
Dr. Fish: Had several late minute cancellations and some others who are going to be joining us later. But thanks for your patience and good morning everyone. I am Dr. Douglas Fish, the Drug Utilization Review or DUR Board Chairperson and it is my privilege today to call to order the May 12th, 2022 meeting of the DUR Board. I would like to welcome everyone who is participating in today's meeting and thanks to those of you who are in the room and have joined us here in person here in Albany.

Just a few logistical items to get us started. Today's meeting is being webcast over the Internet. The webcast will be archived on the DOH website for at least 30 days. Posting of the archived webcast to the DOH website usually takes place within 2 to 3 business days from the day of the meeting. The archived webcast today will include the audio as well as information that is being displayed on the screen throughout the day.

For those who are actively participating in today's meeting including the DUR Board Members, support staff, public speakers, please keep your microphones or audio device on mute until such time as you're providing comments or have questions, particularly if you are participating remotely to help minimize any of the background noise and feedback. And also remember to turn your mics off after speaking. At this time it is my pleasure to introduce and turn it over to Kim Leonard who will give some introductions, opening remarks, and we will do a roll call within the room. So, Kim.

Kim Leonard: Thank you Doug. Good morning everyone, I appreciate everyone, your continued willingness to serve on the DUR Board and to contribute to this important work, especially on a beautiful May day. I also want to say this time to thank both Nancy Balcom and Jackie Jacobi for their dedicated service to this Board. We are all grateful for the amount of time and effort they gave to the Board and for their dedicated service to New York's Medicaid Health Program and also its beneficiaries.

In addition, I want to welcome our newest Magellan pharmacist Dr. Mina Kwon who, Mina has replaced Eileen Zimmer as our Clinic Account Manager and going forward she will be presenting the Preferred Drug Program Clinical Information part. So welcome.

Mina Kwon: Thank you Kim and good morning everybody.

Kim Leonard: That's all I have. I'm going to turn it over to Tony to lay out today's agenda and the plans for today's meeting.

Tony Merola: Let's just do quick introductions around the table. So Tony Merola, Department of Health.

Kim Lorenzo: Department of Health.

Kim Leonard: Department of Health.

Monica Toohey: Department of Health.

Barbara Rogler: University of Buffalo.

Mina Kwon: Magellan.

Tony Merola: Okay so just a roadmap for today. There's generally three agenda items; the first being the Preferred Drug Program, there's ten therapeutic classes as listed on the agenda for which we have new clinical information for three of those ten. All ten of those will be reviewed in Executive Session later today. Those three agenda items where we have new clinical information that will be presented by Mina are the anti-migraine agents, the acne agents topical, and then the growth hormone. So those are the three clinical presentations that you will see today under that particular agenda item, but like I said, all ten classes will be reviewed in Executive Session. We have one drug utilization review agenda item as we call it, and that's for Esketamine nasal spray or a.k.a. Spravato, and then our pharmacy program update regarding asthma guidelines and the use of the corticosteroids and long active beta agonist combinations for maintenance and reliever therapy. So that's basically our agenda for today.

So, I think we can move right into the public comment period. So at this time the scheduled speakers will present public testimony to the Board. Here is the speaker list in the order that the speakers will present. Public comments are limited to the specific topics on the agenda, must be no longer than 2 minutes. Speakers just keep in mind that your testimonies are then provided to the DUR Board so we just ask that you highlight your public comments as needed to stay within the allotted timeframe. So Dan Flores, John Deason, Corey O'Brien, and Dana Canning will be using the podium up here when your speaker slot is time to present your public testimony. So final instructions for the speakers, we ask you to introduce yourself, noting who you work for or who you're representing today and if you have any financial relations, interest, conflicts of interest pertaining to today's proceedings. At that time, you'll have 2 minutes to complete your comments, your public testimony. Speakers, you don't have to abruptly stop if you go over a little bit but we do ask that you conclude your comments or bring your comments to a conclusion and then if you just wait for a minute to see if there's any questions from the DUR Board members before moving onto the next speaker or the next topic. So with that said, our first speaker is Nirali Patel. She has the first two speaker slots. The first one is atogepant and ubrogepant. So we will start with Nirali. The microphone is yours and after the first presentation, Nirali we can stop to see if there's questions before you move onto the second presentation of the second drug okay.

Nirali Patel: Sounds good. So thank you. Good morning everyone. My name is Nirali Patel I'm a medical outcomes and science liaison with Abbvie. I want to begin today by thanking you for providing me the opportunity to speak regarding atogepant and ubrogepant. Let's start with atogepant which is branded as Qulipta. Migraine is a chronic disease with significant burden. A patient with frequent migraine attacks can experience significant loss of work productivity and have higher total costs direct and indirect costs compared to patients that do not have migraines, requiring a medication such as atogepant. Atogepant is a CGRP human receptor antagonist specifically indicated for the preventative treatment of episodic migraine in adult patients. It comes in 10, 30 and 50 mg doses which do not require any titration, however dosing can be modified based on drug/drug interactions and special population needs. Atogepant has a quick onset of action, just about 1 to 2 hours and has a half-life of 11 hours which makes it suitable for once daily dosing with clearance in about 3 days. Atogepant is the only CGRP agent with no contraindications or warnings or precautions on the label and the most commonly reported adverse events in the phase 3 trial were constipation, nausea and upper respiratory tract infections; none of which were considered serious. The primary endpoint of change from

baseline and free from migraine days across a 12 week treatment period was achieved with all three doses of atogepant when compared against placebo. The benefits of atogepant were seen as early as day 1 after the first dose as fewer patients experienced a migraine day vs. placebo. In addition, all 6 of our secondary endpoints made it into the prescribing information including 3 patient reported outcomes which supports our primary endpoint that with a reduction in migraine days, there is an improvement in function. All three doses of atogepant specifically reduced mean _____ free headache days and mean _____ acute medication use by approximately 50%. Fifty-five at 60% of the patient experienced at least a 50% reduction of migraine days across the 12-week treatment period which is higher than any other CGRP agent that's currently on the market. And then finally at weeks 9-12, 21 to 28% of the patients experienced 100% reduction of migraine days. So these patients were completely migraine free. So that concludes my presentation for atogepant. Does anybody have any questions for me before I go onto ubrogepant?

Tony Merola: Any questions from the DUR Board members? Just remember to unmute your line. Okay hearing none, you may continue.

Nirali Patel: So now moving on to ubrogepant which is branded as Ubrelvy. Poor acute treatment management of migraine patients can lead to almost 3 times higher chances of progression of the disease to chronic migraine. Therefore, it is essential to treat migraine patients with a migraine specific product which is not associated with medication overuse headache such as ubrogepant. Ubrogepant is a CGRP receptor antagonist specifically designed for the acute treatment of migraines. So Abbvie has two separate products; one for the prevention, and one for acute treatment. The dosing options include 50 and 100 mg which can be modified based on drug/drug interactions and special population needs. The drug starts working at 1 ½ hours with a half-life of 5 to 7 hours. Ubrogepant has no warnings or precautions in the prescribing information. It does have one contraindication for patients that are on strong CYP34 inhibitors. And then the most commonly reported adverse event in the phase 3 sturdy were nausea, somnolence and dry mouth. None of these adverse events were considered serious. In the phase 3 study, we evaluated the co-primary efficacy and points of pain freedom and bothersome symptoms freedom at 2 hours post dose compared to placebo which were met by both the 50 and the 100 mg doses. Both doses compared to placebo also met key secondary endpoints such as 2-hour pain relief and 2 to 24 hours pain freedom. The really like thing about ubrogepant is that if patients do not experience pain freedom 2 hours after taking the first dose, they can take another dose anywhere from between 2 to 24 hours. In our study, second dose efficacy pain free rates were significantly higher than placebo having rates of 55% for the 50 mg dose compared to 33% for placebo. At this point, we would like to respectfully request the ubrogepant for the acute treatment of migraine and atogepant for the preventative treatment of migraine be added to the PDL. Thank you every one for your attention and time. And I can take any questions that you may have for me.

Tony Merola: Any questions? Okay hearing none, thank you and the next speaker is Elizabeth Lubelczyk.

Elizabeth Lubelczyk: Good morning and can you hear me okay?

Tony Merola: Yes, loud and clear.

Elizabeth Lubelczyk: Okay good morning my name is Elizabeth Lubelczyk and I'm Evidence Now liaison with Eli Lilly. I will be providing testimony on Galcanezumab brand name Emgality this morning. Emgality is a humanized monoclonal antibody that binds to the CGRP ligand and blocks its binding to the receptor. It is indicated for the preventive treatment of migraine and treatment of episodic cluster headache in adults. Since the clinical trial data for Emgality in the prevention of migraines have been discussed previously, I will focus on new information on Emgality today. In the 9 month open label extension of the Regain Chronic Migraine Study which was open to patients after completing their 3 months double blind placebo controlled portion of the study, a sustained effect of Galcanezumab was demonstrated with reduction in monthly migraine headache days between 8.5 and 9 at months 12. No new safety findings were identified with longer exposure. There was a high level of treatment persistence with 81% of patients completing the study and 5% of patients discontinuing due to adverse effects. The open label extension study of the Conquer Phase 3 B study was designed to evaluate the effects of Galcanezumab for up to 6 total months in patients who had experienced prior failures of 2 to 4 standard of care migraine preventative medication categories. Despite patient history of discontinuing multiple previous treatments, adherence to Galcanezumab in this clinical trial was 94%. Patients treated with Galcanezumab in the double blind period continue to show further mean reduction in monthly migraine headache days in a 3-month open label period demonstrating a durable effect of therapy. A retrospective observation study was conducted comparing real world treatment patterns for patients with migraine who initiated a CGRP monoclonal antibody and specifically Galcanezumab vs. standard of care migraine preventative treatment. In this study, approximately 50% of patients discontinued their standard of care treatment within a month of initiation while less than 20% of patients continued CGRP monoclonal antibody or specific Galcanezumab index treatment. Compared with patients on standard of care, patients on CGRP monoclonal antibody and specifically Galcanezumab had higher treatment adherence persistence and were less likely to discontinue their treatment over 6 to 12 months of follow up. Complete safety information can be found in the prescribing information for Emgality. That wraps up my testimony and I'd be happy to take any questions.

Tony Merola: Any questions for Elizabeth? Hearing none, next speaker in Dan Flores.

Daniel Flores: So very happy to again be able to address the Board in person and virtually for the folks out there. My name is Dan Flores, I'm a pharmacist and MSL Health Outcomes liaison with Amgen Global Scientific Affairs to provide a clinical update on Aimovig Erenumab and advocate for greater choice in migraine preventions. Key clinical updates published in 2021 referenced in my testimony template. Erenumab studies at 24-week double blind head-to-head study of Erenumab vs. oral Topiramate for prevention of migraine and treatment in adults, tolerability and persistence were superior for Erenumab with 11% of patients in the Erenumab group discontinuing therapy compared to 39% of Topiramate patients discontinuing. Efficacy was superior with a reduction of 50% or more in mean monthly migraine days seen in 55% of the Erenumab group compared to just 31% for Topiramate. Improvements in assessed quality of life were also seen - the only published study directly comparing an anti-CGRP to a prophylactic standard of care. Also references is a retrospective IQ via real world cohort analysis that looked at Aimovig's impact on the use of acute migraine meds among 64,000 US adults receiving Aimovig. Acute migraine med use was assessed 6 months prior to and 6 months after initiation of Aimovig finding that 48% of patients discontinued one of those acute migraine meds. 36% of previous Triptan users discontinued and importantly 32% of opioid users and 32% of Butalbital users also discontinued those meds. In my previous testimonies,

I've reviewed attributes that are unique to Aimovig, unique mechanism of action, dosing flexibility, clinical data, but what additional evidence exists to differentiate it, as a former P&T decision-maker myself what sticks out the most is that Aimovig non-preferred for 3 years now still accounts for 30% of the use in this category. That indicates to me that these agents are not 100% interchangeable. Patients have to fail multiple oral meds, fail injectable preventatives one or two of those, make multiple visits to a limited number of specialists, and these are all costs to the New York Medicaid system. For these reasons, and the unmet need demonstrated, I respectfully request the Board consider addition of Aimovig to the New York PDL. Thank you for your time. If there are any questions.

Tony Merola: Any questions for Dan? Hearing none, thanks. Next speaker Charles Argoff.

Charles Argoff: Thank you very much for the opportunity. I am a neurologist by training, I'm a Professor at Albany Medical College, I direct our Comprehensive Pain Center, I also am Director of ACGME Accredited Pain Fellowship, and I have multiple disclosures. I am happy to furnish you with a list. I have developed clinical trials. I speak on behalf of certain treatments and I have done advisory boards and consultant in both pain management as well as headache. I've also been the co-author of multiple nation and/or international guidelines for headache and facial pains particularly trigeminal neuralgia and other chronic pain conditions. With this I want to make a couple of very important points, and some of them have been made already. Migraine disease affects more than 40 million people and you have our testimonies and you have my written testimony, it's among the top 10 medical conditions associated with the years lived with disability. But, really is amazing and it was just expressed by Dr. Flores' last comment is that there's been an explosion of scientific discovery in migraine that has led to new treatments that, as you hear, there is data that are better than older treatments. And that leads to the importance of access to people. So there are new medications to prevent migraine headaches. New medications, some of them you've heard about already to abort migraine headaches and new nonmedical approaches. There is no one on this board today talking about devices but they are another way of helping people. And so, I urge you to incorporate the principles of evidence-based medicine into New York State's approach to drug utilization. Evidence-based medicine as originally defined by David Sackett and what it is and what it isn't was published as an article in the British Medical Journal 1996 is the conscientious explicit and judicious views of current best evidence in making decisions about the care of individual patients. That is the most important thing that we have as clinicians to help someone and to prevent costs increasing in New York State Medicaid is having the opportunity to choose the best treatment for the person in front of us and that means having wide range of choices. Evidence-based medicine is not just looking up a randomized controlled study and saying, "Well there's no comparatives so they must all be the same" which is how I believe that some of the decisions has been made in the past. It's not just merely reviewing study results. Public health policy therefore must reflect the needs of an individual person. All established therapies need to be available for consideration to optimize the likelihood of successful outcome. Limiting the number of treatments on formulary in this case for migraine disease will not meet the needs of the people who different and it won't control costs in the long run. If all established treatments are not available, the principle of evidence-based medicine will not be met and people will suffer. Thank you for the opportunity to speak with you today.

Tony Merola: Any questions for Charles? Okay thank you very much Charles. Next speaker, Nicholas Saikali.

