# P&T Committee Meeting Minutes
# Commercial/Marketplace/CHIP
# June 2023 e-Vote

## DRUG REVIEWS

### BRIUMVI (ublituximab)

**Review:** Briumvi is a CD20-directed cytolytic antibody indicated for the treatment of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease in adults. Briumvi is a recombinant chimeric monoclonal IgG1 antibody with reduced fucose content directed against CD20-expressing B-cells. The exact mechanism by which Briumvi exerts therapeutic effects in multiple sclerosis is unknown, but it is thought to involve binding of CD20 on the surface of pre-B and mature B lymphocytes which results in cell lysis. Briumvi joins other CD-20 directed therapies for the treatment of RMS, Ocrevus, Kesimpta, and Rituximab (off-label). Additionally, Briumvi is being evaluated to determine if it will be studied for the treatment of primary progressive MS. Currently, Ocrevus is the only treatment indicated for PPMS.

Briumvi is administered as an intravenous infusion under the close supervision of an experienced healthcare professional with access to appropriate medical support to manage severe reactions, such as serious infusion reactions. The first infusion is administered as 150 mg of Briumvi over 4 hours. The second infusion is 450 mg IV infusion administered over 1 hour two weeks after the first infusion. Subsequent infusions are 450 mg IV infusions administered over 1 hour 24 weeks after the first infusion and every 24 weeks thereafter. Patients should be observed for at least one hour after the completion of the first two infusions. Briumvi is supplied as single-dose vials containing 150 mg/6mL. Prior to the initiation of Briumvi, patients should receive a Hepatitis B screening to determine if patients has active HBV, testing for quantitative serum immunoglobulins, and all immunizations according to immunization guidelines at least 4 weeks prior to Briumvi for live or live-attenuated vaccines and at least 2 weeks prior for non-live vaccines.

The safety and efficacy of Briumvi were evaluated in ULTIMATE I and ULTIMATE II, two randomized, double-blind, double-dummy, parallel group, active comparator-controlled clinical trials of identical design in patients with RMS for 96 weeks. Patients were randomized to received Briumvi IV infusions according to the recommended dosage with oral placebo (ULTIMATE I n=274, ULTIMATE II n=272) or Aubagio 14 mg daily with IV placebo given on the Briumvi schedule (ULTIMATE I n=275, ULTIMATE II n=273). Patients included in the study had experienced at least one relapse in the previous year, two relapses in the previous two years, or had the presence of a T1 gadolinium (Gd)-enhancing lesion in the previous year. Patients were also required to have an Expanded Disability Status Scale (EDSS) score from 0 to 5.5 at baseline.

The primary efficacy outcome in both ULTIMATE I and ULTIMATE II was the annualized relapse rate (ARR) over the treatment period. Additional outcome measures included total MRI T1 Gd-enhancing lesions by Week 96, total new or enlarging MRI T2 hyperintense lesions by Week 96, and time to confirmed disability progression for at least 12 weeks. Confirmed disability progression was evaluated in a pooled analysis of ULTIMATE I and II.

Results of ULTIMATE I and II showed that Briumvi significantly lowered the ARR compared to Aubagio. Briumvi statistically significantly reduced the number of T1 Gd-enhancing lesions and the number of new or enlarging T2 lesions in both studies compared to Aubagio. There was no statistically significant difference in disability progression confirmed at 12 weeks between Briumvi-treated and Aubagio-treated patients.

Warnings and precautions for Briumvi include risk of infusion reactions which can include pyrexia, chills, headache, influenza-like illness, tachycardia, nausea, throat irritation, erythema, and an anaphylactic reaction. In ULTIMATE I and II, patients received methylprednisolone, an antihistamine, and possibly

other premedication (i.e., acetaminophen) to reduce the risk of infusion reactions prior to each infusion. The incidence of infusion reactions in ULTIMATE I and II who received treatment with Briumvi was 48%, with the highest incidence within 24 hours of the first infusion. There were no fatal infusion reactions, but 0.6% of patients experienced serious infusion reactions, some requiring hospitalization. Other precautions include risk of serious, life-threatening, or fatal, bacterial and viral infections, risk of fetal harm when administered to a pregnant woman, and risk of reduction of immunoglobulin levels as expected with any B-cell depleting therapy. The most common adverse reactions during clinical trials were infusion reactions and upper respiratory reaction.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

**Clinical Discussion:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Financial Discussion:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Outcome:** Briumvi is a pharmacy benefit and will be added to the medical benefit cost share list. When processed at Specialty pharmacy, Briumvi will process on the Specialty tier or the Brand Non Preferred tier for members with a three tier benefit. The following prior authorization criteria will apply:

- Medical record documentation of a diagnosis of a relapsing form of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease **AND**
- Medical record documentation that member is 18 years of age or older **AND**
- Medical record documentation that Briumvi is prescribed by a neurologist **AND**
- Medical record documentation of a Hepatitis B Screening **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to one formulary alternative

**GPI Level:** GPI-12

**RPH SIGNOFF REQUIRED:** Yes

**AUTHORIZATION DURATION/QUANTITY LIMIT:** Initial authorization will be for 12 months with a quantity limit of 3 doses if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for a period of 12 months with a quantity limit of 2 doses if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

## FAST FACTS

**CIBINQO (abrocitinib)**

**Clinical Summary:** Cibinqo is now indicated for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate-to-severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

The dosing recommendations for Cibinqo in the expanded age group remain the same at 100 mg orally once daily. If an adequate response is not achieved with Cibinqo 100 mg orally daily after 12 weeks, increasing the dosage to 200 mg orally once daily should be considered. Therapy should be discontinued if inadequate response is seen after the dosage increase to 200 mg once daily.

The updated indication to include adolescents age 12 to <18 years of age is a result of data from JADE TEEN, a phase 3, randomized, placebo-controlled clinical trial. JADE TEEN, which supported the expanded indication, evaluated both the 100 mg and 200 mg doses of Cibinqo versus placebo in adolescents 12 to <18 years of age with moderate-to-severe AD while also on background therapy with topical medications. The trial evaluated measures of improvements in skin clearance, itch, disease extent, and severity, including the Investigator Global Assessment (IGA), Peak Pruritus Numerical Rating Scale (PP-NRS), and Eczema Area and Severity Index (EASI).

