Alaska Medicaid Pharmacy and Therapeutics Meeting

MINUTES OF MEETING
April 21, 2023

Committee Members Present:
John Riley, PA, Acting Chairman
Robert Carlson, MD
Casey Gokey MD
Valarie Bixler, PharmD
Diane Liljegren, R.Ph.
Claudia Phillips, MD
Charles Ryan, MD
Trisha White, R.Ph.

Committee Members Absent:
Jonathan Harrison, PharmD
Sarah Doren-Atchison, PharmD

Others Present:
Ryan Ruggles, Pharm D
Umang Patel
Brandon Yip, Sanofi
Lisa Carman, Genentech
Charles Semling PharmD, DHSS
Nirmal Ghuman, Janssen
Kellie Morland, United Therapeutics Corporation

1. Call to Order – Chair

Mr. Riley called the meeting to order.

2. Roll Call

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

3. Public Comments - Local Public/Health Practitioners

None.

4. Class Review, Discussion & Vote

4-A. Cystic Fibrosis: CFTR potentiator class (Red); Inhaled Antibiotics (Green); Pancreatic Enzymes (Green)

Hereditary Angioedema (Blue Class)

Umang Patel gave the Magellan presentation for hereditary angioedema. Hereditary Angioedema, or AAE, is a rare dominant autosomal genetic disorder that affects about 6,000 individuals in the US. Characterized by recurrent episodes of non-paretic non-pitting subcutaneous or submucosal edema involving the skin or mucosal tissues of the upper respiratory or GI tract. Although swelling can resolve spontaneously in several days without treatment, laryngeal edema may be fatal and the pain of GI attacks can be incapacitating. Symptoms can begin as early as 2 years of age and persist throughout life in 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 2 types of C1INH deficient H AE type 1 and type 2. Type 1 is the most common in which the body does not produce enough C1INH occurring in about 85 percent of patients with this condition. Type 2 is characterized by the presence of normal or high levels of dysfunctional C1INH. HAE prophylaxis is needed to reduce edema caused by stress or procedure likely to precipitate an attack or decrease the number of severity or angioedema attacks.

The World Allergy Organization European Academy of Allergy and Clinical Immunology in 2021 recommend PDC1INH such as Berinert or Cinryze or Haegarda, Takhzyro or Orladyeo as first line for long-term prophylaxis. Recombinant such as Ruconest and androgens are suggested as second-line long-term prophylaxis. The guidelines also recommend that HAE attacks be treated with Berinert, Cinryze, Haegarda and Ruconest, Kalbitor or Firazry and no one agent is preferred over the other. The guidelines recommend that intubation or surgical airway intervention be considered early in progressive upper airway edema. If the aforementioned agents are not available solvent detergent treated plasma should be used. If it is not available fresh frozen plasma can be used. Antifibrinolytics or androgens should not be used for on demand treatment of HAE attacks due to no or minimal benefit.

In February 2023, the FDA approved an expanded indication Takhzyro to include use in pediatric patients ages 2 to less than 12 years of age for prophylaxis to prevent attacks of hereditary angioedema. This was previously only approved for use in adults. No changes in warnings or dosage or availability. Patient with renal impairment, there are no dedicated studies that have been conducted to evaluate the PK or for patients with renal impairment.

There was no utilization for Alaska in the last 3 months or the last year so it was 0 percent in line with PDL due to no prescriptions or 100 percent in line with PDL depending on your view.

Previous motion Dr. Liljegren moved the drug in the class were therapeutic alternatives to include at least one prophylaxis and one treatment intervention. Seconded by Ms. White. The motion passed unanimously.

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

Hemophilia (Red Class)

Umang Patel gave the Magellan presentation for Hemophilia. Hemophilia is a rare, inherited bleeding disorder where the blood does not clot properly due to an absence of one of the coagulation factors present in normal blood. It is identified as an X-linked congenital bleeding disorder that has an estimated frequency of 1 in 5,000 to 10,000 births. It typically effects males on the maternal side due to X-linked inheritance however females may also rarely be affected but are more commonly carriers of the disease. Up to 30 percent 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 to be around 400,000 persons. It is estimated that there are approximately 17,000 to 20,000 persons in the US that are afflicted with hemophilia. There are two main types, Type A and Type B. Type A is also known as Factor VIII deficiency, classical hemophilia or standard hemophilia. It is more common than hemophilia B and presents in 80-85 percent of all hemophilia patients. Patients with Type A exhibit low or missing levels of clotting Factor VIII. Type B is also known as Factor IX deficiency or Christmas Disease. Those with Type B have low or missing levels of clotting factor IX.

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

Von Willebrand disease is similar to hemophilia A. this is a group of inherited bleeding disorders related to the absence of 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. This is equal in males and females. There are three major subtypes of Von Willebrand identified; Type 1, 2 and 3. Type 1 is a partial quantitative deficiency of Von Willebrand factor deficiency and accounts for the majority, about 75 percent of all patients. Type 2 is more pronounced qualitative deficiency and comprises almost all the remaining 25 percent of patients. This is further divided into four variants; 2A, 2B, 2M and 2N. Type 3 is characterized by a complete Von Willebrand deficiency and occurs very rarely. Their inherit Factor VIII levels are typically very low.