Nicholas Saikali: Yes, hi good morning everyone. Thank you for having me on. I appreciate it and I am a neurologist and Board Certified in neurology, headache medicine, as well as neuro imaging at Dent Neurological Institute, a private neurology group but we do academic as well. I'm the Director of the Headache Fellowship as well here and as Dr. Argoff said, I also have many disclosures, I'd be happy to provide the list but I do speak and I'm a consultant on advisory boards for multiple products on the market, especially in the migraine world. So, I want to piggyback a little bit on Dr. Argoff and he made a great point about how, and also previous that have been on, about how important and how disabling unfortunately migraines have given 40 million Americans a disability that is disabling. I am also a migraine sufferer as well as every member of my family and I'm sure many of you on the line have either dealt with or had known someone who deals with a migraine headache, although it doesn't cause morbidity but it does cause disability. And so many people do go to work and it is present that they're at work suffering with a migraine and that's costing healthcare I think much more. So with that said, I would like to mention that I've been blessed enough to be practicing for about 12 years now and over the past 4 to 5 years there's been a lot of new therapies out there for migraines which is very promising and many more coming into research. These have not only just show how efficacious these medications are on preventing and aborting migraine headache, which by the way, every single patient should be on the abortive or acute treatment and not everyone needs prevention but it is an option that they need. And the patient preference is my opinion of who needs preventative. But they are efficacious and they have amazing tolerability with no drug/drug interactions. These are CGRP medications that we've been talking about. So I'm glad to be on this to discuss this and how they have different mechanisms of action to each one of them. So not one size fits all really. So we do need choices as providers but more so patients need choices and options. And these have altered the quality of life and decrease has been seen in emergency room visits, as well as urgent care visits. So, I urge you to please, I'll finish up with one example. I have one of a very prominent Buffalonian and patient of mine who is also one of my good friends who was started on one of these monoclonal antibody medications and it has altered his life. And he has been on multiple others in the past and seen multiple specialists even multiple headache centers around the world and was finally found a medication and was able to get it but after 1 year, he was told that he had to switch to another one due to formularity. And unfortunately, he's been on two of the others over the past year because that was what was advised by the insurance company on the formulary and none have worked on him. He is back to having disability and not functioning who is again, very prominent person in Buffalo and gives a lot back to the community. So, I'm urging you, and he still has not been able to get back to the first one that he's tried and worked extremely well, almost was migraine free. Went from 10 to 12 migraines a month down to 1 or 2 and so I urge to please give these options. I think we're all on the line to help these patients and help not only our patients but also our family members. But I appreciate you taking the time. Thank you for listening and best of luck. God bless you. Any questions?

Tony Merola: Any questions for Nicholas? Okay hearing none we can move onto the next speaker, Paul Isikwe.

Paul Isikwe: Can you all hear me?

Tony Merola: Loud and clear.

Paul Isikwe: Good morning everyone my name is Paul Isikwe; I'm part of the Value Evidence and Outcome Seen with Teva's US Medical Affairs Group. I'm here today to provide information about Ajovy often known as Fremanezumab. Ajovy is indicated for the preventative treatment of migraines in adult patients. I want to first begin by stating that Ajovy is enhanced CGRP but as previously mentioned by Dent Institute, all CGRPs are not the same. Ajovy does have a different mechanism of action, a different dosing profile and a different safety profile. Ajovy is a full humanized IG2 monoclonal antibody that binds to the CGRP ligand and blocks it from binding to the CGRP receptor. Ajovy is the only long acting self administered subcutaneous anti CGRP with the option of either a monthly or quarterly dosing allowing it to be dosed as few as four times per year either with the auto injector or with the refill syringe. Ajovy quarterly is now available also in a triple pack combination. Ajovy may be administered by your healthcare provider, patient and/or its caregiver. Throughout the clinical trials the most common adverse reaction were injection site reactions across 24 clinical studies. An Ajovy clinical trial development program more than 4,000 patients with migraines have been exposed to Ajovy. Since post marketing there has been no new additional safety signals seen across the _____ population. Since market approval Ajovy data from 2 additional studies have been available the focus in a long-term extension study. I will now explain why Ajovy's patient experience during the clinical trial would focus specifically on the difficult to treat migraine patients who suffered from co-morbidities including acute headache medication overuse, along with depression. In the Halo long-term study reductions in migraines were stable for both regimens of each 3 month period suggesting that there was no wearing off of Ajovy in this patient population. Also, in the Halo long-term study, Ajovy treatment resulted in long-term reductions in monthly days of use of any acute headache medication. No in the focus study Ajovy was examined more in 800 migraine patients who had previous experienced inadequate responses to 2 to 4 classes of preventative medication. Patients in this particular study did experience a statistically significant reduction in the monthly average number of migraine days for both monthly and the quarterly doses. Now, jumping into evaluating in a real world experience with Ajovy, in pharmacy claims analysis found that the total annual claims for acute medications, specifically opioids and triptans as well as portions of patient's filling other claims for these medications, that also reduced significantly for that patient population. The safety and efficacy for Fremanezumab is currently in a phase 4 clinical trials being studied in the preventative treatment of migraines in patients who have major depressive disorder, migraine and sleep and also migraine in children or adolescence. The data I shared with you today demonstrates why the drug should remain on the preferred drug list for the State of New York so patient's can have access to this treatment. That brings me to the conclusion for this particular product. If there's any questions from the committee I can take it at the moment.

Tony Merola: Any questions for Paul on Antimigraine before we move into Movement Disorder Agents? Okay Paul we can make the transition.

Paul Isikwe: Okay so the next product that I will be speaking about will be Austedo. Austedo is the only FDA approved therapy for the treatment of Tardive dyskinesia along with chorea associated with Huntington Disease. It is an orphan drug designation specifically for Huntington's Disease. Austedo is the first FDA approved therapy using the deuterated technology. Deuterium such as substitution results in a different jaded pharmacokinetic profile allowing for lower dosing, less frequent administration and also reduces fluctuations in plasma and drug concentrations vs. tetrabenazine. There is a box warning that exists for the use of Austedo but this is specifically in patients who suffer from Huntington's Disease. The warning is

not associated with patients who are diagnosed with Tardive dyskinesia. In December 2020 Austedo's labeling was updated to reflect the following, the maximum recommended dose for Austedo does not prolong the QT interval to any clinically relevant extent. Labeling also no longer requires the assessment of the QTC interval before and after increasing the dose of Austedo to greater than 24 mg in patients who are at risk for QT prolongation or in patients using other drugs known the prolonged QTC. Please refer to the prescribing information for additional information specifically about the complete safety profile. Now in TD patients the most common adverse reactions were nasopharyngitis along with insomnia. In patient's with HD the most common adverse reactions were somnolence, diarrhea, dry, mouth and fatigue. Austedo does provide flexible dosing for patients with 6 mg, 9 mg and 12 mg oral tablets. In an analysis based on world-wide data, the mean daily dose of Austedo was determined to be around 25.6 mg along with 28.5 mg in TD patients and HD patients respectively. The efficacy for Austedo was established in a 3 week randomized double blinded placebo controlled multi center trial that was conducted in 500 patients. The safety and efficacy of Austedo is currently being investigated in dyskinesia and cerebral palsy in children and adolescence currently in phase 3 RCT. I ask the members of the therapeutics community to consider the data that I have presented and shared with you today for Austedo specifically for your TD and HD patients so they can have access to it in the great State of New York. That brings me to the conclusion for Austedo, specifically within the Movement Disorder category. Any questions at this time I can take them.

Tony Merola: Any questions for Paul?

Female: I have a question if it's okay.

Tony Merola: Sure, who is this?

Jadwiga Najib: This is Jadwiga Najib.

Tony Merola: Hi Jadwiga.

Jadwiga Najib: Just a quick question. You had mentioned that the box warning it says for the use of Austedo and there was actually a box warning that you mentioned so is it the increased risk of depression and suicidal thoughts in Huntington's Disease? Because it's not specific. You mentioned in Tardive dyskinesia but there's another label from actually this month May 2022 which your reference has the reference from 2020 as the PDF package insert. So I just want to have that clarification because at the bottom it says that Austedo was also contraindicated in patients who are suicidal and patients with untreated or inadequately treated depression. So are you referring to the suicidality or the QT interval as the warning that you mentioned?

Paul Isikwe: I'm referring specifically to the QTC interval of the one that you mentioned, I believe that's still in the package but specifically for the QTC that one was removed.

Jadwiga Najib: Okay thank you.

Tony Merola: Thank for the question Jadwiga any other questions for Paul? Hearing none John Deason.

John Deason: Alright can you hear me okay? So I appreciate the opportunity today, as you mentioned, my name is John Deason. I am a managed care liaison with Neurocrine Biosciences and appreciate the opportunity to address the Board today. Specifically around Ingrezza or generic Valbenazine capsules indicated for the treatments of adults with Tardive dyskinesia or TD. TD is an often persistent as well as disruptive condition. It's associated with prolonged use of dopamine or septer blocking agents; that includes antipsychotic as well as antiemetic agents. I just have one quick clinical update for the Board, I just wanted to make you aware that recommendations from a recent systematic review include BMET 2 inhibitors as first line treatment for Tardive dyskinesia or TD. And in addition the 2020 APA schizophrenia guidelines also recommend BMET 2 inhibitors for the treatment of TD. We respectfully request that you allow patients and providers access to Ingrezza by adding it as a preferred agent to the State's PDL for the treatment of Tardive dyskinesia in adults. With that I'll give the rest of my time back to the Board, but just again I appreciate the opportunity and happy to answer any questions that anyone in the room or anybody online may have.

Tony Merola: Thanks John. Any questions for John? Hearing none, thank you next speaker would be Matthew Shapiro.

Matthew Shapiro: Thank you, good morning. My name is Matthew Shapiro I'm the Director of Public Affairs for the National Alliance on Mental Illness- New York State. I have no financial or anything to disclose any conflict of interest. But I am here, I'm very grateful for the opportunity to speak for people living with a mental illness who do suffer from chronic diseases and use medication which sometimes leads to movement disorders; Tardive dyskinesia specifically which has been discussed by the past few speakers. New York State does not recommend specific medications but we do believe in person-centered care and a big element of person centered care being that a patient has a full range of therapies available to them to treat their individual needs and individual set of symptoms. So, we know right now in the movement disorder it is limited. While we don't recommend specific medications we do want to expand it so all therapies can be included that are currently treating Tardive dyskinesia and get preferred status. So, you have my written testimony. I thank you for your time and this opportunity to represent people living with a mental illness.

Tony Merola: Thank you Matt. Any questions for Matt? Okay we are now back to Elizabeth Lubelczyk.

Elizabeth Lubelczyk: Okay. So good morning my name is Elizabeth Lubelczyk and again, I'm an evidence outcomes liaison with Eli Lilly. Now I'll be providing testimony of dulaglutide or Trulicity. Trulicity is a GLP-1 receptor Agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with Type 2 diabetes and is also indicated to reduce the risks of major adverse cardiovascular events in adults with Type 2 diabetes who have established cardiovascular disease or multiple cardiovascular risk factors. Trulicity is a once weekly subcutaneous injection delivered via a single dose pen that has a hidden attached self-retracting needle and requires no reconstitution or mixing. The initial dose is .75 mg once weekly. The dose can be increased if needed for additional glycemic control to 1.5 mg, 3 mg and then up to 4.5 mg with four weeks on each dose. I will focus the remainder of my comments on two recent publications. The first – looking at a post hoc analysis of a ward 11 which is the dose escalation study comparing dulaglutide 1.5 mg to 3 mg and 4.5 mg. This

analysis evaluated the change in baseline hemoglobin A1C in four subgroups by hemoglobin A1C level - less than 8%, 8 to 9%, 9 to 10%, and greater than or equal to 10%. Mean reductions in hemoglobin A1C were observed across all baseline hemoglobin A1C subgroups at 36 weeks. More patients randomized to 3 or 4.5 mg achieved a hemoglobin A1C less than 7 at 36 weeks regardless of baseline hemoglobin A1C. the largest hemoglobin A1C reductions were observed for those at highest baseline hemoglobin A1C regardless of dulaglutide dose. In the additional hemoglobin A1C lowering achieved with escalation to 3 or 4.5 mg was greater with higher baseline A1C levels. A recently published Real World Evidence study demonstrated that patients initiating Trulicity were significantly more adherent, more persistent on therapy, and had more mean days of persistence over 6 and 12 months compared to Semaglutide. Trulicity has a proven safety intolerability profile that is similar to the class. For full safety details please see the prescribing information. thank you again for the opportunity to address the Board and I'd be happy to entertain any questions.

Tony Merola: Any questions for Elizabeth? Okay hearing none, next speaker is Corey O'Brien.

Corey O'Brien: Good morning, my name is Corey O'Brien I'm a pharmacist and medical account associate director at NovoNordisk. And today I will be sharing some clinical information regarding Semaglutide or brand name Ozempic. Ozempic is a GLP-1 receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with Type 2 diabetes and to reduce the risk of major cardiovascular events in adults with Type 2 diabetes and establish cardiovascular disease. The efficacy and safety of Ozempic was previously established in a sustain program. In sustain 6 Ozempic presented reduction in major adverse cardiovascular events and in sustain 7 Ozempic demonstrated greater reductions in HBA1C and weight relative to Trulicity. On March 28th, the FDA announced approval of Ozempic 2.0 mg once weekly subcutaneous injection. Approval was based on the results from the Sustain Forte trial which compared Ozempic 2.0 vs. 1.0 as add-on therapy in patients who needed a treatment intensification. Results showed a superior reduction in HBA1C with Ozempic 2.0 vs. 1.0. Moreover nearly 68% of patients treated with Ozempic 2.0 achieved an HBA1C less than 7, which is recommended by the ADA guidelines. Lastly, patients treated with Ozempic 2.0 experienced roughly 14 pounds of weight loss and side effects were similar between the two doses. So in conclusion, New York State has an estimated 1.6 million adults with a diagnosis of diabetes – with many of these patients requiring treatment intensification to achieve HBA1C goals. In the Sustain Clinical Program, Ozempic has previously demonstrated a reduction in major adverse cardiovascular events and greater glycemic control and weight reduction vs. active comparators. Moreover the FDA approval of Ozempic 2.0 offers an additional dose to achieve weight loss and glycemic control in patients in need of treatment intensification. For that reason, I would kindly ask the Board for your consideration to add Ozempic as a preferred agent to your drug list. Thank you for your time.

Tony Merola: Thank Corey, any questions for Corey? Seeing or hearing none, thank you. Next speaker Dana Canning.

Dana Canning: Good morning. My name is Dana Canning and I am health outcomes liaison with GSK. I would like to thank you for the opportunity to present Trelegy Ellipta for consideration of adding Trelegy to the New York State Medicaid Preferred Drug list. Trelegy Ellipta contains an ICS a LAMA and a LABA and is the only once daily single inhaler triple therapy combination product, FDA approved for COPD and for asthma in patients aged 18

years and older. I understand that clinical and safety information was provided for your review. Therefore, I'd like to use this time to highlight some key clinical aspects of Trelegy in COPD. Trelegy is supported by robust clinical trials and real world evidence data. In the landmark impact study, Trelegy met the primary endpoints by significantly reducing the annual rate of moderate and severe exacerbations compared with BREQ by 15% and compared with Anoro by 25%. The most common adverse effects with Trelegy are upper respiratory tract infection, pneumonia, and bronchitis. Two recently published real world evidence studies for Trelegy included adherence and persistence to once daily Trelegy Ellipta vs. multiple inhaler triple therapy among patients with COPD. Results showed patients who initiated therapy with Trelegy had significantly higher adherence at both 6 and 12 months and were 91% more likely to be persistent on therapy than patients who initiated on multiple inhaler triple therapy. The second published real world study benefit of prompt vs. delayed use of Trelegy Ellipta following a COPD exacerbation, showed patients who initiated Trelegy within 30 days after their first COPD related exacerbation had a 21% lower annual rate for overall exacerbations vs. those who initiated Trelegy between 31 and 180 days after their first exacerbation. Thank you for your time this morning to present Trelegy Ellipta and are there any questions?

Tony Merola: Any questions for Dana? Seeing and hearing none, thank you very much. And our last speaker today would be Nicole Trask.