The safety and effectiveness of Cibinqo in pediatric patients 12 years of age and older weighing 25 kg or more with atopic dermatitis has been established. In trials, Trial-AD-1 and Trial-AD-2, 124 adolescent subjects 12 to less than 18 years old with moderate-to-severe atopic dermatitis were enrolled and randomized to receive either Cibinqo 100 mg (N=51), 200 mg (N=48), or matching placebo (N=25) in monotherapy. An Additional 284 adolescent subjects 12 to less than 18 years of age with moderate-to-severe atopic dermatitis, were enrolled and randomized to receive either Cibinqo 100 mg (N=95) or 200 mg (N=94) or matching placebo (N=95) in combination with topical corticosteroids in Trial-AD-4. Efficacy and adverse reaction profile were consistent between the pediatric patients and adults. Therefore, the safety profile for Cibinqo in the expanded age group (12 to <18 years) remains the same as is for those 18 years and older.

**Current Formulary Status:** Pharmacy benefit requiring prior authorization; specialty tier or brand non preferred for members with a 3 tier benefit.

**Recommendation:** No changes recommended to the formulary placement or authorization duration of Cibinqo at this time. It is recommended to update policy 711.0 to include the new FDA approved age range:

- Medical record documentation of a diagnosis of moderate to severe atopic dermatitis **AND**
- Medical record documentation that Cibinqo is prescribed by or in consultation with an allergist, dermatologist, or immunologist **AND**
- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation of one of the following:
    - Therapeutic failure on an adequate trial of at least one medium (or higher) potency topical corticosteroid **OR**
    - For members with an intolerance or contraindication to topical corticosteroids or for members in whom topical corticosteroids are inadvisable: Therapeutic failure on, intolerance to, or contraindication to a topical calcineurin inhibitor **AND**
- Medical record documentation of contraindication to, intolerance to, or therapeutic failure on an adequate trial of phototherapy (UVA/UVB treatment) **AND**
- Medical record documentation of contraindication to, intolerance to, or therapeutic failure to Dupixent **AND**
- Medical record documentation that Cibinqo will not be used in combination with another Janus kinase (JAK) inhibitor, biologic immunomodulator or with other immunosuppressants including but

not limited to azathioprine and cyclosporine

**MEDISPAN AUTHORIZATION LEVEL:** GPI-12

**QUANTITY LIMIT:** No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.

- QL FOR LETTER ONLY: 1 tablet per day, 30 day supply per fill

**AUTHORIZATION DURATION:** Initial approval will be for 6 months if the reviewing provider feels it is medically appropriate. Subsequent approval will be for 12 months and will require medical record documentation of lack of disease progression or continued disease improvement.

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**EYLEA (aflibercept)**

**Clinical Summary:** Eylea is now indicated for the treatment of retinopathy of prematurity (ROP). Previous approvals are for neovascular (wet) age-related macular degeneration (AMD), macular edema following retinal vein occlusion (RVO), diabetic macular edema (DME) and diabetic retinopathy (DR). Retinopathy of prematurity (ROP) is a developmental vascular proliferative disorder that occurs in the retina of preterm infants with incomplete retinal vascularization. It is a common cause of potentially preventable childhood blindness in the United States.

The recommended dose for (ROP) is 0.4 mg (0.01 ml) administered by intravitreal injection. Treatment may be given bilaterally on the same day. Injections may be repeated in each eye and the treatment interval between doses into the same eye should be at least 10 days. For the treatment of ROP in preterm infants, the vial should only be used; pre-filled syringe should not be used for this population.

A total of 168 pre-term infants with ROP randomized to Eylea, treated with 0.4 mg dose, or laser, in 2 clinical studies:

- BUTTERFLEYE [which was a 52-week study]
- FIREFLEYE [included 24 weeks of treatment]
- FIREFLEYE NEXT [this was an observational follow up of the FIREFLEYE study through week 52])

Eligible patients had a maximum gestational age at birth of 32 weeks or a maximum birth weight of 1500 grams and had to weigh > 800 grams on the day of treatment, had to have treatment naïve ROP classified according to the International Classification for Retinopathy of Prematurity in at least one eye with one of the following retinal findings:

- - ROP Zone 1 Stage 1+, 2+, 3 or 3+
- - ROP Zone II Stage 2+ or 3+
- - AP-ROP (aggressive posterior ROP)

Both studies assessed efficacy, safety, and tolerability of EYLEA in randomized, 2-arm, open-label, parallel-group studies. The studies were conducted in pre-term infants with ROP providing a comparison between EYLEA treatment and laser (photocoagulation therapy). Each eligible eye received the assigned study treatment at baseline. Re-treatment and /or rescue treatment was administered if needed based on pre-specified criteria. The rescue or re-treatment could potentially include the alternative treatment (EYLEA or laser). Re-treatment with EYLEA, if required, was administered up to two times in a particular eye, with at least 28 days between consecutive injections. In the BUTTERFLEYE study, infants were

randomized in a 3:1 ratio to receive 1 of 2 treatment regimens: EYLEA 0.4 mg at baseline and if required, up to 2 additional injections and laser photocoagulation in each at baseline and if required, retreatment. In the FIREFLEYE study, infants were randomized to the same two treatments but in a 2:1 ratio. Rescue treatment was administered if required, per pre-specified criteria.

In both studies, greater than 92% of all treated patients in the EYLEA group received bilateral injections during the study. Adverse reactions established for adult indications are considered applicable to pre-term infants with ROP and are listed in the table below, though not all adult adverse reactions were observed in the clinical studies in infants.

The primary efficacy endpoint of each study was the proportion of patients with absence of active ROP and unfavorable structural outcomes (retinal detachment, macular dragging, macular fold, retrolental opacity) at week 52 of chronological age. The proportion of patients without clinically significant reactivations of ROP who also did not develop unfavorable structural outcomes was higher in each arm of each study than would have been expected in infants who had not received treatment. Neither trial demonstrated superiority or inferiority of one arm compared to the other arm.

In (ROP), following intravitreal injection, abnormal angiogenesis and tortuosity may recur. Infants should be closely monitored until retinal vascularization is complete or assurance that reactivation of ROP will not occur.

