously.

**MR. GREEAR MOVED A CLASS EFFECT. SECONDED BY DR. CARLSON. THE MOTION PASSED UNANIMOUSLY.**

***Anti-Infective: Hepatitis B Agents (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Hepatitis B Agents. The utilization report was reviewed, and 93.8% were for preferred products. At the last review, a motion of therapeutic alternatives passed unanimously.

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

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

**MARGARET OLMON**, a representative of Abbvie, discussed Mavyret, a treatment option for HCV patients without cirrhosis or with compensated cirrhosis. We request that Mavyret continue to be available for the Medicaid patients in Alaska. It is the only once-daily pangenetic ribavirin-free regiment, FDA approved to treat patients above the age of 12 who weight at least 45 kilograms with

chronic hepatitis C virus across all genotypes 1 through 6. This includes those who do and do not have cirrhosis, have treatment experience, or have HIV or chronic kidney disease. Mavyret can also be administered to patients after a kidney transplant regardless of baseline renal disease. Up to 95% of patients with HCV can be treated with Mavyret. A high percentage of patients awaiting treatment in Alaska are eligible for an eight-week course of therapy. Several studies and their outcomes were reviewed. Mavyret carries a boxed warning regarding the risk of hepatitis B reactivation in patients co-injected with HCV and HBV, as do all direct acting antivirals. It is contraindicated in patients with moderate or severe hepatic impairment, Child-Pugh B or C, and those with any history of prior hepatic decompensation. The most common adverse reactions were headache and fatigue. Mavyret is well tolerated and requires no liver monitoring or baseline assistance testing. No dosage or duration adjustments are needed for patients with HIV co-infection or for any level of renal impairment, including dialysis. Please see the full prescribing information for comprehensive safety and efficacy data. We request that Mavyret remain on the Alaska PDL.

**COLEEN FONG**, a representative of Gilead, discussed Epclusa. Epclusa consists of a six-dose combination, which was described. Last year, the FDA updated the prescribing information in regard to patients with renal impairment. No renal adjustment is recommended in patients with any degree of renal impairment, based upon a phase-two, open-label study. Several studies and their outcomes were reviewed. Common adverse events included headache, fatigue, and nausea. As of March of this year, an expanded indication for use of Epclusa in patients who are at least 6 years of age or older who weigh at least 17 kilograms or more was granted. Dosing recommendations were reviewed. The ASTRO Clinical Trial Program and its outcomes were reviewed. Epclusa is a single tablet regiment that has demonstrated high FCR rates in the range of 94-100%, has limited drug/drug interaction, and provides a consistent cure rate across genotypes, and among patients in clinical trials and real-world studies. Patients as young as 6 years of age and older, weighing at least 17 kilograms or more, can now have a treatment option for the management of chronic hepatitis C. We request that Epclusa be included on the Alaska PDL.

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

genotype is an important factor in selecting the optimal treatment planning, dictating drug selection, dose, and duration of treatment. There are six HCV genotypes and more than 50 subtypes, and the HCV genotypes varies across the world. Genotype 1 is the most common worldwide and accounts for 70% to 75% of U.S. infections. Among African Americans, the frequency of genotype 1 is even higher at an estimated 90%. In the U.S., genotype 1a and 1b represent about 75% and 25% of genotype 1 cases, respectively. Genotype 2 and 3 account for the majority of the other 25% to 30% of HCV infections in the U.S. Genotype 4 predominates in Egypt. Genotype 5 is localized to South Africa. Genotype 6 is localized to Hong Kong and Southeast Asia.

Guidelines from the Kidney Disease Improving Global Outcomes and the U.S. Preventative Services Task Force were provided and/or reviewed.

Discontinuations were reviewed. In May 2019, Merck discontinued Rebetol oral solution around June 2019. In July 2019, Kadmon reported to the FDA that their intent was to discontinue their various formulations of ribavirin. The products were available until November 2019. All other formulations of ribavirin are still available. In September 2019, Merck announced plans to discontinue marketing of Pegintron injection on or near May 2021. In September 2019, Bristol Myer Squibb announced discontinuation of the remaining strengths of Daklinza tablets.