Nicole Trask: Good morning everyone. My name is Nicole Trask and I'm a pharmacist with Janssen Scientific Affairs. I appreciate the time to provide testimony on Spravato nasal spray. Spravato is indicated for two critically distinct patient populations; the first being treatment for resistant depression or TRD in adults in combination with an oral antidepressant, and also depressive symptoms in adults with Major Depressive Disorder with acute suicidal ideation or behavior. The clinical development program included the ongoing phase 3 extension study Sustain Three which demonstrated the long-term safety tolerability and efficacy of Spravato in combination with an oral antidepressant in patients with TRD. The median treatment duration was 2.6 years and 35.6% of patients achieved remission at the time of induction while 46.1% achieved remission at the maintenance endpoint. With continued follow up, improvements in depressive symptoms were sustained and there were no new safety signals. In terms of site of care, the FDA label does not restrict treatment to a specific healthcare setting. We know that patients at immanent risk proven at numerous sites of care inpatient and outpatient settings alike. Consensus guidelines including the ADA's guideline on MDD and _____ suicide initiative recommend the least restrictive settings for treatment that will address the patient's safety and promote improvement in their condition. As the decision to hospitalize is complex, it is recommended that the decision be made between the patient and their healthcare provider. And lastly, the _____ program requires that Spravato be dispensed by a REM certified pharmacy to a REM certified healthcare setting and administered under the direct supervision of the HCP the patient is enrolled in the REM registry. I want to highlight that no patient will ever possess this drug outside the direct supervision of the HCP. And with that, I thank you for your time today and would open it up for questions.

Tony Merola: Any questions for Nicole? Okay hearing none, thank you Nicole and that concludes the public comment period. I would just like to take all the speakers that took time out of their day to participate with us here and Doug I think we can move on.

Dr. Fish: Great and thank you to all the speakers and thank you Tony. Also just want to give Dr. Ignacio who has joined us a chance to introduce himself and welcome.

Dr. Renante Ignacio: Thanks sorry, I was kind of delayed with traffic here.

Dr. Fish: Very good. Also just want to announce that no DUR Board members have recused themselves for any conflicts of interest today. And so with that, we can move forward. And Tony I'll just let you introduce the next part of the program.

Tony Merola: Yes, so just referring to the agenda, I think we'll just make one tweak. I think the first part of the reviews being done today was Preferred Drug Program but it might be better that we leave those until a little later and then move into Executive Session so they're kind of piggybacked to one another. So with that I think we'll start with Spravato presentation which is under the drug utilization review part of the agenda, part B if you will. So I think we'll move into that and doing that presentation is Irene Reilly. So Irene can we do an audio check.

Irene Reilly: Sure, can you hear me?

Tony Merola: Yes, loud and clear thank you. So we are pulling up your slides right now so just give it a minute. There is just a slight delay. Irene can you see the slides now?

Irene Reilly: Yep.

Tony Merola: Okay so I will turn it over to you.

Irene Reilly: Thank you so much. So the purpose of the presentation is to cover our review of Esketamine nasal spray also known as Sparavato. The aim is to provide recommendations to the Board for the management of Esketamine in the New York State Medicaid program. Before I get into the presentation I would like to note that the report and the presentation were co-authored by me and Dr. Barbara Rogler.

Esketamine is an N methyl D aspartate receptor antagonist. It is also the S in enantiomer of Ketamine. Ketamine is a racemic mixture. Esketamine was approved in March of 2019 in conjunction with an oral antidepressant for the treatment of adults with treatment resistant depression and end depressive symptoms associated with acute suicidal ideation or behavior in adults with Major Depressive Disorder. As we heard from the earlier speaker, it's marketed as Spravato by Janssen Pharmaceuticals. This drug is marketed under the trade name Spravato and the effective of Esketamine although its been approved for treatment of adults with Major Depressive Disorder and Acute Suicidal Ideation or Behavior, it is notable that the effectiveness of Esketamine in preventing suicide or reducing suicidal ideation or behavior has not been demonstrated. Also, the use of Esketamine does not preclude the need for hospitalization if clinically warranted. Additionally, Esketamine is not approved as an anesthetic agent like its risky counterpart Ketamine. As we heard earlier, Esketamine is approved for two indications; for patients with treatment resistant depression. In terms of the recommended dosing there's two phases of treatment, an induction phase and maintenance phase. Induction is the first four weeks and the recommended dose is 56 mg administered intranasally followed by 56 mgs or 84 mg twice per week. And in the maintenance phase which is weeks 5 and onward, for the first four weeks or 5 to 8, dose of 56 or 84 mg would be continued at a lower frequency so once

weekly as opposed to twice per week and then for weeks 9 and beyond, either the patient could continue at the same dose or reduce the dosing frequency to once every 2 weeks. For Major Depressive Disorder with Acute Suicidal Ideation or Behavior, the recommended dose is 84 mg intranasally twice per week for 4 weeks and the dose can be reduced to 56 mg twice per week based on how the patient is tolerating the drug. Notably the use of Esketamine in conjunction with an oral antidepressant for more than 4 weeks has not been systematically evaluated for this indication.

So, in terms of how Esketamine is supplied, it's supplied as a nasal spray device which contains a total of 28 mg and each device delivers two sprays. So the patient would administer one spray per nostril for a total dose of 28 mg. The drug should be stored at room temperature. Notably the drug is a schedule 3 controlled substance and thus must be handled with adequate security, accountability, and proper disposal. In terms of the administration, Esketamine must be administered under the direct supervision of a healthcare provider and a treatment session involves administration followed by observation of the patient in a healthcare setting. So the patient will his or herself administer the drug one spray per nostril but under the observation of a healthcare provider. So, as mentioned the two sprays would deliver a total dose of 28 mg so the patient must wait 5 minutes after that dose is administered so the drug can be absorbed before administering another two sprays for a total dose of 56 mg or repeat the process and administer a third time to achieve a dose of 84 mgs. Once the total dose has been administered the patient must be monitored for at least 2 hours by a healthcare provider. Prior to the first dose, a baseline blood pressure must be measured and then repeated 40 minutes after administration. Before the patient receives the drug, the healthcare provider must instruct the patient not to engage in potentially hazardous activities as the drug is known to cause sedation and dissociation. Patients should not eat for 2 hours or drink 30 minutes prior to administration of the drug, and if they are using another nasal medication such as a corticosteroid or decongestant, it is recommended to separate administration and to consider administering the other agent the corticosteroid or decongestant as an example, as least 1 hour prior to Esketamine.

Because of the risk of abuse and misuse, and serious adverse outcomes resulting from sedation and dissociation, Esketamine is only available through a restricted program under risk evaluation and mitigation strategy known as Spravato REMS. The program requires inpatient and outpatient healthcare settings and pharmacies not associated with an inpatient healthcare setting to be certified. Pharmacies operating under the same drug enforcement as the administration license and located within the inpatient healthcare setting are considered certified under the inpatient healthcare setting. If a patient is to receive Esketamine in an outpatient medical office or clinic, then the patient must also be involved in Spravato REMS, and the product must never be dispensed directly to a patient for home use.

For a diagnostic and statistic manual of mental disorders, Fifth Edition or the DSM-V describe Major Depressive Disorder as a disorder characterized by discrete episodes at least 2 weeks in duration that involve changes in affect, cognition, and neurovegetative functions and remissions between episodes. Major Depressive Disorder is a prevalent condition affecting individuals of all ages. The Substance Abuse and Mental Health Service Administration or SAMHSA has published data from their 2020 national survey on drug use and health which indicated that about 8.4% of adult or individuals aged 18 years or older had a Major Depressive episode. The disease course of Major Depressive Disorder is variable – with some individual rarely

experiencing remission defined as a period of at least 2 months with no symptoms or only 1 or 2 mild symptoms, and other experiencing lengthy periods of remission between episodes for complete symptom resolution. Lower recovery rates have been observed among individuals with more severe symptoms, persistent symptoms and those with symptoms of psychosis, prominent anxiety or personality disorders.

Notably suicidal behavior can occur at all times during major depressive episodes. And per the DSM-V thoughts of death, suicidal ideation or suicide attempts are common among individuals with Major Depressive Disorder. Some risk factors for suicide include a history of suicide attempts or threats, male sex, living alone, and presence of prominent feelings of hopelessness.

Unfortunately, remission is not achieved among all individuals with Major Depressive Disorder. Those who do not achieve remission may suffer from Treatment-Resistant Depression. There is no consensus definition for Treatment-Resistant Depression at this time. The most widely accepted definition appears to be *failure to achieve remission after two trials of a medication of adequate dose and duration*. Notably there are differences among sources and the recommended treatment options for Treatment-Resistant Depression, doses and durations and determinates of treatment adequacy. Also, although Treatment-Resistant Depression is commonly associated with Major Depressive Disorder, this phenomenon may be observed in patients with other depressive disorders such as the depressed phase of Bipolar Disorder. Some clinical risk factors for the development of Treatment-Resistant Depression have been identified and are listed on this slide. They include: symptom severity of the current episode. Frequent and recurrent depressive episodes. Long duration of illness. Bipolar features. Current psychosocial stressors and comorbidities, and failed psychotherapy tries, failed electroconvulsive therapy, and greater number of hospitalization.

Several guidelines have been published on the management of adults with Major Depressive Disorder. However few focus on the management of Treatment-Resistant Depression and few still address the use of Esketamine likely due to the recency of its approval. Esketamine was approved in March of 2019. As an example, SAMHSA includes information about Esketamine in its treatment and prevent Protocol 42. This tip was focused on the treatment of substance use disorder in patients with comorbidities. So, in this publication, SAMHSA states that Esketamine was FDA approved in 2019 for Treatment-Resistant Depression however, the organization does not make recommendations regarding use of Esketamine in this publication.

Two recently published guidelines focus on Treatment-Resistant Depression as summarized on this slide; one is a guideline offered by a Canadian expert group and the other was written by the Polish National consultant. Starting with the Canadian guidelines, the objective of this publication was to determine a standard definition, model and assessment of Treatment-Resistant Depression. What they found from a review of the literature was that there was agreement on a requirement for two treatment failures to constitute treatment resistant depression. However there was a lack of agreement on the definition of adequate dose or duration and outcome measures. They noted that failure was usually defined as a less than 50% reduction in symptom severity and the duration of trials ranged from 4 to 12 weeks. Also, there were varying opinions on the effectiveness of switching from one antidepressant to another and using agents in the same or different classes.

So, in contrast the Polish guideline sought to determine strategies for management of Treatment-Resistant Depression and outlined five different strategies that are listed on the bottom right side of this slide. So the first is to optimize the dose and duration of the antidepressant therapy. Second is to change the antidepressant to one of a different class. Third is to consider using combination therapy with antidepressants of different mechanisms of action. The fourth strategy is to augment therapy with mood stabilizers, specifically Lithium, thyroid hormones, atypical antipsychotics, essential nervous system stimulus or Esketamine. And then the fifth strategy that was outlined was to consider nonpharmacologic therapies. Although Esketamine was mentioned in the consideration for augmentation therapy, there was no elaboration on its role.

So in terms of treatment of Major Depressive Disorder in general, there are several guidelines that have been published and some examples include those that are listed on this slide, so the Canadian guideline or specifically the guideline from the Canadian Network for Mood and Anxiety Treatments published in 2016. Also published that year was a guideline from the American College of Physicians. The British Association for Psychopharmacology guidelines published in 2015, and then the World Federation of Societies of Biological Psychiatry which was a 2-part guideline; the first part addressing acute treatment of Unipolar Depression was published in 2013 and the second part addressing maintenance therapy of Major Depressive Disorder was published in 2015.

So, all of these guidelines have recommendations on initial therapy for Major Depressive Disorder, considerations for switching therapy and then combination therapy. Some similarities are listed at the bottom of this slide - so, all of the guidelines seem to coincide in their recommendations on considering switching therapy in patient's with poor tolerance or lack of response to initial recurrent therapy. They also recommend considering combination therapy in patients with lack of response to initial or current therapy as long as the patient does not have tolerability issues. And then in terms of the choices of augmentation therapy, there were some similarities as well. So first and second line agents generally included the second generation antipsychotics quetiapine, Aripiprazole, Olanzapine, Lithium, triiodothyronine or T3 thyroid hormone and Mirazapine a tetracyclic antidepressant.

Not all of the organizations that were listed on the last slide have recommendations addressing patients with inadequate response or resistant depression; for example, the American College of Physicians did not address this issue in their guideline. In those that do, the recommendations differ. For example, the Canadian guidelines suggest longer evaluation periods and less emphasis on symptom reduction and more emphasis on improvement and functioning and quality of life. The British Association for Psychopharmacology recommends considering multiple combinations concurrently. The World Federation of Societies for Biological Psychiatry recommends considering longer term maintenance therapy with longer term being defined as 3 or more years. And then also the same organization recommends considering maximizing antidepressant doses, or switching antidepressants or combining antidepressants from different classes, augmenting therapy or combining antidepressants with nonpharmacologic therapy for these patients.

The efficacy of Esketamine has been evaluated in multiple studies to date. There were four phase 2 and four phase 3 efficacy studies submitted to the Food and Drug Administration or the FDA in the new drug application. Two of the phase 3 trials were considered sufficiently

supportive of the efficacy of Esketamine for Treatment-Resistant Depression. These studies were named TRANSFORM-2 and SUSTAIN-1. I'll go into more detail about these two studies in the next slide.

Treatment Resistant Depression was defined in these trials as lack of clinically meaningful improvement after treatment with at least 2 different antidepressant drugs prescribing adequate doses for adequate durations during the current depressive episode. And all of the subjects in these studies were randomized to receive Esketamine or placebo in addition to a newly initiated oral antidepressant which was one of the following: Duloxetine, Escitalopram, Sertraline, or extended release Venlafaxine.

So this slide shows selected characteristics of the two pivotal trials for Treatment-Resistant Depression, TRANSFORM-2 and SUSTAIN-1. So the design of these studies were slightly different. they were both randomized double blind, multi center, placebo controlled trials. However TRANSFORM-2 involved a 4-week treatment phase of patients with a 24 week follow up. These patients were adults aged 18 to 64 years with Treatment-Resistant Depression and there were 324 that were evaluated in this study. They were randomized to receive Esketamine at a dose of 56 mg or 84 mg twice weekly or placebo and the primary endpoint was change from baseline in the Montgomery-Asberg Depression Rating Scale or MADRS total score at week 4. And just to note, because MADRS was used for a number of these studies, MADRS is a scale that's frequently used to measure symptoms of clinical depression and in clinical trials and there are 10 items in this scale. Nine of these items are based on patient report and one is based on the rater's observation of the patient during the interview, with each item rated on a scale of 0 to 6 for a total possible score ranging from 0 to 60. And the higher scores are indicative of more severe symptoms. so that being said, in terms of results for the primary endpoint for TRANSFORM-2 the least square mean change from placebo at week 4 was a reduction in 4 points or a difference of 4 points on the MADRS total score, and this difference was found to be statistically significant. For SUSTAIN-1, so the objective of this study was different from that of TRANSFORM-2. They were again looking at efficacy of Esketamine but specifically for delaying relapse of depressive symptoms in patients who had achieved stable remission or were considered stable responders so who had already received 16 weeks of Esketamine treatment; so, 4 weeks of induction and then 12 additional weeks of optimization. So, this was considered to be a withdrawal study and it was events driven. There were 705 adults in this trial again, ages 18 to 64 years. They were continued on Esketamine at the dose that they previously received in the optimization phase or placebo. And the primary endpoint for SUSTAIN-1 was time to relapse as measured by the hazard ratio. So what they were looking for was relapse rates and what they found was in the patients who were considered stable remitters, so those who had achieved stable remission prior to initiation of this study, risk of relapse was reduced by 51% in these patients. Whereas in stable responders, the risk of relapse was reduced by 70% and both of these results were found to be statistically significant.

