

**1. Call to order:**

The meeting was called to order at 7:00 a.m.

**2. Review of the minutes:**

The minutes of the June 2018 Meeting and the July and August 2018 Fax Vote Minutes were approved by the Committee.

**3. New Business:**

**Medication reviews**

Drug Class	Drug Name	Formulary Coverage Recommendation
Tyrosine Kinase Inhibitor	Tavalisse (fostamatinib)	May add with a prior authorization and quantity limit
Alpha2-Adrenergic Agonist	Lucemyra (lofexidine)	May add with a prior authorization and quantity limit
Calcitonin Gene-Related Peptide Antagonist	Aimovig (erenumab-aooe)	May add with a prior authorization and quantity limit
Antineoplastic Agent	Yonsa (abiretone)	May add with a prior authorization and quantity limit
Antiseptic Agent	Eskata (hydrogen peroxide)	Do not add
Erythropoiesis Stimulating Agent Biosimilar	Retacrit (epoetin alfa-epbx)	May add with a prior authorization
Colony Stimulating Factor Biosimilar	Fulphila (pegfilgrastim-jmdb)	May add with a prior authorization
Antineoplastic Agent	Kymriah (tisagenlecleucel) <i>*new indication</i>	May add with a prior authorization
Phenylalanine-metabolizing Enzyme	Palynziq (pegvaliase-pqpz)	May add with a prior authorization and quantity limit
Janus Kinase Inhibitor	Olumiant (baricitinib)	May add with a prior authorization and quantity limit
Janus Kinase Inhibitor	Xeljanz (tofacitinib) <i>*new indication</i>	May add with a prior authorization and quantity limit
Antineoplastic Agents	Mekinist and Tafinlar (trametinib and dabrafenib) <i>*new indication</i>	May add with a prior authorization and quantity limit
Tumor Necrosis Factor Blocking Agent	Cimzia (certoliumab Pegol) <i>*new indication</i>	May add with a prior authorization and quantity limit
Antineoplastic Agent	Tibsovo (ivosidenib)	May add with a prior authorization and quantity limit

Drug Class	Drug Name	Formulary Coverage Recommendation
Gonadotropin-releasing Hormone Receptor Antagonist	Orilissa (elagolix)	May add with a prior authorization and quantity limit
Anticonvulsant	Epidiolex (cannabidiol)	May add with a prior authorization
Oral Contraceptive Agent	Balcoltra (levonorgestrel and ethinyl estradiol, and ferrous bisglycinate)	Do not add
Proton Pump Inhibitor	ESOMEPE-EZS Kit (esomeprazole magnesium)	Do not add with a quantity limit
Antihypertensive/ Antiarthritic	Consensi (amlodipine and celecoxib)	Do not add with a quantity limit
Topical Emollient	Atopaderm (ceramides, hyaluronic acid)	Do not add
Anti-pruritic	Kamdoy (lidocaine)	Do not add
Wound Care Agent	Lidotrex (lidocaine, aloe vera, collagen)	Do not add
Topical Emollient	Metopic (urea)	Do not add
Wound Care Agent	Hyclodex (hypochlorous acid)	Do not add
Antipsychotic Agent	Aristada Initio (aripiprazole lauroxil)	May add with a prior authorization and quantity limit
Estrogen Derivative	Imvexxy (estradiol)	Do not add

All voted in favor to approve the recommendations noted above.

#### 4. **New policies**

##### **RX.PA.523 Burosumab-twza (Crysvita)**

- This policy was created to promote appropriate use. Highlights of this policy include specialist prescribing, chart documentation that confirms the member's diagnosis, and no contraindications to this therapy.

All voted in favor to approve the policy as presented.

##### **RX.PA.525 Fostamatinib disodium hexahydrate (Tavalisse)**

- This policy was created to promote appropriate use. Highlights of this policy include specialist prescribing, a diagnosis of chronic immune thrombocytopenia, prerequisite medication trials, and an appropriate platelet level.

All voted in favor to approve the policy as presented.

##### **RX.PA.526 Emicizumab-kxwh (Hemlibra)**

- This policy was created to promote appropriate use. Highlights of this policy include specialist prescribing, an appropriate diagnosis, discontinuing other prophylactic therapies, and ensuring requested dose is within the recommended dosing guidelines.

All voted in favor to approve the policy as presented.

##### **RX.PA.524 Pegvaliase-pqpz (Palynziq)**

- This policy was created to promote appropriate use. Highlights of this policy include specialist prescribing, an appropriate diagnosis, documentation of a baseline phenylalanine level.

