DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS FROM THE NOVEMBER 2022 MEETING

INFORMATION FOR THE UNIFORM FORMULARY BENEFICIARY ADVISORY PANEL MEETING JANUARY 4, 2023

I. UNIFORM FORMULARY REVIEW PROCESS

Under 10 United States Code § 1074g, as implemented by 32 Code of Federal Regulations 199.21, the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee is responsible for developing the Uniform Formulary (UF). Recommendations to the Director, Defense Health Agency (DHA) or their designee, on formulary or Tier 4/not covered status, prior authorizations (PAs), pre-authorizations, and the effective date for a drug's change from formulary to non-formulary (NF) or Tier 4 status are received from the Beneficiary Advisory Panel (BAP), which must be reviewed by the Director or their designee before making a final decision.

II. UF DRUG CLASS REVIEWS—ATOPY AGENTS—ORAL JANUS KINASE INHIBITOR (JAK-1) SUBCLASS

P&T Comments

A. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—Relative Clinical Effectiveness Conclusion

Background—The P&T Committee evaluated the relative clinical effectiveness of the oral JAK inhibitors approved for treating atopic dermatitis, commonly known as eczema. The drugs in the subclass include upadacitinib (Rinvoq), and abrocitinib (Cibinqo). This is the first time the oral JAK inhibitor subclass has been reviewed for formulary status.

The Atopy Class is a newly created drug class with a variety of agents indicated for atopic dermatitis (AD) and other disease sates. It is comprised of products with differing mechanisms of action for treating eczema, including JAK inhibitors [Rinvoq, Cibinqo, and topical ruxolitinib (Opzelura)]; interleukin antagonists [dupilumab (Dupixent), benralizumab (Fasenra), mepolizumab (Nucala), and omalizumab (Xolair)]; calcineurin inhibitors [pimecrolimus (Elidel), tacrolimus (Protopic, generic)], and a phosphodiesterase-type 4 (PDE-4) inhibitor [crisaborole (Eucrisa)]. There is a mix of oral, injectable, and topical formulations in the class. The oral JAK inhibitors, tofacitinib (Xeljanz) and baricitinib (Olumiant), will remain in the Targeted Immunomodulatory Biologics (TIBs) class, as they are not approved for treating atopic dermatitis.

Rinvoq and Cibinqo differ markedly in their FDA-approved indications. Rinvoq is approved for a variety of conditions, to include atopic dermatitis (moderate-severe), rheumatoid arthritis (moderate-severe), psoriatic arthritis, ulcerative colitis, and ankylosing

spondylitis, while Cibinqo is solely approved for atopic dermatitis (moderate-severe). *(Note that the new Rinvoq indication for non-radiographic axial spondyloarthritis will be reviewed at the February 2023 P&T Committee meeting).*

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (15 for, 0 opposed, 1 abstained, 2 absent) the following:

Professional Treatment Guidelines

- Standard first-line treatments for atopic dermatitis include topical therapies (e.g., calcineurin inhibitors and topical corticosteroids) and consideration of phototherapy before initiating systemic therapies.
- The International Eczema Council 2017 guidelines summarize considerations for initiating systemic treatment options for treating atopic dermatitis. Patients with moderate-to-severe atopic dermatitis should be given appropriate topical therapies and disease management education. In patients with persistent symptoms, consideration for alternative diagnoses and phototherapy, if appropriate, is warranted. Patients who continue to have persistent moderate-to-severe atopic dermatitis symptoms despite the above measures are appropriate candidates for systemic therapy.

Efficacy

- There are no head-to-head trials comparing Rinvoq and Cibinqo. FDA approval was based on several randomized controlled trials (RCT) conducted for each medication.
- For both products, RCTs demonstrated statistically significant achievement of reduction in Investigator Assessment and Eczema Area Severity Index (EASI) scores (which measures the extent and severity of disease) for atopic dermatitis compared to placebo.
- A 2022 JAMA Dermatology network meta-analysis (NMA) assessed new systemic treatment options for atopic dermatitis, and included several RCTs for Rinvoq and Cibinqo, along with other products approved for this indication.
    - The NMA concluded the higher strengths of Rinvoq 30 mg and Cibinqo 200 mg daily were associated with slightly improved scores than Dupixent 300 mg given every other week (standard adult dosage). Rinvoq 15 mg daily was associated with similar scores to standard dose Dupixent, while Cibinqo 100 mg daily was associated with slightly worse scores.
- A 2021 Institute for Clinical and Economic Review (ICER) NMA also evaluated newer systemic treatment options for atopic dermatitis. The results reported that Rinvoq 30 mg was more likely to achieve a 75% reduction in the Eczema Area Severity Index (EASI-75) score thresholds than Cibinqo 200 mg or other

systemic interventions, including Dupixent. However, Rinvoq 30 mg was not statistically superior to Cibinqo 200 mg in achieving EASI-75 thresholds.

Safety

- Pooled trial data show that Rinvoq and Cibinqo have similar discontinuation rates due to adverse events, both reported at 5%. Rinvoq is associated with a higher proportion of adverse events related to upper respiratory infection and acne, while Cibinqo carries a higher risk for nausea.
- Rinvoq and Cibinqo both require similar pre-treatment and post-treatment screenings. The black box warnings are identical for both products, and include serious infection,-increased all-cause mortality, malignancy, major adverse cardiac events, and thrombosis. Of note, this black box warning was issued as a result of increased safety signals from another JAK inhibitor, Xeljanz, during studies conducted in patient with rheumatoid arthritis.
- For Rinvoq, the RCTs enrolled sufficient numbers of patients from special populations (e.g., geriatric, pediatric, compromised renal or hepatic function), resulting in a recommendation for dose modification for geriatric patients and an indication for pediatric patients; additionally, dose reduction is required in severe renal failure patients. Cibinqo currently has insufficient geriatric and pediatric data and must be avoided in severe renal and hepatic failure.

Individual Agents

- *upadacitinib (Rinvoq):* Advantages of Rinvoq include FDA-approval for diseases other than atopic dermatitis. For atopic dermatitis, Rinvoq is approved for adults and for children as young as 12 years of age and weighing more than 40 kilograms. Additional indications are under investigation.
- *abrocitinib (Cibinqo):* Cibinqo's product labeling is limited to treating atopic dermatitis in adults, and there is insufficient data for treating special populations.

Overall Conclusions

- When treating atopic dermatitis, indirect comparisons from NMAs suggest higher doses of Rinvoq and Cibinqo are somewhat more effective than Dupixent. Direct efficacy comparisons of Rinvoq and Cibinqo have yet to be conducted.
- In terms of efficacy, there is a high degree of therapeutic interchangeability between Rinvoq and Cibinqo. In terms of safety, there is a moderate degree of therapeutic interchangeability as each medication carries a few unique adverse events, and long-term safety will need to be further defined for both agents.
- In order to meet the needs of MHS beneficiaries, one oral JAK inhibitor is required for treatment of atopic dermatitis.

B. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—Relative Cost Effectiveness Analysis and Conclusion

Relative Cost Effectiveness Analysis and Conclusion—The Committee reviewed the solicited bids from manufacturers and conducted cost minimization analysis (CMA) and a budget impact analysis (BIA). The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 2 absent) the following:

- CMA results showed upadacitinib (Rinvoq) was more cost effective than abrocitinib (Cibinqo), based on designating Rinvoq as UF and Cibinqo as NF.
- A BIA and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating upadacitinib (Rinvoq) as UF, with abrocitinib (Cibinqo) as NF demonstrated the most cost avoidance for the MHS.

C. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—UF/NF Recommendations

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) the following:

- UF
  - upadacitinib (Rinvoq) *moves from NF to UF*
- NF
  - abrocitinib (Cibinqo) remains *NF*
- Tier 4 (Not covered) – None

D. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—Manual PA Criteria

PA criteria were originally recommended when the individual oral JAK inhibitors were first evaluated by the Committee as new drugs. The current PA criteria for both Rinvoq and Cibinqo require trial of topical medications (corticosteroid and a topical calcineurin inhibitor), first, consistent with professional guidelines for treating atopic dermatitis.

The P&T Committee recommended (16 for, 0 opposed, 2 abstained) maintaining the current manual PA criteria for Rinvoq, and updates to the manual PA criteria for Cibinqo in new users. Note that for Rinvoq, the current PA requirements for indications other than atopic dermatitis still apply (e.g., a trial of Humira is still required before Rinvoq in patients with arthritis).