The Medical and Safety Advisory Committee in 2022 published guidelines providing recommendations regarding prophylaxis to patients with hemophilia A or B with or without inhibitors. Because of the benefits demonstrated by prophylactic therapy they recommend the prophylaxis be considered optimal therapy for individuals with severe hemophilia A or B where endogenous factor levels are found to be less than 1 percent. It can also be used in patients with mild or moderate hemophilia who have a severe phenotype. Prophylactic therapy should be initiated early, prior to the age of 3 years and before the second joint bleed, and may be considered within the first six months after birth to decrease the potential for intracranial hemorrhage. Prophylactic options include standard half-life factor, extended half-life factor and

non-factor replacement. Bypassing agents may be used for prophylaxis in those with inhibitors however for hemophilia A patients with inhibitors bypassing agents are less effective than prophylaxis with emicizumab. For prophylaxis in hemophilia A patients standard half-life factors are usually given 2 to 4 times a week and extend half-life factors are usually given 1 to 3 times a week with the goal trough values for factor VIII levels of at least 1 percent and minimal or no spontaneous bleeds. When factors are utilized for prophylaxis the dosing frequency can be individualized based on PK studies. In contrast, laboratory-based assays are not currently approved for assessing response in patients receiving non-factor replacement. Standard half-life and extended half-life factor VIII prophylaxis can be given in the morning to prevent bleeding events during the day however timing of the dose is not considered as relevant for the extended half-life factor IX products. Adherence to prophylactic regimens should be monitored and a patient's regimen may need to be adjusted across the patient's life based on changes in physical activity and risk of traumatic bleeding.

In October 2022, the FDA approved the indication of Recombinant and Rebinyn to be expanded to include routine prophylaxis to reduce the number of bleeding episodes in adults and children with hemophilia B. It does have a few other indications. There is limitation of use for it not being indicated for immune tolerance induction in patients with hemophilia B. No changes in warnings or precautions. No changes in dosage or existing indications just the new indication of routine prophylaxis dosing is approved for 40 international units per kilogram body weight once weekly. No changes in availability.

In December 2022, the FDA approved Hemgenix, an adeno-associated virus vector-based gene therapy for the use in adults with hemophilia B who currently use Factor IX prophylaxis therapy or have current or history of life-threatening hemorrhage or have repeated serious spontaneous bleeding episodes. In terms of warning and precautions it is recommended to monitor drug administration and for at least 3 hours after the end of infusion as infusion reactions may occur. If symptoms occur slow or interrupt the administration and restart administration at a slower infusion once it is resolved. In regards to dosage it is recommended that clinicians perform baseline testing to select patients including testing for factor IX inhibitor presence and liver health tests. The recommended dose is 2 x 10 to the 13^{th} genome copies per kilogram of body weight. It is administered as an IV infusion after dilution with 0.9 normal saline at a constant infusion rate of 500 mL per hour or 8 mL per minute. It is available via IV suspension. For patients with special populations such as hepatic or renal impairment there is no dose adjustment required in either geriatric patients, hepatically impaired patients or renally impaired patients.

In February 2023, the FDA approved Altuviiio for use in adults or pediatric patients with hemophilia A for routine prophylaxis to reduce frequency of bleeding episodes, on demand treatment and control of bleeding episodes and perioperative management of bleeding. The limitation was that it is not indicated for the treatment of Von Willebrand disease. Hypersensitivity reactions including anaphylaxis may occur. Similarly, to the previous slides infusion reactions if symptoms occur it is recommended that clinicians immediately discontinue treatment and initiate appropriate treatment. For routine prophylaxis it is 50 international units per kilogram once weekly. For on demand treatment and control of bleeding episodes and perioperative management it is also 50 IU per kilogram. It is available in injection doses of 250,

500, 750, 1000, 2000, 3000 or 4000 IU. These are found in powder in a single dose vial for reconstitution.

Utilization shows that 100 percent is in line with PDL. Previously Ms. White moved the drugs in the class were therapeutic alternatives and include at least one prophylactic medication. This was seconded by Dr. Phillips and passed unanimously.

Public Comments for Hemophilia (Red Class)

BRANDON YIP, director of medical value and outcomes for Sanofi Specialty Care, gave a testimony regarding their new product for hemophilia Altuviiio. It is an extended half-life factory product for hemophilia patients. It is indicated in adults and children for factory deficiency for once weekly dosing. The committee should have received some launch materials that I sent a few weeks ago during the launch. That includes a nice summary of a brief background of disease, indication and dosing, mechanism of action and some of the study design baseline characteristics and some summary highlights of efficacy and safety information. He stated he is available for any specific questions that the committee may have.

LISA CARMAN, medical affairs executive director for Genentech. She talked about Hemlibra. She submitted updated data to the committee and just wanted to discuss some of the highlights around hemophilia. Hemlibra is a monoclonal bispecific antibody that was approved in November 2017. It is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding in newborns and adults in patients with or without inhibitors. This is a sub-q patient injection. It can be given as maintenance sub-q either weekly, every other week or monthly. Treatment guidelines now recommend that prophylaxis is considered optimal therapy for patients with severe hemophilia A that should be started early and prior to the onset of frequent bleeding. In terms of safety, there is a box warning for thrombotic angiopathy events. The most frequent adverse reactions that are observed in patients, greater than 10 percent, are injection site reactions, headache and arthralgia. In terms of efficacy, long term efficacy and watching patients out to 168 weeks, 79 percent had 0 bleeds and equated to a 68 percent reduction in bleed rate in patients who had prior factor VIII prophylaxis. Lastly, she mentioned that they have done some models and looked at healthcare utilization and Hemlibra prophylaxis is expected to lower total costs in the hemophilia space. She is available for questions.

DR. RYAN MOVED THAT THE DRUGS IN THE CLASS ARE THERAPEUTIC ALTERNATIVES AND INCLUDE AT LEAST ONE PROPHYLACTIC MEDICATION. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Cardiovascular

ACE Inhibitor and Renin Inhibitors (Green Class)

Umang Patel gave the Magellan presentation on ACE Inhibitor and Renin Inhibitors.

Hypertension affects approximately 45 percent of adults in the United States along with 1 in 3 American adults having pre-hypertension. The highest prevalence is among African American men and women. Approximately 54 percent of men and women have high blood pressure compared to 46 percent of Caucasian men and women and 39 percent of non-Hispanic Asians and 36 percent of Hispanics. It is estimated that hypertension is controlled only in a quarter of patients with the condition. The KDIGO guidelines, the Kidney Disease Improving Global Outcomes, published an update to their guidelines last year on managing diabetes and patients with CKD. ACE inhibitors and ARBs are used across a lot of cardiovascular disease states. It is recommended that patients with diabetes, hypertension, albuminuria start treatment with an ACE inhibitor or an ARB titrated to maximally tolerated approved dose. Treatment with an ACE inhibitor or ARB can also be considered in patients with normal blood pressure in the setting of diabetes and albuminuria. For patients who require additional BP lowering on ACE inhibitor ARB therapy or for those who do not have albuminuria dihydropyridine, CCDs and or diuretics can be considered.

