The following tables list the agenda items as well as the Options for Consideration that are scheduled to be presented and reviewed at the April 18, 2024 meeting of the Pharmacy and Therapeutics Advisory Committee.

SINGLE AGENT REVIEWS

Agent	Options for Consideration
New Product to Market Voquezna® (vonoprazan)	**Proton Pump Inhibitors: Non-Preferred (NPD)** **Approval Duration: 8 weeks initial approval, 6 months for renewal** • *Vonoprazan works by suppressing basal and stimulated gastric acid secretion at the secretory surface of the gastric parietal cell through inhibition of the H^+, K^+-ATPase enzyme system in a potassium competitive manner.* **Initial Approval Criteria:** • Diagnosis of diagnostically confirmed erosive esophagitis; **AND** • Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of erosive esophagitis; **AND** • Patient has had a ≥ 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to 2 preferred agents in this PDL class. **Renewal Criteria:** • Diagnosis of diagnostically confirmed erosive esophagitis; **AND** • Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of erosive esophagitis; **AND** • Patient has experienced symptom improvement or control during initial treatment course. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 1 tablet per day
New Product to Market Voquezna Dual Pak® (vonoprazan/amoxicillin) Voquezna Triple Pak® (vonoprazan/amoxicillin/clarithromycin)	**H. Pylori Treatment: Non-Preferred (NPD)** **Approval Duration: 30 days** • *Vonoprazan works by suppressing basal and stimulated gastric acid secretion at the secretory surface of the gastric parietal cell through inhibition of the H^+, K^+-ATPase enzyme system in a potassium competitive manner. Amoxicillin and Clarithromycin*

Agent	Options for Consideration
	are antimicrobial agents that work by various mechanisms to treat bacterial infections. **Approval Criteria:** • Diagnosis of diagnostically confirmed *H. pylori* infection; **AND** • Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of *H. pylori*; **AND** • Patient has had a ≥ 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to Pylera. **Age Limit:** ≥ 18 years of age **Quantity Limit:** Voquezna Dual Pak: 1 carton of 28 tablets and 84 capsules per 14-day supply Voquezna Triple Pak: 1 carton of 56 tablets and 56 capsules per 14-day supply.

New Product to Market
Fabhalta® (iptacopan)
	Non-PDL
	
	Approval Duration: 4 months for initial, 1 year for renewal
	
	• *Iptacopan inhibits Factor B, which acts proximally in the alternative pathway of the complement cascade to control C3B-mediated intravascular and extravascular hemolysis.*
	
	Initial Approval Criteria:
	• Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry results demonstrating both of the following:
	  ○ The absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins (e.g., CD55, CD59) on at least two cell lineages; **AND**
	  ○ PNH granulocyte clone size ≥ 10%; **AND**
	• Prescribed by, or in consultation with, a hematologist or other appropriate specialist in the treatment of paroxysmal nocturnal hemoglobinuria (PNH); **AND**
	• Patient will not be using a C5 complement inhibitor (e.g., Soliris, Ultomiris) or a C3 complement inhibitor (e.g., Empaveli) while taking Fabhalta.

Agent	Options for Consideration
	Renewal Criteria: • Physician attestation of clinical benefit, such as reduction in number of blood transfusions needed, improvement or stabilization of hemoglobin levels, reduction in hemolysis. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 2 capsules per day
New Product to Market Jesduvroq® (daprodustat)	**Erythropoiesis Stimulating Proteins: Non-Preferred (NPD)** **Approval Duration: 6 months** • *Jesduvroq works by increasing transcription of the HIF-responsive genes, including erythropoietin.* **Initial Approval Criteria:** • Diagnosis of chronic kidney disease (N18.9); **AND** • Pretreatment hemoglobin level ≤ 11g/dl; **AND** • Patient has been receiving dialysis for at least 4 months; **AND** • Patient is not receiving treatment with any other erythropoiesis stimulating agents. **Renewal Criteria:** • Documentation (e.g., progress note, laboratory report) demonstrating a positive response to therapy. **Quantity Limit:** 1mg one daily 2mg one daily 4mg one daily 6mg two daily 8mg three daily
New Product to Market Wainua™ (eplontersen)	**Non-PDL** **Approval Duration: 1 year** • *Eplontersen is a ligand-conjugated antisense oligonucleotide that degrades transthyretin (TTR) mRNA, thereby decreasing TTR protein and thus amyloid deposits in the liver.* **Initial Approval Criteria:** • Patient has a definitive diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis/FAP