FDA communications were reviewed. In August 2019, the FDA issued a Drug Safety Communication warning about rare occurrence of serious liver injury with the use of three agents approved for the treatment of HCV: Mavyret, Zepatier, and Vosevi. Through January 8, 2019, a total of 63 cases of liver decompensation, including eight deaths, have been reported via the FAERS database and medical literature. Over half of the cases initially reported no cirrhosis or compensated cirrhosis at baseline but were later found to have evidence of advanced disease or other risk factors that may have contributed. Healthcare practitioners should continue to prescribe these agents for those without liver impairment or with mild impairment, assessing severity at baseline and closely monitoring for signs or symptoms of worsening function. These agents should be discontinued in patients who develop signs or symptoms of liver decompensation or as clinically indicated.

In September 2019, the FDA approved Sovaldi for the treatment of chronic HCV genotype 2 or 3 injection in pediatric patients 3 years of age or older without cirrhosis or with compensated cirrhosis for use in combination with ribavirin. Previously, it was only approved in pediatric patients 12 years of age or older or weighing greater than 35 kilograms. The FDA also approved a 150-milligram and 200-milligram oral pellet formulation of Sovaldi.

In September 2019, the FDA expanded the indication of Mavyret to include adolescents 12 years of age or older, or weighing greater than 45 kilograms, with chronic HCV genotype 1, 2, 3, 4, 5 or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A).

In November 2019, the FDA approved Harvoni for the treatment of chronic HCV genotypes 1, 4, 5 or 6 infection in pediatric patients 3 years of age or older without cirrhosis or with compensated cirrhosis. Previously, it was only approved in pediatric patients 12 years of age or older or weighing over 35 kilograms. The FDA also approved a 33.75-milligram per 150-milligram and a 45-milligram per 200-milligram oral pellet formulation.

The utilization report was reviewed, and 94.6% were for preferred products. At the last review, a motion of therapeutic alternatives passed unanimously.

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

***Anti-Infective: Otic Antibiotics (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Antifungals, Oral. The utilization report was reviewed, and 33.3% were for preferred products. At the last review, a motion of therapeutic alternatives passed unanimously.

**MR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE OTIC GLUCOCORTICOID COMBINATION. SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.**

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

***Genitourinary: Benign Prostatic Hyperplasia (BPH) Agents (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Benign Prostatic Hyperplasia (BPH) Agents. The utilization report was reviewed, and 97.6% were for preferred products. At the last review, a motion for therapeutic alternatives to include one alpha blocker and one androgen hormone inhibitor passed unanimously.

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

***Public comment on Genitourinary: Bladder Relaxant Preparations (Blue Class)***

There were no public comments.

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

Guidelines from the American Urological Association were reviewed.

In January 2020, the FDA approved the first generic of Myrbetriq by Sawai Pharmaceutical, Mirabegron ER. It is indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency; and the treatment of overactive bladder with symptoms or urge urinary incontinence, urgency, and urinary frequency in combination with solifenacin. While not contraindicated, it should be used cautiously in patients with uncontrolled narrow-angle glaucoma or gastric and/or urinary retention. Dosage recommendations were reviewed. It is available in tablet formulation.

In October 2019, Pfizer discontinued the manufacture of Detrol LA 2-milligram and 4-milligram blister packs. Bottles of 30, 90 and 500 count remain available.

The utilization report was reviewed, and 69.9% were for preferred products. At the last review, a motion of therapeutic alternatives with the understanding that the DUR Committee would review this class passed unanimously.

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

***Genitourinary: Vaginal Antibiotics (Green Class)***

Dr. Umang Patel gave the Magellan presentation on Vaginal Antibiotics. The utilization report was reviewed, and 95.3% were for preferred products. At the last review, a motion of therapeutic alternatives passed unanimously.

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

## 5. Review Minutes from January 2020

**MR. RILEY MOVED TO APPROVE THE JANUARY 2020 MEETING MINUTES AS SUBMITTED. SECONDED BY (UNIDENTIFIED MALE). THE MOTION PASSED UNANIMOUSLY.**

## 6. Comments from Committee Members or Chair

There were no comments from committee members.

## 7. Adjourn

The public portion of the meeting adjourned at 11:00 a.m. and the committee moved into executive session