So with regard to the other indications, so use of Esketamine for depressive symptoms in patients with Major Depressive Disorder and Acute Suicidal Ideation or Behavior, there were two phase 3 trials that have been published. Some of the characteristics of these trials are presented in this slide. So the two trials are ASPIRE I and ASPIRE II and they were identical design. So these were randomized double blind, multi center, placebo controlled studies involving a 4-week treatment phase and then 9-week follow up period. It includes patients who were adults aged 18-64 years with Major Depressive Disorder based on DSM-V criteria and

active Suicidal Ideation with Intent and the need for psychiatric hospitalization. There were 226 adults in ASPIRE I and 230 in ASPIRE II. I would like to comment that the patients in ASPIRE I and ASPIRE II were initially hospitalized in a psychiatric unit, unlike the patients in the other trials and they were on either oral antidepressant monotherapy or combination therapy with another antidepressant, atypical antipsychotic or mood stabilizer in addition to Esketamine or placebo. So they were receiving comprehensive standard care treatment and they were initially hospitalized for 5 days.

The primary endpoint for both ASPIRE I and ASPIRE II was changing MADRS total score from baseline to 24 hours after the first dose was administered and both studies had significant findings so the _____ mean change from placebo at 24 hours in ASPIRE I was about 3.8 points difference and then in ASPIRE II the difference was 3.9 points.

So in the phase 3 trials involving patients with Treatment-Resistant Depression; significant improvements in the MADRS scores were observed with Esketamine from baseline to 4 weeks and the FDA noted that the changes in scores were comparable to those observed with other FDA-approved antidepressants.

In phase 3 trials involving patients with Major Depressive Disorder and Acute Suicidal Ideation or Behavior, significant reductions in MADRS scores were observed from baseline to 24 hours after the first dose and they remained low through the follow up period.

Since its approval, additional trials have been conducted on Esketamine and multiple meta-analysis have been published. Among these a recent and comprehensive study was conducted by Vasquez and colleagues. This was a random-effects meta-analysis. And their objective was to determine the relative efficacy and tolerability of different therapies used in combination with antidepressants. The therapies that they investigated included Aripiprazole, Brexpiprazole, Cariprazine, Olanzapine, Risperdal, clonidine and Ziprasidone as second generation antipsychotics, Lithium and Esketamine. They identified and included short-term randomized placebo controlled trials that were evaluated in these drugs in combination with an antidepressant for treatment of unipolar major depressive episodes in adults. So short-term was defined as a duration of 12 weeks or less. And the investigators used a random-effects model to pool the effect sizes and calculate odds ratios with 95% competent _____. Summarized response rates for these different therapies. In addition, they calculated numbers needed to treat to express clinical efficacy of the individual drugs.

A total of 49 trials were included in this meta-analysis or which involved more than one drug arm. They identified 28 trials that involved second-generation antipsychotics, 14 trials that involved Lithium and 7 trials involving Esketamine. And trials of Esketamine were all 4-weeks in duration and all of the studies were considered short-term, no more than 12 weeks. So the Lithium trials ranged from about 2 to 5 weeks and antipsychotic trials ranged from about 6 ½ to 8 weeks. What they found in terms of the efficacy was that Esketamine was of intermediate efficacy. So, response rates were between those observed with the second-generation antipsychotics and with Lithium. So Lithium was considered to have the highest efficacy with an odds ratio of 2.22. Number-needed-to-treat estimates did not differ significantly among the individual drugs and classes.

So, in terms of coverage of Esketamine in the New York State Medicaid fee-for-service program, effective May 12th, so today, Esketamine is no longer available just as a medical benefit, it can be billed by REM certified specialty pharmacy. A survey was conducted of the New York State Medicaid Managed Care Organizations regarding coverage of Esketamine, 15 of the managed care organizations responded and what was found was the majority of them or 14 of them have established clinical criteria for Esketamine. In terms of coverage by comparative state Medicaid programs we looked at those of California, Colorado, Florida, Massachusetts, Michigan, Pennsylvania and Texas -so seven programs in total. Of them, 5 had established clinical criteria for Esketamine. And in terms of our Drug Utilization Review, we conducted a retrospective analysis of pharmacy medical claims for Esketamine for the timeframe of January 1st, 2020 through December 31st of this last year and identified a total of 81 unique members in the overall population fee-for-service and managed care who received Esketamine nasal spray with a total of 1,047 claims during this timeframe.

So based on the available guidelines and the literature that we reviewed, we at the University of Buffalo recommend the following: So we recommend requiring prior authorization for Esketamine nasal spray requests to confirm FDA approved and Compendia-supported uses. To require provides a test that before initiating Esketamine intranasal therapy that they obtained a baseline score on a clinical assessment tool such as the 17-item Hamilton Rating Scale for Depression, 16-item Quick Inventory of Depressive Symptomatology, or 10-item Montgomery-Asberg Depression Rating Scale. To establish clinical criteria to require the use of at least 2 oral antidepressants for an adequate duration and at an adequate dose with or without adjunctive therapy before initiating Esketamine. And to establish clinical criteria to require the concomitant use of an oral antidepressant with Esketamine nasal spray.

We also recommend some renewal criteria. So, we recommend that the criteria consist of utilizing the same clinical assessment tool that was used at the baseline and the provider attesting that Esketamine has resulted in an improvement in depressive symptoms for a patient. And the provider attesting to monitoring for signs of potential drug abuse or misuse.

That concludes my presentation. I will take any questions at this time.

Dr. Fish: Thank you Irene that was excellent. Who has questions for Dr. Reilly?

Female: Thank you Irene for this presentation. Very well done thank you and I think Esketamine is a great agent to have in this Treatment-Resistant Depression scenario especially with high suicidality. One of the questions I do have regarding with events program, they do say to monitor for 3 hours. And I just wanted to find out if that was through basically because the hypertensive effects of this medication can last up to 4 hours and yes, you are right it does initially go up 40 minutes after a dose but is it also due to the dissociative effects and if you have any data on that?

Irene Reilly: Yes, I believe its not just due to the effects on blood pressure but also the concerns for sedation and dissociation and serious adverse outcomes associated with that, that the patient should be observed and also the reason for having the REMS program in the first place.

Female: Okay thank you.

Donna Chiefari: This is Donna; I have a question if I may. The PA criteria that you have the third bullet actually says, at least 2 oral antidepressants and I'm just curious as to why it wouldn't be 2 different classes of antidepressants? I thought that's what some of the guidance was suggesting.

Irene Reilly: So, the reason that we didn't specify that these agents had to be from different pharmacological classes is because that was not consistently found among the guideline recommendations. So, some recommendations were just try 2 different antidepressants potentially from the same class, so to be less restrictive we just decided to omit the language and just recommend for 2 oral antidepressants.

Donna Chiefari: Understood, thank you.

Dr. Fish: Other questions for Irene? Okay hearing none then I think do we have a motion?

Tony Merola: To discuss and vote on the DOH recommendations to the DUR Board.

Lisa Anzisi: Lisa Anzisi makes a motion.

Dr. Fish: And do we have a second?

Male: Second.

Dr. Fish: Okay thank you very good. Okay Georgia can we open up the DOH recommendation slides for this particular topic and we will walk through them. So we're just doing a little audio change here. It was a little loud here in the room but I think that's better.

Male: We're all vibrating, tingling or something.

Tony Merola: So I'm hoping, let me reach out to Donna Chiefari because we just heard her voice. Donna can you still hear us pretty well?

Donna Chiefari: Yeah, I can hear you fine.

Tony Merola: Okay so it was just inside the room that we were hearing it awful loud I think is the way to say it. Okay thanks, we appreciate that John. So what we'll do is we'll go through the recommendations themselves take it through the entire, only 3 or 4 slides here and then we'll backtrack to do any discussion and vote from there. So we'll take it through once and then backtrack to the top okay Doug?

Dr. Fish: Sounds good.

Tony Merola: Alright, Georgia can you move the next slide? So this is more or less a point of clarification in terms of some information that actually Irene presented. I think it was on slide 16 with regards to activating this drug under the pharmacy benefit. So, this is just a point of clarification that Prospective Claims Editing or we call it ProDUR will be used to confirm FDA-approved or compendia-supported uses on Treatment Resistant Depression in adults and

depressive symptoms in adults with Major Depressive Disorder with acute suicidal ideation or behavior. And also within the context of confirming that there's a concurrent use with an oral antidepressant. So again, point of clarification based upon some information that Irene had presented and I believe it was slide 16 regarding pharmacy coverage.

So the next couple of slides are actually recommendations to the Board. These are modeled after the recommendations from SUNY that Irene just presented. So recommendation 1: Before initiating Esketamine nasal spray, prescribers must attest that they have obtained a baseline score using a validated clinical assessment tool for depression. And there are some examples of the clinical assessment tools again, from the presentation that Irene did. So that's the first recommendation. Again, we'll walk through then all and then we'll backtrack.

The second recommendation: Trial of at least two oral antidepressants prior to Esketamine nasal spray.

And I think there is one more, recommendation 3: after the initiation of Esketamine nasal spray therapy, every six months prescribers must attest that Spravato has resulted in improvement of depressive symptoms from the baseline using the same baseline clinical assessment tool for depression. And I believe those are the three recommendations.

So I think we can go back to the top Doug and then start from there. And we can discuss them and then vote on them.

Dr. Fish: We are doing the voting by consensus as we've done before. But we will now open up the first recommendation for discussion by the DUR members. So, do you want to review it again Tony?

Tony Merola: Oh yeah sure, we just turned on some audio that we shouldn't have I guess. Before initiating Esketamine nasal spray (Spravato), prescribers must attest that they have obtained a baseline score using a validated clinical assessment tool for depression.

Dr. Fish: Thank you so this recommendation is now open for discussion.

Gloria Rodriguez: Gloria Rodriguez with a question, clarification are we going to require a specific HAMD score or MADRS score as a threshold or this is just sort of baseline documentation and monitoring?

Monica Toohey: Just baseline documentation and monitoring.

Gloria Rodriguez: So you're not asking for confirmation of the diagnosis of MDD based on one of these scores? It's just for kind of continuing to monitor the score going forward?

Monica Toohey: Through the clinical editing that we do, we will look for Major Depressive Disorder and we'll look for concurrent therapy because that's part of the FDA labeling but in addition to that, that will happen and then this will have to be validated.

Dr. Fish: Dr. Rodriguez that's Monica Toohey who is speaking.

Gloria Rodriguez: Sorry what was that?

Dr. Fish: That's Monica Toohey who is addressing your question.

Gloria Rodriguez: Thank you.

Guthrie Maseo: I have another question here Guthrie Maseo. With regards to the assessment tools are we limiting ourselves to those three assessment tools named in the slide. Because with the geriatric population there is more tools that we use not of these three here.

Irene Reilly: Yeah, these are just examples; some of the ones I guess were more prevalent in the studies. It's pretty much anything that's out there.

Dr. Fish: Other comments or questions? Okay hearing none, I think we are reading to proceed to the vote. Do we have any abstentions? Remember to unmute your mics. Any opposed? Okay so this recommendation passes. There's no abstentions or objections.

Tony Merola: Doug we probably should clarify the total number of members on the voting just to make that point of clarification to record the vote.

Dr. Fish: So the total was 13.

Tony Merola: Okay so can we just state that as such?

Dr. Fish: So we have 13 who are approving of the DOH recommendation 1. Next recommendation #2.

Tony Merola: Okay recommendation #2: Trial of at least two oral antidepressants prior to Esketamine nasal spray.

Gloria Rodriguez: So I'm Gloria Rodriguez again here, so that's two indications for this medication; one is treatment of Resistant Depression and the other one is MDD with SI so my concern with this recommendation is that its assuming that we're only using it for the first recommendation, not the second. And why would we delay a good treatment for MDD with SI acute SI until two oral antidepressant trials? So I'm a bit concerned that this kind of assumes is only going to be used for treatment for Resistant Depression.

Barb Rogler: Gloria this is Barb Rogler thank you very much for that question. We totally acknowledge that because we do realize that at the call center we would have built in criteria for patients who did have suicidal ideation or behaviors who did present at institution and could not have tried two antidepressants. So, that will be built into the call center and there will be a by-pass for those patients.

Gloria Rodriguez: So can we then change this recommendation to specify for the use of Spravato for treatment of symptoms of depression trial of at least 2 oral antidepressants prior to Esketamine nasal spray.

Barb Rogler: Could we add a statement? So are you say, I just want to rephrase, exclude this criterion for patients who have suicidal behavioral ideations that started Esketamine in an institution is that what you're looking for here?

Gloria Rodriguez: That is certainly an improvement. Again, because I think we would be delaying potentially life saving medication for someone until they complete 2 trials of an antidepressant which could be a very long time. so if we're talking about 4 to 6 weeks of a therapeutic dose, we're talking months of delay and potentially life saving medication for someone who is suicidal.

Monica Toohey: This is Monica again. I think we could probably limit this recommendation to just the Major Depressive Disorder with Treatment-Resistant Depression. Because again, like Barb said with the call center, one of the first questions we'll ask is to make sure that there's not the suicide ideation so then you would bypass, you would kind of approve at that point, you're not going to go through the rest. So we could kind of put that up front.

Barb Rogler: I think she's just looking for something here to say that.

Gloria Rodriguez: Yeah, I think it would be helpful for providers to know that they don't need to sort of meet this criterion if they have someone who is suicidal at their doorstep.

Tony Merola: Okay thank you Gloria, we're trying to do some on the fly editing to this slide here. So just bear with us. We'll project it here in a second and then Gloria your feedback would be appreciated once we project it.

Tara Thomas: Tony this is Tara while you're editing is it important that we include any reference to duration of trials in this recommendation to Gloria's point the 6 weeks?

Monica Toohey: We don't typically, this is Monica again Tara, we don't typically pin ourselves into that. We do our best to kind of operationalize it and if we need to adjust it some we also do that too and we utilize all the information that Buffalo puts together for us to make that determination of how to look back and how long and that sort of thing. But we hate to lay it out distinctly here because then we kind of get boxed into it.

Tara Thomas: Okay. Thank you.

Jadwiga: Hi, this is Jadwiga, on the same note do we want to put in there that a trial has also been done with an adjunct treatment measurement, lithium was shown to be positive, actually Lithium was one of the agents that actually decreases suicidality, Clonazepam being the other one but not being used here in this situation. So putting in some wording that an adjunctive treatment was utilized? I mean in the Canada one they actually used monotherapy of Quetiapine a treatment used in depression. It's actually approved for depression by itself so maybe putting something in there with the adjuncts?

Barb Rogler: Jadwiga this is Barbara. Thank you very much for those comments. When we worked with multiple key stakeholders across the State of New York, we did debate that and one thing that the stakeholders are very loud and clear about is that there was no consensus on the use of adjunctive therapy. We do acknowledge that in some circumstances, some of the

guidelines that adjunctive therapy was used and is indicated but we wanted to keep the recommendation broad and also support other key stakeholders across New York State.

Jadwiga: Thank you Barbara.

Tony Merola: Okay maybe we can backtrack to Gloria's comments. So Gloria we made a minor slight adjustment to the slide based upon your feedback. And again, we've added to the initial recommendation *when used for Treatment-Resistant Depression*.

Gloria Rodriguez: Yeah I think it's clear now.

Tony Merola: Thank you for that.

Dr. Fish: Do I have a motion to adopt this revised recommendation which now reads: Trial of at least two oral antidepressants prior to Esketamine nasal spray when used for Treatment Resistant Depression.