AHA, ACC and Heart Failure Society of America in 2022 published a guideline on the management of heart failure in 2022. For patients at risk for heart failure, Stage A, who have hypertension, the guideline recommends optimal control of BP using guideline-directed medical therapy and a goal BP of less than 130/80 mm Hg for patients with a cardiovascular disease risk greater than 10 percent. Patients with pre heart failure, Stage B, and with a left ventricular ejection fraction 40 percent or less should be placed on an ACE inhibitor to prevent symptoms and to reduce mortality. If a patient is intolerant to an ACE inhibitor and has a history of recent MI an ARB should be used instead. Patient with heart failure with reduced injection fraction and a New York Heart Association class II to III symptoms are recommended to be placed on the angiotensin receptor/neprilvsin inhibitor Entresto to reduce morbidity and mortality. However, an ACE inhibitor can be prescribed when the use of an ARNI is not feasible or an ARB can be used if a patient is intolerant to an ACE inhibitor and if the use of an ARNI is not feasible. GDMT for patients with HFrEF also includes beta blockers, mineralocorticoid receptor antagonists and SGLT2i. Medications used for HFrEF should be optimized to target doses unless not well tolerated. Dihydropyridine CCBs may be used for treatment of high BP in patients with heart failure who do not meet BP goals despite optimization.

For ACE and Renin inhibitors it was about 97 percent in line with PDL. For angiotensin modulator - CCB combinations it was about 89 percent in line with the PDL. ARBs were about 93 percent in line with the PDL. For last year's motion Dr. Liljegren moved that all three subgroups in the class were therapeutic alternatives to include at least one ACE inhibitor, one ARB and one ARNI agent. This was seconded by Dr. Loren-Atchison and it passed unanimously.

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

Anti-anginal, Anti-ischemic Agents (Green Class)

Umang Patel gave the Magellan presentation on anti-anginal and anti-ischemic agents.

There was a discontinuation though it does not quantify as a significant clinical update. In December 2022, Gilead announced that they were discontinuing brand name Rinexa 500 and 1000 mg ER tablets.

Roughly 88 percent is in line with PDL. Previous motion Dr. Phillips moved a class effect. This was seconded by Ms. White and passed unanimously.

DR. PHILLIPS MOVED THE DRUGS WERE THERAPEUTIC ALTERNATIVES, SECONDED BY DR. RYAN. THE MOTION WAS PASSED UNAMIMOUSLY.

Anticoagulants (Green Class)

Umang Patel gave the Magellan presentation on anticoagulants. Given this is a green class we will go right into utilization.

This was just shy of 99.6 percent in lien with the PDL. Previous years motion, Dr. Liljegren moved the drugs in the class were therapeutic alternatives to include one oral agent, one injectable agent, one DOAC for PE and CV prophylaxis and Warfarin. This was seconded by Dr. Carlson and passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE ORAL AGENT, ONE INJECTABLE AGENT, ONE DOAC FOR PE AND CV PROPHYLAXIS AND WARFARIN, SECONDED BY DR. WHITE. THE MOTION WAS PASSED UNANIMOUSLY.

Betablockers (Green Class)

Uman Patel gave the Magellan presentation on betablockers. This again was a green class and moved right to utilization.

Roughly 96 percent in line with PDL. Previous years motion Dr. Liljegren moved that it be considered a class effect to include at least one medication for the indication of heart failure. This was seconded by Dr. Doren-Atchison and passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASSBE CONSIDERED CLASS EFFECT TO INCLUDE AT LEAST ONE MEDICATOIN FOR THE INDICATION OF HEART FAILURE, SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Calcium Channel Blockers (Blue Class)

Umang Patel gave the Magellan presentation on calcium channel blockers. In terms of hypertension CCBs have been shown to effectively reduce blood pressure. In isolated systolic hypertension CCBs have been shown to reduce the systolic blood pressure more than diastolic blood pressure thereby reducing the pulse pressure. In patients with ISH treatment with

nitrendipine, a CCB not available in the United States, reduced the stroke rate by 42 percent and cardiovascular morbidity by 30 percent.

CCBs improve clinical symptoms of angina and are well tolerated. Long acting CCBs are recommended for the treatment of unstable angina when beta-blockers are not tolerated or do not relieve symptoms. For vasospastic or prinzmetal's angina is effectively treated with CCBs by reducing the frequency of anginal attacks.

In March 2022, the FDA approved amlodipine oral solution for the treatment of hypertension in adults 6 years of age and older, to lower blood pressure and coronary artery disease and angiographically documented coronary artery disease in patients without heart failure or an ejection fraction less than 40 percent.

The indication is for hypertension in adults and children 6 years of age and older, for CAD chronic stable angina, vasospastic or angiographically documented CAD. Warning and precautions are very similar to all CCBs. Geriatric patients are recommended to start dosing at the low end of the dose range. For hepatic impairment start dosing at the low end of the dose range. For patients with renal impairment there are no dedicated studies to value the PK in renal patients. Recommended starting dose for adults is 5 mg orally once daily with a maximum of 10 mg orally once daily. In small, fragile or elderly patients or patients with hepatic insufficiency it is recommended to start at 2.5 mg orally once daily. Pediatric patients should take 2.5 mg to 5 mg orally once daily. It is available in an oral solution 1 mg/mL.

Roughly 99.5 percent are in line with the PDL. Previous years motion Dr. Liljegren moved the drugs in the class were therapeutic alternatives to include one short acting, one extended release and one non-dihydropyridine agent. This was seconded by Dr. Begay-Bruno and passed unanimously.

