AHCCCS

Pharmacy and Therapeutics Committee Meeting Minutes

April 29, 2019

12:00PM- 5:00 PM

701 E. Jefferson Phoenix, AZ 85034- Gold Room- 3rd Floor

Members Present:

Charles Goldstein
Otto Uhrik
Kelly Flannigan
Raul Romero
Yvonne Johnson
Sandra Brownstein
Dan Lindell
Aida Amado
Loann Nguy
Stephen Borodkin
Shawn McMahon

AHCCCS Staff:

Sara Salek
Suzi Berman
Robin Davis
Susan Junck

Magellan Medicaid Admin:

Hind Douiki
Chris Andrews

Members Absent:

Jose Arindaeng
Robert Marotz

WELCOME AND INTRODUCTIONS: SARA SALEK, M.D., CHIEF MEDICAL OFFICER, AHCCCS

1. Dr. Sara Salek called the meeting to order at 12:05 PM and welcomed committee members, staff and public attendees.
    a. P&T Minutes from July 17, 2018 were reviewed and approved with no changes made.
    b. P&T Operational Policy Update - AHCCCS P&T Operational Policy
    c. Conflict of Interest Statement - Conflict of Interest Disclosure Form

NON-SUPPLEMENTAL REBATE CLASS REVIEW: HIND DOUIKI, PHARM D, MAGELLAN

1. The following Non-Supplemental Drug Classes were reviewed:

a. Antidepressants, Other –

i. Preferred Products
1. Bupropion (Oral)
2. Bupropion SR
3. Bupropion Sr (Oral)
4. Bupropion XL (Oral)
5. Duloxetine (oral) (20mg, 30mg, & 60mg)
6. Mirtazapine ODT (Oral)
7. Mirtazapine Tablet (oral)
8. Trazodone (oral)
9. Venlafaxine (oral)
10. Venlafaxine ER Capsules (oral)

ii. The remaining agents in this class are non-preferred

iii. Grandparenting applies to this class with the exception of Venlafaxine tablets (unless split tablet dosing is required).

iv. The committee voted on the above recommendations
1. All committee members voted in favor of the recommendations
2. No committee members voted against the recommendations.
3. No committee members abstained.

b. Antidepressants, SSRI's –

i. Preferred Products
1. Citalopram Solution (oral)- PA required for under the age of 6 and greater than the age of 12 years.
2. Citalopram Tablet (oral)
3. Escitalopram Tablet (oral)
4. Fluoxetine Capsule (oral)
5. Fluoxetine Solution (oral) - PA required for under the age of 6 and greater than the age of 12 years.
6. Fluvoxamine (oral)
7. Paroxetine Tablet (oral)
8. Sertraline Concentrate (oral)- PA required for under the age of 6 and greater than the age of 12 years.

9. Sertraline Tablet (oral)

ii. The remaining agents in this class are non-preferred
iii. Grandparenting will not apply
iv. The committee voted on the above recommendations
    1. Ten committee members voted in favor of the recommendations
    2. One committee member voted against the recommendations.
    3. No committee members abstained.

c. **Bone Resorption Suppression and Related Agents –**
    i. Preferred Products
        1. Alendronate Solution (oral)
        2. Alendronate Tablets (oral)
        3. Calcitonin Salmon (nasal)
        4. Raloxifene (AG) (oral)
    ii. The remaining agents in this class are non-preferred
    iii. Grandparenting will apply
    iv. The committee voted on the above recommendations
        1. All committee members voted in favor of the recommendations
        2. No members voted against the recommendations.
        3. No committee members abstained.

d. **Bronchodilators, Beta Agonist -**
    i. Preferred Products
        1. Long Acting Inhalers
            a. Serevent (Inhalation)
        2. Nebulized Agents
            a. Albuterol Neb Soln 0.63, 1.25mg (inhalation)
            b. Albuterol Neb Soln 100mg/20ml (inhalation)
            c. Albuterol Neb Soln 2.5mg/0.5ml (inhalation)
            d. Albuterol Neb Soln 2.5mg/3ml (inhalation)
            e. Levalbuterol Neb Soln (inhalation)
        3. Oral Agents
            a. Albuterol Syrup (oral)
        4. Short-Acting Agents
            a. Proair HFA (Inhalation) – Band Only
            b. Proventil HFA (Inhalation)- Brand Only
            c. Ventolin HFA (Inhalation) – Brand Only
    ii. The remaining agents in this class are non-preferred
    iii. Grandparenting will not apply except for Perforomist (inhalation) and Brovana (inhalation)
    iv. The committee voted on the above recommendations.
        1. All committee members voted in favor of the recommendations
        2. No members voted against the recommendations.
        3. No committee members abstained.