Tara Thomas: Motion, this is Tara.

Dr. Fish: Thank you and do I have a second?

Casey Quinn: This is Casey I second it.

Dr. Fish: Thank you Casey. Any other comments, questions, or discussion on this recommendation before we vote? Okay, hearing none, are there any abstentions? Any one opposed? There is a bee in the room. Okay so this passes the 13 members unanimously in support of this recommendation. Recommendation #3.

Tony Merola: Sure. *After the initiation of Esketamine nasal spray therapy, every six months prescribers must attest that Spravato or Esketamine nasal spray has resulted in improvement of depressive symptoms from the baseline using the same baseline clinical assessment tool for depression.*

Dr. Fish: Thank you Tony.

Gloria Rodriguez: So a clarifying question. Are we going to require specific, what is the definition of improvement? It's just a decrease in score or percentage in decrease of score? And does this mean that the provider is going to have to call every 6 months to attest this or is this just testing in the documentation?

Monica Toohey: Hi, this is Monica again. This is really just attesting to the fact that they've done this and there's documentation. We're not really like validating the score of even necessarily taking down any information on it other than it had been done and there was improvement.

Gloria Rodriguez: And just to clarify this is just on the medical record documentation or you will require that there is another call for not prior authorization, continued authorization to provide this information.

Monica Toohey: Right there will be another call that would have to be done to continue the therapy but this would have to be attested to and once that's done, it would be fairly quick to do that.

Dr. Fish: Other comments or questions? Okay hearing none I think we are ready to vote on DOH recommendation #3. So again, *After the initiation of Esketamine nasal spray therapy, every six months prescribers must attest that Esketamine nasal spray has resulted in improvement of depressive symptoms from the baseline using the same baseline clinical assessment tool for depression.* Do we have any abstentions? Any opposed? Was that can you repeat please?

Joe Chiarella: It's Joe I'm just trying to see if this thing finally works so you can hear me.

Dr. Fish: Welcome. Wonderful Dr. Chiarella, we knew you were there, nice to hear your voice and were you commenting here on this recommendation specifically as we're voting?

Joe Chiarella: I was saying I'm not abstaining.

Dr. Fish: Okay so I think let me just verify one more time. Any abstentions? Any opposed? Okay this recommendation passes unanimously 13 votes. Thank you.

Tony Merola: Okay that concludes that topic. Doug is there's no objections, I think we might want to take just a 10 minute break. We'll plan on starting back up you know 10 minutes extending into 15 minutes we all know right, so we'll plan on starting back up at 11:15 so it's about 11:00 and then we'll go into the PDP recommendations or I'm sorry the PDP clinical reviews and then after that we'll go to Executive Session and just to let those people in the audience know, when we go to Executive Session, we have to vacate this room because we are also using this room for Executive Session. So we'll be back in 15 minutes. Thank you.

Dr. Fish: Welcome back everybody so Dr. Mina Kwon from Magellan will be presenting the new clinical information on three classes; the antimigraine agents, topical acne agents and growth hormones. And we will be bringing up the first slide sets here and welcome.

Dr. Mina Kwon: Good morning everybody just doing my check to make sure everybody can hear me okay.

Tony Merola: And Mina after each one of these drug classes we'll take questions from the DUR Boards, so we'll take the three one at a time does that make sense. Go right ahead.

Mina Kwon: Okay so the first class we will be reviewing today are the antimigraine agents other class. So for new clinical information in this class we have a new drug Qulipta or atogepant and we will also be going over new indication and some key label revisions for Nurtec ODT.

So Qulipta is a Calcitonin gene-related peptide antagonist indicated for the preventative treatment of episodic migraines in adults. It is available as oral tablets in three different strengths; 10, 30 and 60 mgs to be taken once daily with or without food. For patient's with severe renal impairment or end stage renal disease, it is recommended to take the dose of 10 mg once daily and there are no contraindications or warnings.

So the most common average drug reaction that patients experience with the drug are nausea, constipation, and fatigue. There are some recommended dosage modifications with drug interactions with any strong CYP34 inhibitors, take 10 mg once daily. With strong and moderate CYP34 inducers to take 30 mg or 60 mg once daily. And with OAPP inhibitors 10 or 30 mg once daily.

For specific populations based on animal data, it may cause fetal harm in pregnancy. Qulipta is to be avoided in patients with severe hepatic impairment. Safety and efficacy has not been established in pediatric patients. There are no clinical comparative studies available within this class with Qulipta.

So, now we are going to be going over Nurtec ODT, with some new indication and some key label revisions. Nurtec is now FDA approved for the preventative treatment of episodic migraine in adults. Previously it was only approved for acute treatment of migraine with or without aura in adults. The dosage for the new indication for preventative treatment is 75 mg taken orally every other day. There are some key label revisions for Nurtec. There was information included to provide pregnancy exposure registry to monitor for pregnancy outcomes for women exposed to Nurtec during pregnancy. The results of a lactation study were also provided and the data supports that transfer of Nurtec into breast milk is low. The label was also updated regarding some drug/drug interaction information for inhibitors of P-gp and BCRP. Another dose of Nurtec ODT is to be avoided within 48 hours with potent P-gp inhibitors. And concomitant administration of Nurtec ODT with BCRP inhibitors is not expected to have clinically significant impact on rimegepant exposure.

So here is a PDL snapshot of what the antimigraine agents other class looks like today. Of note, is the change to the therapeutic classes for migraine products. The triptans are now in a class of their own in the antimigraine agent's triptan class and the CGRP antagonists and other antimigraine agents now sit in this antimigraine agents other class.

So, to recap, we've discussed the new drug Qulipta which is an oral CGRP antagonist indicated for the preventative treatment of episodic migraine insults. There are no head to head comparative trials available for this drug within the class. Currently 2 of the 6 is non-preferred on the PDL. There are commended dosage modifications for potential drug/drug interactions and also dose modifications; 10 mg is recommended for patients with severe renal impairment or end stage renal disease. We also went over a new indication and some key label revisions for Nurtec ODT. Nurtec is now FDA approved for preventative treatment for episodic migraine in adults where as prior was only used for acute treatment. And currently the product is non-preferred. That concludes the review for this class. Are there any questions?

Dr. Fish: Thank you any questions for Dr. Kwon on the antimigraine agent?

Tony Merola: Doug just a point of clarification that this is new clinical information since the DUR Board last reviewed the class. We should have probably made that point up front. But this is just the new information since the last review. And that holds true with all of the presentations today Mina will be doing today. It's new information since the previous review and the preview review dates actually have been posted on the agenda or had been on the agenda posted 30 days prior to the meeting.

Dr. Fish: Thanks Tony. Any questions? Alright hearing none we will move to the next presentation.

Mina Kwon: So the next class we will be reviewing today are acne agents topical. For new clinical information in this class we have a new drug Winlevi or clascoterone. Winlevi is an androgen receptor inhibitor indicated for the topical treatment of acne vulgaris in patients 12 years of age and older. It's available as a 1% cream in 60 gram tubes and it is to be applied as a thin layer to the affected area twice daily, recommended in the morning and evening. For contraindications and warnings, there are warnings that it may cause local irritation, itching, burning, skin redness, or peeling may be experienced with the cream and it's recommended to discontinue or reduce frequency of application if this occurs. HPA axis suppression can also develop and it's recommended to withdraw use if this does occur. There is a warning that pediatric patients may be more susceptible to systemic toxicity with the cream and elevated potassium levels were observed in some subjects during clinical trials.

The most common adverse drug reaction seen with the cream are external in nature, any erythema, reddening, pruritus, scaling, and dryness, edema, stinging and burning also did occur. There are no drug interactions reported with the cream. For specific populations there is no available data on use in pregnancy women. And safety and efficacy has only been established for those 12 years of age and older.

So, here is a PDL snapshot of what the acne agent's topical class looks like today. To recap we discussed the new drug Winlevi which is an androgen receptor inhibitor indicated for the topical treatment of acne vulgaris in patients 12 years of age and older. This is a new mechanism of action for treatment of acne vulgaris. There are no head to head comparative trials available for this drug within the class, and currently Winlevi is non-preferred on the PDL. That concludes everything.

Dr. Fish: Thank you. Any questions on the topical acne agents, the new clinical information?

Tony Merola: Mina can you maybe just move the mic a little bit closer just looking at some comments via the chat feature.

Dr. Fish: Okay shall we move to the growth hormones?

Mina Kwon: Okay is that better?

Tony Merola: In the room it definitely is okay. Again, we'll monitor...

Gloria Rodriguez: Yes, better.

Mina Kwon: Thank you for the confirmation. Okay so the last class we have to review today are growth hormones.

So for new clinical information in this class we have a new drug Skytrofa or lonapegsomatropin. So Skytrofa is a human growth hormone indicated for the treatment of pediatric patients one year and older who weigh at least 11.5 kilograms and have growth failure due to an inadequate

secretion of endogenous growth hormone. It is available for injection in 9 different strengths listed there on the slide, as a lyophilized powder and single dose dual chamber prefilled cartridges. It is administered subcutaneously via its auto injector to the abdomen, buttock, or thighs with regular rotation of the injection sites once weekly.

For contraindications and warning, Skytrofa is contraindicated in acute critical illness, hypersensitivity to somatropin or any of the excipients. Children with closed epiphyses, active malignancy, active proliferative or severe nonproliferative diabetic retinopathy, and it is also contraindicated in children with Prader-Willi syndrome. For warnings there was warnings for severe hypersensitivity, increased risk of neoplasms, diabetes and glucose intolerance may be unmasked, intracranial hypertension, fluid retention, hypoadrenalism, hypothyroidism may become evident or worsened, slipped capital femoral epiphysis and progression of preexisting scoliosis may develop. And there is also a warning for pancreatitis.

The most common adverse drug reaction seen in pediatric patients were viral infection, pyrexia, cough, nausea and vomiting, hemorrhage, diarrhea, abdominal pain, arthralgia, and arthritis. There are drug interactions with any sort of replacement or pharmacologic glucocorticoid therapy, Cytochrome P450 metabolized drug, oral estrogen and insulin and/or antihyperglycemic agents. In these cases either it would be monitored or the Skytrofa or the other drug would be thus modified.

For specific populations, there is no available data on use in pregnant woman and again, safety and efficacy has only been established for pediatric patients 1 year of age and older who weigh at least 11.5 kilograms.

So for clinical comparative studies within the class, Skytrofa was studied in Treatment-Naïve Pediatric patients with growth hormone deficiency and compared Skytrofa with daily Somatropin, Genotropin was used. The study was a multi center randomized open label access controlled parallel group phase 3 study and it was conducted in 161 treatment-naïve treatment prepubertal pediatric subjects with growth hormone deficiency. There were randomized 2 to 1 so 105 subjects received once weekly Skytrofa and 56 subjects received daily Somatropin. The dose in both arms was equivalent to .24 mg/kilogram per week so they either got it once weekly with the Skytrofa or separated out in daily doses with the Genotropin. The primary efficacy endpoint was annualized height velocity at week 52 and treatment with once weekly Skytrofa resulted in an annualized height velocity of 11.2 cm/year while treatment with daily Somatropin achieved an annualized height velocity of 10.3 cm/year. This was specifically significant. For secondary outcomes, the height standard deviation score changed from baseline was 1.1 in the Skytrofa arm and 1.96 in the daily Somatropin arm at week 52 and this was also specifically significant. So here is the PDL snapshot of what the growth hormone class looks like today.

To recap, we discussed the new drug Skytrofa which is a human growth hormone indicated for growth hormone deficiency in pediatric patients 1 year and older administered once weekly subcutaneously available in 9 different strength. There was a head to head trial that compared Skytrofa with daily Somatropin, Genotropin in treatment-naïve pediatric patients with growth hormone deficiency that resulted in an annualized height velocity difference of .9 cm per year and a height standard deviation score change from baseline of 1.1 with Skytrofa vs. .96 with daily Somatropin that were specifically significant. Currently Skytrofa sits as non-preferred.

Dr. Fish: Thank you. Any questions on the growth hormone class presentation we just heard? Okay well I think it was pretty clear. So thank you. So we are through our new class information on the preferred drug program and now I think we are ready to move to Executive Session.

Tony Merola: I think so if there are no objections Doug, we'll move to Executive Session. It's 11:30.

Dr. Fish: We're ahead of schedule about 30 minutes or so.

Tony Merola: Yeah we have to do some IT work here for Executive Session. For those that are involved in the Executive Session Board Members and the DUR Board support staff, we're going to move onto a zoom platform so you've got to give us a couple of minutes to do that. So why don't we start Executive Session at 11:45 and again for DUR Board members and support staff, we're going to move over to a zoom application to do that and those involved should have that information. Then Executive Session I think we should be able to complete Executive Session about 45 minutes from the start of that Executive Session which brings us to 12:30 we'll take lunch for a half hour. How about we try to be back here at 1:00 and then we'll do the PDP recommendations and then the last agenda item which is the asthma guidelines. Does that sound like a plan, a timeline?

Dr. Fish: Sounds good.

Tony Merola: So we'll see the DUR Board staff on a zoom application in about 15 minutes. Thank you.

Dr. Fish: This meeting is being recorded. Alright. Good afternoon welcome back to our afternoon session of the Drug Utilization Review Board Meeting. We're just going to go through roll call again just to make sure that we can hear everyone that they can hear us and that we've got quorum. So I'm just going to start in order that I see them on my screen. Dr. Rodriguez?

Gloria Rodriguez: Here.

Dr. Fish: Thank you. Brock Lape.

Brock Lape: Yes.

Dr. Fish: Thank you. Dr. Quinn?

Casey Quinn: Present.

Dr. Fish: Dr. Chiefari?

Donna Chiefari: I'm here.

Dr. Fish: Jadwiga Najib?

Jadwiga Najib: Present.

Dr. Fish: Jim Hopsicker?

Jim Hopsicker: Hi Doug.

Dr. Fish: Hi Jim thank you. John Powell.

John Powell: Here.

Dr. Fish: Thank you. Dr. Chiarella?

Joseph Chiarella: I'm here.

Dr. Fish: Very good. Dr. Anzisi?

Lisa Anzisi: Present.

Dr. Fish: Pete Lopatka.

Peter Lopatka: I'm here.

Dr. Fish: Dr. Ignacio?

Renante Ignacio: I'm here.

Dr. Fish: Tara Thomas?

Tara Thomas: Hi Doug.

Dr. Fish: Very good and I think that's it. So good. As I said, welcome back. No official action was taken during the Executive Session and first I would like to ask for a motion to present and discuss the DOH recommendations that pertain to the Preferred Drug Program agenda items. So do we have a motion to open up this discussion?

Donna Chiefari: So moved, this is Donna.

Renante Ignacio: Second.

Dr. Fish: Thank you Donna, thank you Dr. Ignacio perfect. So I'm going to turn it over now to Mr. Merola to present our recommendations.

Tony Merola: Thank you Dr. Fish. So projecting in the screen of the DOH recommendations, this is the standard clinical criteria for non-preferred products. We always show this slide up front. Non-preferred drugs, remember are still available and then there's standard clinical criteria is here. The first one revolves around treatment failure with a preferred product. The second one revolves around having an adverse drug reaction to a preferred product. And the third standard clinical criteria question here is successful therapeutic control on a non-preferred

product and transition to a preferred product is medically contraindicated. And any other clinical indications developed by the DUR Board. So, that's the standard clinical criteria.