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

Erythropoiesis Stimulating Agents (Red Class)

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 RBC production from bone marrow. It acts on the erythroid progenitor cells in the bone marrow to cause late differentiation and maturity of the RBCs. 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 the anemia.

Beta thalassemia is a rare inherited blood disorder marked by the reduction of functional hemoglobin levels, 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 2 to 4 weeks and are dependent on medical care for survival. Treatment for beta thalassemia is highly dependent on the type of thalassemia, progression and severity of disease as well as the presence or absence of certain symptoms. Treatment options may include regular blood transfusions, chelation therapy, removal of the spleen and/or gallbladder and bone marrow transplantation. Reblozyl is the first FDA approved erythroid maturation agent which 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 for anemia are well over a year old so they are in the appendix for the committee to review at their leisure.

In February 2023 the FDA approved Jesduvroq, a hypoxia-inducible factor prolyl hydroxylase inhibitor as the first oral treatment for anemia due to CKD in adults who have been receiving dialysis for more than 4 months. It is not indicated as a substitute for transfusion in patients requiring immediate correction of anemia or in patients not on dialysis. It has not shown that it improves quality of life, fatigue or patient well-being. There are black box warnings. It increases the risk of thrombotic vascular events and the targeting of a hemoglobin level greater than 11 g/dL is expected to further increase the risk of death and arterial venous thrombotic events. It is recommended to see the full prescribing information for starting dosage based on hemoglobin level, liver function and concomitant medications and for dose titration and monitoring recommendations. It is a tablet formulation that can be found in 1, 2, 4, 6 and 8 mg dosages. For patients who are pregnant this may cause fetal harm so clinicians are urged to keep an eye out for patients who are of child bearing age. For patients who are nursing, breast feeding is not recommended until 1 week after the final dose of the medication. For patients with hepatic impairment, it is recommended to reduce the starting dose in patients with moderate hepatic impairment classified as Child Pugh Class B and is not recommended for severe hepatic impairment Child Pugh Class C.

Utilization was 100 percent in line with PDL. Previously Dr. Liljegren moved the drugs in the class were therapeutic alternatives, seconded by Dr. Doran-Atchison and passed unanimously.

DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUDIC ALTERNATIVES, SECONDED BY DR. CARLSON. THE MOTION PASSED UNANIMOUSLY.

Lipotropics, other (Green Class)

Umang Patel gave the Magellan presentation on lipotropics, other and PCSK9 inhibitors. These are bundled together because they fall in the same disease state.

For lipotropics other PDL compliance was roughly 45 percent in line with the PDL. The previous years motion Dr. Liljegren moved the drugs in the class were therapeutic alternatives. Seconded by Dr. Doran-Atchison and passed unanimously.

A bulk of the utilization came from a lot of generics that are either not reviewed or not preferred.

DR. SEMLING MOVED FOR THERAPEUTIC ALTERNATIVES, SECONDED BY DR. RYAN. THE MOTION PASSED UNANIMOUSLY.

PCSK9 Inhibitors (Green Class)

Umang Patel moved directly to utilization for PCSK9 inhibitors. It shows roughly 100 percent in line with the PDL. Previous years motion shows in the transcript that Dr. Ryan made and seconded the motion though this appears to be a problem in the transcript. It did however pass unanimously.
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DR. RYAN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, WHICH WAS SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

Platelet Aggregation Inhibitors (Green Class)

Umang Patel gave the Magellan presentation on platelet aggregation inhibitors.

Utilization was roughly 99.8 percent in line with PDL. Previous years motion, Dr. Doran-Atchison moved the drugs in the class were therapeutic alternatives to include at least clopidogrel. This was seconded by Ms. White and passed unanimously.

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

Pulmonary Arterial Hypertension (Blue Class)

Public Comments for Pulmonary Arterial Hypertension: (Blue Class)

NIRMAL GHUMAN, a pharmacist and principal scientific account lead with Janssen Scientific Affairs, wanted to make it aware that he is available for any questions regarding OPSUMIT and UPTRAVI.

KELLIE MORLAND, a director of value and evidence strategy with United Therapeutics Corporation. She discussed the latest clinical update for the inhaled medication TYVASO and TYVASO DPI. In May 2022, the FDA approved TYVASO DPI, a new formulation, and

inhalation device for TYVASO for the treatment of pulmonary arterial hypertension as well as pulmonary hypertension associated with interstitial lung disease or PHILD to improve exercise ability. Both products remain the only FDA approved therapies for the treatment of patients with PHILD, a serious condition which furthers the symptoms and decreases survival among patients who are suffering from ILD. The approval of TYVASO DPI was supported from data from our BREEZE study which was an open label study of 51 PHI patients on a stable regimen of nebulized TYVASO who were transitioned to the DPI device. Patients with PH who transitioned demonstrated safety and tolerability during the treatment phase with significant improvements in their 6 minute walk distance, device preference and satisfaction as well as patient reported outcomes. Results from the optional extension phase suggest that the improvement in the 6 minute walk distance that was observed in the open label study was sustained over 51 weeks. Patient tolerability was consistent with the expected known safety profile for TYVASO. She also shared some recently published findings from a real-world analysis that compared TYVASO and VENTAVIS. These are the two nebulized prostacyclin analogs that are approved in the US for the treatment of pulmonary arterial hypertension. TYVASO is taken 4 times a day and VENTAVIS is taken 6 to 9 times a day. In this study patients with PAH who were initiating TYVASO or VENTAVIS were identified in claims data and treatment adherence, persistence, healthcare resource use and cost were evaluated in the 12 months following their treatment initiation. Patients who initiated TYVASO had significantly greater persistence with therapy at both 6 and 12 months compared to VENTAVIS. Both data points were statistically significant. At 6 months, specifically, 65 percent of TYVASO patients compared with 36 percent of VENTAVIS patients were persistent with therapy and at 12 months 47 percent of TYVASO patients compared with 16 percent of VENTAVIS patients were persistent with therapy. Finally, TYVASO patients had a 29 percent reduction in the risk of hospitalization and significantly fewer hospitalizations and ED visits at 12 months versus VENTAVIS. No differences in total costs were observed between persistent patients initiating either treatment. Given these findings we ask you to consider moving both products to on formulary on the Alaska Medicaid PDL for both PAH and PHILD patients.

