AHCCCS

Pharmacy and Therapeutics Committee Meeting Minutes

May 23, 2019

9:00 AM- 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
Dan Lindell
Loann Nguy
Stephen Borodkin
Shawn McMahon
Denise Volkov

AHCCCS Staff:

Sara Salek
Suzi Berman
Lauren Prole
Susan Junck

Magellan Medicaid Admin:

Hind Douiki
Chris Andrews

Members Absent:

Robert Marotz
Sandra Brownstein
Aida Amado

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

1. Dr. Sara Salek called the meeting to order at 9:07AM and welcomed committee members, staff and public attendees.
    a. P&T Minutes from April 29, 2019 were reviewed and approved with no changes made.
        i. First: Raul Romero
        ii. Second: Kelly Flannigan
        iii. One abstention- Denise Volkov

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

The following Supplemental Rebate Classes were reviewed:

1. Analgesics, Long Acting Narcotics
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: none

2. Antibiotics Inhaled
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

3. Anticoagulants
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

4. Antimigraine CRGPs
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

5. Antipsychotics Second Generation Oral
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

6. Antipsychotics Long Acting Atypical Injectables
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

7. COPD Agents
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

8. Cytokine and CAM Antagonists
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

9. Epinephrine – Self-Injected
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

10. Glucocorticoids, Inhaled
    a. Clinical review: Hind Douiki, PharmD- Magellan
    b. Public Testimony: None

11. Growth Hormone
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

12. Hepatitis C Agents
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

13. Hypoglycemics, Incretin Mimetics/Enhancers
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

14. Hypoglycemics, Insulin and Related Agents
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

15. Opioid Dependence Treatments
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony:
        i. Will Humble
        ii. Michael Dekker, DO

16. Pancreatic Enzymes
    a. Clinical review: Hind Douiki, PharmD - Magellan
    b. Public Testimony: None

17. Progestational Agents
    a. Clinical review: Hind Douiki, PharmD – Magellan
    b. Public Testimony: None

18. Stimulants and Related Agents
    a. Clinical review: Hind Douiki, PharmD – Magellan
    b. Public Testimony: None

New Drug Reviews: Hind Douiki, Pharm D- Magellan

1. Apadaz: (benzhydrocodone/acetaminophen)
    a. Public Testimony: None

2. Delstrigo: (doravirine/lamivudine/tenofovir disoproxil fumarate)
    a. Public Testimony: None

3. Epidiolex: (cannabidiol)
    a. Public Testimony: None

4. Motegrity: (prucalopride)
    a. Public Testimony: None

5. Pifeltro: (doravine)
    a. Public Testimony: None

6. Xofluza: (baloxavir marboxil)
    a. Public Testimony: None

Executive Session – Closed to the Public

Preferred Drug Recommendation to the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List for the following classes:

1. Analgesics, Long Acting Narcotics
    a. Preferred Products – Prior authorization required for all products.
        i. Butrans- Brand Name Only is Preferred
        ii. Embeda
        iii. Fentanyl transdermal (not including the 37.5mg, 62.5 mg & 87.5 strengths)
        iv. Morphine ER tablet
        v. Tramadol ER (generic Ultram ER)
        vi. Xtampza ER- Brand preferred
    b. Removed from Drug List: No changes
    c. Grandparenting: Yes
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.

iii. No committee members abstained.

2. Antibiotics Inhaled
    a. Preferred Products
        i. Bethkis – Prior authorization required.
        ii. Kitabis Pak – Prior authorization required.
    b. Removed from Drug List: No changes
    c. Grandparenting for Caytson only.
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

3. Anticoagulants
    a. Preferred Products
        i. Oral Agents
            1. Eliquis, Eliquis Dose Pack
            2. Pradaxa
            3. Xarelto, Xarelto Dose Pack
            4. Warfarin
        ii. Injectable Agents
            1. Enoxaparin syringe, enoxaparin syringe (AG)
            2. Enoxaparin vial
    b. Removed from Drug List: No Changes
    c. Grandparenting: Yes
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No Committee members abstained.