If we move on so the first drug class we'll look at cholesterol absorption inhibitors. You see all these slides format is the same. So, just to orientate you to that, the preferred products are on the left, non-preferred products on the right column and any changes to the current preferred and non-preferred status are actually in green or red font. So what you can see here is the Department of Health is recommending one change and its moving ezetimibe to preferred status.

Dr. Fish: Thank you Tony. Are there any questions or discussion regarding the DOH recommendation to move ezetimibe to preferred status? And just remember to unmute yourself if you have a comment or question. Last chance. Okay. I think we're ready to vote on this recommendation. And again, we'll do it the same way, we'll vote by consensus so we will start with abstentions and opposed and then those in favor. So anyone abstaining from voting on this recommendation Cholesterol Absorption Inhibitors? Any opposed? Okay so this proposal this recommendation passes 13 unanimous votes. Next up.

Tony Merola: Antimigraine other. Just one change here but before I mention the change I will note that we also have clinical criteria on this class. The clinical criteria is on the bottom of the page for completeness. The only recommended change here is moving Nurtec ODT to preferred status.

Dr. Fish: Thank you, Tony. Any discussions, comments, questions regarding the recommendation to move Nurtec ODT to preferred status on the antimigraine agents? Okay, hearing none, we will move to vote. Any abstentions? Any opposed? This recommendation then passes unanimously, 13 votes in favor of adding Nurtec ODT. Next up, movement disorder agents.

Tony Merola: One change here, adding Ingrezza to preferred status.

Dr. Fish: Any discussions, comments, questions at the recommendation to add Ingrezza to preferred status among movement disorder agents? Hearing none, we will move to vote. Any abstentions? Any opposed? This passes unanimously with 13 in favor. Next, topical acne agents. This had a new clinical review today.

Tony Merola: Correct Doug. The new drug is listed there. It is in preferred status. The recommendation is that it remains there. So, actually, there are no changes to the class as it stands today on the PDL. No changes recommended.

Dr. Fish: Any discussion, comments, or questions? So, the new agent is added, and I will ask if there are any abstentions? Any opposed? Hearing none, this passes unanimously, 13. Next class, topical antifungals.

Tony Merola: Just one change here, Doug. It is moving Ketoconazole cream and shampoo to preferred status.

Dr. Fish: Any discussion, comments, or questions adding Ketoconazole cream and shampoo to preferred status among topical antifungals? Hearing none, let's move to voting. Any abstentions? Any opposed? This passes unanimously, 13 votes in favor. Next class, the Dipeptidyl Peptidase-4 inhibitors.

Tony Merola: So, two changes here, moving Kazano and Nesina to preferred status.

Dr. Fish: Thank you, Tony. Any discussion, comments, or questions regarding moving Kazano and Nesina to preferred status among the DPP-4 inhibitors? Doesn't seem to be too controversial when we are adding agents to preferred status. So, we are ready to vote. Any abstentions? Any opposed? This passes unanimously, 13 votes in favor. Next, the Glucagon-like Peptide Agonists.

Tony Merola: And keeping with the theme, adding another drug to the preferred status, Ozempic. And as I said, as you see through these slides, the clinical criteria is on the bottom here, and we are not recommending any changes to the clinical criteria, and again, just recommending that Ozempic become preferred.

Dr. Fish: Thank you, Tony. Any discussion, comments, or questions regarding the recommendation to add Ozempic to the GLP-1 agonists preferred drug program? Hearing none, let's vote. Any abstentions? Any opposed? This passes unanimously, 13 votes in favor, and I am checking the comments and chats just to make sure we are not missing anybody that people can't speak. Just remember to unmute yourself if you want to make a comment. Next class, growth hormones, also reviewed today.

Tony Merola: No changes here. The new drug is currently in non-preferred status, Skytrofa. That is the drug that Mina presented earlier today. We are not proposing any changes to this drug class.

Dr. Fish: Okay, so no proposed changes, addition of the Skytrofa to the non-preferred drug list for growth hormones. Any discussion, comments, or questions? Hearing none, are there any abstentions? Any opposed? This motion passes, 13 votes in favor. Next up, the antihyperuricemics.

Tony Merola: And the one change here is moving febuxostat to preferred status.

Dr. Fish: Thank you, Tony. Any discussion, comments, or questions on the DOH recommendation to add febuxostat to the list of preferred agents of antihyperuricemics? Hearing none, let's vote. Any abstentions? Any opposed? This passes unanimously, 13 votes in favor. And lastly, anticholinergics/COPD agents.

Tony Merola: So, two changes here. Moving Spiriva Respimat to preferred status and moving Tudorza Pressair to non-preferred status.

Dr. Fish: Thank you, Tony. Any discussion, comments, or questions regarding the recommendations? Okay, hearing none, are there any abstentions? Any opposed? This recommendation passes unanimously, 13 votes in favor. So that concludes...

Tony Merola: Yeah, that concludes the portion, the preferred drug program portion. Of note, so the DOR Board's recommendations that we just voted on here will go to the Commissioner of Health for final approval, so we will pend until we get the recommendations to the Commissioner of Health for final approval, and that will be represented in the meeting summary that we will post on the website shortly after this meeting. Just a point of clarification, but yes, I think for today, we are done with the preferred drug program topic on the agenda.

Dr. Fish: Okay, thank you, and thanks for your votes there. Next, we will move up to an asthma guideline update.

Tony Merola: Yes, this is the last topic of the day, and we should have Linda Catanzaro on the line. Linda, can you hear us?

Linda Catanzaro: Yes, can you hear me?

Tony Merola: Yes, loud and clear.

Linda Catanzaro: Okay.

Tony Merola: So, if there are no objections, we will move onto the asthma update provided by Linda Catanzaro.

Linda Catanzaro: Alright, good afternoon, everyone and thank you. If we can move onto slide two, so the purpose of this presentation, the primary objective is to review updates to asthma treatment guidelines related specifically to the use of inhaled corticosteroids/long-acting beta agonist combinations, commonly referred to ICS/LABA, as both maintenance and reliever therapy, and we will discuss implications for the New York State Medicaid program. Utilization of ICS/LABA combinations throughout the entire New York State Medicaid populations, including the fee-for-service program in managed care organizations will also be reviewed. Next slide. So, the National Asthma Education and Prevention Program guidelines for treatment of asthma, sponsored by the National Heart, Lung, and Blood Institute of the National Institutes of Health were updated in December of 2020. The previous updates of these guidelines occurred in 2017, sorry, 2007, with the Expert Panel Report (EPR-3). Of note, the 2020 update was not a complete update of EPR-3, but focused on specific questions about six priority topics, and one of these topics included intermittent use of ICS. The Agency for Healthcare Research and Quality has subsequently conducted systematic reviews to address these questions and provide evidence to update the guidelines on these topics, and these reviews were published during 2017 and 2018. Next slide. So in addressing intermittent use of ICS, the NAEPP 2020 focused updates include recommendations for use of select ICS-LABA medications as both maintenance and reliever therapy. The Global Initiative for Asthma (GINA) guidelines, which are updated annually, have included recommendations for use of select ICS-LABA as both maintenance and reliever therapy for the past several years. Food and Drug Administration approved labeling for ICS-LABA products does not include use as reliever therapy; however, such use is included in official compendia. Next slide. So briefly, this is just an overview to review the pharmacologic management approaches for treating asthma, and both NAEPP and GINA recommend assessment of asthma control using objective measures on an ongoing basis and prior to any regimen changes. Both list preferred therapies and alternative therapies at each step based on what is supported by the evidence, and there are

slight differences in the number of steps and age brackets for younger patients, which we will review. So, this diagram just shows that continual monitoring is recommended by NAEPP, assessment of adherence, inhaler technique, environmental factors, and comorbidities should be ongoing, and stepdown therapy should take place if possible, if asthma is well controlled for at least three consecutive months. And step up in therapy as needed and reassessment in four-to-six weeks is recommended. Next slide, please. So, this chart outlines the NAEPP definitions of asthma severity, based on symptoms and pharmacologic steps that correspond with the severity level. So, the 2020 update continued to use the step pharmacologic approach to asthma management that was based on asthma severity defined in EPR-3. So, the first row shows the defined asthma severity levels, intermittent, mild persistent, moderate persistent, and severe persistent. And then in defining severity, the guidelines note that it is measured most easily and directly in a patient not receiving long-term control therapy, so the second row shows how severity is defined based on symptoms while a patient is not on controller therapy, so symptoms less than or equal to two days a week would be considered intermittent, and mild if symptoms are more than two days a week but not daily. Moderate if symptoms are daily, and severe persistent if symptoms occur throughout the day. So, the next row shows pharmacologic treatment steps that correspond with the severity levels, so step one corresponds with intermittent. Step two, mild persistent, step three and four, moderate persistent, and steps five and six, for severe persistent. The note is that in the 2020 updates, steps three and four in the pharmacologic step therapy corresponds with moderate to severe persistent asthma, defined as moderate to severe, so there is just a slight overlap in the comparisons between the 2007 levels and the way they are defined and the 2020 update. And lastly, the level of control based on symptoms when a patient is receiving controller medication, and so based on the symptoms, in the second row, if they have symptoms less than or equal to two days a week, and they are on controller therapy, they would be considered well controlled. More than two days a week, not well controlled. Symptoms daily, not well controlled, and symptoms throughout the day would be very poorly controlled. Next slide, please. So, for each of the recommendations in the NAEPP 2020 guidelines update, the expert panel indicated the direction of the recommendation as being either for or against a particular intervention, and they defined the strength of that recommendation. So, this is the list of how those strengths, the strength of the recommendations is defined. So, a strong recommendation for an intervention indicates that the benefits of the intervention outweigh risks for most individuals, and most individuals would want and should receive it. A conditional recommendation for an intervention means that it is an appropriate course of action for different individuals based on values and preferences. Most will want it but many will not. And then a conditional recommendation against an intervention means most individuals will not want it, but some will, and it may be appropriate for some. And a strong recommendation against means that most should not receive it, but some will still want it. So, in addition to these strengths for recommendation, the panel also defines evidence certainty as high, moderate, low, or very low. Next slide, please. So, also within the published guidelines, there is a table that NAEPP summarizes the implications for the strength of the recommendations for the various interventions. So, this is just an excerpt from that table, including some of the key statements. And so, the implications are summarized for individuals as described in the previous slide, as well as clinicians. So, for a strong recommendation for, both of these are strong, a strong recommendation for an intervention or a particular recommendation for an intervention. So, for clinicians, a strong recommendation means that most individuals should receive the intervention, and formal decision aids are not likely to be needed. For policymakers, a strong recommendation indicates that the recommendation can be adapted as policy or performance measure in most situations. And adherence to this

recommendation according to the guideline could be used as a quality criterion or performance indicator. And then lastly, for researchers, they mention for the strong recommendation that is supported by credible research and additional research is unlikely to alter the recommendation. Next slide, please. So with regard to the use of ICS/LABA accommodations as maintenance and reliever therapy, the following question was researched for the update, and the stated question is what is the comparative effectiveness of ICS with LABA used as both controller and quick-relief therapy compared to ICS with or without LABA used as controller therapy in individuals aged five years and older with persistent asthma? And based on the evidence that was gathered through the systematic reviews, the recommendations from the expert panel stated again and recommending ICS-formoterol combinations in a single inhaler used as both daily controller and reliever therapy, meaning “single maintenance and reliever or SMART therapy for individuals aged four and up with moderate to severe persistent asthma. This is rated as a strong recommendation with high certainty of evidence for ages 12 and up and moderate certainty of evidence for ages four to eleven when compared to higher-dose ICS with as-needed use of a short-acting beta agonist or same-dose ICS-LABA with as needed SABA, which would be considered conventional therapy. Conditional recommendation with high certainty of evidence for ages 12 and up compared to a higher dose of ICS-LABA and as-needed SABA. And they noted there was insufficient evidence to make this last recommendation in the age range, for the age group of four-to-eleven-year-olds. Next slide, please. So, with regards to the systematic review and meta-analysis that was conducted by or sponsored by AHRQ to gather this evidence, they looked at the effects of SMART medication with persistent asthma. This was published in 2018 and provided the key evidence supporting the strong recommendation for SMART. Investigators searched for randomized clinical trials and observational studies in MEDLINE, EMBASE, and Cochrane database through November 2017. The interventions compared SMART versus ICS with or without a LABA as controller and as-needed SABA as reliever therapy. The target population of patients aged five and up with persistent asthma, and the main outcome was asthma exacerbations. Next slide, please. So, this chart contains a summary of the results of the meta-analysis. So, for patients aged 12 and up, 16 random trials were included with an overall size of 22,524 patients with a mean age of 42 years, 65% female. Also, investigators noted that most patients were taking medium to high doses of ICS as baseline, representing severity worst than mild persistent asthma. So, the compared groups were SMART versus, the first row shows SMART versus same daily dose of ICS alone with as-needed SABA. They also looked at SMART versus same daily dose ICS-formoterol combination with as-needed SABA, and SMART versus higher daily dose of ICS-formoterol with as-needed SABA. And the age range of four-to-eleven-year-old patients, there was one study that included a subgroup analysis of 341 patients in this age range, and the average age was eight years with 31 percent female. And they compared SMART versus higher daily dose of ICS alone with as-needed SABA against SMART versus same daily dose of ICS-formoterol and as-needed SABA. So, for all the comparators, the take home is that the comparison favors that SMART is associated with a significantly reduced risk of asthma exacerbations. In the twelve and up age range, as you can see, it was primarily based on a composite outcome, which included asthma exacerbations requiring systemic corticoid steroids, hospitalization, or emergency department visits. And in all of this age range, lowering the risk ranged from 23 to 62 percent, looking at all of these results in the last column. I just want to make one note of a correction. The risk difference interval at the left column in the bottom shows minus 33.6 percent to 12.1. That should actually be minus 12.1 percent. That is important because that shows the significance there. I just wanted to make that correction. So, of note, 15 of these 16 studies, including the pediatric subgroup, used budesonide-formoterol