All voted in favor to approve the policy as presented.

**RX.PA.529 Baricitinib (Olumiant)**

- This policy was created to promote appropriate use. Highlights of this policy include specialist prescribing, an appropriate diagnosis of moderate to severe severity, adequate trials of preferred agents, and appropriate laboratory values.

*All voted in favor to approve the policy as presented.*

**RX.PA.105 Febuxostat (Uloric)**

- This policy was created to promote appropriate use. Highlights include diagnostic criteria, pre-requisite medication trials and dietary modifications, discontinuation or dose reduction of any medication that could cause hyperuricemia, and an attestation for members with cardiovascular disease.

*All voted in favor to approve the policy as presented.*

**5. Policy revisions****RX.PA.076 Pulmonary Hypertension Agents**

- This policy was updated to remove criteria for treprostinil (Orenitram) that required that the member be currently maintained on an inhaled or parenteral prostacyclin product and have been assessed for switch to oral treprostinil therapy by a pulmonary hypertension specialist.

*All voted in favor to approve the policy as presented.*

**RX.PA.109 Prophylactic Hereditary Angioedema Products - Cinryze and Haegarda**

- This policy was updated to account for FDA-approved expanded age indication for Cinryze. Cinryze is now indicated in children age 6 years and older.

*All voted in favor to approve the policy as presented.*

**RX.PA.135.1 Tocilizumab IV (Actemra)**

- This policy was updated to clarify criteria for a diagnosis of Chimeric Antigen Receptor (CAR) T-cell therapy induced cytokine release syndrome. Members undergoing CAR T-cell therapy are eligible for coverage of tocilizumab IV.

*All voted in favor to approve the policy as presented.*

**RX.PA.145 Sipuleucel-T (Provenge)**

- This policy was updated to remove the requirement for review by a Medical Director prior to approval.

*All voted in favor to approve the policy as presented.*

**RX.PA.039 Erythropoiesis Stimulating Agents**

- This policy was updated to clarify the indication for a reduction for the need for allogeneic red blood cell transfusions in order to be consistent with the prescribing information.

*All voted in favor to approve the policy as presented.*

**RX.PA.514 Buprenorphine injection (Sublocade)**

- This policy was updated so that criteria is consistent with other medications used for the treatment of opioid dependency. Clarification surrounding the requirements for members on concurrent benzodiazepine or central nervous system depressant was added.

*All voted in favor to approve the policy as presented.*

**RX.PA.517 Ibalizumab-uiyk (Trogarzo)**

- This policy was updated to clarify that requirement for adherence to anti-retroviral regimen on reauthorization is only required for members participating in Commercial formularies.

*All voted in favor to approve the policy as presented.*

**RX.PA.283 Narcotics in Children and Adolescents**

- This policy was updated to remove references to the state of Pennsylvania in the criteria requiring review of a Prescription Drug Monitoring Program.

*All voted in favor to approve the policy as presented.*

**RX.PA.283.1 Narcotic Analgesics in Adults**

- This policy was updated to remove references to the state of Pennsylvania in the criteria requiring review of a Prescription Drug Monitoring Program.

*All voted in favor to approve the policy as presented.*

**RX.PA.291 Cough and Cold Medications in Children/Adolescents**

- This policy was updated to remove references to the state of Pennsylvania in the criteria requiring review of a Prescription Drug Monitoring Program.

*All voted in favor to approve the policy as presented.*

**RX.PA.067 Oral and Topical Oncology Agents**

- This policy was updated to include criteria for the appropriate use of Yonsa, Kisqali, Erleada and Xtandi. Highlights of policy include appropriate diagnoses and preferred medication trials for Yonsa and Xtandi.

*All voted in favor to approve the policy as presented.*

**RX.PA.521 Avatrombopag (Doptelet)**

- This policy was created to promote appropriate use. Highlights of this policy include specialist prescribing, appropriate diagnosis, baseline platelet count, procedure date and type, and no contraindications to this therapy.

*All voted in favor to approve the policy as presented.*

**RX.PA.055.1 Abatacept Subcutaneous (Orencia)**

- This policy was updated to include a grandfathering statement for Medicaid members who are stable on therapy based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.068 Intravenous Immune Globulin (IVIG) and Subcutaneous Immune Globulin (SCIG)**

- This policy was updated to add criteria for off-label use for the treatment of Myasthenia Gravis in children.