Umang Patel gave the Magellan presentation on pulmonary arterial hypertension. Pulmonary hypertension is characterized by an increase in pulmonary arterial pressure and secondary right ventricular failure. This is defined as resting mean pulmonary arterial pressure greater than 25 mm Hg. Symptoms include dyspnea, dizziness, syncope, fatigue, peripheral edema, angina, palpitations and other symptoms all of which are exacerbated by exertion. There is no cure and if left untreated pulmonary hypertension is a life-threatening disease with a poor prognosis. Management should be limited to specialized centers where clinicians are experienced in the evaluation and treatment of patients with pulmonary hypertension. Although the number of approved therapies for pulmonary arterial hypertension has grown in the past years the prognosis is still poor with approximately 50 percent mortality within the first 5 years after diagnosis. There are many causes of pulmonary arterial hypertension 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 pulmonary arterial hypertension. Other etiologies in PAH include drugs and toxins, collagen, vascular resistance, human immunodeficiency virus, portal hypertension, chronic thromboembolism and congenital heart disease. The World Health Organization classifies patients into 5 groups based on etiology. Group I now refer to pulmonary arterial

hypertension. Group II refers to PH due to left heart disease. Group III refers to PH due to lung disease. Group IV refers to PH due to blood clots in the lungs. 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.

In terms of guidelines the European Society of Cardiology and the European Respiratory Society in 2022 stated that the guidelines for diagnosis and treatment of pulmonary hypertension includes UPTRAVI and oral ORENITRAM. In patients with idiopathic heritable or drug associated PAH, negative for vasoreactivity without cardiopulmonary comorbidities and at low or intermediate risk for death, UPTRAVI may be added to ERA and PDE-5 inhibitor therapy, Class 2A level B. Sequential drug combination therapy to reduce the risk of morbidity and mortality events includes the addition of UPTRAVI to ERAs and/or PDE-5 inhibitors and the addition of oral ORENITRAM to ERA, PDE-5 inhibitor or riociguat monotherapy both Class 1 level B.

Effective June 27, 2022 the FDA changed the requirements for TRACLEER after which prescriber may delegate a designee for certain administrative activities and certified pharmacies can enter testing and counseling information through the REMS website. Changes were made to the outpatient pharmacy operations to verify safe use conditions for the REMS Pre-Dispense Authorization.

In July 2022, Teva reported to the FDA discontinuation of epoprostenol sodium for injection and the corresponding sterile diluent. No future production is expected for an extended period. GSKs brand name Flolan remains available.

In February 2023, the FDA approved the first generic to Actelion’s UPTRAVI tablets from Zydus.

In May 2022, the FDA approved TYVASO DPI, a prostacyclin mimetic indicated for the treatment of (1) PAH to improve exercise ability (studies establishing effectiveness predominately included patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH or PAH associated with connective tissue disease) and (2) pulmonary hypertension associated with interstitial lung disease to improve exercise ability (study establishing effectiveness predominately included patients with etiologies of idiopathic interstitial pneumonia inclusive of idiopathic pulmonary fibrosis, combined pulmonary fibrosis and emphysema and WHO Group 3 connective tissue disease).

TYVASO DPI inhibits platelet aggregation and increases the risk of bleeding. May cause bronchospasm and patients with a history of hyperreactive airway disease may be more sensitive. The initial dosage should be one 16 mcg cartridge per treatment session. Dosage should be increased by an additional 16 mcg per treatment session at approximately 1 to 2 week intervals, if tolerated. Titrate to a target maintenance dose of 48 mcg to 64 mcg per treatment session 4 times daily. IT is available in an inhalation powder, single dose plastic cartridges containing 16, 32, 48 or 64 mcg of Treprostinil as a dry powder formulation. In terms of special populations patients with pregnancy there are limited case reports of use in pregnant women and it is

insufficient inform of drug associated risk of an adverse event. In terms of patients with renal impairment there are no dose adjustments required.

In March 2023 Sildenafil (Revatio) IV solution and oral suspension labeling updated with new indications for the treatment of PAH (WHO Group I) in pediatric patients aged 1 to 17 years of age to improve exercise ability and in pediatric patients too young to perform standard exercise testing. It is indicated in adults for the treatment of pulmonary arterial hypertension (WHO Group I) to improve exercise ability and delay clinical worsening. In pediatric patients ages 1 to 17 it is indicated for the treatment of pulmonary arterial hypertension (WHO Class I) to improve exercise ability and in pediatric patients too young to perform standard exercise testing pulmonary hemodynamics thought to underline improvements in exercise. In adults dosing should be 20 mg three times a day and the dose may be increased based on symptoms and tolerability. In pediatric patients less than 20 kg the dose should be 10 mg three times a day, 20 kg to 45 kg should be 20 mg three times a day and greater than 45 kg should be 20 mg three times a day. In adults' dosage for the injection should be 10 mg three times a day administered as an intravenous bolus injection. IT is available in 20 mg tablets, 10 mg/mL oral suspension (when reconstituted) and for injection 10 mg/12.5 mL in a single use vial. In terms of special populations patients who are pregnant there is limited published data from randomized control trials, case control trials and case series and they do not report a clear association with birth defects. In terms of renal impairment there are no dose adjustments required.

Utilization was about 59 percent in line with the PDL. Previous motion Dr. Liljegren moved the drugs were therapeutic alternatives to include at least one from each class plus one inhaled product. This was seconded by Dr. Ryan and passed unanimously.

Dr. Ryan brought up that he is wondering if any adjustments needed to be made in the motion this year to account for the non-PDL drugs.

Dr. Phillips felt that it seemed providers are using it.