The updated PA criteria for Cibinqo in new users will now include the requirement for trial of the injectable interleukin antagonist Dupixent, and a trial of Rinvoq; this is in addition to a trial of a topical corticosteroid and a topical calcineurin inhibitor.

The Manual PA criteria is as follows:

1. **abrocitinib (Cibinqo)**

   Updates from Nov 2022 are in bold and strikethrough

   Manual PA criteria apply to all new users of abrocitinib (Cibinqo) and (Cibinqo) is approved if all criteria are met:

   - Patient is 18 years of age or older
   - Medication is prescribed by an allergist, dermatologist, or immunologist
   - Drug is used to treat moderate to severe atopic dermatitis
   - **The patient's disease is not adequately controlled with other systemic drug products including biologics (i.e., Dupixent) OR it is inadvisable to use other systemic drug products including biologics**
   - Patient failed, has a contraindication, or intolerability to one medication in EACH of the following **four ~~two~~** categories:
     - Topical Corticosteroids: high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)
     - Topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)
     - **Injectable interleukin antagonist: dupilumab (Dupixent)**

       Oral JAK: upadacitinib (Rinvoq)
   - Patient is unable to access, has a contraindication to, or intolerability to UVB phototherapy
   - Patient has had a negative TB test in the last 12 months (or is adequately managed)
   - Patient has no history of venous thromboembolism (VTE)
   - Provider is aware of the boxed FDA warnings
   - Patient does not have neutropenia (ANC < 1000)
   - Patient does not have lymphocytopenia (ALC < 500)
   - Patient does not have anemia (Hgb < 8)
   - Patient is not taking a concomitant JAK inhibitors, immunosuppressants, or biologic immunomodulatory agents

Non-FDA-approved uses are not approved.
PA expires in 1 year. Renewal PA criteria will be approved indefinitely.

Renewal criteria: (Initial TRICARE PA approval is required for renewal) The patient's disease severity has improved and stabilized to warrant continued therapy

2. **upadacitinib (Rinvoq)**

   Note that there were no changes to the current Rinvoq criteria for the other indications (Rheumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis or Ankylosing Spondylitis– see the August 2022 P&T Committee meeting minutes for the full criteria)

   Step therapy and manual PA criteria apply to all new users of upadacitinib (Rinvoq ER).

   Manual PA Criteria: Rinvoq is approved if all criteria are met:

   For Atopic Dermatitis

   - The patient is 12 years of age or older
   - The drug is prescribed by a dermatologist, allergist, or immunologist
   - The patient has moderate to severe atopic dermatitis
   - The patient's disease is not adequately controlled with other systemic drug products, including biologics (for example, Dupixent) **OR it is inadvisable to use other systemic drug products including biologics**
   - The patient has a contraindication to, intolerability to, or has failed treatment with one medication in each of the following categories:
     - Topical Corticosteroids:
       - For patients 18 years of age or older; high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)
       - For patients 12 to 17 year of age: any topical corticosteroid
     - Topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)
   - The patient has a contraindication to, intolerability to, inability to access treatment, or has failed treatment with Narrowband UVB phototherapy

   For all indications

   - Patient has no evidence of active TB infection within the past 12 months
   - Patient has no history of venous thromboembolic (VTE) disease
   - Provider is aware of the FDA safety alerts AND Boxed Warnings
   - Patient has no evidence of neutropenia (ANC < 1000)

- Patient has no evidence of lymphocytopenia (ALC < 500)
- Patient has no evidence of anemia (Hgb < 8)
- Patient is not taking Rinvoq concomitantly with other TIBs agents except for Otezla and other potent immunosuppressant's (e.g., azathioprine, cyclosporine)

Non-FDA-approved uses are not approved.

PA expires in 1 year for atopic dermatitis. PA does not expire for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, or ankylosing spondylitis.

Renewal criteria**:** Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if the following apply:

Atopic Dermatitis - The patient's disease severity has improved and stabilized to warrant continued therapy

E. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—UF, PA, and Implementation Period

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) an effective date of the first Wednesday 30 days after signing of the minutes in all points of service.

III. UF DRUG CLASS REVIEWS—ATOPY AGENTS ORAL JANUS KINASE INHIBITOR (JAK-1) SUBCLASS

BAP Comments

A. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—UF/NF Recommendations

The P&T Committee recommended the formulary status for the Atopy Agents as discussed above.

- UF - upadacitinib (Rinvoq) moves from NF to UF
- NF - abrocitinib (Cibinqo) remains NF
- Tier 4/Not Covered - None

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—Manual PA Criteria

The P&T Committee recommended manual PA criteria as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Atopy Agents—Oral Janus Kinase Inhibitor (JAK-1) Subclass—UF, PA and Implementation Plan

The P&T Committee recommended an effective date of the first Wednesday 30 days after signing of the minutes in all points of service.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

IV. UF DRUG CLASS REVIEWS—Red Blood Cell (RBC) Stimulants Erythropoietins Subclass

P&T Comments

A. Hematological Agents—RBC Stimulants Erythropoietins Subclass—Relative Clinical Effectiveness Analysis and Conclusion

Background—This is the first formulary review for the erythropoietin RBC stimulants. The three marketed erythropoietin alfa products are epoetin alfa (Epogen and Procrit), and epoetin alfa-epbx (Retacrit). Epogen and Procrit are the reference biologics, while Retacrit is the biosimilar. Retacrit was reviewed as an innovator drug in August 2018 and designated as UF. Note that darbepoetin alfa (Aranesp) was not included in the class review.

The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

Background

- Epogen, Procrit and Retacrit all have the same FDA-approved indications, including for treating anemia caused by chronic kidney disease, zidovudine therapy, or chemotherapy, and to reduce the need for RBC transfusions in patients undergoing elective, non-cardiac surgery. There are several well-accepted off-label uses.
- These products are available in vials ranging from 2,000 units/mL to 40,000 units/mL. Epogen is not available in a 40,000 units/mL vial.

Professional Treatment Guidelines

- Clinical practice guidelines in the field of nephrology and oncology address the place in therapy for RBC stimulants and the selection of biosimilars. There is no preference for any one erythropoietin agent, either a reference product or a

biosimilar, over the others. There is a lack of evidence that any one erythropoietin product is superior to another.

- The 2012 Kidney Disease: Improving Global Outcomes (KDIGO) clinical practice guideline for anemia in chronic kidney disease recommend erythropoietin agents in patients with anemia who have exhausted all other means of correcting anemia (iron, inflammatory states) and who wish to avoid excessive blood transfusions or symptoms of anemia. No one specific product is recommended, and an individual agent should be chosen based on the balance of pharmacokinetic/pharmacodynamics profiles, safety, clinical outcome data, costs and availability.
- The 2019 American Society of Clinical Oncology/American Society of Hematology guidelines state that erythropoietin stimulating agents may be used in individuals with chemotherapy-induced anemia who have incurable cancer and whose hemoglobin is less than 10 g/dL. The expert panel considers epoetin beta, epoetin alfa, darbepoetin alfa, and biosimilar epoetin alfa-epbx equivalent with respect to effectiveness and safety.

Efficacy

- A large retrospective study in patients with chronic kidney disease evaluated switching between originator and biosimilar epoetin alfa products. The results showed that there were no reported differences in safety or efficacy outcomes when patients were switched between the biosimilar and originator products (Belleudi 2019).

Safety

- The adverse event profiles for the epoetin alfa products differ based on indication. Commonly reported side effects include upper respiratory tract infection, headache, diarrhea, bone and joint pain, and injection site irritation.

Overall Conclusions

- Overall, there is a high degree of therapeutic interchangeability between Epogen, Procrit and Retacrit, as there are no clinically meaningful differences between the reference drug products and the biosimilar.
- In order to meet the needs of MHS beneficiaries, at least one erythropoietin RBC stimulant is required on the formulary.

B. Hematological Agents—RBC Stimulants Erythropoietins Subclass—Relative Cost Effectiveness Analysis and Conclusion

P&T Committee concluded (18 for, 0 opposed, 0 abstained, 0 absent) the following:

- CMA results showed that epoetin alfa-epbx (Retacrit) was more cost effective than epoetin alfa (Epogen, Procrit).

- A BIA and a sensitivity analysis were performed to evaluate the potential impact of designating selected agents as formulary or NF on the UF. BIA results showed that designating epoetin alfa-epbx (Retacrit) as UF and step-preferred, with epoetin alfa (Epogen, Procrit) as UF and non-step-preferred, generated the greatest cost avoidance for the MHS.