*All voted in favor to approve the policy as presented.*

**RX.PA.150 Fingolimod (Gilenya)**

- This policy was updated to account for the expanded age indication and added observation criteria for these pediatric patients based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.169 Fidaxomicin (Dificid) Step**

- This policy was updated to remove trial of oral metronidazole based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.180 Ivacaftor (Kalydeco) Lumacaftor-Ivacaftor (Orkambi) and Tezacaftor Ivacaftor (Symdeko)**

- This policy was updated to account for the expanded age indication and include all available dosage forms of each product.

*All voted in favor to approve the policy as presented.*

**RX.PA.193 Tofacitinib (Xeljanz) and Tofacitinib extended-release**

- This policy was updated to include a grandfathering statement for Medicaid members who are stable on therapy based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.258 Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors**

- This policy was updated to updated to reword and condense the diagnostic criteria for HoFH based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.271 Brivaracetam (Briviact)**

- This policy was updated to account for the expanded age indication and include a grandfathering statement for Medicaid members who are stable on therapy based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.272 Ixekizumab (Taltz)**

- This policy was updated to include a grandfathering statement for Medicaid members who are stable on therapy based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.513 Tisagenlecleucel (Kymriah)**

- This policy was updated to account for new FDA-approved indication and remove requirement for CD19 positivity in certain situations. Kymriah is now approved for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy.

*All voted in favor to approve the policy as presented.*

**RX.PA.513.1 Axicabtagene ciloleucel (Yescarta)**

- This policy was updated to updated to remove requirement for CD19 positivity in certain situations and added criteria for no prior CD19 targeted therapy.

*All voted in favor to approve the policy as presented.*

**RX.PA.518 Voretigene neparvovec-rzyl (Luxturna)**

- This policy was updated to clarify specialist prescribing based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.PA.156.1 Repository Corticotropin Injection (H.P. Acthar Gel) – Medicaid, CHIP**

- This policy was created for the Medicaid and CHIP lines of business. Highlights of this policy include chart documentation of inadequate response to IV steroids on 2 separate occasions for every diagnosis except infantile spasms, requirement of clinical rationale for using H.P. Acthar Gel when IV steroids were not effective, and mandatory referral to the UPMC Care Management Program..

*All voted in favor to approve the policy as presented.*

**RX.PA.149 Pegloticase (Krystexxa)**

- This policy was updated to adjust the diagnostic criteria, define the optimal dosing for combination therapy, require pre-requisite medication trials and dietary modifications, discontinuation or dose reduction of any medication that could cause hyperuricemia, and exclude members with G6PD deficiency.

*All voted in favor to approve the policy as presented.*

**RX.PA.270 Lesinurad (Zurampic) and Allopurinol-Lesinurad (Duzallo)**

- This policy was updated to lower the baseline serum uric acid level and define the optimal dosing range for combination therapy.

*All voted in favor to approve the policy as presented.*

**RX.PA.520 Lutetium Lu 177 dotatate (Lutathera)**

- This policy was updated to reword part of the initial authorization criteria based upon recommendations from DHS.

*All voted in favor to approve the policy as presented.*

**RX.005 Quantity Limits**

- This policy was updated to add limits for blood glucose meters, ESOMP-EZS kit, Crysvida, Doptelet, Jynarque, Lokelma, Lutathera, Osmolex, Aimovig, Consensi, Nalocet, Erleada, Olumiant, Palynziq, Symtuza, Aristada; limits were revised for Viread, Cinryze, Makena, Imbruvica, Morphabond tablets, Aristada, Ilumya, Kalydeco, Orkambi, Akynzeo, Nuplazid.

*All voted in favor to approve the policy as presented.*

**RX.001 Formulary Decision Making Process**

- This policy was updated to reflect current formulary decision making process.

*All voted in favor to approve the policy as presented.*

#### **RX.004 Prescription Refill Too Soon Requests**

- This policy was updated to reflect refill too soon processes.  
*All voted in favor to approve the policy as presented.*

#### **RX.007 Therapeutic Drug Utilization Review (DUR)**

- This policy was updated to reflect current DUR process.  
*All voted in favor to approve the policy as presented.*

#### **Definitions:**

- Must add: Drug will be added to the formulary.
- May add: Drug may be added to the formulary or may be non-formulary. Other drugs already on the formulary are considered equally effective from a clinical standpoint.
- Do not add: Drug will be non-formulary.

**NOTE:** All recommendations are subject to DHS approval and final decision determination by UPMC *for You*.

**UPMC HEALTH PLAN**

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