Charles Semling stated that there are very few claims in this class so that is what is driving it. As far as the non-preferred the sildenafil suspension was 17 percent so that would bump up. They could always use the medically necessary clause in order to get those claims paid.

Dr. Carlson stated that the percentage is high but the numbers are very modest.

Umang Patel added on to what Charles Semling said that if you look at the one-year claims data that is on the SharePoint drive this is the last 3 month window which can actually be skewed depending on the season or the time of the year. If you look at year one utilization it is roughly about 80 percent in line with the PDL.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS OF THERAPEUTIC ALTERNATIVES TO INCLUDE ONE FROM EACH CLASS AND ONE INHALED PRODUCT, DR. CARLSON SECONDED THAT MOTION.

Anti-Infective Agents

Antifungals: Oral (Red Class)

Umang Patel gave the Magellan presentation on antifungals. In terms of oral antifungals opportunistic fungal infections are likely to occur in patients during corticosteroid, immunosuppressant or antimetabolite therapy or in patients with acquired immunodeficiency syndrome, azotemia, diabetes mellitus, bronchiectasis, emphysema, tuberculosis, lymphoma, leukemia or burns. Histoplasmosis, coccidioidomycosis, cryptococcosis, blastomycosis, Para coccidioidomycosis and sporotrichosis are systemic mycoses which can cause disease in both healthy and immunocompromised adults. In contrast, mycoses caused by opportunistic fungi such as candida albicans, Aspergillus spp, Trichosporon, Torulopsis glabrata, Alternaria and mucor are generally found only in an immunocompromised host. IDSA guidelines in 2016 stated that management of aspergillosis recommend voriconazole as the initial treatment option for invasive and extrapulmonary aspergillosis infections. Other azole antifungals approved for aspergillosis may be considered alternatives in salvage therapy. Posaconazole or voriconazole are options for prophylaxis of invasive aspergillosis.

Vulvovaginal candidiasis is caused by an overgrowth of candida in the vagina and results in symptoms of vaginal itching and soreness, abnormal vaginal discharge, painful intercourse and dysuria. After bacterial vaginal infections VVC is the second most common type of vaginal infection in the US causing an estimated 1.4 million outpatient visits. It is estimated that treatment with azole antifungals provides relief of symptoms and negative cultures in 80 to 90 percent of patients with uncomplicated VVC. According to the IDSA 2016 clinical practice guideline for the management of candidiasis in patients with uncomplicated VVC current guidelines recommend a short course (1-3 days) of a topical azole antifungal agent or a single dose 150 mg oral fluconazole. For severe acute candida vulvovaginitis fluconazole 150 mg every 72 hours for a total of 2 or 3 doses is recommended. For recurring vulvovaginal candidiasis 10 to 14 days of induction therapy with a topical antifungal agent or oral fluconazole followed by oral fluconazole 150 mg weekly for 6 months is recommended. In women with HIV infection the IDSA advises the uncomplicated VVC response to a short course treatment with oral fluconazole, topical azoles or oral itraconazole. Severe or recurrent episodes of VVC in HIV infected patients should be treated with oral fluconazole or topical antifungal therapy for at least 7 days. Brexafemme was not available at the time these guidelines were developed. In terms of recurrent VVC, it is a condition that exists when at least four discrete episodes occur in one year or at least three episodes not related to antibiotic use occur in one year. The distinguishing hallmark of recurrent versus persistent infection is the presence of symptom-free intervals. Per the CDC the condition occurs in less than 5 percent of females but does carry with it a substantial financial impact. Vivjoa was not available at the time these guidelines were developed.

In April 2022, the FDA approved Vivjoa, an azole antifungal, to reduce the incidence of RVVC in females with a history of RVVC who are not of reproductive potential, contraindicated in women of reproductive potential. It is an azole antifungal indicated to reduce the incidence of recurrent vulvovaginal candidiasis in females with a history of RVVC who are not of reproductive potential. It is not recommended in severe renal impairment or ESRD with or without dialysis. It is not recommended in moderate or severe hepatic impairment. Based on animal studies it may cause fetal harm. The drug exposure window of approximately 690 days

precludes adequate mitigation of the embryo-fetal toxicity risks. Providers must advise patients that Vivjoa is contraindicated in females of reproductive potential and in pregnant and lactating women because of potential risks to a fetus or breastfed infant. There are two recommended dosage regimens, a Vivjoa only regimen and a Fluconazole/VIVJOA regimen. See the PI/TCR for specific dosing instructions. It is available in a 150 mg of oteseconazole capsule. The fluconazole is not supplied in the carton.

In December 2022, the FDA approved Brexafemme for the reduction in the incidence of recurrent vulvovaginal candidiasis * post-menarchal pediatric females at a dose of 300 mg (two 150 mg tablets) taken 12 hours apart for one day for a total daily dose of 600 mg every month for 6 months. It is a triterpenoid antifungal indicated in adult and post-menarchal pediatric females for the treatment of VVC as well as the reduction in the incidence of recurrent vulvovaginal candidiasis. It may cause fetal harm based on animal studies. Providers must advise females of reproductive potential to use effective contraception during treatment. The recommended dose in adults and post-menarchal pediatric females is 300 mg administered approximately 12 hours apart for one day for a total daily dosage of 600 mg. For reduction in the incidence of RVVC the recommended dosage in adults and post-menarchal females is 300 mg administered approximately 12 hours apart for one day for a total daily dosage of 600 mg monthly for 6 months. IT is available in 150 mg tablets of ibrexafungerp.

Utilization shows 96.9 percent were in line with PDL. Previous years motion Dr. Liljegren moved the drugs in the class were therapeutic alternatives to include at least one fluconazole tablet, one oral terbinafine preparation and one pediatric preparation. This was seconded by Dr. Ryan and passed unanimously.

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

Antifungals: Topical (Green Class)

Umang Patel gave the Magellan presentation on topical antifungals. Moved right to utilization. Approximately 88.8 percent were in line with PDL. Previous years motion 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. This as seconded by Dr. Liljegren and 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. DR. PHILLIPS SECONDED THAT. THE MOTION PASSED UNANIMOUSLY.