C. Hematological Agents— Red Blood Cell (RBC) Stimulants Erythropoietins Subclass— UF Recommendation

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) the following:

- UF step-preferred
  - epoetin alfa -epbx (Retacrit)
- UF non-step-preferred
  - epoetin alfa (Epogen)
  - epoetin alfa (Procrit)
- NF – None
- Tier 4 (Not covered) – None

Note that for Procrit and Epogen a trial of Retacrit is required

D. Hematological Agents—Red Blood Cell (RBC) Stimulants Erythropoietins Subclass— Manual Prior Authorization Criteria

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) PA criteria for Epogen and Procrit. A trial of Retacrit will be required first in new users, unless the patient has failed therapy with or cannot tolerate it.

The Manual PA criteria is as follows:

epoetin alfa (Epogen) and epoetin alfa (Procrit)

Manual PA criteria apply to all new users of epoetin alfa (Procrit and Epogen) and coverage will be approved if all criteria are met:

- Provider acknowledges that epoetin alfa-epbx (Retacrit) is the preferred epoetin alfa for TRICARE and is available without a PA
- The patient has experienced an inadequate response to Retacrit OR
- Patient has had an adverse reaction to Retacrit that is not expected to occur with Procrit or Epogen

Prior Authorization does not expire

E. Hematological Agents—Red Blood Cell (RBC) Stimulants Erythropoietins Subclass— UF, PA, Implementation Period

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday 60 days after signing of the minutes in all points of service.

V. UF DRUG CLASS REVIEWS—Red Blood Cell (RBC) Stimulants Erythropoietins Subclass

BAP Comments

A. Hematological Agents— Red Blood Cell (RBC) Stimulants Erythropoietins Subclass—UF Recommendation

The P&T Committee recommended the formulary status for the hematological agents as discussed above:

- UF step-preferred
  - epoetin alfa -epbx (Retacrit)
- UF non-step-preferred
  - epoetin alfa (Epogen)
  - epoetin alfa (Procrit)
- NF – None
- Tier 4 (Not covered) – None

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Hematological Agents—Red Blood Cell (RBC) Stimulants Erythropoietins Subclass—Manual Prior Authorization Criteria

The P&T Committee recommended Manual PA criteria for Epogen and Procrit as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Hematological Agents—Red Blood Cell (RBC) Stimulants Erythropoietins Subclass—UF, PA, Implementation Period

The P&T Committee recommended an effective date of the first Wednesday 60 days after signing of the minutes in all points of service.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

VI. NEWLY APPROVED DRUGS PER 32 CFR 199.21(g)(5) AND NEW MEDICAL DEVICES

P&T Comments

A. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions

The products were divided into three groups when presented at the P&T Committee meeting. The generic names are provided below. Group 1 included Aspruzyo, Hyftor, Ryaltris, Vivjoa, and Zoryve; Group 2 was comprised of the 2 medical devices, FreeStyle Libre 3 and Omnipod 5, and Group 3 included Tascenso, Sotyktu, Xaciato, Zonisade and Entadfi.

The P&T Committee agreed (Group 1: 16 for, 0 opposed, 0 abstained, 2 absent; Group 2 for the medical devices Omnipod 5 and FreeStyle Libre 3: 18 for, 0 opposed, 0 abstained, 0 absent; and Group 3: 17 for, 0 opposed, 0 abstained, 1 absent) with the relative clinical and cost-effectiveness analyses presented for the newly approved drugs reviewed according to 32 CFR 199.21(g)(5) and new medical devices.

Addition of new medical devices to the TRICARE pharmacy benefit is also reviewed in this section. Medical devices are primarily covered by the TRICARE medical benefit, and any additions to the TRICARE pharmacy benefit are not meant to replace this pathway for procuring medical devices. See the August 2022 DoD P&T Committee meeting minutes (found at https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/DOD-PT-Committee/Meeting-Minutes) for details regarding the clinical and cost effectiveness review of new medical devices. The Committee identified two medical devices for review at this meeting, Omnipod 5 and FreeStyle Libre 3.

B. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—UF Recommendation

The P&T Committee recommended: Group 1 and Group 3: 17 for, 0 opposed, 0 abstained, 1 absent; and for Group 2 for the medical devices Omnipod 5 and FreeStyle Libre 3: 18 for, 0 opposed, 0 abstained, 0 absent;

- UF

- FreeStyle Libre 3 - Therapeutic Continuous Glucose Monitoring System (CGMS); new version of a CGMS for monitoring diabetes. Note that as part of this recommendation FreeStyle Libre 3 was added to the TRICARE pharmacy benefit.
- Omnipod 5 – Miscellaneous insulin device; new version of a covered External Insulin Infusion Pump for administering insulin. Note that as part of this recommendation Omnipod 5 was added to the TRICARE pharmacy benefit. Additionally, due to noncompliance with the Trade Agreements Act, Omnipod 5 is excluded from the TRICARE Mail Order pharmacy and MTF points of service; it is available at retail pharmacies.
- sirolimus 0.2% topical gel (Hyftor) – Immunosuppressives; a topical treatment for facial angiofibromas associated with tuberous sclerosis complex (TSC)
- zonisamide oral suspension (Zonisade) – Anticonvulsant-Antimania Agents; new liquid formulation of zonisamide

- NF:
  - clindamycin 2% vaginal gel (Xaciato) – Antibiotic; vaginal formulation for treating bacterial vaginosis
  - deucravacitinib (Sotyktu) – Targeted Immunomodulatory Biologics (TIBs); an oral tyrosine kinase 2 (TYK2) inhibitor used for systemic treatment of moderate-to-severe plaque psoriasis
  - fingolimod orally dissolving tablets (Tascenso ODT) – Oral Miscellaneous Multiple Sclerosis Agents; new oral disintegrating formulation of fingolimod for patients 10 years of age or older who weigh less than 40 kg
  - oteseconazole (Vivjoa) – Antifungal; for treatment of recurrent vulvovaginal candidiasis (RVVC) in females who are not of reproductive potential
  - ranolazine ER granule (Aspruzyo Sprinkles) – Miscellaneous Cardiovascular Agent; a new sprinkle formulation for treating chronic angina
  - roflumilast 0.3% cream (Zoryve) – Psoriasis Agents; topical phosphodiesterase 4 (PDE-4) for treatment of plaque psoriasis
- Tier 4 (Not covered): The drugs listed below were recommended for Tier 4 status, as they provide little to no additional clinical effectiveness relative to similar agents in their respective drug classes, and the needs of TRICARE beneficiaries are met by available alternative agents. See Appendix H for additional detail regarding Tier 4 agents and formulary alternatives.

- finasteride/tadalafil (Entadfi) – Benign Prostatic Hyperplasia (BPH) Agents; combination product of two drugs already available as in generic formulations, a PDE-5 inhibitor and a 5-alpha reductase inhibitors
    - Entadfi was recommended for Tier 4 placement as it has little to no additional clinical effectiveness relative to similar agents in the class, and the needs of TRICARE beneficiaries are met by available alternative agents. Alternatives include finasteride, dutasteride, and tadalafil tablets.
- olopatadine/mometasone nasal spray (Ryaltris) – Nasal Allergy Agents – Corticosteroids; combination product of two drugs available in generic formulations, a nasal steroids and a nasal antihistamine
    - Ryaltris was recommended for Tier 4 placement as it has little to no additional clinical effectiveness relative to similar agents in the class, the needs of TRICARE beneficiaries are met by available alternative agents, and it contains at least one ingredient that is not covered under the TRICARE benefit (e.g., OTC drug combo product). Alternatives include other legend and OTC treatments formulations for allergic rhinitis: azelastine (Astelin, Astepro), olopatadine (Patanase) flunisolide (Nasarel), fluticasone propionate (Flonase), ipratropium (Atrovent), fluticasone/azelastine (Dymista), budesonide (Rhinocort), triamcinolone (Nasacort), mometasone (Nasonex), beclomethasone (Beconase AQ, QNASL), ciclesonide (Omnaris, Zetonna).

C. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—PA Criteria

The P&T Committee recommended Group 1: 17 for, 0 opposed, 0 abstained, 1 absent; Group 2 for the medical devices Omnipod 5 and FreeStyle Libre 3: 18 for, 0 opposed, 0 abstained, 0 absent; and Group 3: 15 for, 2 opposed, 0 abstained, 1 absent) the following:

- Applying automated and manual PA criteria to new users of Sotyktu. A trial of both Humira and Cosentyx will be required for the treatment of moderate to severe plaque psoriasis.
- Applying manual PA criteria to new users of Tascenso ODT. The PA will require an alternate dosage form of a sphingosine-1 phosphate (S1p) receptor modulator to treat MS to be used first.
- Applying manual PA criteria to new users of Vivjoa for recurrent vulvovaginal candidiasis. Failure of a previous six month course of oral fluconazole is required.