4. Antimigraine Agents, Other
    a. Preferred Products-
        i. Aimovig - Prior Authorization Required
        ii. Emgality Syringe – Prior Authorization Required
        iii. Emgality Pen – Prior Authorization Required
        iv. AHCCCS Contractors' & Fee-For-Service PA Criteria may require the prior use of two preventative medications.
    b. Grandparenting: No
    c. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

5. Antipsychotics, Oral Atypical
    a. Preferred Products – Prior authorization requirements listed on the AHCCCS Drug List are to be continued.
        i. Oral Agents
            1. Aripiprazole tablet
            2. Clozapine ODT, clozapine ODT (AG), clozapine tablet
            3. Latuda
            4. Olanzapine ODT, olanzapine tablet
            5. Quetiapine tablet
            6. Risperidone ODT, risperidone solution, risperidone tablet
            7. Ziprasidone capsule
    b. Moving to Non-preferred
        i. Oral agents
            1. Aripiprazole ODT
            2. Aripiprazole solution
            3. Saphris
    c. Grandparenting: Yes
    d. The committee voted on the above recommendations
        i. Nine committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. One committee member abstained.

6. Antipsychotics Long Acting Injectable
    a. Preferred Products - Prior authorization requirements listed on the AHCCCS Drug List are to be continued.
        i. Abilify Maintena
        ii. Aristada
        iii. Aristada Initio
        iv. Invega Sustenna
        v. Invega Trinza
        vi. Risperdal Consta
    b. Removed from Drug List – No Changes
    c. Grandparenting: Not Applicable
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

7. COPD Agents
    a. Preferred Products
        i. Antimuscarinics-Short Acting
            1. Atrovent
            2. Ipratropium nebulizer

ii. Antimuscarinics-Long Acting
    1. Spiriva HandiHaler
    2. Tudorza Pressair
iii. Beta Agonist/Antimuscarinic Combination-Short Acting
    1. Ipratropium/albuterol nebulizer
    2. Combivent Respimat
iv. Beta Agonist/Antimuscarinic Combination-Long Acting
    1. Bevespi Aerosphere – Prior authorization required.
    2. Stiolto Respimat – Prior authorization required.

b. Removed from Drug List: None
c. Grandparenting: Yes
d. The committee voted on the above recommendations
    i. All committee members voted in favor of the recommendations
    ii. No committee members voted against the recommendations.
    iii. No committee members abstained.

8. Cytokine and CAM Antagonists
    a. Preferred Products
        i. Enbrel Kit, Enbrel Syringe, Enbrel Pen, Enbrel Mini Cartridge – Prior Authorization Required
        ii. Humira Kit, Humira Pen Kit – Prior Authorization Required
        iii. Otezla – Prior Authorization Required
        iv. Xeljanz -**Immediate Release Only** - Prior authorization Required
    b. Removed from Drug List: None
    c. Grandparenting: Yes
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

9. Epinephrine – Self-Injected
    a. Preferred Products
        i. Epinephrine 0.15mg (generic EpiPen Jr)
        ii. Epinephrine 0.30mg (generic EpiPen)
        iii. Symjepi (Epinephrine 0.15mg & 0.30mg)
    b. Moving to Non-Preferred
        i. Epinephrine 0.15mg (generic Adrenaclick)(AG)
        ii. Epinephrine 0.30mg (generic Adrenaclick) (AG)
        iii. EpiPen
        iv. EpiPen Jr
    c. Grandparenting: No
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations

ii. No committee members voted against the recommendations.
iii. No committee members abstained.