**Current Formulary Status:** Medical benefit requiring prior authorization.

**Recommendation:** It is recommended to update MBP 94.0 to include the new indication for retinopathy of prematurity (ROP) with an auth duration of 12 months:

- Medical record documentation of a diagnosis of retinopathy of prematurity (ROP)

**AUTHORIZATION DURATION:** 12 months

**NOTE:** In clinical trials, prematurity was defined as a maximum gestational age at birth of 32 weeks or a maximum birth weight of 1500 grams [3.3 lbs].

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**KALYDECO (ivacaftor)**

**Clinical Summary:** Kalydeco (ivacaftor) is now indicated for the treatment of cystic fibrosis (CF) in patients age 1 month and older who have at least one mutation in the CFTR gene that is responsive to Kalydeco based on clinical and/or in vitro assay data. Previously, Kalydeco was approved in patients age 4 months and older for the same indication. This updated indication also adds dosages of 5.8 mg and 13.4 mg granules.

Granules are still dosed every 12 hours, but new dosage strengths have been added for this updated indication as follows:

- Ages 1 month to less than 2 months: One 5.8 mg packet every 12 hours
- Ages 2 months to less than 4 months: One 13.4 mg packet every 12 hours

**Current Formulary Status:** Kalydeco is a pharmacy benefit on specialty tier or brand non-preferred tier for members with a three- tier benefit, requiring prior authorization with a quantity limit of 2 tablets or granule packets per day, 30-day supply per fill.

**Recommendation:** There are no changes recommended to formulary placement of Kalydeco at this time. However, it is recommended to update the prior authorization criteria in the current policy to include the following:

- Prescription written by a pulmonologist or Cystic Fibrosis Specialist **AND**
- Age greater than or equal to 1 month **AND**
- Medical record documentation of one mutation in the CFTR gene that is responsive to ivacaftor potentiation per product labeling as evidenced by an FDA cleared CF mutation test **AND**
- Medical record documentation that the patient is not homozygous for the F508del mutation in the CFTR gene

**QL FOR LETTER ONLY:** 2 tablets or granule packets per day, 30-day supply per fill

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**KEVZARA (sarilumab)**

**Clinical Summary:** Kevzara is now indicated for treatment of adult patients with polymyalgia rheumatica who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper. Previously, Kevzara was only indicated for treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs).

The recommended dosage of Kevzara for polymyalgia rheumatica is 200mg once every two weeks given as a subcutaneous injection, in combination with a tapering course of systemic corticosteroids. Kevzara can be used as monotherapy following discontinuation of corticosteroids.

The safety and efficacy of Kevzara for PMR was assessed in study 3 (NCT03600818). This was a randomized, double-blind, placebo-controlled, 52-week, multicenter study including adults with PMR diagnosed according to American College of Rheumatology/European Union League against Rheumatism (ACR/EULAR) classification criteria. Patients had at least one episode of unequivocal PMR flare while attempting to taper corticosteroids. Patients were randomized to receive Kevzara 200mg every two weeks with a pre-defined 14 week taper of prednisone (n=60) or placebo every two weeks with a pre-defined 52-week taper of prednisone (n=58). Patients were allowed to receive corticosteroids as rescue therapy if experiencing a disease flare or unable to adhere to the prednisone tapering schedule. The primary end point was the proportion of patients with sustained remission at Week 52. An additional end point was total cumulative corticosteroid dose over 52 weeks. Sustained remission was defined as:

- achievement of disease remission no later than Week 12
- absence of disease flare from Week 12 through Week 52
- sustained reduction of CRP (to < 10 mg/L) from Week 12 through Week 52
- successful adherence to prednisone taper from Week 12 through Week 52

Results of the clinical response data is presented in Table 1. The total actual cumulative prednisone equivalent corticosteroid dose was lower in the Kevzara arm relative to the placebo arm. Kevzara should be discontinued in patient with PMR who develop neutropenia (ANC below 1,000 per mm3 at the end of the dosing interval), thrombocytopenia (platelet count below 100,00 per mm3) or AST/ALT elevations 3 times above the ULN. Dose modifications have not been studied in patient with PMR with these conditions.

**Current Formulary Status:** Non-formulary pharmacy benefit requiring prior authorization with quantity limit.

**Recommendation:** Recommend adding Kevzara to commercial formulary at the specialty tier or the brand non-preferred tier for those with a three-tier benefit. The following changes are recommended to the prior authorization criteria in Commercial Policy 472.0:

**Rheumatoid Arthritis**

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Kevzara is prescribed by a rheumatologist **AND**
- Medical record documentation of a diagnosis of moderate to severe rheumatoid arthritis (RA) made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of RA **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial of two (2) preferred formulary biologics for the treatment of rheumatoid arthritis **AND**
- Medical record documentation that Kevzara is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent

**Polymyalgia Rheumatica**

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Kevzara is prescribed by a rheumatologist **AND**
- Medical record documentation of a diagnosis of polymyalgia rheumatica (PMR) according to American College of Rheumatology/European Union League against Rheumatism (ACR/EULAR) classification criteria **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to systemic corticosteroids **OR**
- Medical record documentation that the member is unable to tolerate a corticosteroid taper **AND**
- Medical record documentation that Kevzara is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent

**AUTHORIZATION DURATION:** 12 months, For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of rheumatoid arthritis on Kevzara therapy is required.

**MEDISPAN AUTHORIZATION LEVEL:** GPI-10

**QUANTITY LIMIT (to letter ONLY):** 2.28 mL per 28 days

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**KEYTRUDA (pembrolizumab)**

**Clinical Summary:** Keytruda is now indicated in combination with enfortumab vedotin (Padcev), for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy. The dosage for the treatment of urothelial carcinoma in combination with Padcev is 200 mg IV every 3 weeks or 400 mg every 6 weeks, until disease progression, unacceptable toxicity, or up to 24 months.

The safety and efficacy of Keytruda in combination with enfortumab vedotin were assessed in KEYNOTE-869, an open-label, multi-cohort study in 121 patients with locally advanced or metastatic urothelial cancer who were ineligible for cisplatin-containing chemotherapy and had received no prior systemic

therapy for locally advanced or metastatic disease. Patients with central nervous system metastases, ongoing sensory or motor neuropathy Grade 2, or uncontrolled diabetes (defined as HbA1c ≥8% or HbA1c ≥7% with associated diabetes symptoms) were excluded from this trial. There were three cohorts: the dose escalation cohort which included 5 patients, Cohort A which included 40 patients, and Cohort K which included 76 patients. All patients received enfortumab vedotin 1.25 mg/kg as an IV infusion over 30 minutes on days 1 and 8 of a 21-day cycle followed by Keytruda 200 mg as an IV infusion on Day 1 of a 21-day cycle. Patients were treated until disease progression or unacceptable toxicity. The primary efficacy outcomes were objective response rate (ORR) and duration of response (DoR) as assessed by BICR according to RECIST v1.1. The median duration of response for Cohort A and the dose escalation cohort was 22.1 months.