e. **Colony Stimulating Factors –**
   i. Preferred Products
      1. Fulphila (subcutaneous)
      2. Neupogen Disp. Syringe (Injection)
      3. Neupogen vial (injection)
      4. Udenyca (subcutaneous)
   ii. Moving to Non-Preferred
      1. Neulasta Kit (injection)
      2. Neulasta Syringe (injection)
   iii. Grandparenting will not apply
   iv. The committee voted on the above recommendations.
      1. All committee members voted in favor of the recommendations
      2. No members voted against the recommendations.
      3. No committee members abstained.

f. **Enzyme Replacement, Gaucher Disease**
   i. Preferred Products
      1. Cerdelga (oral)
      2. Cerezyme 400 units (intravenous)
      3. Elelyso (intravenous)
      4. Miglustat (AG) (oral)
      5. VPRIV 400 units (intravenous)
   ii. Non-preferred products
      1. Miglustat (oral)
      2. Zavesca (oral)
   iii. Grandparenting will not apply
   iv. The committee voted on the above recommendations.
      1. All committee members voted in favor of the recommendations
      2. No members voted against the recommendations.
      3. No committee members abstained

g. Erythropoiesis Stimulating Proteins
   i. Preferred Agent
      1. Retacrit (Injection)
   ii. Moving to Non-Preferred
      1. Aranesp Disp. Syringe (injection)
      2. Aranesp Vial (injection)
      3. Epogen (Injection)
      4. Mircera (injection)
      5. Procrit (injection)
   iii. Grandparenting will not apply
   iv. The committee voted on the above recommendations.
      1. All committee members voted in favor of the recommendations
      2. No members voted against the recommendations.
      3. No committee members abstained.

h. **Hypoglycemics, Alpha-Glucosidase Inhibitors**
   i. Preferred Products
      1. Acarbose (oral)
   ii. Moving to Non-Preferred
      1. Glyset (oral)
      2. Miglitol (oral)
   iii. Grandparenting will not apply
   iv. The committee voted on the above recommendations.
      1. All committee members voted in favor of the recommendations
      2. No members voted against the recommendations.
      3. No committee members abstained.

i. **Hypoglycemics, Metformins –**
   i. Preferred Products
      1. Metformin (oral)
      2. Metformin ER (Glucophage XR) (Oral)
      3. Glyburide-Metformin (Oral)
   ii. The remaining agents in this class are non-preferred
   iii. Grandparenting applies only to Glipizide-Metformin (oral)
   iv. The committee members voted on the above recommendations
      a. All committee members voted in favor of the recommendations
      b. No members voted against the recommendations.
      c. No committee members abstained.

j. Hypoglycemics, SGLT2
   i. Preferred Products
      1. Farxiga (oral)
      2. Invokana (oral)
      3. Jardiance (oral)
   ii. The remaining agents in this class are non-preferred
   iii. Grandparenting will not apply
   iv. The committee members voted on the above recommendations
      a. All committee members voted in favor of the recommendations
      b. No members voted against the recommendations.
      c. No committee members abstained.

k. Immune Globulins
   i. Preferred Products
      1. Bivigam (Intravenous)
      2. Carimune NF Nanofiltered (intravenous)
      3. Flebogamma Dif (Intravenous)
      4. Gamastan S-D vial (Intramuscular)
      5. Gammagard Liquid (Injection)
      6. Gammagard S-D (intravenous)
      7. Gamunex-C (injection)
      8. Hizentra (subcutaneous)

ii. The remaining agents in this class are non-preferred
iii. Grandparenting will not apply
iv. The committee members voted on the above recommendations
    a. All committee members voted in favor of the recommendations
    b. No members voted against the recommendations.
    c. No committee members abstained.