10. Glucocorticoids, Inhaled
    a. Preferred Products
        i. Single Agent Products
            1. Asmanex
            2. Budesonide 1mg Respules
            3. Flovent HFA
            4. Pulmicort Flexhaler
            5. Pulmicort .25 and .5 mg Respules - **Brand Only Preferred**
        ii. Combination Products
            1. Advair Diskus - **Brand Only Preferred**
            2. Advair HFA – **Brand Only Preferred**
            3. Dulera
            4. Symbicort
    b. Moving to Non-Preferred
        i. Single Agent Products
        ii. Pulmicort 1mg Respules
        iii. QVAR (discontinued)
    c. Grandparenting: **Yes with the exception of Budesonide 0.25mg & 0.50mg, Breo Ellipta & QVAR Redihaler.**
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

11. Growth Hormone
    a. Preferred Products
        i. Genotropin Cartridge – Brand Only
        ii. Genotropin Disp Syringe – Brand Only
        iii. Norditropin Pen – Brand Only
    b. Removed from Drug List- No Changes
    c. Grandparenting: No
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

12. Hepatitis C Agents
    a. Preferred Products

i. Mavyret
ii. Sofosbuvir/Velpatasvir (AG)

b. Removed from Drug List - None
c. Grandparenting: Yes
d. The committee voted on the above recommendations
    i. All committee members voted in favor of the recommendations
    ii. No committee members voted against the recommendations.
    iii. No committee members abstained.

13. Hypoglycemics, Incretin Mimetics/Enhancers
    a. Preferred Products
        i. Amylin Analogues
            1. Symlin Pens
        ii. Dipeptidyl Peptidase-4 Enzyme Inhibitors (DPP-4s)
            1. Glyxambi
            2. Janumet
            3. Janumet XR
            4. Januvia
            5. Jentadueto
            6. Kombiglyze XR
            7. Onglyza
            8. Tradjenta
        iii. Glucagon-Like Peptide-1 Receptor Agonists (GLP 1s)
            1. Bydureon Pens, Bydureon vials (discontinued)
            2. Byetta Pens
            3. Victoza
    b. Removed from Drug List- None
    c. Grandparenting for Trulicity Only.
    d. The committee voted on the above recommendations
        i. Nine committee members voted in favor of the recommendations
        ii. One committee member voted against the recommendations.
        iii. No committee members abstained.

14. Hypoglycemics, Insulin and Related Agents
    a. Preferred Products
        i. Rapid Acting Insulins
            1. Humalog Pens
            2. Humalog Vials
            3. Novolog Cartridge
            4. Novolog Pens
            5. Novolog Vials
        ii. Regular Insulins
            1. Humulin R

2. Humulin 500 Pens
3. Humulin 500 Vials

iii. Intermediate Acting Insulins
1. Humulin N

iv. Long-Acting Insulins
1. Lantus Vial
2. Lantus Solostar Pen
3. Levemir Pen
4. Levemir Vials

v. Rapid/Intermediate-Acting Combination Insulins
1. Humalog Mix Pens
2. Humalog Mix vials
3. Novolog Mix Pens
4. Novolog Mix vials

vi. Regular/Intermediate-Acting Combination Insulins
1. Humulin 70/30 Vials

b. Removed from Drug List: None
c. Grandparenting: Yes
d. The committee voted on the above recommendations
i. All committee members voted in favor of the recommendations
ii. No committee members voted against the recommendations.
iii. No committee member abstained.

15. Opioid Dependence Treatments
a. Preferred Products
i. Buprenorphine/Naloxone Products
1. Buprenorphine/naloxone sublingual tablet- **Generic formulations**
2. Suboxone Film – **Brand Name Only**

ii. Buprenorphine Products
1. Buprenorphine sublingual tablet
2. Prior authorization is not required for pregnant and postpartum women.

iii. Naloxone Products
1. Naloxone syringes
2. Naloxone vials
3. Narcan Nasal Spray

iv. Naltrexone Products
1. Naltrexone tablets
2. Vivitrol

v. Alpha Agonist Products
1. Clonidine tablet

b. Removed from Drug List: None
c. Grandparenting: Yes
d. The committee voted on the above recommendations
i. All committee members voted in favor of the recommendations

ii. No committee members voted against the recommendations.
iii. No committee members abstained.