The most common adverse reactions occurring in ≥20% of patients for this patient population were in line with the known safety profile of Keytruda, but also included dysgeusia, peripheral edema, dry eye, dizziness, arthralgia, and dry skin. No new warnings, contraindications, or black box warnings were identified.

**Current Formulary Status:** Medical Benefit, requires a prior authorization. When processed at a Specialty pharmacy, Keytruda processes at the Specialty tier or Brand NP tier.

**Recommendation:** No changes are recommended to the formulary placement of Keytruda. The following criteria should be added to Medical Benefit Policy 119.0 for Keytruda to incorporate the new indication:

**7. Urothelial Carcinoma**

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 18 years of age **AND**
- Medical record documentation of locally advanced or metastatic urothelial carcinoma **AND**
- Medical record documentation of one of the following:
    - Disease progression during or following platinum-containing chemotherapy

    **OR**
    - Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

    **OR**
    - Patient is not eligible for any platinum-containing chemotherapy

    **OR**
    - Patient has high-risk, non-muscle invasive bladder cancer (NMIBC)** **AND**
    - Patient's disease is unresponsive to an adequate trial of Bacillus Calmette-Guerin (BCG) therapy** **AND**
    - Patient is ineligible for or has elected not to undergo cystectomy

    **OR**
    - Patient is not eligible for cisplatin-containing chemotherapy **AND**
    - Use in combination with Padcev

**Discussion:** No comments or questions.

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

**ODACTRA (house dust mite allergen extract)**

**Clinical Summary:** Odactra is an allergen extract indicated as immunotherapy for the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites or by positive skin testing to licensed house dust mite allergen extracts. Odactra is now approved for patients 12 years of age through 65 years of age. It was previously approved for patients 18 years of age through 65 years of age. The recommended dosing still remains one tablet daily.

The efficacy of Odactra for adolescent patients was evaluated in a double-blind, placebo-controlled, randomized field efficacy study conducted in the United States and Canada for a duration of up to 12 months, that compared the efficacy of Odactra (N=741) compared to placebo (N=741) in the treatment of HDM-induced allergic rhinitis. Subjects 12 through 85 years of age were enrolled if they had a history of symptomatic allergic rhinitis and were sensitized to D. farinae and/or D. pteronyssinus as determined by house dust mite specific IgE. Subjects were required to be symptomatic and were not taking symptom-relieving allergy medications at enrollment. Subjects with mild to moderate asthma, defined as asthma of a severity that required, at most, a daily medium dose of an inhaled corticosteroid, were enrolled in the study. Efficacy was assessed through self-reporting of symptoms and medication use. Subjects in active and placebo arms of this study were allowed to take symptom-relieving allergy medications (including oral and ocular antihistamines and nasal corticosteroids) during the study as needed. The primary endpoint was the difference between the treatment and placebo groups in the average TCRS during approximately the last 8 weeks of treatment. Subjects in this study were required to stop taking symptom-relieving allergy medication during the baseline period. The mean rhinitis DSS at baseline was 7.94 out of 12 total points in both the treatment arm and in the placebo arm. The results of this study are shown in the table below (Table 5). Consistent results across age groups were observed, supporting a similar treatment effect in adolescent and adult subgroups.

The warnings and precautions have been updated to state “Inform patients or parents/guardians of the signs and symptoms of serious allergic reactions and instruct them to seek immediate medical care and discontinue therapy should any of these occur.” The most common solicited adverse reactions reported in greater than or equal to 10% of adolescent subjects (12 through 17 years of age) treated with Odactra were throat irritation/tickle, itching in the mouth, itching in the ear, tongue pain, stomach pain, swelling of the uvula/back of the mouth, swelling of the lips, swelling of the tongue, throat swelling, nausea, tongue ulcer/sore on the tongue, and mouth ulcer/sore in the mouth, and diarrhea.

**Current Formulary Status:** Odactra is a non-formulary pharmacy benefit requiring a prior authorization.

**Recommendation:** No changes recommended to the formulary placement or authorization duration of Odactra at this time. However, it is recommended to update policy 500.0 to include the new FDA approved age range.

- Medical record documentation that Odactra is prescribed by or in consultation with an allergist, immunologist, or other physician qualified to prescribe allergy immunotherapy **AND**
- Medical record documentation of age greater than or equal to ~~18~~ 12 years and less than or equal to 65 years **AND**
- Medical record documentation of house dust mite-induced allergic rhinitis confirmed by in vitro testing for IgE antibodies to Dematophagoides fainae or Dermatophagoides pteronyssinus house dust mites **OR** skin testing to licensed house dust mite allergen extracts **AND**
- Medical record documentation that the member has (or will receive) a prescription for an epinephrine auto-injector **AND**
- Medical record documentation that the member does not have severe, unstable, or uncontrolled asthma **AND**
- Medical record documentation that member will no longer be receiving subcutaneous immunotherapy **AND**
- Medical record documentation that Odactra will not be used in combination with sublingual immunotherapy (e.g., Grastek, Oralair, and Ragwitek) **AND**

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to three (3) formulary alternatives, one of which must be an intranasal glucocorticoid

**MEDISPAN AUTHORIZATION LEVEL:** GPI-12

**QUANTITY LIMIT:** No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.
- QL FOR LETTER ONLY: 1 tablet per day

**AUTHORIZATION DURATION:** Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate. The following criteria is required for reauthorization:
- Medical record documentation of sustained improvement in allergic rhinitis symptoms **AND**
- Medical record documentation that the member is tolerating Odactra

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**PADCEV (enfortumab vedotin)**

**Clinical Summary:** Padcev is now indicated in combination with pembrolizumab (Keytruda), for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy. The dosage for the treatment of urothelial carcinoma in combination with pembrolizumab is 1.25 mg/kg (up to a maximum of 125 mg for patients ≥100 kg) IV on Days 1 and 8 of a 21-day cycle, until disease progression, or unacceptable toxicity.