Agent	Options for Consideration
	(familial amyloidotic polyneuropathy) as documented by: ○ Amyloid deposition on tissue biopsy; **OR** ○ Identification of a pathogenic TTR variant using molecular genetic testing; **AND** • Patient has polyneuropathy attributed to hATTR/FAP; **AND** • Patient has NOT received an orthotopic liver transplant (OLT); **AND** • Patient will not be using Wainua in combination with other TTR-reducing agents (e.g., inotersen [Tegsedi], patisiran [Onpattro], tafamidis [Vyndamax, Vyndaqel], vutrisiran [Amvuttra]). **Renewal Criteria:** • Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms, such as improvement in ambulation, neurologic symptoms, or activities of daily living. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 1 auto-injector per 28 days
New Product to Market Agamree® (vamorolone)	**Steroids, Oral: Non-preferred (NPD)** **Approval Duration: 1 year** • *Vamorolone is a corticosteroid that acts through the glucocorticoid receptor to exert anti-inflammatory and immunosuppressive effects. The precise mechanism by which vamorolone exerts its effect in patients with Duchenne Muscular Dystrophy is unknown.* **Initial Approval Criteria:** • Diagnosis of Duchenne Muscular Dystrophy (DMD); **AND** • Patient is currently receiving, or planning to receive, physical therapy; **AND** • Patient has tried prednisone or prednisolone for at least 6 months; **OR** • Patient has experienced 1 of the following adverse reactions directly attributable to previous therapy with prednisone or prednisolone: ○ Significant behavioral changes negatively impacting function at school, home, day care, etc.; **OR**

Agent	Options for Consideration
	○ Significant weight gain (e.g., crossing 2 percentiles and/or reaching 98th percentile for age and sex) **Renewal Criteria:** • Patient continues to receive physical therapy; **AND** • Patient has received benefit from therapy (i.e. stability, improvement or slowing of decline) in one or more of the following areas of assessment: ○ Motor function (North Star Ambulatory Assessment (NSAA) ○ Cardiology ○ Endocrinology ○ Orthopedics (e.g., scoliosis) ○ Pulmonary function. **Age Limit:** ≥ 2 years of age **Quantity Limit:** 7.5 mL per day
New Product to Market Zilbrysq® (zilucoplan)	**Non-PDL class** **Approval Duration: Initial 3 months; Renewal 1 year** • *Zilucoplan is a complement inhibitor indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.* **Initial Approval Criteria:** • Diagnosis of generalized myasthenia gravis (MGFA Clinical Classification Class II to IV) with positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND** • Member has a baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 6; **AND** • Patient has tried and failed at least two immunosuppressive therapies (one corticosteroid and one non-steroid immunosuppressive therapy, e.g., azathioprine, cyclosporine, mycophenolate); **AND** • Patient does not have unresolved Neisseria meningitidis infection. **Renewal Criteria:** • For Initial Renewal: Patient has disease improvement as evidenced by: ○ At least 2-point reduction in MG-ADL total score from baseline; **OR**

Agent	Options for Consideration
	○ Improvement in signs or symptoms that impact daily function; **OR** • For Subsequent Renewal: After an initial beneficial response: ○ Patient is stable on therapy; **OR** ○ Patient requires continuous treatment due to new or worsening disease activity. **Age Limit:** ≥ 18 years **Quantity Limit:** 1 syringe per day

FULL CLASS REVIEWS

PDL Class	Options for Consideration
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	• DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) class, require PA until reviewed by the P&T Committee.
Antihyperuricemics	• DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Antihyperuricemics class, require PA until reviewed by the P&T Committee.
Erythropoiesis Stimulating Proteins	• DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Erythropoiesis Stimulating Proteins class, require PA until reviewed by the P&T Committee.
Steroids, Oral	• DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Steroids, Oral class, require PA until reviewed by the P&T Committee.

PDL Class	Options for Consideration
Pancreatic Enzymes	• DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Pancreatic Enzymes class, require PA until reviewed by the P&T Committee.
Colony Stimulating Factors	• DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Colony Stimulating Factors class, require PA until reviewed by the P&T Committee.

CONSENT AGENDA ITEMS

Consent Agenda	Options for Consideration
For the following therapeutic classes, there are **no recommended changes to the Preferred Drug List (PDL) status**; these may be voted on as a group.	
• **Narcotics, Long Acting** • **Narcotics, Short Acting** • **Narcotic Agonist/Antagonists** • **Narcotics, Fentanyl Buccal Products** • **Antimigraine Agents, Triptans** • **Antimigraine Agents, CGRP Inhibitors** • **Neuropathic Pain** • **Opiate Dependence Treatments** • **Skeletal Muscle Relaxants** • **Phosphate Binders** • **Sickle Cell Anemia Treatments** • **Thrombopoiesis Stimulating Proteins** • **Alpha-Glucosidase Inhibitors** • **Dipeptidyl Peptidase-4 (DPP-4) Inhibitors**	• **Glucagon-Like Peptide (GLP-1) Receptor Agonists** • **Insulin & Related Agents** • **Meglitinides** • **Metformins** • **Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors** • **Sulfonylureas** • **Thiazolidinediones (TZDs)** • **Androgenic Agents** • **Bone Resorption Suppression & Related Agents** • **Glucagon Agents** • **Growth Hormones** • **Progestins for Cachexia** • **Uterine Disorder Treatments**