combination for SMART. And ones that used beclomethasone-formoterol combination, which is a formulation that is not available in the US, but the conclusion overall said SMART reduced the risk of asthma exacerbations compared to conventional therapy. Next slide, please. So, with regard to the recommendations that NAEPP makes for SMART, they know that it is specific to ICS-formoterol because of the fact that it was the only LABA that was reported for SMART, and it has a rapid onset of action and can be used more than twice daily. They noted the recommendation of regular daily use with ICS-formoterol is one-to-two inhalations once or twice daily for maintenance therapy, and then as-needed use would be one-to-two inhalations every four hours as needed for asthma symptoms. The maximum daily formoterol inhalations they recommended is eight for ages four to eleven and twelve for ages twelve and up for both maintenance and reliever therapies. They also note that individuals with an asthma exacerbation in the previous year may be particularly good candidates, and ICS-formoterol should not be used as reliever if a patient is already using ICS-salmeterol for maintenance because of the unknown safety profile of using both. And patients adequately controlled with daily ICS-LABA and as-needed SABA do not need to be switched. Next slide, please. So, the next three slides are just screen shots of NAEPP 2020 updates, showing the stepwise, chronological approach, and this is from the At-A-Glance guide, and the same tables are included within the published guidelines. So, this first table shows the guidance for ages zero to four-year-old, and you will see that they list, they show the asthma severity and the steps, so there are six steps for pharmacologic therapy, and the first row is what is preferred based on the evidence, and the second row would be treatment options that would be considered alternative, and the main thing I wanted to highlight is if you look under steps three and four, there is a note that for children ages four years only to see steps three and four for management of persistent asthma individuals ages five through eleven. So the next diagram, it should be noted it applies to four-year-olds as well. Next slide, please. A similar diagram with six steps and preferred and alternative therapies, and again, I want to highlight steps three and four, the preferred therapy is daily and as-needed combinations, low-dose ICS-formoterol for step three, and medium dose ICS-formoterol for step four. So, this is for ages five to eleven and also includes four-year-olds. Next slide, please. And this is the stepwise chart for ages twelve and up, and again, it is highlighting the preferred treatment. Recommended is daily and as-needed combinations, low-dose ICS-formoterol for step three and medium-dose ICS-formoterol for step four. So to summarize, for these three charts, they show that SMART is the preferred treatment option with ICS-formoterol for ages four and up with moderate to severe asthma at steps three and four. Next slide, please. So these next three slides, we have included the same screen shots of the charts that are included within the GINA, 2021 GINA guideline that show the step approach for management, and these are very similar to the NAEPP. Slight differences being that for this first age bracket, this recommendation is for children ages up to five, and NAEPP was up to four. So, for ages five and younger, they include four steps, and they continue to recommend as reliever therapy short-acting beta agonists. Go onto the next slide. This is for our children ages six through eleven, and if you look at the reliever therapy that is recommended, they do the same thing. They have the preferred controller, the alternative controller option, and then at the bottom, they list the recommended reliever therapy for either option, and so, that is where you can see that along with as-needed short-acting beta agonists, they also recommend ICS-formoterol as a reliever, they call it MART, so they don't have an S in there for a single maintenance or reliever therapy, but it is, they are referring to the same combinations of ICS-formoterol for steps three and four. Next slide, please. And now they define, GINA divides up to recommendations as track one and track two for ages twelve and up. It is the same overall approach. They have five steps, and the track one includes using ICS-formoterol as the reliever

therapy because it reduces the risk of exacerbation compared to using a SABA reliever, so that is recommended as a reliever for all steps, that's one through five, and then again, you will note the recommendation for low-dose maintenance ICS-formoterol in step three and medium dose in step four. Next slide, please. So, this is just a summary of the FDA approved indications for ICS-formoterol products. The first row is Budesonide-formoterol, which includes the brand name Symbicort, as well as a generic metered-dose inhaler indicated for treatment of asthma in patients twelve years and up. The dosage would be two inhalations twice a day of either the 80/4.5 mcg strength inhaler or the 160/4.5 mcg strength. It is also indicated for treatment of asthma in ages six up to twelve years of age to less than twelve years of age, and the recommendation is two inhalations twice daily, the indication rather, is two inhalations twice daily of the 80/4.5 mcg strength. And it is also indicated for maintenance treatment of chronic obstructive pulmonary disease at two inhalations twice daily of the higher strength. Mometasone-formoterol, available by the brand name Dulera, inhalation aerosol is indicated for the treatment of asthma in patients twelve and up with two inhalations twice daily of either the 100/5 mcg strength or the 200/5 mcg strength, the higher strength being the ICS and the 5 mcg being the formoterol, and it is also recommended for treatment of patients five to up to twelve years of age using the lower dose, two inhalations twice daily. So, these are a maintenance therapy dosing. In both package inserts an important limitation for both drugs are listed as being not indicated for relief of acute bronchospasm, and contraindication for both drugs is the primary treatment of status asthmaticus or acute episodes of asthma requiring intensive measures. So, just a note that each of these inhalers contains 120 inhalations for each of these products, so based on the maintenance dosing in the label, if the patient was receiving this full maintenance as listed here, this would require one inhaler every 30 days. Next slide, please. With regards to Compendia-supported use Micromedex for, in Micromedex for both Budesonide formoterol and Mometasone formoterol include the following statements listed under the FDA usage for asthma, and the same statement is listed in both for both products, that the combination ICS-formoterol, preferably in a single inhaler, is appropriate as SMART in individuals four years or older with moderate to severe persistent asthma. Maintenance therapy is delivered as one-to-two puffs once or twice daily and then one to two puffs are taken as-needed for asthma control. It also states that SMART should be offered in moderate to severe persistent asthma Step 3 with low-dose ICS and Step 4 with medium-dose ICS that is uncontrolled on current therapy before moving on to a higher step of therapy. So, they also cite the guidelines, as well as the clinical trials, and they also note the strength of the recommendation based on the comparative therapies that are described in the guidelines, and they also include the same caveat of not to use the formoterol as a reliever in a patient using ICS Deluritol as a controller and also that it is not necessary to switch if someone has loss control by conventional therapy. Next slide, please. So, taking a look at comparative state Medicaid programs, we have, we look at nine programs, and based on the PDL status is both Dulera, brand name, and Symbicort, brand name, are listed as preferred products on all of the PDL and CDL for California, and the age limits, regarding age limits, only one state, Florida, lists a minimum age of five years for both Dulera and Symbicort. And regarding the FDQ limits, three states have FDQ limits. Florida lists one inhaler every 30 days. Michigan has one inhaler every 30 days for Dulera and two inhalers every 30 days for Symbicort, and Pennsylvania also lists on inhaler every month for both products. Next slide, please. So, New York State and New York State Medicaid fee-for-service preferred drug program, both Dulera and Symbicort brand products are preferred. The generic, Budesonide/formoterol is the generic of Symbicort is not preferred. The additional coverage parameters include a prior authorization which is required for all new LABA prescriptions for members under FDA or compendia-supported ages, and what

is listed there is the FDA label pages that we just reviewed. There is also an FQD limit of one inhaler every 30 days for both Dulera and Symbicort. Next slide, please. So, with regard to the utilization of ICS-LABA in New York State Medicaid, fee-for-service, and managed care, we did a retrospective analysis using the Medicaid Data Warehouse for the timeframe of January 1, 2019, through December 31, 2021, and our sample included members with a pharmacy claim for an ICS-LABA product. Next slide, please. So, for members utilizing an ICS-LABA product, the overall utilization in fee-for-service and managed care increased between 2019 and 2020 and 2021. So, the overall utilization increased from approximately 128,000 members in 2019, 130,000 in 2020, and approximately 140,000 in 2021. And overall, so, as far as factors that could have contributed to the increase, it could have been due to the increased Medicaid enrollment, which increased from approximately 6.1 to 7.3 million during this time period, as well as other factors, such as COVID could have impacted the utilization of these products. But overall, the number of members receiving Budesonide/Formoterol increased during this timeframe, while the use of other ICS/LABA products decreased. Next slide, please. With regard to ICS-LABA claims, overall fee-for-service, managed care claims have also increased over the three-year analysis period, approximately 600,000 claims in 2019 to almost 700,000 claims in 2021, Budesonide/formoterol increasing in the market share during that time. Next slide, please. So, in summary, the 2020 NAEPP guideline updates include a strong recommendation for use of ICS-formoterol products as SMART in patients four years of age and older with moderate to severe asthma. The guidelines state that strong recommendations can be adapted as policy or performance measures in most situations. So, FDA labeling for ICS-formoterol products states they are not indicated for treatment of acute bronchospasm, the guideline recommendations for SMART are included with FDA uses in the official compendia. And overall fee-for-serve and managed care utilization of ICS-LABA, including both members and claims, has increased from 2019 through 2021. Next slide, please. So, the guideline recommendation for use of ICS-formoterol as SMART in patients four years of age and up presents the following considerations for New York State Medicaid fee-for-service members: Symbicort and Dulera are both preferred drugs on the fee-for-service PDL. Prior authorization is required for all new LABA prescriptions, including Dulera and Symbicort, for members under FDA- or compendia-supported age limits, as previously stated. And so, we noted that these age limits are defined as five and up for Dulera and six and up for Symbicort. Both drugs appear to be compendia-supported for use as SMART in ages four and up. With regards to F/Q/D limits, both products are currently limited to one inhaler every 30 days, and higher quantities and/or more frequent refills may be needed for SMART. And that wraps up the presentation. I would be happy to take any questions.

Dr. Fish: Thank you very much, Linda. A lot of information there, pretty comprehensive. Do we have questions, comments, discussions from the board members?

Lisa Anzisi: This is Lisa. Just a clarification. So, the guidelines supports for above, but you are going to require a PA if they are four years old?

Linda Catanzaro: Well, they chart the, the PA is currently required, so it is just summarizing what the guidelines are recommending and then just reviewing what the current requirements are.

Lisa Anzisi: Okay, thank you.

Linda Catanzaro: Yup.

Jamie Wooldridge: Hey, everybody, can you hear me? This this is Jamie Wooldridge. For those of you, because I don't see a whole bunch of names or names that I don't always recognize. So, as a board member, I am a pediatric pulmonologist, and I want to be upfront with everybody that I am also one of the physician champions for the New York Department of Health Asthma Control Program, and it was actually the Asthma Control Program that said we need to look at this, and the way that it is set up with Medicaid currently. Because I will tell you that any office, especially pediatric allergists and pulmonologists are spending a lot of time getting PAs in general for Dulera and Symbicort are completing those, and then the current limitation of being able to get just one inhaler per month of Dulera or Symbicort is making it so that we cannot possibly prescribe SMART therapy in a patient if we want to. Because if we prescribe SMART therapy, and they have an exacerbation, and they use some extra doses, they will run out of their medication before they can get the next refill. And so, with that said, and the data that was just presented, the Asthma Control Program is working on, like the whole basis of the program is to work and help pediatricians across the state implement these guidelines in a consistent, sustainable manner. We have, we being the physicians, and there are four physicians that are part of the program, have looked at both the NAEPP guidelines and the GINA guidelines and are supportive of SMART of therapy but not making it a strong recommendation. We are making it as an alternative recommendation to be using SMART therapy, but if we are going to as the State Asthma Control Board make that recommendation that SMART therapy could be used, then we need our Medicaid program to be able to support that with the appropriate number of inhalers. So, I would like to propose that with all of that information that one, if we can get word of the PAs required for all new Dulera and Symbicort, that would be awesome. And then also, if we could make it that they get seven inhalers of Dulera or Symbicort per six-month prime period. That should give them enough to experience two five-day exacerbations during that time period, where they would be using the Dulera or Symbicort as a rescue and their controller. And it gives the ability for us to utilize and prescribe SMART therapy, but it does not give patients too much access to their inhaled corticoid steroids, so that they can be walking around taking it all of the time, and nobody is keeping track of it. So, with that, what cautions do people have? How does this work? How can I make this proposal, what are our next steps?

Tony Merola: This is Tony. Thanks, Jamie. I would like to maybe just go back to Lisa Anzisi's comment about the age limitation, so as Linda presented, we are seeing the slide here that shows the ages of Symbicort and Dulera currently in place, the age limits currently in place. I think we have, given the compendious support for four years of age, I think we intend to change those ages down to four now, given the compendious support. Is that right?

Monica Toohey: That's right. We have it scheduled. It just didn't implement yet. It kind of came up in this whole process when we were doing this for the evaluation of this, so it is scheduled to drop it down to four, so that is kind of our process.

Tony Merola: Okay. So, I think, Lisa, does that provide a little more clarity?

Lisa Anzisi: It does, but I do agree with what Dr. Woolridge says. The quantity limit is going to be an issue, especially if we expect people to transition to this prn.

Tony Merola: Yup. That is the next thing I wanted to maybe chat about with you all is the quantity limit, but I just wanted to make sure we are clear on the age, I will call it, limitation before we move onto potentially talking about the current quantity limit. Okay.

Jamie Woolridge: The thing that is really getting all the prescribers is one, we can't make SMART therapy available because of the quantity of the meds, and then also, the PA required for all new LABA prescriptions is generating a lot of time of support staff on the phone, trying to make this happen.

Tony Merola: Monica, can you comment on Jamie's question about PA for all new LABA prescriptions, and then we can talk about frequency, quantity, duration as a second item.

Monica Toohey: Yeah, the PA is only required for all new LABA if they are under the age that is listed either in the FDA as a compendia, so we

Jamie Woolridge: Okay, so that will help.

Monica Toohey: ...to four, and then it is really just under that age.

Jamie Woolridge: Okay. That clarifies, and that is definitely helpful. I can tell you, even as a peds pulmonologist, I am not prescribing a lot of Dulera and Symbicort for kids less than four years of age.

Tony Merola: Okay, now we can move onto the frequency, quantity, duration limit of one inhaler for 30 days, as it stands today. We can discuss that. So, it sounded like, Jamie, you are thinking that, you know, you would like to see a change there. You had mentioned, well would you repeat kind of your idea there on how to open it up a bit, so patients could get SMART therapy?

Jamie Woolridge: Okay, so, I sat down and thought through it. If a patient is on SMART therapy, and they are taking their daily Dulera or Symbicort, they will need one inhaler per month, and then if you give them a second inhaler every six months, that then gives them an additional 120 puffs of the medication to use as a rescue inhaler, along with their daily controller, as their daily controller. And so, the whole idea between SMART therapy is that if they start experiencing increased symptoms, they are going to use this combination therapy for their rescue, but also get a little inhaled corticoid steroid, which will shorten the duration of the exacerbation, so they won't need that rescue nearly as long, and then it gets patients to stop using their Albuterol all the time, which we see frequently. So, with that said, if you give them an extra inhaler every six months, that is an extra 120 doses. If they are taking that every four hours, that would be ten days' worth of doses. So, if you think about well, they maybe have an exacerbation for five days, they can use that rescue inhaler for a five-day time period. That should get them back under control, so they can get back to not needing a rescue inhaler. The one inhaler, the one extra inhaler in a six-month time period, I will admit, as I have sat down and done the calculations, is cutting it really thin, about how many extra doses that they can have, so with that said, if we went up to two, so they would get eight inhalers per six months, we could consider that. I don't think we want them to have any more than that because now, they have got access to much bigger doses of inhaled steroids that have not been well studied to see what

kind of systemic absorption you get over long term. So, that is the reasoning that I am suggesting, at least an extra one, and if we could, two inhalers for every six months.

Tony Merola: Okay, thank you for that.

Monica Toohey: Yes, this is Monica. The group did talk about that a little bit because we were, when we went through these guidelines and trying to think about potentially to implement something here if we needed to. I think it is doable. It is a little tricky with the clinical editing, but we were just trying to kind of solution that. So, you know, we will do our best if that is something that is suggested to try to accommodate, but we are looking at it now.

Lisa Anzisi: This is Lisa. I also have a comment about school-aged, elementary-school-age kids because I recall that that was always a challenge with the school wanting to keep like a rescue inhaler, so I don't know if this would even be enough, if that were the case.

Jamie Woolridge: So, I will jump in there. The physicians, as part of the Asthma Control Program, we did think about that. That if we need to send one of these to school, then now you have that extra one for your six months tied up at school, and it is actually the main reason that we are thinking about two. Now, if you looked, if you remember the data that you have two every month, I don't think we should increase the prescription to that high of a level because now, like, we really have not studied these patients on that kind of dosing or potential dosing of the inhaled corticoid steroid for systemic side effects. All of the long-term studies on inhaled corticoid steroids have been, you know, the currently available high dose, but nothing more than that. So, yes, in order to cover one inhaler at school for the school year, and I can tell you from experience, usually one inhaler will last the school year because if the kids are needing their rescue inhaler that much, that they are emptying more than one inhaler during a school year, the school nurse is calling the family and saying, hey, something is not right and encouraging the family to get the patient or the child seen and under better control. So, we said one at school, and extra one at home to be used for the SMART therapy, and then your daily controller medicine. That is where you would start talking about two, like eight in a six-month time period or I don't know if you could do so many in a nine or twelve-month time period. I think that would have to depend on the way the system works.