The safety and efficacy of Padcev in combination with pembrolizumab were assessed in EV-103, an open-label, multi-cohort study in 121 patients with locally advanced or metastatic urothelial cancer who were ineligible for cisplatin-containing chemotherapy and had received no prior systemic therapy for locally advanced or metastatic disease. Patients with central nervous system metastases, ongoing sensory or motor neuropathy Grade 2, or uncontrolled diabetes (defined as HbA1c ≥8% or HbA1c ≥7% with associated diabetes symptoms) were excluded from this trial. There were three cohorts: the dose escalation cohort which included 5 patients, Cohort A which included 40 patients, and Cohort K which included 76 patients. All patients received Padcev 1.25 mg/kg as an IV infusion over 30 minutes on days 1 and 8 of a 21-day cycle followed by pembrolizumab 200 mg as an IV infusion on Day 1 of a 21-day cycle. Patients were treated until disease progression or unacceptable toxicity. The primary efficacy outcomes were objective response rate (ORR) and duration of response (DoR) as assessed by BICR according to RECIST v1.1. The median duration of response for Cohort A and the dose escalation cohort was 22.1 months.

The most common adverse reactions occurring in ≥20% of patients for this patient population were in line with the known safety profile of Padcev, but also included decreased potassium, urinary tract infection, constipation, increased potassium, peripheral edema, dry eye, dizziness, and arthralgia. No new warnings, contraindications, or black box warnings were identified.

**Current Formulary Status:** Medical Benefit, requires a prior authorization. When processed at a Specialty pharmacy, Padcev processes at the Specialty tier or Brand NP tier.

**Recommendation:** No changes are recommended to the formulary placement of Padcev. The following criteria should be added to Medical Benefit Policy 209.0 for Padcev to incorporate the new indication:

- Medical record documentation that prescription is written by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of locally advanced or metastatic urothelial cancer **AND**
    - Medical record documentation of one of the following: Medical record documentation that member has received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor, and a platinum-containing chemotherapy in the neoadjuvant/adjuvant, locally advanced or metastatic setting **OR**
    - Medical record documentation that member has received at least one prior line of therapy and is ineligible for cisplatin-containing chemotherapy* **OR**
    - Medical record documentation that member is ineligible for cisplatin-containing chemotherapy* **AND** medical record documentation that Padcev will be prescribed in combination with Keytruda

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**POLIVY (polatuzumab vedotin)**

**Clinical Summary:** Polivy is now approved in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone for the treatment of adults patients who have previously untreated DLBCL, NOS, or HGBL and who have an International Prognostic Index score of 2 or greater. It was previously approved in combination with bendamustine and a rituximab product for the treatment of adults patients with relapsed or refractory DLBCL, NOS, after at least 2 prior therapies.

Polivy was evaluated in the POLARIX study which was a randomized double-blind, placebo-controlled, multicenter trial in patients aged 18-80 years old with previously untreated large B-Cell lymphoma. Eligible patients had an International Prognostic Index of 2-5 and ECOG performance status of 0-2. 84% of the patients had DLBCL, NOS, 11% had HGBL with MYC and BCL2 and/or BCL6 rearrangements or HGBL, NOS, and 5% had other large B-Cell lymphomas. 879 patients were randomized 1:1 to receive Polivy plus R-CHP or to receive R-CHOP for six 21-day cycles with two additional cycles of rituximab alone. CSF was administered prophylactically in both groups. The primary endpoint evaluated was progression-free survival. Secondary measures included modified event-free survival. After a median follow-up of 28.2 months, the percentage of patients surviving without progression was higher in the Polivy group in the R-CHOP group.

The types and incidences of adverse events were generally similar among the two groups. No new safety considerations emerged.

**Current Formulary Status:** Polivy is covered as a medical benefit requiring prior authorization criteria.

**Recommendation:** No changes to formulary status or authorization duration are recommended. It is recommended to update policy MBP 200.0 to include the following changes:

Diffuse Large B-Cell Lymphoma, Previously Untreated

- Medical record documentation that Polivy is written by an oncologist or hematologist **AND**
- Medical record documentation of age ≥ 18 years **AND**
- Medical record documentation of previously untreated diffuse large B-cell lymphoma (DLBCL), not otherwise specified or high-grade B-cell lymphoma (HGBL) **AND**
- Medical record documentation of an International Prognostic Index score of 2 or greater **AND**
- Medical record documentation Polivy will be used in combination with rituximab, cyclophosphamide, doxorubicin and prednisone (R-CHP).

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**TAKHZYRO (lanadelumab)**

**Clinical Summary:** Takhzyro is a plasma kallikrein inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients 2 years and older. It was previously indicated in patients 12 years and older. For pediatric patients 6 to less than 12 years of age, the recommended starting dosage is 150 mg SQ every 2 weeks. A dosing interval of 150 mg every 4 weeks may be considered if the patient is well-controlled (e.g., attack free) for more than 6 months. For pediatric patients 2 to less than 6 years of age, the recommended dosage is 150 mg SQ every 4 weeks.

The safety and effectiveness of Takhzyro for prophylaxis to prevent attacks of HAE have been established in pediatric patients 2 years of age and older. Use of Takhzyro for this indication in patients 12 years of age and older was supported by a subgroup analysis by age of 10 patients aged 12 to 18 years of age) and pediatric patients (2 to less than 12 years of age), and safety and pharmacodynamic data from an open-label, multicenter study in pediatric patients with HAE aged 2 to less than 12 years that enrolled 21 patients (4 patients were aged 2 to less than 6 years and 17 patients were 6 to less than 12 years of age). The pharmacodynamic response observed in this trial for pediatric patients 2 to less than 12 years of age was similar to that seen in adult and pediatric patients 12 years of age and older. The safety and effectiveness of Takhzyro in pediatric patients less than 2 years of age have not been established.

The updated guidelines, The International WAO/EAACI Guideline for the Management of Hereditary Angioedema- the 2021 Revision and Update, now consider danazol as second line therapy. Takhzyro, plasma-derived C1 inhibitors, and Orladeyo are recommended as first line therapy.