16. Pancreatic Enzymes
    a. Preferred Products
        i. Creon
        ii. Zenpep
    b. Removed from Drug List: None
    c. Grandparenting: Yes
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

17. Progestational Agents
    a. Preferred Products
        i. Makena Auto Injector- Brand Only
        ii. Makena MDV - Brand Only
        iii. Makena SDV – Brand Only
    b. Moving to Non-Preferred
        i. Hydroxyprogesterone caproate
        ii. Hydroxyprogesterone caproate multi dose vial
        iii. Hydroxyprogesterone caproate multi dose vial (AG)
        iv. Hydroxyprogesterone caproate single dose vial
        v. Hydroxyprogesterone caproate single dose vial (AG)
    c. Grandparenting: Yes
    d. The committee voted on the above recommendations
        i. All committee members voted in favor of the recommendations
        ii. No committee members voted against the recommendations.
        iii. No committee members abstained.

18. Stimulants and Related Agents
    a. Preferred Products
        i. Adderall XR - **Brand Only**
        ii. amphetamine salt combination
        iii. Aptensio XR - **Brand Only**
        iv. atomoxetine, atomoxetine (AG)
        v. clonidine ER
        vi. Concerta – **Brand Only**
        vii. Daytrana - **Brand Only**
        viii. Dexmethylphenidate
        ix. Dexmethylphenidate (AG)

x. Dextroamphetamine tablet
xi. Dyanavel XR - **Brand Only**
xii. Focalin XR – **Brand Only**
xiii. guanfacine ER
xiv. Methylin Solution – **Brand Only**
xv. methylphenidate
xvi. methylphenidate CD, methylphenidate CD (AG)
xvii. methylphenidate ER (generic Ritalin LA)
xviii. Quillichew ER- **Brand Only**
xix. Quillivant XR - **Brand Only**
xx. Ritalin LA 10mg capsule – **Brand Only**
xxi. Vyvanse Capsule – Brand Only
xxii. Vyvanse Chewable Tablet - **Brand Only**

b. Removed from Drug List
   i. Dextroamphetamine Capsules ER
   ii. Focalin
   iii. As a reminder Kapvay is not a federally and state reimbursable drug.
c. Grandparenting: No
d. The committee voted on the above recommendations
   i. All committee members voted in favor of the recommendations
   ii. No committee members voted against the recommendations.
   iii. No committee members abstained.

New Drug Recommendations and Vote

1. Apadaz: (benzhydrocodone/acetaminophen)
   a. Recommendation is Non-Preferred
      i. Nine committee members voted in favor of the recommendation.
      ii. No committee members voted against the recommendation.
      iii. One committee member abstained.

2. Delstrigo: (doravirine/lamivudine/tenofovir disoproxil fumarate)
   a. Recommendation is Non-Preferred.
      i. All committee members voted in favor of the recommendation.
      ii. No committee members voted against the recommendation.
      iii. No committee members abstained.

3. Epidiolex: (cannabidiol)
   a. Recommendation is Non-Preferred.
      i. All committee members voted in favor of the recommendation.
      ii. No committee members voted against the recommendation.

iii. No committee members abstained.

4. Motegrity: (prucalopride)
   a. Recommendation is Non-Preferred
      i. All committee members voted in favor of the recommendation.
      ii. No committee members voted against the recommendation.
      iii. No committee members abstained.

5. Pifeltro: (doravine)
   a. Recommendation is to add Pifeltro to the AHCCCS Drug List.
      i. All committee members voted in favor of the recommendation.
      ii. No committee members voted against the recommendation.
      iii. No committee member abstained.

6. Xofluza: (baloxavir marboxil)
   a. Recommendation is Non-Preferred.
      i. All committee members voted in favor of the recommendation.
      ii. No committee members voted against the recommendation.
      iii. No committee members abstained.

BIOSIMILAR UPDATE: NONE

2019-2020 MEETING DATES

2019 Meeting Dates:

- **October 16, 2019**

2020 Meeting Dates

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

ADJOURNMENT

The meeting adjourned at 4:15 PM.

First: Dr. Goldstein and Second by Dr. Romero. Minutes recorded by Suzi Berman.

Suzanne Berman

Suzi Berman, RPh, Director of Pharmacy Services Date: October 16, 2019