Tony Merola: Okay, thank you for that.

Jamie Woolridge: I do hope I am not making this more complicated.

Dr. Fish: No, that helps. Your comment is clear. There is also a comment in the chat. I don't know if this really adds to the conversation, but I will just mention it. The question says is there an allowance for a 30-day supply to be filled early in the Medicaid program and does that have any impact here or a partial fill, hard to do a partial fill on an inhaler, but that is the comment.

Tony Merola: Yes, I think it does have an impact, but it is all in the timing of when that early refill is needed. If somebody is using it as SMART or as rescue, early after they got it, or was it dispensed at the pharmacy? I am not sure that an early refill would address the problem of running out of the inhaler early. The timing would have to be perfect. They would have to be at the end of their inhaler. I am not sure if that works.

Joseph Chiarella: One of the questions I guess I would have is the question of dispensing six or seven inhalers at a time. It is a considerable expense, and the members often lose them, as opposed to let's say letting them refill it on the 20th day of the 30-day supply.

Monica Toohey: I mean the way that the current system works, at least for Medicaid, is it will allow for a person to get something filled early, but then it does, kind of over time, holds them to the amount. So, you can get up to ten days early in a 90-day period to get a prescription refilled, so that is already allowed, but I think we are trying to, I mean, that is already out there. I think we are trying to make sure that, it would be, it is really tied to a 90-day period in how it works, so it is ten days early over every 90-day period for a prescription. So, it could potentially happen, and they could get that filled, but I think the better way to do it is to make for an allowance, and we decide what that should be, so that, again, they are not always trying to utilize that because depending on the time when they come out for it, it might be earlier than the ten days, right? So, say they had used a lot, it may not cut it in the early refill process.

Tony Merola: So, Monica, could the

Jamie Woolridge: I understand, and if you want to clarify that I am not advocating that every six months, patients get seven inhalers because that will not go well. They will lose them.

Monica Toohey: Yeah, no, and we wouldn't want to do that either. We would make sure that it wasn't, you know, we would have checks in place so that they weren't getting that many at one time.

Jamie Woolridge: Okay, good.

Monica Toohey: That's what gets a little tricky in the system because you kind of want to hold the day's supply, right, but then you also want to make those allowances every, you know, six months, so that is where we were kind of talking about how best to do that, so we didn't leave it all open, like you could get seven at once. But, I think we can get around it, so I would just suggest that that is the recommendation you think we need to make it, and we will make it work in some way.

Tony Merola: Okay, let's give the board a visual here. We just threw a slide together quickly, and I will throw it back to Jamie in terms of what this looks like in general, and then we can get a motion and a second to actually open it up for a vote, but just so people get a visual, so Georgia just projected it, so it just states what our current limitation is on Symbicort and Dulera. It is one inhaler every 30 days, and then down below in the box that has the DUR Board recommendation that the quantity limit be changed to allow up to seven inhalers every six months, and Jamie mentioned seven or eight, so we just threw seven in there for now, but just some feedback from the DUR Board members.

Joseph Chiarella: I think it is reasonable that the question would be how everyone would operationalize that on the pharmacy side.

Tony Merola: So, everyone, so Joe, just for clarification, this is just fee for service. You said everyone, so I am not so sure everyone would include...

Monica Toohey: I mean we share the recommendations with Monica, we share the recommendations with the managed care plans in hope that they will do something very similar. Everybody is a little different operationally how they will do it, but I think the intent is just what Jamie said. You will be able to get one extra one in the six-month period; not seven at once, so I think we could make it clear to the managed care plans that when we share the information that that was the concern that we were trying to get an extra inhaler or two on board, so that they could use it for exacerbations. But right now, it kind of reads this way, and someone, if you didn't know any of this conversation, might take it as, oh, I get seven, but that is not really the intent. It is just to allow that extra one or two. So, we can work on the language here, but we can certainly convey to managed care, as well.

Lisa Anzisi: This is Lisa. Would it be a rolling six months or would this be locked into a calendar year? It would be good if it was just a rolling six months.

Monica Toohey: Yeah, it should be rolling.

Jamie Woolridge: That would be awesome.

Joseph Chiarella: Again, this is Joe again, and I don't want to belabor the point. Usually, the state's recommendations are always picked up by the managed care plans, and it is a question of how you would operationalize it, so it might be better if it was a little more specific, and then the plans could figure out how to program their PBMs to comply or to make it happen.

Tony Merola: Yeah, I agree, Joe. Do you have any recommendations on how we could maybe tweak this language a bit to make it more specific to help the managed care plans?

Joseph Chiarella: I mean, I sort of took the point there that if the school wants one, so, you know, again, normally, you would refill on the 90th percentile, so that would allow them three-or-four days early. Could you change that for these particular inhalers to 75th percentile, so they would be able to get one early? Could the first dispensing be two inhalers, and then one a month after that? I don't know. I don't want to speak for the pharmacy folks because they will kill me if it is not programmable, but something like that.

Monica Toohey: Well, that's why we were trying to be a little careful because everybody has different limitations. You know, I don't know that you would want to say the first fill only because what if they decided halfway through, I want to get two now. You could say at least two fills, like, one fill of two inhalers in a six-month period, and the rest be one, but then again, I don't know how well everyone could do that. I didn't want to, like Tony came over to ask me, like what should we say, and that is where it gets tricky.

Tara Thomas: Monica and Joe, this is Tara. From an MCO perspective, there is a way to do this. I think each plan, if they were to decide to adopt this, could come up with a potentially different solution. You know, today, we code for a max day supply, so it would be today coded as like two inhalations per day. We can code for a quantity over a given amount of time, so we could code seven inhalers over 180 days, but, you know, I think each plan would have to kind of think about what are the risks with the various approaches because if you do code for a quantity over time, they could potentially get all seven of them as the first fill. So, to Monica's point, I

think here at the board, we want to be maybe not too specific because not everybody will have the same approach or the same thought about the approach.

Joseph Chiarella: That sounds reasonable.

Jamie Woolridge: The “easiest” thing would be, let’s just give everybody two inhalers every month, but that is a lot of inhaled steroids out floating around and lost inhalers and cost and things like that. Even as a peds pulmonologist, I don’t want all of my patients to get two Dulera or Symbicort every month or have access to that. It is going to mess up my ability to track what they are doing with their medications. It is just, it is not a good solution. I do understand how from, like trying to operationalize seven-to-eight inhalers, and I really, as I continue to think about it, would advocate for eight because you need an inhaler at the school. If I am going to say to a family, this is now your rescue medicine, they are going to turn around and say, I need one to take to school.

Lisa Anzisi: And it could be for only certain ages with children because I don’t think that is the case with older, you know, middle school, high school. They probably carry it themselves.

Jamie Woolridge: Middle school, nope, in middle school, they are going to the nurse’s office. High school, they are carrying it themselves, but a lot of high schools, they shouldn’t be, but nobody is calling them on it.

Dr. Fish: Dr. Woolridge, maybe one way to think about this, and I certainly understand you wouldn’t want people having twelve-or-fourteen inhalers over six months, but maybe, Monica, I don’t know if it could work that you could set the monthly limit at two, but the six-month limit at seven or eight, so that there is a maximum limit at a year, so that it could accommodate that.

Monica Toohey: Yeah, you could totally...(someone else cuts in here). They still could, you know, do two, two, one, and then be out, but we could work with it. There are things to consider, but it is better that way because you could give a titer.

Jamie Woolridge: The other thought I had, and I talked to my physician partners with the Asthma Control Board, is that can we also, whatever recommendation we make today, can we readdress, can we look at the data in six months to see how often our patients are exceeding these limits?

Monica Toohey: Absolutely. We can look at the data in six months. I would probably recommend that we might go a little bit longer, you know, and we will work with you on that, and we will work on...

Jamie Woolridge: I am interested in 12 months. Did I say six?

Monica Toohey: Yes, six months is fine. You know what? What I would encourage you to do if there are other variables that you would like to look at as we are just looking at trends, well, I didn’t as DOH this, but (laughter), we can work with you on what is it that you would like to see. You know what I mean? We can definitely show trends and things like that, but if there is something else that you would like to see, we will work through DOH to accommodate you.

Jamie Woolridge: Okay, that is great.

Tony Merola: So, we asked Georgia here to tweak the language based upon some of the comments we got from Joe and Tara. You know, Tara used the phrase over 180 days, so we just tweaked the language. I don't know if that is better, if people, if that is more understandable or acceptable for people. Any inputs there? Okay, hearing none, I am sorry, go ahead.

Gloria Rodriguez: I just had a thought. How about saying to be changed to allow the additional dispensation of either one-or-two inhalers over a 180-day period or six months?

Tony Merola: We hear you, Gloria. Yeah.

Monica Toohey: Yeah, I mean I think you can.

Jamie Woolridge: I like that.

Tony Merola: Okay, alright. Let's, I am going to have Georgia maybe tape that in real time and put the pressure on it.

Gloria Rodriguez: Sorry, I was trying to make a comment before, and my audio wasn't working, so I apologize. You guys made a change, and then I made a comment.

Tony Merola: We hear you loud and clear. Let's see if we can get this done on the screen here, so people can see it because if we go in this direction, we are going to have to look for a motion and a second to bring this up to vote, so we just want to make sure everybody is kind of on the same page visually.

Joseph Chiarella: One or two is a slippery slope. Why not say up to two because everyone is going to disagree on that at the end.

Tony Merola: Good point, Joe. Yup. Well taken. Okay, more comments?

Female: I like this.

Male: Yeah.

Tony Merola: Okay, we are getting closer.

Female: I think we are real close.

Tony Merola: Okay. So, if we are that close, we will probably look for a DUR Board member to make a motion to bring this recommendation to a vote.

Female: So moved!

Tony Merola: I hear one.

Joseph Chiarella: I will second it. It is Joe.

Tony Merola: Thanks, Joe.

Dr. Fish: More comments or discussions?

Tony Merola: Any other discussion?

Dr. Fish: So, it now reads the quantity limit for mometasone/formoterol and budesonide/formoterol be changed to allow for the additional dispensing of up to two inhalers over a 180-day period. I will give people a minute to just ponder this language.

Joseph Chiarella: Doug, would we put in an effective date on this, so that people can operationalize this?

Tony Merola: Joe, this is Tony. I don't think we can because we have to send, the timeline associated with post-meeting processes is we have got to post the meeting summary, and there are a number of other things, so it is hard to put an implementation date on it until we go through those post-meeting processes.

Joseph Chiarella: Okay, just a thought. That's fine.

Tony Merola: No, good idea. It is just that it is hard to determine when we can get, I will call them, final determinations back from the Commissioner. We are still kind of looking at it here, so, just bear with us. Doug is chiming in here.

Dr. Fish: This is Doug. Ken and I are just conferring because to me, something that might be missing is, is it additional to what. So, Ken is suggesting to allow for the dispensing of up to two additional inhalers. It is not an additional dispensing time if it is additional inhalers that are being dispensed. So, I think that is probably accurate, maybe moving the word additional is, and then do we need to in any way say what it is in addition to or is it so clear that it doesn't need to be stated?

Female: Sorry, of just the current criteria.

Jamie Woolridge: The current criteria gives you one a month.

Monica Toohey: Right.

Jamie Woolridge: Which is standard dosing, it works.

Monica Toohey: And this is in addition, you know, this is the additional piece to that. So, I just think refer back to the top.

Dr. Fish: Oh, right. It is up there at the top. Okay, yeah, the current quantity limit is there listed as one inhaler every 30 days. So, it now reads the quantity limit for mometasone/formoterol and budesonide/formoterol will be changed to allow for the dispensing of up to two additional inhalers over a 180-day period.

Tony Merola: Right, so it would be in addition to that one every 30 days. Is that clear? I just want to make sure it is clear. It is clear to me.

Dr. Fish: I think it says what we mean now.

Tony Merola: Okay, alright.

Dr. Fish: Do others agree?

Jamie Woolridge: So, just to make sure I understand, so, what would probably end up being the final wording is current quantity limit for Dulera and Symbicort is one every 30 days, but allow for dispensing of up to two additional inhalers over a 180-day period.

Tony Merola: That sounds about right. Right, Monica?

Monica Toohey: Yup, that's it.

Jamie Woolridge: Yup, good. I like that.

Tony Merola: Yeah, that's good, and Doug, this meeting is being recorded, so we will be able to notate that.

Dr. Fish: Okay.

Jamie Woolridge: Yeah, I really do because for most patients, they are not going to be prescribed SMART therapy because I will tell you that in, like in the field of at least pediatrics, we are still not 100 percent sure what we think of SMART therapy, but we want to have the option to try it, now that it has been tested and approved. We need to see it happening in real life, so this gives us the ability to do that without everybody just getting a whole lot of inhalers all at once without people really thinking about what they are doing and what they are prescribing. And also allowing us to track these inhalers to make sure patients are filling them appropriately and not over filling them.

Dr. Fish: Fair enough. I think we want to be smart about it.

Jamie Woolridge: Yes.

Dr. Fish: So, do we have a motion to modify the current frequency, quantity, duration limit for Dulera and Symbicort from a board member?

Jamie Woolridge: So moved.

Dr. Fish: And a second?

Lisa Anzisi: Second, Lisa.

Joseph Chiarella: I will second it again.

Dr. Fish: Okay, thank you. And are there any more comments or discussion? This was robust, really good. Okay, I think we are ready to put it up for a vote. So, are there any abstentions to the current recommendation, and I will just read it one last time, the quantity limit for mometasone/formoterol or Dulera and budesonide/formoterol or Symbicort will be changed to allow for the dispensing of up to two additional inhalers over a 180-day period. Any abstentions? Any opposed? The recommendation as cited passes unanimously, 13 votes in favor, 14. Dr. Woolridge?

Dr. Woolridge: I want to take this moment to thank everybody from the Drug Utilization Review Board. Our program, because it really does allow us, now having this, once we have this recommendation in place, it will allow us to continue to do the work and help physicians implement the guidelines appropriately and sustainably, which is what our goal is to keep kids out of the hospital. So, thank you very much.

Dr. Fish: Well, thank you for your input, Dr. Woolridge. It was helpful, and Tony, it was 14 with your addition.

Tony Merola: Yes, Jaime makes 14 for the vote, yup, correct.

Dr. Fish: I think that is our last item of business. So, I just really appreciate, this was a really good discussion. I think we landed in a good place here on the asthma guidelines. I think the Asthma Control Program and the Department of Health will also be pleased, so appreciate all of the providers that reached out to you, Dr. Woolridge, and all that you have done to enlighten us and everyone on the board regarding this issue, and all the topics today for your input. So, thank you very much, and I am going to turn it over to Kim for any last comments, and then maybe to Tony.

Kim: No, I would just echo those things to the board members for their participation and their continued work on behalf of the New York State Medicaid Program. I will remind you all to check for an email in the next couple of days from Jackie regarding the next meeting, and I think that is all I have. I don't know if Tony has anything additional to add.

Tony Merola: Just one thing to mention for DUR Board members, if there are any of your colleagues out there who are interested in joining the board, currently we have one physician vacancy, one pharmacist vacancy, and one nurse practitioner/midwife vacancy. So again, any of your colleagues interested in joining the board, please have them send their resume/CV to us, and they can use the DUR@health.ny.gov mailbox. With that, I think, Doug, we can officially adjourn and maybe head outside for a bit and enjoy the summer day that we are having here in early to mid-May.

Dr. Fish: Very good. Thank you, all. Get home safely.

Tony Merola: Thanks, everybody.