- Applying manual PA criteria to new users of Aspruzyo Sprinkle, Zonisade, Zoryve, and Hyftor, consistent with the existing PA requirements for using alternate dosage forms for readily available generic tablets.
- Applying PA criteria to new users of FreeStyle Libre 3 and Omnipod 5, consistent with what is already in place for the earlier versions of these two medical devices.

The Manual PA criteria is as follows:

1. deucravacitinib tablets (Sotyktu)

Step therapy and manual PA criteria apply to all new users of Sotyktu

Automated PA Criteria: The patient has filled a prescription for adalimumab (Humira) and secukinumab (Cosentyx) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

AND

Manual PA Criteria: If automated criteria are not met, Sotyktu is approved if all criteria are met:

- The provider acknowledges that Humira is the Department of Defense's preferred targeted biologic agent. The patient must have tried Humira and Cosentyx AND:
- The patient had an inadequate response to Humira and Cosentyx OR
- The patient experienced an adverse reaction to Humira and Cosentyx that is not expected to occur with the requested agent OR
- The patient has a contraindication to Humira and Cosentyx
- Patient is 18 years of age or older
- Patient has diagnosis of moderate to severe plaque psoriasis and is a candidate for systemic therapy or phototherapy
- The patient has had an inadequate response to non-biologic systemic therapy. (For example: methotrexate, aminosalicylates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressant's [e.g. azathioprine], etc.)
- Patient has evidence of a negative TB test result in past 12 months (or TB is adequately managed)
- May not be used concomitantly with other TIBs agents
- Provider acknowledges the FDA safety alerts and boxed warnings and precautions associated with Sotyktu

Non-FDA-approved uses are not approved
PA does not expire

2. fingolimod (Tascenso ODT)

Manual PA criteria apply to all new users of Tascenso ODT, and coverage is approved if all criteria are met:

- Patient is ≥ 10 years and weighs ≤ 40 kg
- Patient has a documented diagnosis of a relapsing form of multiple sclerosis (MS)
- Medication is prescribed by a neurologist
- Patient has tried and failed or has a contraindication (i.e. swallowing difficulties) to fingolimod capsule
- Patient is not concurrently using a disease-modifying therapy (e.g., beta interferons [Avonex, Betaseron, Rebif, Plegridy, Extavia], glatiramer [Copaxone, Glaptopa], dimethyl fumarate [Tecfidera], diroximel fumarate [Vumerity], monomethyl fumarate [Bafiertam], cladribine [Mavenclad], teriflunamide [Aubagio])
- Patients of childbearing potential agree to use effective contraception during treatment and for 2 months after stopping therapy
- Patient has not failed a course of another S1p receptor modulator (e.g., Gilenya, Mazyzent, Zeposia, Ponvory)
- Provider acknowledges that all recommended Tascenso ODT monitoring has been completed and the patient will be monitored throughout treatment as recommended in the package insert. Monitoring includes complete blood count (CBC); liver function tests (LFT), varicella zoster virus (VZV) antibody serology, electrocardiogram (ECG), pulmonary function tests (PFTs), blood pressure, skin assessments and macular edema screening as indicated.

Non-FDA approved uses are not approved, including for patients weighing > 40 kg
PA does not expire.

3. oteseconazole (Vivjoa)

Manual PA criteria apply to all new users of Vivjoa and coverage is approved if all criteria are met:

- The prescription is written by a gynecologist
- Patient is post-menopausal OR post-menarchal and not of reproductive potential (i.e. history of tubal ligation, salpingo-oophorectomy, or hysterectomy)

- Patient has a diagnosis of recurrent vulvovaginal candidiasis (RVVC) confirmed by microscopy, nucleic acid amplification testing (NAAT) testing, or culture. RVVC is defined as greater than or equal to four acute episodes of symptomatic vulvovaginal candidiasis within a one year period
- Patient has experienced therapeutic failure, contraindication, or intolerance to a six month maintenance course of oral fluconazole.

Non FDA-approved uses are not approved
PA renewal is not allowed; no refills allowed; each course of therapy requires a new PA

4. ranolazine ER granule (Aspruzyo Sprinkles)

Manual PA criteria apply to all new users of Aspruzyo Sprinkle

Manual PA criteria: Coverage is approved if all criteria are met:

- The patient is 18 years of age or older
- The patient has a diagnosis of chronic angina
- Provider must document why the patient requires Aspruzyo Sprinkle and cannot take ranolazine ER tablets (*write in*)

Non-FDA approved uses are not approved.

PA does not expire

5. roflumilast 0.3% cream (Zoryve)

Manual PA criteria apply to all new users of Zoryve.

Manual PA criteria: Coverage is approved if all criteria are met:

- The patient is 18 years of age or older
- Patient is 12 years of age or older
- The medication is being prescribed by, or in consultation with, a dermatologist
- The patient has a diagnosis of plaque psoriasis
- The patient must have tried for at least 2 weeks and failed, have a contraindication to, or have had an adverse reaction to both of the following:
  - A topical corticosteroid
    - For patients 18 years of age or older: high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) OR

    - For patients 12 to 17 year of age: any topical corticosteroid
  - A topical calcineurin inhibitor (i.e., tacrolimus, pimecrolimus)

Non-FDA approved uses are not approved.
PA does not expire.

6. sirolimus 0.2% gel (Hyftor)

Manual PA criteria apply to all new users of Hyftor and c is approved if all criteria are met:

- Hyftor is prescribed by or in consultation with a dermatologist or other provider experienced in tuberous sclerosis treatment
- Patient has a documented diagnosis of facial angiofibroma associated with Tuberous Sclerosis Complex (TSC)
- Provider acknowledges the recommendation to monitor for hyperlipidemia during treatment

Non-FDA approved uses are not approved.
PA does not expire

7. zonisamide oral suspension (Zonisade)

Manual PA criteria apply to all new users of Zonisade and coverage is approved if all criteria are met:

- Provider acknowledges generic zonisamide capsule are available to TRICARE patients and do not require a PA
- Medication is prescribed by a neurologist
- Patient has diagnosis of partial-onset epilepsy
- Patient requires a liquid formulation due to swallowing difficulty
- Patient has tried and failed or has a contraindication to at least one formulary anti-epileptic drug

Non-FDA approved uses are not approved.
PA does not expire

8. Freestyle Libre 3

Manual PA criteria apply to all new users of Dexcom G6, FreeStyle Libre2, or **FreeStyle Libre 3.**

Patients who have previously received a CGM under the TRICARE medical benefit [e.g., durable medical equipment (DME)] must still fill out the prior authorization criteria below in order to receive these CGMs under the TRICARE pharmacy benefit.

Note: Other CGM systems are not part of the TRICARE pharmacy benefit but may be covered through the TRICARE DME process.

Manual PA criteria: Coverage is approved if all criteria are met:

- The patient has a diagnosis of Type 1 diabetes mellitus OR Type 2 diabetes mellitus
- One of the following situations applies:
    - Patient is using basal and prandial insulin injections; OR
    - Patient is using a continuous subcutaneous insulin infusion (i.e., insulin pump) OR
    - Patient has Type 2 diabetes mellitus and is receiving insulin therapy and has a history of severe hypoglycemia episodes requiring medical intervention
- **CGM** is prescribed by an endocrinologist or diabetes specialist
    - **Diabetes management expert is defined as: licensed independent practitioner experienced in the management of insulin dependent diabetics requiring basal and bolus dosing or a pump and familiar with the operation and reports necessary for proper management of continuous glucose monitoring systems. This is a self-certification.**
- Documentation from the patient record must be submitted with all of the following:
    - Diagnosis
    - Medication history, including use of insulin
    - Completion of a comprehensive diabetes education program for the patient
    - Patient agrees to wear CGM as directed
    - Patient agrees to share device readings with managing healthcare professional for overall diabetes management
- Patient meets the following age requirements
    - Dexcom G6: Patient is 2 years of age or older
    - FreeStyle Libre 2 or **FreeStyle Libre 3**: Patient is 4 years of age or older
- Provider and patient will assess the usage of self-monitoring of blood glucose (SMBG) test strips, with the goal of minimizing/discontinuing use

Initial prior authorization expires in 1 year
PA renewal will be required annually

Renewal criteria: Coverage will be approved on a yearly basis if all of the following apply (Note that initial TRICARE PA approval is required for renewal)