l. Oncology, Oral

i. Preferred Products
    1. Gleevec – Brand Only
    2. Mercaptopurine
ii. Moving to Non-Preferred
    1. Imatinib (oral)
    2. Purixan (oral)
iii. Grandparenting applies to all except Imatinib (oral) and Purixan (oral).
iv. The committee members voted on the above recommendations
    a. All committee members voted in favor of the recommendations
    b. No members voted against the recommendations.
    c. No committee members abstained.

m. Ophthalmics, Anti-Inflammatory/Immunomodulator

i. Preferred Products
    1. Restasis (ophthalmic) – PA required
ii. Moving to Non-Preferred
    1. Cequa (ophthalmic)
    2. Restasis Multidose (ophthalmic)
    3. Xiidra (ophthalmic)
iii. Grandparenting only applies to Xiidra (ophthalmic)
iv. The committee members voted on the above recommendations
    a. All committee members voted in favor of the recommendations
    b. No members voted against the recommendations.
    c. No committee members abstained.

n. Otic Antibiotics

i. Preferred Products
    1. Ciprodex (Otic)
    2. Ciprofloxacin (Otic)
    3. Neomycin/Polymyxin/HC Soln/Susp (otic)
ii. Moving to Non-Preferred
    1. Cipro HC (otic)
    2. Coly-Mycin S (otic)
    3. Ofloxacin (otic)
    4. Otiprio (otic)
    5. Otovel (otic)
iii. Grandparenting: None
iv. The committee members voted on the above recommendations
    a. All committee members voted in favor of the recommendations
    b. No members voted against the recommendations.

c. No committee members abstained.

o. PAH Agents, Oral and Inhaled –PA applies to this class

i. Preferred Products
   1. Adcirca (oral)
   2. Letairis (oral)
   3. Revatio Suspension (oral)- PA required for children greater than 12 years of age. Brand Only.
   4. Sildenafil (oral)
   5. Tracleer Tablet (oral)

ii. The remaining agents in this class are non-preferred.

iii. Grandparenting applies

iv. The committee members voted on the above recommendations
   a. All committee members voted in favor of the recommendations
   b. No members voted against the recommendations.
   c. No committee members abstained.

p. Thrombopoiesis Stimulating Products – PA applies to this class

i. Preferred Products
   1. Nplate (sub-q)
   2. Promacta tablet (oral)

ii. Moving to Non-Preferred
   1. Doptelet (oral)
   2. Mulpleta (oral)
   3. Promacta Suspension (oral)
   4. Tavalisse (oral)

iii. Grandparenting applies to Tavalisse (oral)

iv. The committee members voted on the above recommendations
   a. All committee members voted in favor of the recommendations
   b. No members voted against the recommendations.
   c. No committee members abstained.

Executive Session – Closed to the Public

BUTALBITAL/APAP/CAFFEINE TABLETS AND CAPSULES -

1. A request was submitted to review the cost of Butalbital/APAP/Caffeine tablets vs. capsules. The cost of the capsules was three times the cost of tablets.
2. A Motion was made to remove the capsules from the AHCCCS Drug List and add a quantity limit of 120 per month for Butalbital/APAP/Caffeine tablets.
   a. Committee members voted on the above recommendations
      i. Ten committee members voted in favor of the recommendations
      ii. One committee member voted against the recommendations.
      iii. No committee members abstained.

BIOSIMILAR UPDATE: NONE

The biosimilars for Herceptin and Avastin have been approved, by the FDA; they have not been released into the market. AHCCCS will make the determination if coverage of the biosimilars is less costly than the branded agents. Until that decision is rendered, Contractors shall continue to cover only the branded Herceptin and Avastin.

NEW DRUG REVIEWS: NONE

2019-2020 MEETING DATES

2019 Meeting Dates:

- **May 23, 2019**
- **October 16, 2019**

2020 Meeting Dates

- **January 22, 2020**
- **May 19 & 20, 2020**
- **October 14, 2020**

ADJOURNMENT

The meeting adjourned at 4:01 PM
Minutes recorded by Robin Davis

Suzi Berman RPh May 23, 2019

Suzi Berman, RPh — Date
Director of Pharmacy Services