**Current Formulary Status:** Pharmacy Benefit available at the Specialty tier, Prior Authorization required.

**Recommendation:** There are no changes to formulary status or quantity limits at this time

- Medical record documentation of age greater than or equal to ~~12~~ 2 years **AND**
- Medical record documentation that Takhzyro is prescribed by an allergist, immunologist, hematologist, or dermatologist **AND**
- Medical record documentation of a diagnosis of hereditary angioedema (HAE) established and supported by documentation of:
    - Recurrent, self-limiting, non-inflammatory subcutaneous angioedema without urticaria which lasts more than 12 hours **OR**
    - Laryngeal edema **OR**
    - Recurrent, self-remitting abdominal pain which lasts more than 6 hours, without clear organic etiology **AND**
- Medical record documentation of specific abnormalities in complement proteins, in the setting of a suggestive clinical history or episodic angioedema without urticaria; supported by:
    - Medical record documentation of two (2) or more sets of complement studies, separated by one month or more, showing consistent results of:
        - Low C4 levels **AND**
        - Less than 50% of the lower limit of normal C1-INH antigenic protein levels **OR**
        - Less than 50% of the lower limit of normal C1-INH functions levels **AND**
- Medical record documentation of history of more than one (1) severe event per month **OR** a history of laryngeal attacks **AND**

- Medical record documentation that Takhzyro is being used as prophylactic therapy for hereditary angioedema (HAE) attacks **AND**
- Medical record documentation that the member is receiving an appropriate dose* based on patient's age **AND**
- ~~Medical record documentation of therapeutic failure on, intolerance to, or contraindication to danazol~~

**QUANTITY LIMIT (for letter only):**
- 300mg/2mL: 4 mL per 28 days
- 150mg/mL: 2 mL per 28 days

*Note to Reviewer:
- **Adult and Pediatric Patients 12 Years of Age and Older:** 300 mg subcutaneously (SQ) every 2 weeks. [A dosing interval of 300 mg every 4 weeks is also effective and may be considered if the patient is well-controlled (e.g., attack free) for more than 6 months].
- **Pediatric Patients 2 to Less Than 12 Years of Age:**
  - Pediatric Patients 6 to Less Than 12 Years of Age**:** Starting dosage: 150 mg SQ every 2 weeks. [A dosing interval of 150 mg every 4 weeks may be considered if the patient is well-controlled (e.g., attack free) for more than 6 months].
  - Pediatric Patients 2 to Less Than 6 Years of Age: Starting dose: 150 mg SQ every 4 weeks.

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**TRIKAFTA (elexacaftor, tezacaftor, and ivacaftor)**

**Clinical Summary:** Trikafta is now indicated for the treatment of cystic fibrosis (CF) in patients aged 2 years and older who have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data. Previously Trikafta was indicated in patients 6 years and older. A new formulation of oral granules of Trikafta was approved for treatment in patients less than 6 years of age. The recommended dosage for the new population of pediatric patients aged 2 to less than 6 years of age is oral granules given 12 hours apart based on weight.

The safety and efficacy of Trikafta for the treatment of CF have been established in pediatric patients aged 2 to less than 18 years who have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data. The effectiveness in patients 2 to less than 12 years was extrapolated from patients aged 12 years and older with support from population pharmacokinetic analyses. Safety in patients aged 2 to less than 6 years of age was derived from a 24-week, open-label, clinical trial in 75 patients aged 2 to less than 6. The safety profile of patients in the new population was similar to that observed in trials of patients 12 years and older. No new safety concerns were identified.

**Current Formulary Status:** Trikafta Tablets: Specialty/Brand NP tier, PA, QL: 84 tablets per 28 days

**Recommendation:** Trikafta packets should be added to the Specialty tier or Brand Non Preferred tier for members with a three-tier benefit to match the placement of Trikafta tablets. It will require a prior authorization and will be added to the Commercial Policy 606.0 for Trikafta. The following changes are recommended to Policy 606.0 to incorporate the new pediatric population and the new formulation:
- Medical record documentation of age greater than or equal to ~~6 years~~ 2 years **AND**
- Medical record documentation of a diagnosis of cystic fibrosis **AND**

- Medical record documentation that the medication is prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis **AND**
- Medical record documentation of one of the following, as detected by a Food and Drug Administration (FDA) cleared cystic fibrosis mutation test:
    - Medical record documentation that the patient has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene **OR**
    - Medical record documentation that the patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive based on in vitro data per product labeling

**MEDISPAN AUTHORIZATION LEVEL:** GPI-10 *(to allow for tablets and packets)*

**QUANTITY LIMIT:** *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- Trikafta Tablets: QL FOR LETTER ONLY: 3 tablets per day, 28 day supply per fill
- Trikafta Oral Granules: QL FOR LETTER ONLY: 2 packets per day, 28 day supply per fill

**AUTHORIZATION DURATION**: Initial approval will be for four (4) months and subsequent approvals will be for twelve (12) months. Additional authorizations will require medical record documentation of improvement or stabilization in the signs and symptoms of cystic fibrosis. The medication will no longer be covered if the member experiences worsening of disease.

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

## UPDATES

### ANDEXXA (andexanet alfa)

**Background:** Upon annual review, it is recommended to update the criteria for use of the Andexxa policy MBP 183.0. The update to the Andexxa policy is intended to accurately represent the current verbiage in the FDA-approved indication.

**Recommendation:** MBP 183.0 Andexxa (andexanet alfa)

Andexxa (andexanet alfa) will be considered medically necessary when ALL of the following criteria are met:

- Medical record documentation that Andexxa is being used for the reversal of anticoagulation due to life-threatening or uncontrolled bleeding in patients treated with rivaroxaban ~~and~~ or apixaban.

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

### HEREDITARY ANGIOEDEMA PROPHYLAXIS AGENTS UPDATE

**Background:** The policies for agents used for hereditary angioedema (HAE) prophylaxis require a step through danazol. This includes the commercial policies for Orladeyo (berotralstat) and Haegarda [C1 Esterase Inhibitor Subcutaneous (Human)], and the medical benefit policies for Cinryze and Berinert [C1 Esterase Inhibitors (Human)]. The updated guidelines, The International WAO/EAACI Guideline for the Management of Hereditary Angioedema- the 2021 Revision and Update, now consider danazol as second line therapy. Takhzyro, plasma-derived C1 inhibitors, and Orladeyo are recommended as first line therapy. Input was requested from Allergy/Immunology. At time of documentation, still awaiting feedback. Also awaiting potential rebate opportunities.