- Confirmation that the patient has seen an endocrinologist or diabetes specialist at least once within the past year
- Confirmation that the patient has utilized CGM daily
- Provider and patient will assess the usage of self-monitoring of blood glucose (SMBG) test strips at every visit, with the goal of minimizing/discontinuing use
- Patients with T2DM continue to require daily basal and prandial insulin injections
- Patient continues to agree to share data with managing healthcare professional for the purposes of clinical decision making

9. Omnipod 5

Note that Omnipod 5 is currently only available at retail pharmacies

Manual PA criteria apply to all new users of Omnipod 5 pods and kits, and coverage is approved if all criteria are met:

Note: Current utilization of Omnipod 3 and 4 is not automatic approval for Omnipod 5. A new PA is required for Omnipod 5

- Omnipod 5 is prescribed by or in consultation with an endocrinologist
- The patient has a documented diagnosis of Type 1 diabetes mellitus
- Patient meets one of the following:
  - The patient is on an insulin regimen of 3 or more injections per day using both basal and prandial insulin and has failed to achieve glycemic control after six months of Multiple Daily Injection (MDI) therapy OR
  - Patient is utilizing another insulin-pump device and is switching to Omnipod 5
- The patient has completed a comprehensive diabetes education program
- The patient has demonstrated willingness and ability to play an active role in diabetes self-management

Initial prior authorization expires after 1 year
Renewal criteria: Note that initial TRICARE PA approval is required for renewal.

Omnipod 5 is approved for 1 year for continuation of therapy if all criteria are met
- Patient has been successful with therapy as shown by increased time in range (TIR), improved A1c, OR

- Patient has experienced decreases in hypoglycemic episodes

D. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—PA Criteria UF, Tier 4, and PA Implementation Period

The P&T Committee recommended (Group 1 and Group 3: 17 for, 0 opposed, 0 abstained, 1 absent; and Group 2 for the medical devices Omnipod 5 and FreeStyle Libre 3: 18 for, 0 opposed, 0 abstained, 0 absent an effective date of the following:

- **New Drugs Recommended for UF or NF Status:** an effective date of the first Wednesday two weeks after signing of the minutes in all points of service.
- **New Drugs Recommended for Tier 4 Status:** 1) An effective date of the first Wednesday 120 days after signing of the minutes in all points of service, and 2) DHA send letters to beneficiaries who are affected by the Tier 4/Not Covered recommendation at 30 days and 60 days prior to implementation.

Addendum to the UF recommendation, PA and implementation period for tadalafil oral suspension (Tadliq) – Pulmonary Arterial Hypertension (PAH) drugs – alternative dosage form of a PDE-5 inhibitor: Tadliq was initially recommended for Tier 4 placement. However, after the DoD P&T Committee meeting was held, specialist feedback supported off-label use to treat children with congenital heart disease who have failed sildenafil therapy. An electronic vote was taken to determine whether Tadliq should be designated as nonformulary, with PA and MN criteria, and an implementation of 2 weeks.

Formulary Status: The P&T Committee recommended (16for, 0 opposed, 0 abstained, 2 absent) nonformulary status for Tadliq.

Manual PA Criteria: **The Committee also recommended (16 for, 0 opposed, 0 abstained, 2 absent) automated and manual PA criteria in new and current users of Tadliq. The PA Criteria is as follows:**

Automated PA Criteria: PA does not apply to patients younger than 18 years of age (age edit) AND if the patient has filled a prescription for sildenafil oral suspension at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 720 days. If automated criteria are not met:

Manual PA Criteria: Tadliq is approved if all criteria are met:

- Tadliq is prescribed by a cardiologist or a pulmonologist

- Patient has documented diagnosis of WHO group 1 pulmonary arterial hypertension (PAH)
  - Patient has had a right heart catheterization (documentation required)
  - Results of the right heart catheterization confirm the diagnosis of WHO group 1 PAH
- Patient is not receiving other PDE-5 inhibitors, nitrates, or riociguat (Adempas) concomitantly
- Patient requires a liquid formulation due to swallowing difficulty AND
- Patient has had an adequate trial and failure OR has had an adverse reaction to sildenafil

Non-FDA-approved uses are not approved, including for erectile dysfunction or for benign prostatic hyperplasia (BPH)

Prior authorization does not expire.

Implementation Plan: **The Committee also recommended (16 for, 0 opposed, 0 abstained, 2 absent) an implementation period of the first Wednesday 2 weeks after signing of the minutes at all points of service.**

VII. NEWLY APPROVED DRUGS PER 32 CFR 199.21(g)(5) AND NEW MEDICAL DEVICES

BAP Comments

A. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—UF/NF/Tier 4 Recommendation

The P&T Committee recommended the formulary status for the newly approved drugs as discussed above.

- UF:
  - FreeStyle Libre 3
  - Omnipod 5
  - Hyftor
  - Zonisade
- NF:
  - Xaciato
  - Sotyktu
  - Tascenso ODT

- Vivjoa
- Aspruzyo Sprinkles
- roflumilast 0.3% cream (Zoryve) – Psoriasis Agents; topical phosphodiesterase 4 (PDE-4) for treatment of plaque psoriasis
- Tadliq

- Tier 4 (Not covered):
  - Entadfi
  - Ryaltris

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—PA Criteria

The P&T Committee recommended the PA criteria for new drugs as stated previously.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

C. Newly Approved Drugs per 32 CFR 199.21(g)(5) and New Medical Devices—UF, PA and Implementation Plan

The P&T Committee recommended the implementation plans as described above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

VIII. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA

P&T Comments

A. New Manual PA Criteria—Glaucoma Agents: Cholinergics/Cholinesterase Inhibitors—echothiophate ophthalmic solution (Phospholine Iodide)

Phospholine Iodide was reviewed as part of the Ophthalmic Glaucoma Agents class review in February 2007 and was designated as UF. At that time, it was considered a third-line treatment for glaucoma with a unique niche in therapy. In May 2021, national supplies of Phospholine Iodide were depleted after the sole manufacturer discontinued production. A new manufacturer has started producing Phospholine Iodide and it is now significantly less cost effective than prior to market withdrawal. MHS provider feedback relayed that this product is rarely used and recommended prior authorization criteria to ensure appropriate use. The P&T Committee recommended manual PA criteria in new users of in order to restrict use to optometrists with a glaucoma specialty, or ophthalmologists.

The PA criteria for echothiophate ophthalmic solution (Phospoholine Iodide) is as follows:

Manual PA criteria apply to all new users of Phospholine Iodide, and coverage is approved if all the following criteria are met:

- The provider acknowledges that most other eye drops for glaucoma are available to TRICARE patients without a prior authorization. Providers are encouraged to consider changing the prescription to a different glaucoma agent if appropriate.
- The prescription is written by an optometrist with a glaucoma specialty or an ophthalmologist

Non-FDA approved uses are not approved
Prior authorization does not expire.

B. New Manual PA Criteria—Glaucoma Agents: Cholinergics/Cholinesterase Inhibitors—echothiophate ophthalmic solution (Phospholine Iodide Implementation Plan

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) that the new PA for Phospholine Iodide, become effective the first Wednesday 60 days after the signing of the minutes

IX. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA

BAP Comments

A. New Manual PA Criteria—Glaucoma Agents: Cholinergics/Cholinesterase Inhibitors—echothiophate ophthalmic solution (Phospholine Iodide)

The P&T Committee recommended manual PA criteria in new users of Phospholine Iodide, as listed above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. New Manual PA Criteria—Glaucoma Agents: Cholinergics/Cholinesterase Inhibitors—echothiophate ophthalmic solution (Phospholine Iodide Implementation Plan

The P&T Committee recommended an effective date of 60 days for Phospholine Iodide, as listed above

BAP Comments

Concur: Non-Concur: Abstain: Absent:

X. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA for NEWLY APPROVED DRUGS NOT SUBJECT TO 32 CFR 199.21(g)(5)

P&T Comments

A. New Manual PA Criteria for Newly Approved Drugs Not Subject to 32 CFR 199.21(g)(5)

Manual PA criteria were recommended for two recently marketed drugs that contain active ingredients that are widely available in low-cost generic formulations. Due to the pathway used to gain FDA approval, these products do not meet the criteria for innovators and cannot be reviewed for formulary status. These drugs all have numerous cost-effective formulary alternatives available that do not require prior authorization. For the products listed below, PA criteria is recommended in new and current users of oxycodone/acetaminophen, and new users of venlafaxine besylate, requiring a trial of cost effective generic formulary medications first.

a) **Narcotic Analgesics and Combinations—oxycodone 2.5-, 5-, 7.5-, and 10 mg/acetaminophen 300 mg tablets and oxycodone 10 mg/acetaminophen 300 mg/5 mL oral solution—**The fixed dose combination of oxycodone/acetaminophen (Percocet, generic) is a narcotic pain reliever, commonly combined with 325 mg of acetaminophen. Numerous cost-effective generic formulations are available along with several other short-acting opioids (e.g., hydrocodone/acetaminophen, codeine/acetaminophen, oxycodone IR, etc.). Alternatives in an oral solution include oxycodone 5 mg/acetaminophen 325 mg/5mL and oxycodone 5 mg/5 mL. The various combinations of oxycodone/acetaminophen 300 mg are not cost effective compared to other available short-acting opioids.