Antivirals: Influenza (Blue Class)

Umang Patel gave the Magellan presentation on antivirals and influenza. Influenza is a common illness affecting most people at least once in their lifetime. It is an uncomplicated illness that typically resolves after 3 to 7 days. It is often self-limiting. Persons at higher risk for influenza complications are less than 2 years of age or greater than 65 years of age, immunocompromised patients, pregnant/postpartum patients, less than 19 years old with longer 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. Vaccination is the primary method for preventing influenza. Inactivated influenza vaccines are available in quadrivalent and trivalent formulations while recombinant influenza vaccine and LAIV4 are available in quadrivalent formulations. There is also a high-dose inactivated vaccine and adjuvanted inactivated influenza vaccine available in trivalent formulations. For the 2022-2023 season inactivated influenza vaccines recombinant vaccines and live attenuated vaccines are available. All available vaccines for the 2022-2023 season are quadrivalent formulations. Each year the season influenza vaccines are designed to protect against the 4 predominant groups of flue Type A and B viruses. Vaccine virus components are chosen based on which flu viruses caused illness during the prior flu season, the extent to which those viruses are circulating prior to the upcoming season, the potential efficacy of the previous season's vaccines against those viruses and the ability of vaccine viruses to provide cross protection across subtype lineage. Current vaccines available in the US target an influenza A (H1) virus, an influenza A (H3) virus, an influenza B/Yamagata lineage virus and an influenza B/Victoria lineage virus.

In 2023 the CDC recommended 3 FDA approved neuraminidase inhibitor antiviral drugs from the 2021-2022 season. These are Tamiflu, Relenza and Rapivab. The fourth recommended FDA approved product is the cap-dependent endonuclease inhibitor Xofluza. Adamantanes are not recommended for use in the US due to resistance in these drugs by many influenza A and B viruses. Empiric antiviral treatment without waiting for laboratory confirmation is recommended as early as possible for any patient with confirmed or suspected influenza who has severe complicated or progressive illness, is hospitalized or at high risk for complications. In addition, empiric antiviral treatment of non-high-risk outpatients with suspected influenza can be started based on clinical judgement without an office visit. According to the CDC oseltamivir, oral or enteric, is the recommended antiviral for patients with severe, complicated or progressive illness who are hospitalized. There is insufficient data for Relenza, Rapivab or Xofluza in patients with severe influenza. Co-infection with influenza A or B viruses and SARS-COV-2 can occur and should be considered, particularly in hospitalized patients with severe respiratory disease.

The American Academy of Pediatrics in 2022 recommend antiviral treatment as early as possible and beyond 48 hours of symptom onset in children hospitalized with suspected or confirmed influenza, children with severe complicated or progressive influenza and children at high risk for complications. Treatment may also be considered within 48 hours of symptom onset in non-high-risk children and children with household contacts younger than 6 months of age or at high risk for complications. The AAP states that any licensed influenza vaccine that is appropriate for age and health status may be given. They do not prefer one product over another including IIV or live attenuated influenza vaccine. In addition, if 2 doses of vaccine are required in a given season the doses do not need to be the same brand and a combination of IIV and LAIV may be given if appropriate for age and health status.

In August 2022, the FDA expanded the indication of Xofluza to include those 5 to 11 years of age for treatment of acute uncomplicated influenza in patients who have been symptomatic for no more than 48 hours and otherwise healthy and for those 5 to 11 years of age for post-exposure prophylaxis of influenza; previously approved for patients greater than 12 years of age with acute uncomplicated influenza less than 48 hours from symptom onset who are otherwise healthy or at high-risk of influenza related complications and for post-exposure prophylaxis in patient greater than 12 years of age. It is indicated for the treatment of acute uncomplicated influenza in patients who have been symptomatic for no more than 48 h9ours and who are otherwise healthy adults and pediatric patients 5 years of age or older or adults and pediatric patients 12 years of age and older who are at high risk of developing influenza related complications. Post exposure prophylaxis of influenza in patients 5 years of age and older following contact with an individual who has influenza. Co-administration of Xofluza with polyvalent cation-containing laxatives, antacids or oral supplements such as calcium, iron, magnesium, selenium or zinc should be avoided. Dosage is stratified by age, weight and indication. See the insert for further dosage information. It is available in 40 and 80 mg tablets as well as oral suspension 40 mg/20mL when constituted for final concentration of 2 mg/mL.

Utilization is 91.8 percent in line with PDL. Previous years motion Dr. Ryan moved the drugs in the class were therapeutic alternatives to include oseltamivir. This was seconded by Dr. Begay-Bruno and passed unanimously.

Dr. Carlson asked why the immunizations were never discussed. Charles Semling answered by stating that the vaccines do not meet the definition of a covered outpatient drug since it is a biologic product. Therefore, it is not reviewed.

DR. RYAN MOVED THAT THE DRUGS ARE THERAPEUTIC ALTERNATIVES TO INCLUDE OSELTAMIVIR. DR. CARLSON SECONDED THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Fluoroquinolones: Oral (Green Class)

Umang Patel gave the Magellan presentation on fluoroquinolones.

Utilization is approximately 97 percent in line with PDL. Previous motion Dr. Liljegren moved a class effect. This was seconded by Dr. Ryan and passed unanimously.

DR. RYAN MOVED THE DRUGS TO CLASS EFFECT, DR. PHILLIPS SECONDED THAT. THE MOTION WAS PASSED UNANIMOUSLY.

Hepatitis B Agents (Blue Class)

Umang Patel gave the Magellan presentation on hepatitis B agents. Chronic hepatitis B virus affects an estimated 880,000 to 1.89 million people in the United States. In 2018, the number of acute HBV cases int eh US reported to the CDC was 3,322 although the CDC estimates the actual number of new infections to be approximately 21,600. Chronic HBV infection is defined as persistence of hepatitis B surfactant antigen for more than 6 months, high levels of HBV DNA

and presence of hepatitis B e Antigen in the serum. It occurs in approximately 5 to 10 percent of individuals with acute HBV infection. Long-term effects of chronic HBV infection include cirrhosis, liver failure and hepatocellular carcinoma. HBV infections acquired by infants are significantly more likely to progress to chronic HBV infections as compared to infections acquired by adults. The US Preventative Service Task Force recommends screening adults and adolescents as increased risk for infection and pregnant women.

In 2022, the CDC stated that patients undergoing treatment for hepatitis C virus infection who are receiving oral direct acting antivirals may be at a greater risk for HBV reactivation. Prior to initiation of DAAs these patients should be tested for previous or current HBV infection. Patients testing positive for an active HBV infection should be treated for the HBV infection prior to or in conjunction with DAA therapy for HCV infection. Likewise, those testing positive for a prior or active HBV infection should receive additional monitoring during and upon completion of HCV treatment to detect HBV reactivation. Patients with a low or undetectable HBV DNA level can either receive prophylactic HBV treatment for the duration of DAA treatment or be monitored at regular intervals for HBV reactivation with HBV DNA testing. Elimination of HBV transmission in the US by broadening recommendations for HBV immunizations is the ultimate goal. The HBV vaccine series is now offered to infants and children in the US to reduce the risk of chronic HBV infection. The estimated number of acute HBV infections in the US has significantly declined by approximately 88.5 percent since recommendations for HBV were first published in 1982. The 2018 recommendations by the Advisory Committee on Immunization Practices advises universal vaccination of all stable infants weighing greater than 2,000 grams beginning at birth and vaccine administration to unvaccinated children and adolescents. The 202 recommendations by the ACIP recommend universal HBV vaccination in all adults aged 19 to 59 years of age.

In October 2022, the FDA website stated that based on a business decision, GlaxoSmithKline will discontinue Epivir HBV oral solution 5 mg/mL oral solution and 100 mg tablet. Distribution of the product is anticipated to stop approximately March 2023. There are generic versions of the tablet but none for oral solution.

Utilization was approximately 75 percent in line with PDL. Previous motion, Dr. Ryan moved the drugs in the class were therapeutic alternatives. Seconded by Dr. Liljegren and passed unanimously.

DR. RYAN MOTIONED THAT THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, WHICH WAS SECONDED BY DR. CARLSON. THE MOTION WAS PASSED UNANIMOUSLY.

Hepatitis C Agents (Green Class)

Umang Patel gave the Magellan presentation on hepatitis C agents.

Utilization was roughly 99 percent in line with PDL. Previous motion Dr. Doren-Atchison moved the drugs were therapeutic alternative. This was seconded by Dr. Ryan and passed unanimously.

DR. RYAN MOVED THAT THE DRUGS ARE THERAPEUTIC ALTERNATIVES. DR. PHILLIPS SECONDED THAT MOTION. THE MOTION WAS PASSED UNANIMOUSLY.

Otic Antibiotics (Green Class)

Umang Patel gave the Magellan presentation on otic antibiotics.

Utilization was roughly 57 percent in line with the PDL. This is primarily due to generic authorized generic medications, specifically Cipro and Dexa. Previous years motion Dr. Ryan moved the drugs in the class were therapeutic alternatives to include at least one otic glucocorticoid combination seconded by Mr. Riley and passed unanimously.
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DR. RYAN MOTIONED THAT THE DRUGS IN THE CLASS ARE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LESAT ONE OTIC WITH A GLUCOCORTICOID COMBINATION. CASEY GOKEY SECOND THAT MOTION. THE MOTION WAS PASSED UNANIMOUSLY.

Genitourinary

Benign Prostatic Hyperplasia (Green Class)

Umang Patel gave the Magellan presentation on benign prostatic hyperplasia.

Utilization was about 94 percent in line with PDL. Previously Dr. Ryan moved the drugs in the class were therapeutic alternatives to include one alpha blocker and one androgen hormone inhibitor. This was seconded by Dr. Liljegren and passed unanimously.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE ALPHABLOCKER AND ONE ANDROGEN HORMONE INHIBITOR. DR. RYAN SECONED THAT MOTION. THE MOTION WAS PASSED UNANIMOUSLY.

Bladder Relaxant Preparations (Green Class)

Umang Patel gave the Magellan presentation on bladder relaxant preparations.

Utilization was approximately 73 percent in line with the PDL. There is specifically cone medication that was non-preferred that drew a lot of that non-preferred utilization. Previously Dr. Ryan moved the drugs in the class were therapeutic alternatives. This was seconded by Dr. Liljegren and passed unanimously.

DR. RYAN MOVED THE CLASS ARE THERAPEUTIC ALTERNATIVES. DR. PHILLIPS SECONED THAT MOTION. THE MOTION WAS PASSED UNANIMOUSLY.

Vaginal Antibiotics (Green Class)

Umang Patel gave the Magellan presentation on vaginal antibiotics.

Utilization was approximately 95 percent in line with PDL. Previously Dr. Ryan moved the drugs in the class were therapeutic alternatives. Dr. Doran-Atchison seconded and this passed unanimously.

DR. PHILLIPS MOVED THE DRUGS IN THE CLASS ARE THERPEUTIC ALTERNATIVES. DR. RYAN SECONED THAT MOTION. THE MOTION WAS PASSED UNANIMOUSLY.

4. Review Minutes from January

There were no changes to the January meeting minutes.

DR. PHILLIPS MOVED TO APPROVE THE JANUARY MEETING MINUTES. SECONDED BY CASEY GOKEY. THE MOTION WAS PASSED BY ALL MEMBERS.

4. End of Public Meeting
5. Comments From Committee Members
6. Adjourn

DR. RYAN MOVED TO ADJOURN THE MEETING. THE NEXT MEETING WAS SCHEDULE FOR SEPTEMBER 15, 2023. WITHOUT OBJECTION, THE MEETING WAS ADJOURNED.