**Recommendation:** Remove criteria for step through danazol for Commercial policies 471.0 (Haegarda) and 660.0 (Orladeyo). Remove criteria for step through danazol for Medical Benefit policy MBP 85.0 (Cinryze). Add other prophylactic agents to Medical Benefit policy MBP 84.0 (Berinert). No other recommended changes at this time.

#### Commercial Policy 660.0 (Orladeyo)

An exception for coverage of Orladeyo may be made for members who meet the following criteria:

- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation that Orladeyo is prescribed by an allergist, immunologist, hematologist, or dermatologist **AND**
- Medical record documentation of a diagnosis of hereditary angioedema (HAE) established and supported by documentation of:
    - Recurrent, self-limiting, non-inflammatory subcutaneous angioedema without urticaria which lasts more than 12 hours **OR**
    - Laryngeal edema **OR**
    - Recurrent, self-remitting abdominal pain which lasts more than 6 hours, without clear organic etiology **AND**
- Medical record documentation of specific abnormalities in complement proteins, in the setting of a suggestive clinical history or episodic angioedema without urticaria; supported by:
    - Medical record documentation of two (2) or more sets of complement studies, separated by one month or more, showing consistent results of:
        - Low C4 levels **AND**

        - Less than 50% of the lower limit of normal C1-INH antigenic protein levels **OR**
        - Less than 50% of the lower limit of normal C1-INH functions levels **AND**
- Medical record documentation of history of more than one (1) severe event per month **OR** a history of laryngeal attacks **AND**
- Medical record documentation that Orladeyo is being used as prophylactic therapy for hereditary angioedema (HAE) attacks **AND**
- Medical record documentation that Orladeyo is not being used in combination with another prophylactic human C1 esterase inhibitor (Cinryze or Haegarda) or lanadelumab (Takhzyro) therapy for hereditary angioedema ~~**AND**~~
- ~~Medical record documentation of therapeutic failure on, intolerance to, or contraindication to danazol~~

### Commercial Policy 471.0 (Haegarda)

A formulary exception for coverage of Haegarda may be made for members who meet the following criteria:

- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation that Haegarda is prescribed by an allergist, immunologist, hematologist, or dermatologist **AND**
- Medical record documentation of a diagnosis of hereditary angioedema (HAE) established and supported by documentation of:
    - Recurrent, self-limiting, non-inflammatory subcutaneous angioedema without urticaria which lasts more than 12 hours **OR**
    - Laryngeal edema **OR**
    - Recurrent, self-remitting abdominal pain which lasts more than 6 hours, without clear organic etiology **AND**
- Medical record documentation of specific abnormalities in complement proteins, in the setting of a suggestive clinical history or episodic angioedema without urticaria; supported by:
    - Medical record documentation of two (2) or more sets of complement studies, separated by one month or more, showing consistent results of:
        - Low C4 levels **AND**
        - Less than 50% of the lower limit of normal C1-INH antigenic protein levels **OR**
        - Less than 50% of the lower limit of normal C1-INH function levels **AND**
- Medical record documentation of history of more than one (1) severe event per month **OR** a history of laryngeal attacks **AND**
- Medical record documentation that Haegarda is being used as prophylactic therapy for hereditary angioedema (HAE) attacks ~~**AND**~~
- ~~Medical record documentation of therapeutic failure on, intolerance to, or contraindication to danazol~~

### Medical Benefit Policy MBP 85.0 (Cinryze C1 esterase inhibitor, human)

Cinryze (C1 esterase inhibitor, human) will be considered medically necessary for the commercial, exchange and CHIP lines of business for prophylaxis against attacks of hereditary angioedema when the following criteria are met:

- Member is 6 years of age or older; **AND**
- Prescription is written by an allergist, immunologist, hematologist or dermatologist; **AND**
- Medication is being used as prophylactic therapy for HAE attacks; **AND**
- Diagnosis of hereditary angioedema has been established and supported by physician provided documentation of:
    - Recurrent, self-limiting non-inflammatory subcutaneous angioedema without urticaria, lasting more than 12 hours; **OR**
    - Laryngeal edema; **OR**

- Recurrent, self-remitting abdominal pain lasting more than 6 hours, without clear organic etiology

**AND**

- the presence of specific abnormalities in complement proteins, in the setting of a suggestive clinical history of episodic angioedema without urticaria; supported by
  - Medical record documentation of 2 or more sets of complement studies, separated by one month or more, showing consistent results of
    - Low C4 levels **AND**
    - Less than 50% of the lower limit of normal C1-INH antigenic protein levels **OR**
    - Less than 50% of the lower limit of normal C1-INH function levels

**AND**

- ~~Physician provided documentation of failure on, intolerance to, or contraindication to danazol; **AND**~~
- Physician provided documentation of history of more than one (1) severe event per month OR a history of laryngeal attacks

### Medical Benefit Policy MBP 84.0 (Berinert C1 esterase inhibitor, human)

Berinert (C1 esterase inhibitor, human) will be considered medically necessary for the commercial, exchange, CHIP and Medicare for the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema in adults and pediatrics when the following criteria are met:

- Prescription is written by an allergist, immunologist, hematologist or dermatologist; **AND**
- Medication is being used for the treatment of an acute attack of hereditary angioedema; **AND**
- Not used in combination with other approved treatments for acute HAE attacks; **AND**
- Physician provided documentation of a diagnosis of hereditary angioedema evidenced by:
  - Recurrent, self-limiting non-inflammatory subcutaneous angioedema without urticaria, lasting more than 12 hours; **OR**
  - Laryngeal edema; **OR**
  - Recurrent, self-remitting abdominal pain lasting more than 6 hours, without clear organic etiology

**AND**

- the presence of specific abnormalities in complement proteins, in the setting of a suggestive clinical history of episodic angioedema without urticaria; supported by
  - Medical record documentation of 2 or more sets of complement studies, separated by one month or more, showing consistent results of
    - Low C4 levels **AND**
    - Less than 50% of the lower limit of normal C1-INH antigenic protein levels **OR**
    - Less than 50% of the lower limit of normal C1-INH function levels

**AND**

- For patients with more than one severe episode of angioedema per month, or those with a history of laryngeal attacks, physician provided documentation of one of the following:
  - use of concurrent prophylactic therapy
    **OR**
  - failure on, intolerance to, or contraindication to prophylactic therapy with Takhzyro **AND** Haegarda **AND** Cinryze **AND** Orladeyo **AND** danazol~~).~~ ~~*~~

~~*Only applies to patients with more than one severe episode of angioedema per month, or those with a history of laryngeal attacks~~

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

**IMBRUVICA (ibrutinib)**

**Background:** Pharmacyclics LLC has voluntarily removed the following indications which were previously approved under accelerated approval:

- Treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy
- Treatment of adult patients with marginal zone lymphoma (MZL) who require systemic therapy and have received at least one prior anti-CD20-based therapy

The Imbruvica 560 mg tablet formulation has also been withdrawn.

**Recommendation:** The following changes are recommended to Commercial policy 315.0 to reflect the indication changes:

~~Mantle Cell Lymphoma~~

- ~~Medical record documentation that Imbruvica is prescribed by a hematologist or oncologist **AND**~~
- ~~Medical record documentation of mantle cell lymphoma (MCL) **AND**~~
- ~~Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one prior therapy~~

**Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma**

- Medical record documentation that Imbruvica is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of chronic lymphocytic leukemia (CLL) **OR** small lymphocytic lymphoma (SLL)

**Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma with 17p deletion**

- Medical record documentation that Imbruvica is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of chronic lymphocytic leukemia (CLL) with 17p deletion **OR** small lymphocytic lymphoma with 17p deletion

**Waldenström's macroglobulinemia**

- Medical record documentation that Imbruvica is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of a diagnosis of Waldenström's macroglobulinemia

~~Marginal Zone Lymphoma~~

- ~~Medical record documentation that Imbruvica is prescribed by a hematologist or oncologist **AND**~~
- ~~Medical record documentation of marginal zone lymphoma **AND**~~
- ~~Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one prior anti-CD20-based therapy~~

**Chronic Graft Versus Host Disease (cGVHD)**

- Medical record documentation that Imbruvica is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of chronic graft versus host disease **AND**
- Medical record documentation of age greater than or equal to 1 year **AND**
- Medical record documentation of therapeutic failure on one or more lines of systemic therapy **AND**
- Medical record documentation that the member is receiving an appropriate dose** based on the age and body surface area (BSA)

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**KERENDIA (finerenone)**

**Background:** Kerendia (branded product of finerenone) is a nonsteroidal mineralocorticoid receptor antagonist approved for treatment of chronic kidney disease (CKD) associated with type 2 diabetes mellitus (T2DM).1 The medication has been shown to reduce the risk of progression of CKD, development of end stage renal disease, cardiovascular death, nonfatal myocardial infarction, and hospitalization for heart failure in adults with diabetic kidney disease (DKD).

The two major studies that evaluated the effect of finerenone in this population (FIDELIO-DKD and FIGARO-DKD) required participants to be on maximum tolerated doses of an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) prior to study enrollment. While there are no direct comparator trials of finerenone versus a sodium/glucose cotransporter 2 inhibitor (SGLT2i) for treatment of DKD, a meta-analysis of placebo controlled trials suggests that SGLT2is are superior to finerenone in delaying progression of renal disease and preventing adverse cardiac outcomes. Subgroup analysis of the FIDELITY-DKD trial showed renal and cardiovascular effects of finerenone were similar regardless of treatment with an SGLT2i and a reduced incidence of hyperkalemia in the patients taking both medications versus finerenone monotherapy. This analysis, as well as a study in rats with hypertension induced CKD, suggests combination therapy with an SGLT2i and finerenone may provide increased efficacy in reducing risks associated with DKD than either agent alone.

The use of finerenone in adults with DKD who experience albuminuria (albumin creatinine ratio > 30mg/g) despite being treated with an SGLT2i and maximally tolerated renin-angiotensin system inhibitor, such as an ACEi or an ARB, is supported by ADA and KDIGO clinical practice guidelines. While SGLT2i's were not first line therapy for DKD at the initiation of the FIDELIO-DKD and FIGARO-DKD trials, these agents are now considered standard of care for patients with DKD regardless of glycemic status.

Geisinger nephrology was consulted and is supportive of the updated recommendations requiring maximally tolerated ACEi/ARB and one SGLT-2 inhibitor. They additionally provided input on the definition of persistent albuminuria and recommended utilizing an albumin creatinine ratio greater than 30 mg/g.

**Recommendation:** The following changes are recommended to existing policies based on updated guidelines and the recommendation of Geisinger nephrology:

- Medical record documentation of a diagnosis of chronic kidney disease associated with type 2 diabetes **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- ~~Medical record documentation of serum potassium less than or equal to 5.0 mEq/L **AND**~~
- Medical record documentation of one of the following:
  - Serum Potassium ≤ 5.0 MEQ/L **OR**
  - Serum Potassium ≤ 5.5 MEQ/L if already established on therapy **AND**
- Medical record documentation of persistent albuminuria (albumin to creatinine ratio consistently greater than 30 mg/g) despite treatment with both of the following:
  - Maximally tolerated angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) **AND**
  - One sodium-glucose co-transporter 2 (SGLT-2) inhibitor with proven kidney or cardiovascular benefit

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to two (2) of the preferred sodium-glucose cotransporter 2 (SGLT-2) inhibitors Food and Drug Administration (FDA)-approved for the member's diagnosis

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**LETROZOLE UPDATE**

**Background:** For commercial/exchange/CHIP plans, we require a prior authorization for letrozole for members under 45 years of age to prevent use for fertility for plans without a fertility benefit. Letrozole costs around $11 for a 30 day supply. A case was brought to our attention by a hematologist/oncologist MTDM pharmacist for a rare type of cancer in a young patient. This case was discussed at our pharmacist meeting, and it was decided to remove the prior authorization requirement for commercial/exchange/CHIP plans.

**Recommendation:** There are no changes to formulary placement for letrozole. However, it is recommended to remove the prior authorization requirement for all members.

**Outcome:** The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

---

**Voting responses were received from 31 of 51 members. The vote was unanimously approved.**

The next bi-monthly scheduled meeting will be held on July 18th, 2023 at 1:00 p.m.

Meeting will be held virtually via phone/Microsoft Teams.