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) manual PA criteria for oxycodone/acetaminophen 300 mg tablets and solution in

new and current users, due to the significant cost differences compared with numerous available alternative agents. The PA criteria is as follows:

Manual PA criteria: Oxycodone/acetaminophen 300 mg tablets and solution are approved if all criteria are met:

- Provider acknowledges other oxycodone/acetaminophen formulations, including oxycodone/acetaminophen 325 mg tablets and solution are available without requiring prior authorization.
- The provider must explain why the patient can't take a different oxycodone/acetaminophen formulation. (*write-in*)

Non-FDA-approved uses are not approved.
Prior authorization does not expire.

b) Antidepressants: Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs):—venlafaxine besylate 112.5 mg tablets—Venlafaxine hydrochloride (HCl) is available in a variety of doses in both capsules and tablets including 37.5 mg and 75 mg dosages which can be taken together to obtain a dose of 112.5 mg. Venlafaxine HCl is more cost-effective than the venlafaxine besylate 112.5 mg formulation made by a sole manufacturer.

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) manual PA criteria apply to all new users of venlafaxine besylate 112.5 mg tablet, due to the significant cost differences compared with numerous available alternative agents The PA criteria is as follows:

Manual PA criteria: Venlafaxine besylate 112.5 mg tablet is approved if all criteria are met:

- Provider acknowledges other formulations of venlafaxine, including venlafaxine hydrochloride are available without requiring prior authorization.
- The provider must explain why the patient can't take a different formulation of venlafaxine. (*write-in)*

Non-FDA-approved uses are not approved.
Prior authorization does not expire.

B. New Manual PA Criteria for Newly Approved Drugs Not Subject to 32 CFR 199.21(g)(5) Implementation Plan

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) the new PAs for oxycodone/acetaminophen 300 mg tablets and solution in new and current users, and venlafaxine besylate 112.5 mg

tablets will become effective the first Wednesday 60 days after the signing of the minutes, and DHA will send letters to patients affected by the new oxycodone/acetaminophen PA.

XI. UTILIZATION MANAGEMENT—NEW MANUAL PA CRITERIA for NEWLY APPROVED DRUGS NOT SUBJECT TO 32 CFR 199.21(g)(5)

BAP Comments

A. New Manual PA Criteria for Newly Approved Drugs Not Subject to 32 CFR 199.21(g)(5)b

The P&T Committee recommended manual PA criteria for oxycodone/acetaminophen 300 mg tablets and solution in new and current users, and venlafaxine besylate 112.5 mg tablets in new users, due to the significant cost differences compared with numerous available alternative agents as stated above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. New Manual PA Criteria for Newly Approved Drugs Not Subject to 32 CFR 199.21(g)(5)b. Implementation Plan

The P&T Committee recommended the new PAs will become effective the first Wednesday 60 days after the signing of the minutes.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XII. UTILIZATION MANAGEMENT—Updated PA Criteria for New FDA-Approved Indications

P&T Comments

A. Updated PA Criteria for New FDA-Approved Indications

The P&T Committee evaluated updates to the PA criteria for several drugs, due to new FDA-approved indications or expanded age ranges. The updated PA criteria outlined below will apply to new users.

a) **Cystic Fibrosis Agents—lumacaftor/ivacaftor oral granules (Orkambi)—** Manual PA criteria were updated to expand the age indication for patients with Cystic Fibrosis as young as 1 year of age. Orkambi was previously indicated for children over the age of 2.

b) **Leukemia and Lymphoma Agents: Bruton Tyrosine Kinase (BTK) Inhibitors Subclass—ibrutinib (Imbruvica)**

   i. **Pediatric chronic graft versus host disease (cGVHD):** Manual PA criteria were updated to include the expanded age indication in pediatric patients age 1 year and older with cGVHD after failure of one or more lines of systemic therapy.

   ii. **Capsules and tablet formulations:** Manual PA criteria were also revised for the Imbruvica tablet formulation, which previously required a trial of Imbruvica capsules first, due to cost-effectiveness (See the May 2018 the DoD P&T Committee meeting minutes). Due to recent pricing changes, the requirement for a trial of Imbruvica capsules prior to using the 420 mg and 560 mg tablets will be removed. Note that a trial of capsules will continue to be required before use of the lower strength Imbruvica tablets (140 mg and 280 mg tablets). The PA updates will apply to new patients.

c) **Luteinizing Hormone-Releasing Hormone (LHRH) Agonists-Antagonists—relugolix/estradiol/norethindrone (Myfembree) and elagolix (Orilissa)—**The manual PA criteria were updated for Myfembree to expand use for treating moderate to severe pain associated with endometriosis. Myfembree when used for this indication will require a trial of nonsteroidal anti-inflammatory drugs (NSAIDs) and hormonal contraceptives first; this is also required for a similar agent already approved for endometriosis, elagolix (Orilissa). Additionally, the PA expiration section of the Orilissa PA was updated to more closely align with the Myfembree PA. Both PAs are now approved for a lifetime expiration of 24 months without a need for renewal, according to the package insert limits for 2 years of therapy.

d) **Oncological Agents: Lung Cancer—crizotinib (Xalkori)—**Manual PA criteria were updated to expand use to adult and pediatric patients 1 year of age and older with unresectable, recurrent, or refractory inflammatory myofibroblastic tumor that is anaplastic lymphoma kinase-positive.

e) **Oncological Agents: 2nd-Generation Antiandrogens—darolutamide (Nubeqa)—**The manual PA criteria were updated to allow use for the treatment of adult patients with metastatic hormone-sensitive prostate cancer in combination with docetaxel. The current step-therapy requirements for the class will still apply; a trial of enzalutamide (Xtandi) is required first unless the patient has a contraindication, inadequate response, or adverse reaction to Xtandi.

f) **Oncological Agents: Acute Myelogenous Leukemia (AML)—ivosidenib (Tibsovo)—**Manual PA criteria were updated to expand use in combination with azacitidine for the treatment of newly diagnosed AML in adults 75 years or

older, or who have comorbidities that preclude use of intensive induction chemotherapy.

g) **Oncological Agents—pemigatinib (Pemazyre)—**The manual PA criteria were updated to include a new indication for the treatment of adults with relapsed or refractory myeloid/lymphoid neoplasms with fibroblast growth factor receptor (FGFR1) rearrangement

h) **Oncological Agents—trametinib (Mekinist)**—The manual PA criteria were updated to expand use for the treatment of adult and pediatric patients 6 years of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options. Note that this indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

i) **Targeted Immunomodulatory Biologics (TIBs): Non-Tumor Necrosis Factor (TNF) Inhibitors —risankizumab On-Body Injector (Skyrizi OBI)**—PA criteria have applied to Skyrizi since August 2019 for the original indication of moderate-to-severe plaque psoriasis in adults who are candidates for phototherapy or systemic therapy. An expanded indication for psoriatic arthritis was reviewed at the February 2022 DoD P&T Committee meeting.

   Skyrizi's package labeling was recently expanded to include adults with moderately to severely active Crohn's disease. The new OBI is solely approved for Crohn's disease, and Skyrizi syringes and pens are only indicated for plaque psoriasis and psoriatic arthritis. In pivotal trials, Skyrizi was only compared to placebo, and practice guidelines do not yet mention Skyrizi's role in therapy for Crohn's disease. Step-therapy applies to the TIB class, requiring a trial of Humira first. In addition, the other Skyrizi indications (plaque psoriasis and psoriatic arthritis) require a trial of Cosentyx and Stelara first. Since Cosentyx is not approved for Crohn's disease, the step therapy will only require a trial of Humira and Stelara when Skyrizi is used for Crohn's disease. The current PA for the pen and syringe formulations of Skyrizi will also be updated to exclude use for Crohn's disease, consistent with package labeling.

j) **TIBs: Non-TNF Inhibitors—ustekinumab (Stelara)—**Manual PA criteria were updated for Stelara for treating active psoriatic arthritis to now include patients 6 to 17 years of age. Although there is currently a step-therapy for Stelara requiring a trial of Humira first, this will not apply to pediatric patients, as Humira is not indicated for active psoriatic arthritis in this patient population. This is similar to the current PA criteria for Stelara for the pediatric plaque psoriasis indication (e.g., a trial of Humira first is not required).

B. Updated Manual PA Criteria and Implementation Plan

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) updates to the manual PA criteria for Orkambi, Imbruvica, Myfembree, Orilissa, Xalkori, Nubeqa, Tibsovo Pemazyre, Mekinist, Skyrizi, and Stelara.in new users. Implementation will be effective the first Wednesday 60 days after signing of the minutes.

XIII. UTILIZATION MANAGEMENT—Updated PA Criteria for New FDA-Approved Indications

BAP Comments

A. Updated PA Criteria for New FDA-Approved Indications

The P&T Committee evaluated updates to the PA criteria for several drugs, due to new FDA as outlined above.

BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

B. Updated Manual PA Criteria for New FDA-Approved Indications Implementation Plan

The P&T Committee recommended an effective date of 60 days after signing of the minutes for the drugs discussed above.

BAP Comments

Concur: ***Non-Concur:*** ***Abstain:*** ***Absent:***

XIV. UTILIZATION MANAGEMENT—Updated PA Criteria for reasons other than New Indications: Androgens-Anabolic Steroids: Testosterone Replacement Therapies- Testosterone Cypionate and Testosterone Enanthate Injection

P&T Comments

A. Updated PA Criteria for Reasons other than New Indications: Androgens-Anabolic Steroids: Testosterone Replacement Therapies- Testosterone Cypionate and Testosterone Enanthate Injection

At the February 2022 DoD P&T Committee meeting, a new PA was placed on injectable versions of testosterone cypionate and testosterone enanthate, allowing use in adult males with hypogonadism and transgender males 16 years of age and older. Implementation of this PA occurred in July 2022. Updated criteria were recommended during the November 2022 P&T Committee as noted below. Additional updates will be considered for all dose forms, including the injectable form, of testosterone during the February 2023 class review.

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) updates to the manual PA criteria for the testosterone replacement therapies in new users. The following PA revisions were recommended:

1. Allow children less than one year of age to bypass the PA via an age edit. This will account for use in micropenis, which is typically treated with three doses of injectable testosterone within the first year of life.
2. Allow for use in males (assigned male at birth) if they are less than 18 years old and the prescription is written by or in consultation with a pediatric endocrinologist.
3. Allow for use in breast cancer in females if the medication is prescribed by an oncologist. Injectable testosterone is FDA-approved for use in breast cancer in females.

The Manual PA criteria is as follows for testosterone cypionate and testosterone enanthate:

Updates from the November 2022 meeting are in bold and strikethrough

PA does not apply to patients less than 1 year of age (age edit)

Manual PA criteria applies to new users of testosterone cypionate or testosterone enanthate IM injections and coverage is approved if all criteria are met:

- Coverage approved for male patients **(patients male at birth)** if:
  - **Patient is younger than 18 years of age if:**
    - **Prescription is written by or in consultation with a pediatric endocrinologist OR**
  - Patient is 18 years of age or older AND
    - Patient has diagnosis of hypogonadism as evidenced by 2 or more morning total testosterone levels below 300 ng/dL AND
    - Provider has investigated the etiology of the low testosterone levels and acknowledges that testosterone therapy is clinically appropriate and needed AND
    - The patient does not have prostate cancer AND
    - The patient is experiencing symptoms usually associated with hypogonadism OR

- Coverage approved for female-to-male gender reassignment (endocrinologic masculinization) if:
  - Patient has diagnosis of gender dysphoria made by a TRICARE-authorized mental health provider according to the most current edition of the DSM
  - Patient is an adult, or is 16 years or older
  - Patient has experienced puberty to at least Tanner stage 2
  - Patient has no signs of breast cancer AND
  - For gender dysphoria biological female patients of childbearing potential, the patient IS NOT pregnant or breastfeeding AND
  - Patient has no psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (e.g. unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment) OR
- **Coverage approved for females if:**
  - **Patient has diagnosis of breast cancer**
  - **Prescription is written by or in consultation with an oncologist**

Non-FDA-approved uses are NOT approved.
Not approved for concomitant use with other testosterone products.
Prior Authorization ~~**does not expire**~~ **expires in 1 year**

<u>Renewal Criteria</u>: Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if one of the following apply:

- **The patient has had a positive response to therapy**
- **The risks of continued therapy do not outweigh the benefits**

B. Updated PA Criteria for Reasons other than New Indications: Androgens-Anabolic Steroids: Testosterone Replacement Therapies- Testosterone Cypionate and Testosterone Enanthate Injection

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent) an effective date of the first Wednesday 60 days after signing of the minutes.

XV. UTILIZATION MANAGEMENT—Updated PA Criteria for reasons other than New Indications: Androgens-Anabolic Steroids: Testosterone Replacement Therapies- Testosterone Cypionate and Testosterone Enanthate Injection

BAP Comments

A. Updated PA Criteria for Reasons other than New Indications: Androgens-Anabolic Steroids: Testosterone Replacement Therapies- Testosterone Cypionate and Testosterone Enanthate Injection

The P&T Committee recommended PA revisions as listed above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

B. Updated PA Criteria for the testosterone replacement therapies in new users and Implementation Plan

The P&T Committee recommended the implementation plan as stated above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XVI. UTILIZATION MANAGEMENT—Updated PA Criteria for Removal of Indication and Implementation Plan

P&T Comments

Over the past several months, the FDA has removed certain indications from several oncology drugs due to safety issues. The P&T Committee recommended updates to the PAs below, based on recent FDA action.

The P&T Committee recommended (16 for, 0 opposed, 0 abstained, 2 absent) to remove the following indications:

a) **Oncologic Agents: Ovarian Cancer—olaparib (Lynparza)—**The indication for the treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy has been removed, due to an increased risk of death. Other Lynparza indications remain for ovarian cancer, breast cancer, pancreatic cancer, and prostate cancer.

b) **Oncologic Agents - Multiple Myeloma—ixazomib (Ninlaro) —**A new limitation of use states that Ninlaro is not recommended for use in the maintenance setting or in newly diagnosed multiple myeloma in combination with lenalidomide and

dexamethasone outside of controlled clinical trials due to an increased risk of death. The indication for use in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy remains.

Implementation will be effective the first Wednesday 60 days after signing of the minutes.

XVII. UTILIZATION MANAGEMENT—Updated PA Criteria for Removal of Indication and Implementation Plan

BAP Comments

The P&T Committee recommended to remove the Lynparza as outlined above. Implementation will be effective the first Wednesday 60 days after signing of the minutes.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XVIII. CHANGE IN COPAY: Tier 1 Copay for Zimhi and Ella and Implementation Period

P&T Comments

A copay change from the current tier 2 copay to the tier 1 copy was recommended for two products, a narcotic antagonist and an emergency contraceptive.

a) **Emergency Contraceptives: ulipristal acetate (Ella)**: Ella is currently available at the Tier 2 copay. Ella was recommended for Tier 1 status to provide a high-value medication at a lower cost to beneficiaries.

b) **Narcotic Antagonists: naloxone injection 5 mg/0.5 mL (Zimhi)**: Zimhi was recommended for Tier 1 status, as it is a high value and cost-effective reversal agent for opioids. Commercial health plans commonly lower naloxone copays, and another new naloxone formulation, Kloxxado, was designated with the tier 1 copay at the November 2021 DoD P&T Committee meeting.

The authority for the above recommendations is codified in 32 CFR 199.21(e)(3) from the Final Rule published June 3, 2020 which states "in implementing this rule, the Committee will not only evaluate drugs for exclusion from coverage, but will also include identifying branded drugs that may be moved to Tier 1 status with a lower copayment for beneficiaries. The intent of identifying agents in this manner as well as the new exclusion authority is to yield improved health, smarter spending, and better patient outcomes."

XIX. CHANGE IN COPAY: Tier 1 Copay for Zimhi and Ella and Implementation Period

BAP Comments

The P&T Committee recommended applying the Tier 1 copay to Zimhi and Ella, with implementation as outlined above.

BAP Comments

Concur: Non-Concur: Abstain: Absent:

XX. RE-EVALUATION OF NF GENERICS: Alzheimer's Agents, 2nd Generation Antihistamines, and Proton Pump Inhibitors

P&T Comments

Background—The DHA Pharmacy Operations Division (POD) Formulary Management Branch (FMB) monitors changes in clinical information, current costs, and utilization trends to determine whether the formulary status of NF drugs that are now available in generic formulations needs to be readdressed. The historical standard for reevaluating generically available Tier 3/NF agents for return to formulary status was established at the May 2007 DoD P&T Committee meeting and reiterated in the DoD P&T Committee meeting minutes from November 2012. To summarize, generic products must be "A-rated" as listed in the Orange Book as therapeutically equivalent to the reference product, available in stable and sufficient supply, and the NF agent must be cost effective relative to similar agents on the Uniform Formulary, defined as a weighted average cost per day (or alternative measure) less than or equal to similar agents in the UF class.

The P&T Committee discussed the above standard and agreed that considerations in addition to relative cost should be taken into consideration when discussing formulary status changes. Additionally, reassessing relative clinical and cost effectiveness of generically available Tier 3/NF agents could result in changes to other formulary management tools, including manual and step prior authorizations. Other considerations may include but are not limited to place in therapy and clinical evidence relative to formulary options; desire for a broader choice of formulary options; administrative burden; volume of use; likelihood of inappropriate use if formulary management tools are removed; and the requirement that Tier 3/NF agents generally be filled only at Mail.

The DoD P&T Committee reviewed current utilization, formulary status, generic availability and relative cost-effectiveness, including the weighted average cost per 30-day equivalent prescriptions for three drugs from the Alzheimer's Agents, 2nd Generation Antihistamines, and Proton Pump Inhibitors (PPIs), when compared to their respective formulary alternatives.

a) ***Alzheimer's Agents (Cholinesterase Inhibitors): donepezil 23 mg (Aricept 23 mg, generics)***—Donepezil 23 mg tabs were compared to formulary alternatives, including galantamine tabs, galantamine 24h ER caps, rivastigmine caps, and rivastigmine transdermal patch. The P&T Committee concluded that, although the weighted average cost per 30-day equivalent prescription for donepezil 23 mg tabs is currently somewhat higher than donepezil 5 or 10 mg tablets or orally dissolving tablets, it is within the range of other

formulary options. In addition, there is currently low utilization use of the 23 mg tab, which is unlikely to substantially increase in volume.

b) ***2nd Generation Antihistamines: levocetirizine (Xyzal, generics); desloratadine (Clarinex, generics)*** —Levocetirizine and desloratadine were compared to formulary alternatives, including cetirizine, loratadine, and fexofenadine (included on the Uniform Formulary as covered OTCs). The P&T Committee concluded that the two generically available desloratadine products (the 5 mg tab and 2.5- and 5-mg rapidly dissolving tabs), as well as levocetirizine 2.5 mg/5 mL oral solution, are still substantially more costly than the formulary alternatives. Generic levocetirizine 5 mg tabs, on the other hand, are now comparable in price to generic fexofenadine 180 mg, which is on the Uniform Formulary. Of particular note in this class is that many products are available in both OTC and legend versions; desloratadine is the only remaining product that is legend-only. The P&T Committee also noted that the cost of generic desloratadine 5 mg tabs is lower at retail network pharmacies than at MTFs or Mail Order. Utilization of desloratadine rapidly dissolving tabs is very low.

c) ***PPIs (Tabs/Caps subclass): lansoprazole (Prevacid, generics)***—The Tier 3/NF agents lansoprazole 15 and 30 mg caps were compared to formulary alternatives, including tab or cap formulations of omeprazole, pantoprazole, rabeprazole, and esomeprazole, all of which are on the UF. Additional formulary tools apply to the Tabs/Caps subclass: a step PA requires a trial of either omeprazole or pantoprazole prior to receiving rabeprazole or esomeprazole, while a manual PA requiring a trial of all UF agents applies to the two Tier 3/NF agents, lansoprazole and omeprazole/sodium bicarb caps. Dexlansoprazole (Dexilant, generics) is Tier 4/not covered.

The P&T Committee noted that while generic lansoprazole capsules are still more costly than omeprazole or pantoprazole, they are less costly than esomeprazole, which is on the UF. In addition, the cost of generic lansoprazole caps is lower at retail network pharmacies than at MTFs or Mail Order.

The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 0 absent) the following, effective the first Wednesday 30 days after the signing of the minutes.

- *Alzheimer's Agents (Cholinesterase Inhibitors):* Return donepezil 23 mg tabs to UF status;

- *2nd Generation Antihistamines: levocetirizine (Xyzal, generics); desloratadine (Clarinex, generics)*
  - Return levocetirizine 5 mg tabs to UF status
  - Maintain levocetirizine 2.5 mg/5 mL solution as Tier 3/NF
  - Maintain all desloratadine products (5 mg tabs, 2.5 and 5 mg rapidly dissolving tabs, and desloratadine/PSE [Clarinex D 12H]) as Tier 3/NF.

- *Proton Pump Inhibitors (Tabs/Caps subclass): lansoprazole (Prevacid, generics)*
    - Return lansoprazole 15 and 30 mg caps to UF status, but place them behind the step in the same status as rabeprazole and esomeprazole
    - Maintain omeprazole/sodium bicarb caps as Tier 3/NF

XXI. RE-EVALUATION OF NF GENERICS AND IMPLEMENTATION PLAN: Alzheimer's Agents, 2nd Generation Antihistamines, And Proton Pump Inhibitors

BAP Comments

The DoD P&T Committee recommended the formulary status of the Alzheimer's drug, antihistamine and PPIs as listed above, with an effective date the first Wednesday 30-days after the signing of the minutes

BAP Comments

Concur: Non-Concur: Abstain: Absent

XXII. TIER 4/NOT COVERED RE-REVIEW: Review of Current Tier 4 Products and Rapid Acting Insulins—Insulin Aspart/Niacinamide (Fiasp)

P&T Comments

If the P&T Committee determines that a pharmaceutical agent provides very little or no clinical effectiveness relative to similar agents, it may recommend complete or partial exclusion of that agent from the TRICARE pharmacy benefits program. Drugs designated as Tier 4/Not Covered status are not available at the MTFs or Mail Order points of service, and beneficiaries are required to pay the full out-of-pocket cost at retail network pharmacies**.**

With respect to the pharmaceutical agents currently designated as Tier 4/Not Covered, the P&T Committee concluded that there is a lack of new clinical data that supports a specific clinical need for these products which is not met by formulary agents. Additionally there is a lack of new clinical data to challenge the conclusion that the current Tier 4/Not Covered drug offer little or no clinical effectiveness relative to formulary agents.

Rapid Acting Insulins: insulin aspart/niacinamide (Fiasp)—The P&T Committee reviewed specific data regarding the July 1, 2020 implementation of Tier 4/Not Covered status for insulin aspart/niacinamide (Fiasp) as well as new clinical evidence published after the November 2019 DoD P&T Committee evaluation of the rapidly-acting insulins.

For insulin aspart/niacinamide (Fiasp), the P&T Committee concluded that:

- Fiasp is a formulation of insulin aspart that contains niacinamide, a form of vitamin B3.
- Although Fiasp has a faster onset of action of approximately 2.5 minutes, the change in pharmacokinetic profile does not show a clinically significant difference in A1C or post-prandial blood glucose compared to insulin aspart (Novolog).
- There is no data to show that Fiasp is superior to other rapid-acting insulins. Pivotal studies demonstrated that Fiasp is non-inferior when compared to Novolog, but did not show superiority.
- New data since 2019 evaluating use of Fiasp in insulin pumps found Fiasp was comparable to insulin aspart (Novolog) in term of efficacy and safety, but failed to demonstrate any significant differences in glycemic control (i.e., time-in-range as measured by continuous glucose monitoring). Limitations of the data include small patient enrollment and short study duration.
- There is no new data to change the previous clinical conclusion that Fiasp provides very little to no clinical effectiveness for treating diabetes relative to formulary rapid acting insulins.

The P&T Committee recommended (17 for, 0 opposed, 0 abstained, 1 absent), to maintain Tier 4/Not Covered status for insulin aspart/niacinamide (Fiasp).

XXIII. TIER 4/NOT COVERED RE-REVIEW: Review of Current Tier 4 Products and Rapid Acting Insulins—Insulin Aspart/Niacinamide (Fiasp)

BAP Comments

The P&T Committee recommended to maintain Tier 4/Not Covered status for insulin aspart/niacinamide (Fiasp) as stated above.

BAP Comments

Concur: Non-Concur: Abstain: Absent: