AUGUST 22, 2017

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE MEETING

NORTH CAROLINA STATE HEALTH PLAN
3200 ATLANTIC AVENUE, RALEIGH, NC 27604

BINDER DIVIDER

“Introduction”

North Carolina State Health Plan
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Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA

Pharmacy and Therapeutics (P&T) Committee Meeting
Tuesday, August 22nd 2017, 6:00 p.m. to 8:00 p.m.

Agenda

	Topic:	*Presenter:*
I.	**Welcome**	Carl Antolick III, Chair
	• Call to Order	
	• Introduction(s)	Dee Jones, EA
II.	**Conflict of Interest Statement**	Carl Antolick III, Chair
III.	**Minutes from May 23, 2017 Meeting***	Carl Antolick III, Chair
IV.	**Old Business**	Carl Antolick III, Chair
	• Formulary Development and Management at CVS Caremark®	
V.	**Formulary Updates***	Carl Antolick III, Chair
	• 2018 Formulary Updates	Carl Antolick III, Chair
	o Removals	
	o Add Backs	
	• Hyperinflation Exclusions	Carl Antolick III, Chair
	• Tier Changes	Carl Antolick III, Chair
	o Negative	
	o Positive	
	• New Drug Reviews	
	o Soliqua® 100-33	Jennifer Burch, PharmD, CDE
	o Afstyla®	David Konanc, MD
	o Trulance®	John Anderson, MD
	o Tymlos®	John Anderson, MD
	o Rhofade®	Matthew Flynn, MD
	o Rubraca®	Michael Spiritos, MD
	o Rydapt®	Michael Spiritos, MD
	o Vraylar®	Randy Grigg, MD
VI.	**Utilization Management Policy Review***	Carl Antolick III, Chair
	• New Policies	
	o Albenza®, Biltricide®, Emverm® Limit Policy	John Engemann, MD
	o Ciclopirox Topical Solution 8% Policy	Matthew Flynn, MD
	o Elidel® Policy	Matthew Flynn, MD
	o Protopic® Policy	Matthew Flynn, MD

*Requires a vote by the P&T Committee

- Soriatane® Policy — Matthew Flynn, MD
- Prudoxin®, Zonalon® Policy — Matthew Flynn, MD
- Sitavig® Policy — Matthew Flynn, MD
- Rosacea Policy — Matthew Flynn, MD
- Cuprimine®, Syprine® Policy — Joseph Shanahan, MD
- Voltaren® Gel Policy — Jennifer Burch, PharmD, CDE
- Lidoderm® Policy — Jennifer Burch, PharmD, CDE

- Existing Policies
  - Daraprim® Policy — John Engemann, MD
  - Dificid® Policy — John Engemann, MD
  - Influenza Treatment Policy — John Engemann, MD
  - Grastek® Policy — Joseph Shanahan, MD
  - Oralair® Policy — Joseph Shanahan, MD
  - Ragwitek® Policy — Joseph Shanahan, MD
  - Solodyn®, Ximino® Policy — Matthew Flynn, MD
  - Restasis® Policy — John Anderson, MD
  - Testosterone Oral Policy — Jennifer Burch, PharmD, CDE
  - Testosterone Policy — Jennifer Burch, PharmD, CDE
  - Solaraze® Policy — Jennifer Burch, PharmD, CDE

VII. Other Topics* — Carl Antolick III, Chair

- P&T Committee Charter

VIII. Adjourn — Carl Antolick III, Chair

- Next Meeting: Tuesday, November 14, 2017
- Directions to the Longleaf Building

*Requires a vote by the P&T Committee

STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

ETHICS AWARENESS & CONFLICT OF INTEREST REMINDER

(to be read by the Chair of the P&T Committee or his or her designee at the beginning of each meeting)

In accordance with the NC State Health Plan for Teachers and State Employees' ethics policy, it is the duty of every member of the Pharmacy and Therapeutics Committee, whether serving in a vote casting or advisory capacity, to avoid both conflicts of interest and appearances of conflict.

Does any Committee member have any known conflict of interest or the appearance of any conflict with respect to any manufacturers of any medication to be discussed at today's meeting?

Or, if during the course of the evaluation process if you identify a conflict of interest or the appearance of a conflict.

If so, please identify the conflict or appearance of conflict and refrain from any undue participation[1] in the particular matter involved.

[1] *"A public servant shall take appropriate steps, under the particular circumstances and considering the type of proceeding involved, to remove himself or herself to the extent necessary, to protect the public interest and comply with this Chapter, from any proceeding in which the public servant's impartiality might reasonably be questioned due to the public servant's familial, personal, or financial relationship with a participant in the proceeding." See N.C.G.S. §138A-36 (c). If necessary, the Chairman or individual member involved should consult with his ethics liaison, legal counsel, or the State Ethics Commission to help determine the appropriate response in a given situation. Rev. 1-16-07*

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MINUTES OF THE PHARMACY AND THERAPEUTICS (P&T) COMMITTEE MEETING
MAY 23, 2017

PRESENT:

Jennifer Burch, PharmD, Owner, Central Compounding Center
John Anderson, MD, MPH, Chief Medical Officer of Duke Primary Care
Matthew K. Flynn, MD, Founder, Family Dermatology
David Konanc, MD, Neurologist, Raleigh Neurology Associates
Joseph Shanahan, MD, Owner, Shanahan Rheumatology & Immunotherapy
Ira Protas, RPh, Chair, Director of Pharmacy Benefits, NCSHP
Jamilah Brunson, PharmD, Secretary, Clinical Pharmacy Manager, NCSHP (non-voting member)
Lotta Crabtree, JD, Deputy Executive Administrator, NCSHP (non-voting member)
Carl Antolick III, PharmD, Clinical Pharmacist, NCSHP (non-voting member)
Connie Rominger, Medical Team Lead, BCBSNC Member Rights & Appeals (non-voting member)
Heather Renee Jarnigan, RPh, Clinical Advisor, CVS Health (non-voting member)

GUESTS:

Natasha Davis, Pharmacy Benefits Program Manager, NCSHP
Neha Zadoo, Pharmacy Business Analyst, NCSHP
Lucy Barreto, DDS, MHA, Healthcare Product Manager, NCSHP
Margaret Balogun, Administrative Support Associate, NCSHP
Justin Emerson, RPh, Director, Government Accounts, CVS Health
Scott Ramsey, MBA, Regional Account Executive, Boehringer Ingelheim
Angela Sutton Furniss, MBA, Regional Account Executive, Dexcom
Mike Laraway, Account Executive, Novo Nordisk
Jason Richardson, Regional Account Manager, Allergan
Chris Roland, Corporate Accounts Associate Director, Tesaro
John Sutter, MBA, Senior Account Executive, Merck
Stephanie Miller, Regional Sales Director, AstraZeneca
Ken Krause, Senior Account Executive, Eli Lilly
Kimberly Turk, Specialty Account Director, GlaxoSmithKline

EXECUTIVE SESSION:

The Chairperson called the executive session to order of the meeting of the P&T Committee to order at approximately 6:00 P.M. (EST). All members of the P&T Committee were offered a light meal and were instructed that there were to be no additional breaks during the meeting.

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In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act the Chairperson read the NCSHP's Ethics Awareness & Conflict of Interest Reminder to the P&T Committee members and requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. No conflicts of interest were noted.

The Chairperson then outlined the meeting agenda, which had previously been distributed to the members together with other materials. The agenda for the meeting included the following subjects which required a vote from the members of the P&T Committee: (1) March 2017 P&T Committee Meeting Minutes; (2) updates and changes to the NCSHP's customized drug formulary; and (3) utilization management criteria.

The Chairperson then asked the P&T Committee members to review March 2017's meeting minutes. Following a motion by Dr. Matthew K. Flynn and seconded by Dr. Jennifer Burch, the Committee unanimously approved the March 23, 2017 minutes, as written.

Dr. Jamilah Brunson outlined the three medications that were being excluded from the formulary as they were an additional NDC as part of an existing formulary exclusion or they were part of the Advanced Controlled Specialty Formulary. Dr. Joseph Shanahan reviewed OTREXUP® and recommended its exclusion. Dr. John Anderson reviewed BERINERT® and recommended its exclusion. Following a motion by Dr. Matthew K. Flynn and seconded by Dr. Jennifer Burch, the Committee unanimously approved the three medications be excluded from the formulary as of August 1st 2017.

Dr. Carl Antolick III presented the medications that were to be removed from the formulary due to hyperinflation, which is defined as egregious price increases over a short period of time. All of the medications listed were branded drug products that have readily-available, clinically-appropriate and more cost-effective alternatives. They include: FANAPT®, COLAZAL®, BENSAL HP®, FML FORTE®, FML LIQUIFILM®, FML®, MINOCIN®, PRED FORTE®, and PRED MILD®. Following a motion by Dr. Matthew K. Flynn and seconded by Dr. Jennifer Burch, the Committee unanimously recommended that the medications discussed would be removed from the formulary as of August 1st 2017.

Dr. Carl Antolick III then presented the proposed quarter 2 tier changes. There were five preferred to non-preferred tier changes, considered negative to the membership, and ten non-preferred to preferred tier changes, considered positive to the membership, respectively. The "negative" tier changes included: KALETRA®, EPZICOM®, MOVIPREP®, ZETIA®, and ALBENZA®. The "positive" tier changes included: CABOMETYX™, DUPIXENT®, EMVERM™, MULTAQ®, ABILIFY®, BELSOMRA®, ONZETRA™, ZEMBRACE™, HORIZANT®, and NUEDEXTA®. Dr. Matthew K. Flynn voiced the concern regarding ALBENZA® and EMVERM®.

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He was under the impression that EMVERM® had recently had a larger price increase and worried that there would be higher plan costs if we preferred EMVERM® over ALBENZA® on the formulary. Heather Renee Jarnigan confirmed that a generic alternative, mebendazole, was not currently available in the marketplace. Dr. Matthew K. Flynn suggested that the Plan research the actual billed price of each medication and because the medications are interchangeable in the practice setting, place the most affordable option on the preferred tier. Following a motion by Dr. David Konanc and seconded by Dr. Matthew K. Flynn, the Committee unanimously recommended that the medications discussed would be placed into their proposed tiers as of August 1st 2017, which included EMVERM® and ALBENZA®, upon the completion of cost analysis research.

Dr. Jamilah Brunson introduced the next agenda item, the addition of new medications to the formulary along with their accompanying utilization management criteria. The drugs that were presented were: Rytary™ (all strengths), vancomycin injection (all strengths and formulations), Dupixent®, Ocrevus™, Eucrisa™, Bavencio®, Zejula™, Stamaril®, Ruconest®, and Namzaric®. Dr. David Konanc, Dr. Matthew K. Flynn, Dr. John Anderson, and Dr. Michael D. Spiritos (absent) provided New Drug Evalutions on the previously named medications and recommended that they all be added to the formulary. Dr. Matthew K. Flynn proposed revisions to the Specialty Guideline Management criteria and will present the revised versions to the Plan at a later date. Following a motion by Dr. Jennifer Burch and seconded by Dr. Joseph Shanahan, the Committee unanimously recommended that all medications and their accompanying utilization management criteria, with the addition of DUPIXENT® upon revision of its coverage criteria, be added to the formulary on August 1st 2017.

Dr. Jamilah Brunson introduced the last agenda item, Utilization Management Criteria. Drs. Flynn, Anderson, Shanahan, and Burch reviewed the following Specialty Guideline Management and utilization criteria: RASUVO®, ENBREL®, HUMIRA®, CINRYZE®, H.P. ACTHAR®, Topical Antifungals, GLUMETZA®-FORTAMET®, SAXENDA®, CONTRAVE®, BELVIQ®, Short-Acting Anti-Obesity, Topical Acne, DIFFERIN®, TAZORAC®, Tretinoins, and Isotretinoins while the criteria for VFEND® and NOXAFIL® were tabled as Dr. John Engemann (absent) had additional revisions that were not able to be brought to the meeting. Dr. Flynn made some additional edits to the following criteria: HUMIRA®, Topical Antifungals, DIFFERIN®, TAZORAZ®, Retinoids, and Isotretinoins and will present written revised criteria at a later date. Following a motion by Dr. Jennifer Burch and seconded by Dr. Matthew K. Flynn, the Committee unanimously recommended all utilization management criteria be used as is, except the mentioned criteria that was being addressed by Dr. Flynn.

The Chairperson explained that the P&T Committee Charter that was to be reviewed was tabled as it required additional revisions from our legal counsel.

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The Chairperson thanked the participants of the Committee and the general public for attending and announced the next meeting date of August 22nd 2017 6:00-8:00 P.M. (EST) at the Dogwood Conference Room in the Longleaf Building, 3200 Atlantic Avenue Raleigh, NC 27604.

The Chairperson adjourned the meeting at approximately 7:30 P.M. (EST).

CVS caremark™

Formulary Development and Management at CVS Caremark®

Development and management of drug formularies is an integral component in the pharmacy benefit management (PBM) services CVS Caremark provides to health plans and plan sponsors. Formularies have two primary functions: 1) to help the PBM provide pharmacy care that is clinically sound and affordable for plans and their plan members; and 2) to help manage drug spend through the appropriate selection and use of drug therapy.

Underlying principles of the CVS Caremark Formulary Development and Management Process include the following:

- CVS Caremark is committed to providing a clinically appropriate formulary.
- Decisions on formulary are made by a committee of independent, unaffiliated clinical pharmacists and physicians.
- The physician always makes the ultimate prescribing determination as to the most appropriate course of therapy.

The CVS Caremark formulary development process is based on nearly two decades of experience as well as extensive clinical pharmaceutical management resources. The formulary is developed and managed through the activities of the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee and Formulary Review Committee.

CVS Caremark National Pharmacy and Therapeutics Committee

The CVS Caremark National P&T Committee is foundational in the process. The P&T Committee is an external advisory body of experts from across the United States, composed of 21 independent health care professionals including 17 physicians and four pharmacists, all of whom have broad clinical backgrounds and/or academic expertise regarding prescription drugs. A majority of the CVS Caremark National P&T Committee members are actively practicing pharmacists and physicians. Two physicians and two pharmacists are experts in the care of the elderly or disabled. One of the physicians is a medical ethicist. The role of the medical ethicist is to assist in the decision-making process by facilitating the discussion, as needed, and to provide unbiased feedback with respect to the logic and appropriateness of the conclusions drawn and the decisions reached. The composition of the CVS Caremark National P&T Committee exceeds the Centers for Medicare and Medicaid Services (CMS) P&T committee requirements for Medicare Part D sponsors and also exceeds URAC standards.

CVS Caremark National Pharmacy and Therapeutics Committee Membership		
4 pharmacists, including	17 physicians, representing	
1 academic pharmacist	Allergy	Internal medicine
1 hospital pharmacist	Cardiology	Infectious disease
2 geriatric pharmacists	Clinical pharmacology	Pediatrics
	Endocrinology	Neurology
	Family practice	Medical ethics
	Gastroenterology	Pharmacoeconomics
	Gerontology	Pharmacology
	Hematology/oncology	Psychiatry-adult/ pediatric/adolescent
		Rheumatology

Data as of February 20, 2017. Subject to change without notice.

The regular voting members on the CVS Caremark National P&T Committee are not employees of CVS Caremark. The CVS Caremark National P&T Committee is charged with reviewing all drugs, including generics that are represented on the CVS Caremark approved drug lists. The approvals made are non-biased, quality driven and evidence based. The clinical merit of the drug, not the cost, is the primary consideration of the CVS Caremark National P&T Committee.

New members are included on the current CVS Caremark National P&T Committee on the basis of: active involvement in clinical practice (patient care), whether in the academic, hospital, or community setting; national recognition in their specialty; contributions to medical and/or pharmacy literature; and previous experience with pharmacy and therapeutics committees. The CVS Caremark National P&T Committee members are compensated for their participation with an appropriate honorarium and any travel/hotel expenses incurred in the process of serving on the P&T Committee.

The CVS Caremark National P&T Committee meets face-to-face on a quarterly basis and, as needed, on an ad hoc basis. CVS Caremark has a stringent conflict of interest policy for CVS Caremark P&T Committee members. CVS Caremark requires each P&T Committee member to complete a Conflict of Interest Disclosure Statement annually. Completed Conflict of Interest Statements are carefully scrutinized by the CVS Caremark Chief Health Officer and Vice President of Clinical Affairs responsible for formulary development and maintenance. An objective party in the CVS Caremark Compliance Department verifies that conflict of interest requirements have been met. Through this careful review, CVS Caremark helps ensure that the P&T Committee meets or exceeds all federal and state regulatory requirements for conflict of interest, including CMS, and all industry accreditation standards, including URAC and the National Committee for Quality Assurance (NCQA).

Clinical Formulary Department

The CVS Caremark National P&T Committee functions are supported by the CVS Caremark Clinical Formulary Department. Clinical pharmacists in the Formulary Department prepare individual Drug Monographs and Therapeutic Class Reviews following a comprehensive review of available clinical literature. Numerous references and information resources are used to assist in the evaluation and review of the medications under consideration for formulary addition. These peer-reviewed resources are selected based on being accurate, reliable, current, comprehensive and well respected.

Formulary Development and Maintenance Process

The CVS Caremark National P&T Committee bases decisions on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information. The CVS Caremark P&T Committee reviews medications from a purely clinical perspective; it does not have access to nor does it consider any information on rebates, negotiated discounts or net costs. In alignment with this clinical perspective, the CVS Caremark National P&T Committee also reviews new drug evaluations, new FDA-approved indications, new clinical line extensions and publications on new clinical practice trends.

In evaluating new drugs for formulary inclusion, the CVS Caremark P&T Committee reviews the individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews prepared by the Clinical Formulary Department. CVS Caremark National P&T Committee members share insights based on their clinical practice and the quality of published literature. FDA-approved drugs products[1] are reviewed and considered for inclusion on the CVS Caremark National Formulary and standard formularies/drug lists by the CVS Caremark National P&T Committee. The CVS Caremark National P&T Committee also reviews and approves all utilization management (UM) criteria (i.e., prior authorization, step therapy and quantity limits outside of FDA-approved labeling).

The CVS Caremark National P&T Committee reviews all standard formularies annually. The review is conducted by drug class to assure that the formulary recommendations previously established are maintained and to recommend additional changes for clinical appropriateness if advisable based on newly available pharmaceutical information. In addition, the CVS Caremark National P&T Committee reviews all UM criteria annually.

Review of new drugs or new indications for drugs in six classes is expedited. These classes include the immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals and antineoplastics. For drugs in these classes, the CVS Caremark National P&T Committee makes a National Formulary and Medicare Part D Drug List status decision within 90 days of launch/ market availability. For drugs outside of these classes, the CVS Caremark National P&T Committee makes a National Formulary decision within 90 days of launch/market availability and a Medicare Part D Drug List status decision within 180 days of launch/market availability. In addition, the CVS Caremark National P&T Committee will make a formulary status decision for the Managed Medicaid Drug List within 90 days of launch/market availability of newly FDA-approved drugs, or will provide a clinical justification if this timeframe is not met.

Formulary Review Committee

The Formulary Review Committee (FRC) is an internal CVS Caremark committee that evaluates additional factors that may affect the formulary. For example, when two or more drugs produce similar clinical results, the FRC may evaluate factors such as:

- Utilization trends
- Impact of generic drugs or drugs designated to become available over-the-counter
- Brand and generic pipeline
- Line of business
- Plan sponsor cost
- Applicable manufacturer agreement
- Potential impact on members

The FRC makes business recommendations based on such factors to the CVS Caremark P&T Committee. It is important to note that any drug product must first be deemed safe and effective by the P&T Committee before it is considered eligible for inclusion on a CVS Caremark Formulary or Drug List, and that any recommendations made by the FRC must be approved by the CVS Caremark National P&T Committee before implementation.

Formulary Management

The formulary is a dynamic tool that may be responsive to changes in the marketplace. It is intended to offer savings to clients while ensuring clinically appropriate products are available for members to use. Clients may choose to utilize CVS Caremark formularies for their plans or use them as the foundation for custom formularies.

Most drug classes have multiple generic and low-cost brand-name options that cover the same indications as more costly brand-name options in the same class. The generic and low-cost brand-name options offer similar efficacy and safety. Since many brand-name drugs do not provide clear clinical and/or financial advantages when compared to available drug options within the therapeutic class, several strategies are available to promote cost-effective use of medications ranging from tiered copayments, excluding products from coverage or having a closed plan design.

- Tiered copayments encourage members to use preferred formulary drugs. A three-tier formulary—typically with generics in the first, lowest cost tier; preferred brand-name drugs at second tier; and non-preferred brand-name drugs at the highest-cost third tier—is the option chosen by the vast majority of plan sponsors working with CVS Caremark.
- Many of our standard formularies also exclude certain products from coverage. The excluded products have alternatives available that will deliver cost savings to plan sponsors.
- Closed formularies will cover a set number of products and the others are not covered unless the claim goes through an override process.

Within these plan designs, clients may opt to implement a formulary exception process where members, after meeting certain criteria, could have an excluded product covered, or could receive a third-tier product at a second-tier copay.

All formularies include generic drugs, and generics are typically in the lowest tier of pricing for members. Brand-name products may be considered preferred or non-preferred in the common three-tier plan design. Preferred brand-name drugs are encouraged with a lower copay than non-preferred brand-name products.

Formulary Compliance

Plan design, as noted above, is primary in achieving formulary compliance. CVS Caremark also provides plan sponsors with a range of solutions that encourage the use of generics and preferred brand-name drugs. Many CVS Caremark clients choose a plan that requires that a cost-effective generic be used before a single-source brand in the same therapeutic class.

Promotion of generics. When an A-rated generic becomes available, it is considered preferred and proactively encouraged. At that point, significant efforts are made to transition utilization to the lower-cost generic product. Client plan design will direct the effort and can be very aggressive and only cover the generic, or be more moderate and require the member to pay the difference between the brand-name drug and the generic if the brand-name product is chosen. Some clients may no longer cover the brand-name drug if a generic is available.

Member-directed formulary education. Members are notified when a new brand-name or generic product replaces a product they are using on the formulary. They are also notified if a product they are using is removed from the drug list, which could occur due to withdrawal from the market for safety reasons. If a non-preferred product has been dispensed at a retail pharmacy due to a prescription marked "Dispense As Written," the member may also be alerted via mail about alternative formulary product(s) that could be available at a lower copayment.

Members can also learn about the formulary through mailings such as the Prescriptions Savings Guide® report, which provides a personalized analysis of their prescription utilization and any opportunity they may have to save money. Such opportunities could include the use of a generic

or preferred brand-name product in place of a non-preferred product, or accessing prescriptions through the CVS Caremark Mail Service Pharmacy. The website Caremark.com, in addition to providing a simple way to order prescription refills, allows the member to access information about their specific drug list, pricing information and generic availability, as well as general drug and health information.

Improving Member Experience and Outcomes

CVS Caremark is focused on helping members achieve their health and wellness goals through proper understanding and utilization of their medications. There are a number of strategies used to support members in their desire for positive outcomes including:

- Helping them become knowledgeable about their plan, benefit structure and drug therapy management options
- Helping them understand and comply with their prescribed therapies by providing:
    - Adherence counseling with all new prescriptions (face-to-face at CVS Pharmacy® locations, by letter through mail service and retail network)
    - Refill reminders (letters, Interactive Voice Response (IVR), Internet) and non-adherent prompts (letters and phone calls)
    - Availability of automatic prescription renewals and refills
    - Information about ways to save on prescriptions by using lower-cost alternatives or lower-cost channels
- Coordinating with plan sponsors to promote enrollment in wellness and health management programs and offering appropriate and timely immunizations
- Making formularies readily available on Caremark.com.

1. All drugs that are legally marketed under the Federal Food Drug and Cosmetic Act (e.g., "grandfathered" drugs).

BINDER DIVIDER

“Formulary Updates”

CVS Health

At CVS Health, we remain committed to helping our clients provide a comprehensive, high quality prescription benefit at a sustainable cost.

The pharmaceutical landscape today is characterized by escalating costs for existing brand drugs and new drugs coming to market at ever-higher prices. We have long recognized that formulary management is the cornerstone of cost containment and have brought innovative, effective strategies to market for many years.

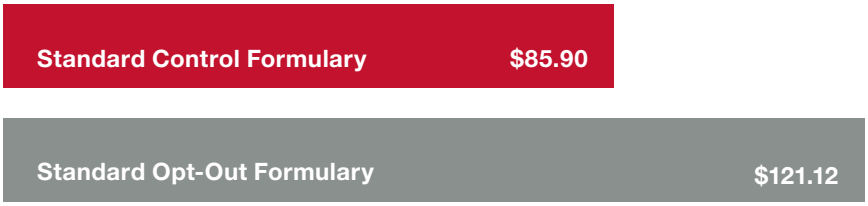
That continues today. Our focus remains on developing forward-looking, industry-leading solutions to ensure our clients get the most value for the investment they are making in their prescription drug benefit.

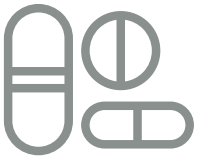
Formulary management is the cornerstone of cost containment

Your plan is aligned with our Standard Control Formulary. First-quarter per-member-per-month (PMPM) cost for 2017 was $85.90 compared to $121.12 for those aligned with a Standard Opt-Out Formulary which does not include formulary removals. Generic Dispensing Rate for Standard Control Formulary clients was 86.5 percent compared to 83.8 percent for those with Standard Opt-Out Formulary.*

Since 2012, when we introduced our industry-leading and rigorous approach to formulary management, through 2018, our formulary strategy is expected to deliver $13.4 billion in cumulative savings to PBM clients, through inclusion of lower cost brands and transition to generics.

Q1 2017 Post-Rebate PMPM Cost





CVS Health continues to be the market leader in formulary innovation

In 2012, we were the first to remove drugs from our formulary. In 2015, we were the first to introduce new-to-market drug evaluations. Value-based management initiatives build upon that success, helping to deliver additional value for the most cost effective treatment options, while advancing health outcomes.

CVSHealth

Transform Value: Beyond Formulary

In addition to our formulary management strategies, we are pleased to announce our new Transform Value program, which is designed to offer incremental benefit based on specific outcomes and cost cap-based management in key trend categories. Outcomes-based management aligns reimbursement for a drug to it achieving a pre-defined outcome. Cost cap-based programs establish a cost threshold based on expected utilization of a drug, for instance as a per-member-per-month cap. The program will launch with:

- **Transform Oncology Value:** This program encompasses several cancer types including breast cancer and non-small cell lung cancer. For members on a certain breast cancer drug, if a plan's average cost is above a pre-determined threshold, the manufacturer would be responsible to add value. If members on a certain non-small cell lung cancer drug progress to secondary therapy and key lab data has been obtained, the manufacturer would contribute additional pre-determined value.
- **Transform Obesity Value:** The manufacturer would be required to provide additional value if members do not achieve a minimum level of weight reduction within the initial assessment period.
- **Transform Respiratory Value:** For members on a certain chronic obstructive pulmonary disorder controller, if a greater percent of these members escalate to triple therapy compared to those on other controllers, the manufacturer would need to provide enhanced value.

Additional detail about the Transform Value program will be shared in mid-September.

Value-based management strategies can help ensure reimbursement is based on the value a drug delivers, not its sales volume or a pre-set price tag

CVS Health

2018 Formulary Removals

CVS Health offers a range of formulary management options that help reduce pharmacy costs for clients and members, while ensuring clinical integrity and access. In addition to expanding our value-based initiatives, effective January 1, 2018 we expect to remove 17 products from our Standard Control Formulary in 10 drug classes.

We remove drugs only when clinically-appropriate, lower-cost (often generic) alternatives are available. Our targeted approach ensures minimum member disruption. For 2018, we estimate that 99.76 percent of members will be able to stay on their current therapy.

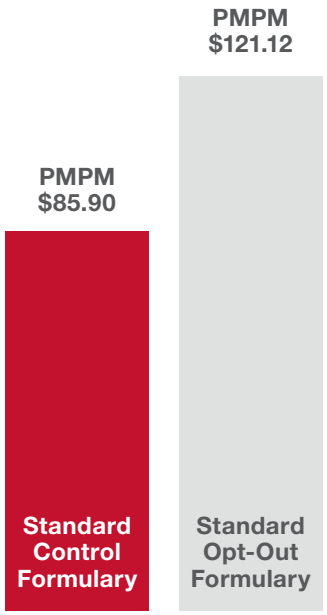
Our proactive member and prescriber communication strategy helps members transition to clinically-appropriate medications, minimizing disruption. Every member's journey is unique and that's why we take a personalized approach to member outreach. Our communications are informed by our data analysis and predictive modeling, which enable us to concentrate our efforts where they are most needed. Our engagement strategies are grounded in research, and we know that better engagement helps improve outcomes as well as member satisfaction.

Future Updates

The autoimmune category is the leading trend driver for commercial clients, due primarily to utilization and price. Many drugs are also obtaining a growing number of supplemental indications, making careful management of this therapeutic class critical to helping payors manage the financial impact.

In addition, consistent with our policy, as a new specialty product launches all existing products in the class will be re-evaluated to determine appropriate formulary placement and potentially removed or added to formulary. New entrants are expected in the hepatitis C class.

We are in the process of finalizing changes for autoimmune and hepatitis C categories, which will be communicated mid-September.



Well managed formularies can lower PMPM costs

Read about our formulary strategy and other pharmacy benefit news and trends, in *Insights*.

Contact your CVS Health Account Representative to discuss our new 2018 formulary strategy and learn more about our range of formulary innovations.

*CVS Health Enterprise Analytics, 2017. Trend data based on a CVS Health commercial PBM client - employer and health plan - cohort. Data not age-adjusted. Savings and trend will vary based on a variety of factors, including demographics, plan design and programs adopted by the client. Client-specific modeling available upon request.

CVSHealth

2018 Standard Control Formulary Removals and Updates

These are the therapy classes with drug removals and updates for 2018. We are in the process of finalizing changes for autoimmune and hepatitis C, which will be communicated mid-September. For 2018, we estimate that 99.76 percent of members will be able to stay on their current therapy.

Class	Products
Antiandrogens	Xtandi [P]
Anticholinergics	Incruse Ellipta [P]
Dermatology Tetracycline	Doryx/Doryx MPC, Monodox
Erectile Dysfunction	Levitra [NP]
Fertility	Follistim
Gaucher's	Elelyso
Incretin Mimetics	Tanzeum
Migraine Injectable	Sumavel Dosepro
Multi-Source Brands	Benicar/Benicar HCT, Effexor XR, Nuvigil, Seroquel XR, Zetia
Multiple Sclerosis Agents	Avonex [NP], Plegridy [NP]
Ophthalmic Allergies	Lastacaft [P]
Ophthalmic Prostaglandins	Lumigan [P]
Ophthalmic Steroids	FML* [P], Pred Mild [P]
Opioid Dependence	Zubsolv [P]
PAH Endothelin Receptor Antagonishs	Opsumit [P]
Post-Herpetic Neuralgia	Horizant
Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors and Combination Products	Jardiance, Synjardy/Synjardy XR, Invokana [P], Invokamet/Invokamet XR [P]
Steroid Beta Agonists Combos	Dulera, Symbicort [P]
Transmucosal IR Fentanyl	Abstral [NP]
Testosterone Replacements	Androgel 1.62% [P]
Urinary Antispasmodics	Gelnique [NP]
Viscosupplements	Hyalgan, Synvisc/Synvisc One

** FML Forte and FML S.O.P. will be preferred. FML Ophthalmic Suspension will be non-preferred.*

NP = Non Preferred drug being added back **P = Preferred drug being added back**

Formulary Drug Removals Effective 1/1/2018* (Branded Products Only)

Brand Name	Generic Name	Therapeutic Class	Rationale	ALTERNATIVES	Affected Members	Percent Affected Members in Therapeutic Class
EFFEXOR® XR	venlafaxine ER	Antidepressants, SNRIs	Multi-source brand with generic equivalents available for both products along with other therapeutically-interchangeable products.	generics	45	0.30%
ZETIA®	ezetimibe	Antilipemics, Intestinal Cholesterol Absorption Inhibitors	Multi-source brand with generic equivalents available for both products along with other therapeutically-interchangeable products.	generics	289	9.97%
SEROQUEL® XR	quetiapine ER	Antipsychotics, Dibenzapines	Multi-source brand with generic equivalents available for both products along with other therapeutically-interchangeable products.	generics	110	4.57%
BENICAR®	olmesartan	Antihypertensive Agent, ARBs	Multi-source brand with generic equivalents available for both products along with other therapeutically-interchangeable products.	generics	135	0.63%
BENICAR® HCT	olmesartan/HCTZ	Antihypertensive Combo, ARBs/Diuretic, Thiazide	Multi-source brand with generic equivalents available for both products along with other therapeutically-interchangeable products.	generics	171	0.46%
NUVIGIL®	armodafinil	Stimulants, Narcolepsy	Multi-source brand with generic equivalents available for both products along with other therapeutically-interchangeable products.	generics	101	1.47%

* A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug.

Formulary Drug Removals Effective 1/1/2018* (Branded Products Only)

Brand Name	Generic Name	Therapeutic Class	Rationale	ALTERNATIVES	Affected Members	Percent Affected Members in Therapeutic Class
DORYX®	doxycycline hyclate DR	Dermatology, Tetracycline	Single-source brands with therapeutically-interchangeable option(s) available, same molecular entity (doxycycline)	generics	8	0.07%
DORYX® MPC	doxycycline hyclate DR	Dermatology, Tetracycline	Single-source brands with therapeutically-interchangeable option(s) available, same molecular entity (doxycycline)	generics	3	0.03%
MONODOX®	doxycycline monohydrate	Dermatology, Tetracycline	Single-source brands with therapeutically-interchangeable option(s) available, same molecular entity (doxycycline)	generics	0	0.00%
FOLLISTIM®	follitropin beta	Fertility, Follicle Stimulating Hormone	Single-source brand with therapeutically-interchangeable option(s) available	novarel, pregnyl, hcG, OVIDREL®, MENOPUR®	42	11.83%
ELELYSO®	taliglucerase alfa	Enzyme Replacement Therapy, Gaucher	Single-source brand with therapeutically-interchangeable option(s) available	CEREZYME®, ZAVESCA®	0	0.00%
TANZEUM®	albiglutide	Antidiabetic Agent, GLP-1 Agonist	Single-source brand with therapeutically-interchangeable option(s) available	VICTOZA®, TRULICITY®	95	1.71%
SUMAVEL® DOSEPRO	sumatriptan	Migraine Injectable, Serotonin Agonists	Single-source brand with therapeutically-interchangeable option(s) available	generics, IMITREX® STATDOSE, ZEMBRACE® SYMTOUCH,	10	0.11%

* A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug.

Formulary Drug Removals Effective 1/1/2018* (Branded Products Only)

Brand Name	Generic Name	Therapeutic Class	Rationale	ALTERNATIVES	Affected Members	Percent Affected Members in Therapeutic Class
HORIZANT®	gabapentin ER	Anticonvulsant, Restless Leg Syndrome	Single-source brand with therapeutically-interchangeable option(s) available, same molecular entity (gabapentin)	gabapentin, ropinirole, pramipexole, NEUPRO®	134	0.50%
JARDIANCE®	empagliflozin	Antidiabetic Agent, SGLT-2 Inhibitors	*See next page;* Single-source brands with therapeutically-interchangeable option(s) available	INVOKANA®, FARXIGA®	2149	46.02%
SYNJARDY® / SYNJARDY® XR	empagliflozin/ metformin IR & ER	Antidiabetic Agent, SGLT-2 Inhibitors/Biguanide Combinations	*See next page*; Single-source brands with therapeutically-interchangeable option(s) available	INVOKAMET®/ INVOKAMET® XR, XIGDUO® XR	27	0.47%
DULERA®	mometasone/ formoterol	Sympathomimetics, Steroid Beta Agonists Combos	*See next page*; Single-source brands with therapeutically-interchangeable option(s) available	ADVAIR®, BREO ELLIPTA®, SYMBICORT®	876	4.20%
HYALGAN®	sodium hyaluronate	Viscosupplements	Single-source brands with therapeutically-interchangeable option(s) available	GEL-ONE®, GENVISC®, SUPARTZ®/ SUPARTZ® FX	11	17.74%
SYNVISC® / SYNVISC® ONE	hylan G-F 20	Viscosupplements	Single-source brands with therapeutically-interchangeable option(s) available	GEL-ONE®, GENVISC®, SUPARTZ®/ SUPARTZ® FX	7	11.11%

* A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug.

Formulary Drug Removals Effective 1/1/2018* (Branded Products Only)

Drug	Rationale
JARDIANCE®, SYNJARDY®/SYNJARDY® XR	There is published data from controlled trials demonstrating a cardiovascular outcomes benefit for patients with type 2 diabetes with both Jardiance and Invokana. Although the trial for Farxiga is not yet complete, there are other data available demonstrating that cardiovascular risk reduction is a class effect for the SGLT-2 inhibitors. The CVD-REAL Trial was a retrospective study that evaluated the risk of heart failure and death in patients newly prescribed SGLT-2 inhibitors vs. other diabetes agents. Based on these data, the CVS Caremark P&T Committee, which includes an endocrinologist specializing in diabetes, found the SGLT-2 inhibitors to have benefit to patients. Invokana may be associated with an increased risk of amputations. However, such an increased risk was found in only one of twelve studies of the drug, and data regarding amputations were not collected systematically in trials of Jardiance and Farxiga. Therefore, the risk of amputation with Invokana versus Jardiance or Farxiga is the subject of further investigation, and the European Medicines Agency requires a warning regarding amputations for all drugs in the class. The U.S. FDA has applied the warning only to Invokana so far. The CVS Caremark P&T Committee approved the coverage of agents in the class, as two agents in the SGLT-2 inhibitor class will be preferred for 2018, giving patients and prescribers multiple options based on an individual patient-prescriber conversation. IF a prescriber does not want to use Invokana, they can use Farxiga. We should note as well that many drugs widely used and approved in the United States have black box warnings. Some common such drugs include: Metformin, All Opioids, Celebrex, Diclofenac, Fluoroquinolone antibiotics – Cipro, SSRI antidepressants, Ribavirin, Epclusa, Harvoni, Metronidazole. Thus, black box warning in itself does not disqualify a drug—it is information to be used by the prescriber.
DULERA®	Symbicort is indicated for treatment of asthma in patients six years and older whereas Dulera is indicated for patients 12 and older; Symbicort is indicated for maintenance treatment of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema, whereas Dulera is not.

* A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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Formulary Exclusion Exception Process

The State Health Plan (Plan) has a custom, closed formulary, which includes drugs that are excluded from the formulary and are not covered by the Plan. This is applicable to the Traditional Pharmacy Benefit (which includes the Consumer-Directed Health Plan, the Enhanced 80/20 Plan and the Traditional 70/30 Plan).

A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug. The exception process is administered by CVS Caremark®, the Plan's Pharmacy Benefit Manager.

There may be circumstances in which the formulary alternatives may not be appropriate for some members. In this case, a member may be approved for the excluded drug with an exception process. An exception is defined as a situation where the member has tried and failed (that is, had an inadequate treatment response or intolerance) to the required number of formulary alternatives; or the member has a documented clinical reason such as an adverse drug reaction or drug contraindication that prevents them from trying the formulary alternatives.

Exceptions Coverage Criteria

The exception coverage criteria process will determine if the excluded medication is approved or denied. Approval for coverage criteria may be different for each of the targeted therapeutic classes depending on the number of formulary alternatives that are available in that class. The below lists **example scenarios** on how the process may work and cases where it would be approved if there are one or more than one formulary alternatives that are available in a therapeutic class.

- If a provider feels changing the course of medication could negatively impact a member's health and therefore the exception is medically necessary.
- If the prescriber provides evidence of trial and failure of 3 formulary alternatives (generics and/or formulary brands) in a class where 3 or more alternatives are available, the request will be approved.
- If the prescriber provides evidence of trial and failure of 2 formulary alternatives (generics and/or formulary brands) in a class where 2 alternatives are available, the request will be approved.
- If the prescriber provides evidence of trial and failure of 1 formulary alternative (generic and/or formulary brands) in a class where only 1 alternative exists, the request will be approved.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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In addition to trying or failing formulary alternatives, approval for an excluded drug can also exist if the prescriber provides evidence of an adverse drug reaction or drug contraindication to the formulary alternatives.

In summary, the requested drug will be covered with prior authorization when the following criteria are met:

- Member is using the requested drug for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines).

AND

- The prescribed quantity falls within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Micromedex, current accepted guidelines).

AND

- The member has tried and experienced an inadequate treatment response or has an intolerance to the required number of formulary alternatives.

OR

- The physician (or member) has a documented clinical reason for their patient experiencing any adverse drug reaction or drug contraindication to the formulary alternatives.

Follow the steps below in requesting an exception for a Plan member:

1. To request an exception form a member's provider can contact CVS Caremark Customer Care at **1-888-321-3124** or find the exceptions form online at the Plan's website at www.shpnc.org by clicking Pharmacy Benefits under Plans for Active Employees.
2. Submit exception form to CVS Caremark via fax at 888-487-9257. A letter of medical necessity from the provider should accompany the exception request form.
3. The exceptions team consists of clinicians who review the exception request and medical necessity letter and any relevant information.
4. After the clinical review, the decision (approval or denial) is then communicated to the provider and the member by mail.
5. If the exception request is approved, the exceptions department will enter the necessary override(s). Authorization duration is defined in the specific medication policy.
6. If the exception request is denied based on clinical review, a denial letter is sent to the provider and the member. The denial letter includes directions on how to appeal the denial.

Exceptions are processed within the following time frames from the time that

information is received:

- Urgent requests from the member's provider are completed typically within 24 hours. Urgent requests should also be noted as such on the exception request form.
- Urgent is defined "urgent as defined by law (that is, your health is in serious jeopardy or, in the opinion of your provider, you will experience pain that cannot be adequately controlled) while you wait to receive approval of your exception."
- Non-urgent requests are completed typically within 72 hours.

Formulary Drug Add Backs Effective 1/1/2018 (Branded Products Only)

Brand Name	Generic Name	Therapeutic Class	Tier Status	Proposed NC Status/Tier	Specialty
XTANDI®	enzalutamide	Antiandrogens	Preferred	5	Y
INCRUSE ELLIPTA®	umeclidinium	Anticholinergics	Preferred	2	N
AVONEX®	interferon beta-1a	Multiple Sclerosis	Non preferred	6	Y
PLEGRIDY®	peginterferon beta-1a	Multiple Sclerosis	Non preferred	6	Y
LASTACRAFT®	alcaftadine	Ophthalmic Anti-allergies	Preferred	2	N
LUMIGAN®	bimatoprost	Ophthalmic Prostaglandins	Preferred	2	N
FML®	fluorometholone	Ophthalmic Steroids	Preferred	2	N
PRED MILD®	prednisolone	Ophthalmic Steroids	Non preferred	3	N
ZUBSOLV®	buprenorphine/naloxone	Opioid Dependence	Preferred	2	N

Formulary Drug Add Backs Effective 1/1/2018 (Branded Products Only)

Brand Name	Generic Name	Therapeutic Class	Tier Status	Proposed NC Status/Tier	Specialty
OPSUMIT®	macitentan	PAH Endothelin Receptor Antagonists	Preferred	5	Y
INVOKANA®	canagliflozin	SGLT-2 Inhibitors/Biguanide Combinations	Preferred	2	N
INVOKAMET®/ INVOKAMET® XR	canagliflozin/metformin	SGLT-2 Inhibitors/Biguanide Combinations	Preferred	2	N
SYMBICORT®	budesonide/formoterol	Steroid Beta Agonists Combos	Preferred	2	N
ANDROGEL® 1.62%	testosterone	Testosterone Replacements	Preferred	2	N
ABSTRAL®	fentanyl	Transmucosal IR Fentanyl	Non preferred	3	N
GELNIQUE®	oxybutynin	Urinary Antispasmodics	Non preferred	3	N

Hyperinflation Exclusions & Tier Changes Effective 10/1/2017 (Branded Products Only)

Brand Name	Generic Name	Therapeutic Category	CVS Status Change	Alternatives	Change Type	Proposed NC Status/Tier	Specialty	# Utilizers (YT)
INDOCIN® SUS 25MG/5ML	indomethacin	Analgesic, NSAID	3--> Not Covered	generics	Hyperinflation Exclusion	NC	N	0
INDOCIN® SUPP 50MG	indomethacin	Analgesic, NSAID	3--> Not Covered	generics	Hyperinflation Exclusion	NC	N	1
NAPROSYN® SUS 125/5ML	naproxen	Analgesic, NSAID	2--> 3	generics	Negative Tiering Change	3	N	0
QUDEXY® XR CAP	topiramate ER	Anticonvulsant, Miscellaneous	2--> 3	generics, FYCOMPA®, OXTELLAR® XR, TROKENDI® XR, VIMPAT®	Negative Tiering Change	3	N	54
GABITRIL® TAB	tiagabine	Anticonvulsant, Miscellaneous	2--> 3	generics, FYCOMPA®, OXTELLAR® XR, TROKENDI® XR, VIMPAT®	Negative Tiering Change	3	N	2

Hyperinflation Exclusions & Tier Changes Effective 10/1/2017 (Branded Products Only)

Brand Name	Generic Name	Therapeutic Category	CVS Status Change	Alternatives	Change Type	Proposed NC Status/Tier	Specialty	# Utilizers (YT)
KLONOPIN® TAB	clonazepam	Anticonvulsant, Benzodiazepine	2--> 3	generics, TROKENDI® XR	Negative Tiering Change	3	N	11
LAMICTAL® XR TAB	lamotrigine ER	Anticonvulsant, Miscellaneous	2--> 3	generics, FYCOMPA®, OXTELLAR® XR, TROKENDI® XR, VIMPAT®	Negative Tiering Change	3	N	55
OPANA® ER TAB	oxymorphone ER	Analgesic, long-acting opioid	2--> 3	morphine ext-rel, HYSINGLA® ER, NUCYNTA® ER, OXYCONTIN®	Negative Tiering Change	3	N	134
SOLIQUA® PEN 100/33	insulin glargine & lixisenatide	Antidiabetic Agent, Long-acting insulin + GLP-1 agonist	3--> 2	n/a	Positive Tiering Change	2	N	27
VEMLIDY® TAB	tenofovir alafenamide	Anti-Infectives/ Antivirals/ Hepatitis B Agents	6--> 5	generics, HEPSERA®, BARACLUDE®, EPIVIR® HBV	Positive Tiering Change	5	Y	3

New-To-Market Block Removals/Formulary Additions Effective 10/1/2017

Brand Name	Generic Name	Therapeutic Category/ Subcategory	Specialty	Rationale	Key Point	NCSHP Tier
RYDAPT® CAP	midostaurin	Antineoplastic/Kinase Inhibitors	Y	New Drug	Only targeted drug for FLT3+ AML	6
ZYTIGA® TAB 500MG	abiraterone acetate	Antineoplastic/Hormonal Antineoplastic Agents/Androgens	Y	New Strength	Higher strength to reduce pill burden	5
PERTZYE® CAP	pancrelipase	Gastrointestinal/Pancreatic Enzymes	N	New Formulation	Novel microspheres; low dose option for infants	3
TEPADINA® INJ	thiotepa	Antineoplastic Agents/Alkylating Agents	Y	New Strength	Higher strength of 100mg/vial	6
HERCEPTIN® INJ 150MG	trastuzumab	Antineoplastic Agents/Miscellaneous	Y	New Strength	Lower strength of 150mg/vial	6
AFSTYLA® KIT	antihemophilic factor (recombinant)	Hematologic/Hemophilia Agents	Y	New Drug	Novel drug design; 2 or 3 times a week dosing	6
VANCOMY/NACL INJ 750/250	vancomycin in sodium chloride for injection	Anti-infectives/ Miscellaneous	N	Additional NDC	generic	3
RUBRACA® TAB	rucaparib	Antineoplastic Agents/Miscellaneous	Y	New Drug	PARP for somatic *BRCA* mutations	6
TRULANCE® TAB	plecanatide	Gastrointestinal/ Irritable Bowel Syndrome/ Irritable Bowel Syndrome with Constipation	N	New Drug	New product to the class	3
XATMEP® SOL 2.5MG/ML	methotrexate	Antineoplastic Agents/ Antimetabolites	N	New Formulation	First ready to use oral solution	3

New-To-Market Block Removals/Formulary Additions Effective 10/1/2017

Brand Name	Generic Name	Therapeutic Category/ Subcategory	Specialty	Rationale	Key Points	NCSHP Tier
VRAYLAR® CAP	cariprazine	Central Nervous System/ Antipsychotics/ Miscellaneous	N	New Drug	New drug to the class	3
ORENITRAM® 5MG TAB	treprostinil	Cardiovascular/Pulmonary Arterial Hypertension/ Prostaglandin Vasodilators	Y	New Strength	Higher strength	5
SOLIQUA® PEN 100/33	Insulin glargine & lixisenatide	Endocrine and Metabolic/ Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist/Insulin Combo	N	New Drug Combination	New product to the class	3
ACZONE® GEL 7.5%	dapsone	Dermatology/ Acne/Topical	N	New Strength	Higher strength	3
RHOFADE® CREAM 1%	oxymetazoline	Dermatology/Rosacea Agents	N	New Drug	New product to the class	3
QBRELIS® SOL 1MG/ML	lisinopril	Cardiovascular/ ACE inhibitor	N	New Formulation	Only oral solution	3
LAZANDA® SPRAY 300MCG	fentanyl	Analgesics/ Opioid Analgesics	N	New Strength	lower strength	3
TYMLOS® INJ	abaloparatide	Endocrine and Metabolic/Calcium Regulators/Parathyroid Hormones	Y	New drug	New product to the class	6
XTAMPZA® ER CAP	Oxycodone ER	Analgesics/ Opioid Analgesics	N	New Formulation	Novel abuse-deterrent formulation	3

New-To-Market Block Removals/Formulary Additions Effective 10/1/2017

Brand Name	Generic Name	Therapeutic Category/ Subcategory	Specialty	Rationale	Key Points	NCSHP Tier
SELZENTRY SOL 20MG/ML	Maraviroc	Anti-infectives/ Antiretoviral/ Chemokine Receptor Antagonists	Y	New Formulation	Oral Solution	2
ISENTRESS HD 600MG	Raltegravir	Anti-Infectives/ Antiretroviral Agents/ Integrase Inhibitors	Y	New Strength	Higher strength to reduce pill burden	2

SOLIQUA® 100/33
(insulin glargine & lixisenatide) injection for subcutaneous use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 3 – Non-preferred Brand
Formulary Alternatives	BASAGLAR® (insulin glargine), LEVEMIR® (insulin detemir), TRESIBA® (insulin degludec), TRULICITY® (dulaglutide), VICTOZA® (liraglutide), TANZEUM® (albigutide)
FDA Approval	November 21, 2016
Therapeutic Class	Antidiabetic Combo Agent: Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist; Insulin, Long-Acting
Indications and Usage	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (less than 60 units daily) or lixisenatide
Dosing	***Forms & Strengths:*** Injection: 100 units of insulin glargine per mL and 33 mcg of lixisenatide per mL in a 3 mL single-patient use pen ***Administration:*** Inject subcutaneously once a day within the hour prior to the first meal of the day. Starting dose is 15 or 30 units depending on current basal insulin or lixisenatide therapy. Use alternative antidiabetic products if patients require a SOLIQUA 100/33 daily dosage below 15 units or over 60 units. ***Adjustments:*** Frequent glucose monitoring and dose adjustment may be necessary for SOLIQUA 100/33 in patients with renal impairment. SOLIQUA 100/33 should be used during pregnancy only if the potential benefits justifies the potential risk to the fetus.
Safety	***Contraindications:*** Use during episodes of hypoglycemia; hypersensitivity to SOLIQUA 100/33 or any of its excipients ***Warnings:*** Hypersensitivity reactions can occur; Pancreatitis; Never share a pen between patients; Hyper- or hypoglycemia with changes; Overdose due to medication errors; Acute kidney injury; Hypokalemia; Fluid retention and heart failure with use of thiazolidinediones (TZDs); Macrovascular outcomes
Key Points	Greater A1C reductions than insulin glargine or lixisenatide alone; fewer GI side effects than lixisenatide; less weight gain than insulin; no greater hypoglycemia risk than insulin glargine
Treatment Guidelines	Lifestyle changes are first line for most patients with type 2 diabetes. Metformin is added if lifestyle changes no do achieve glycemic goals. After 3 months if goals are not met a second oral agent is added or GLP-1 or basal insulin. Consider insulin with or without other agents for the newly diagnosed who are symptomatic or have very elevated A1C & glucose. Due to the progressive nature of diabetes, insulin is eventually need and should not be delayed.
Place in Therapy	Adds an acceptable alternative if metformin cannot be used first line and as a second line agent to add to metformin.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use SOLIQUA 100/33 safely and effectively. See full prescribing information for SOLIQUA 100/33.

SOLIQUA™ 100/33 (insulin glargine and lixisenatide injection), for subcutaneous use

Initial U.S. Approval: 2016

INDICATIONS AND USAGE

SOLIQUA 100/33 is a combination of a long-acting human insulin analog with a glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (less than 60 units daily) or lixisenatide. (1)

Limitations of Use (1):

- Has not been studied in patients with a history of unexplained pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.
- Not recommended for use in combination with any other product containing lixisenatide or another GLP-1 receptor agonist.
- Not for treatment of type 1 diabetes mellitus or diabetic ketoacidosis.
- Not recommended for use in patients with gastroparesis.
- Has not been studied in combination with prandial insulin.

DOSAGE AND ADMINISTRATION

- Discontinue therapy with lixisenatide or basal insulin prior to initiation of SOLIQUA 100/33. (2.1)
- In patients inadequately controlled on less than 30 units of basal insulin or on lixisenatide, the starting dosage is 15 units (15 units insulin glargine/5 mcg lixisenatide) given subcutaneously once daily. (2.1)
- In patients inadequately controlled on 30 to 60 units of basal insulin, the starting dosage is 30 units (30 units insulin glargine/10 mcg lixisenatide) given subcutaneously once daily. (2.1)
- Inject once a day within the hour prior to the first meal of the day. (2.1)
- Maximum daily dosage is 60 units (60 units of insulin glargine and 20 mcg of lixisenatide). (2.1)
- SOLIQUA 100/33 Pen delivers doses from 15 to 60 units with each injection. (2.1, 2.2)
- Use alternative antidiabetic products if patients require a SOLIQUA 100/33 daily dosage below 15 units or over 60 units (2.1)
- See Full Prescribing Information for titration recommendations. (2.2)
- Inject subcutaneously in thigh, upper arm, or abdomen. (2.4)
- Do not administer intravenously, intramuscularly, or by an infusion pump. (2.4)
- Do not dilute or mix with any other insulin products or solutions. (2.4)

DOSAGE FORMS AND STRENGTHS

Injection: 100 units of insulin glargine per mL and 33 mcg of lixisenatide per mL in a 3 mL single-patient use pen. (3)

CONTRAINDICATIONS

- During episodes of hypoglycemia (4)
- Hypersensitivity to SOLIQUA 100/33 either of the active drug substances (insulin glargine or lixisenatide), or any of its excipients. Hypersensitivity reactions including anaphylaxis have occurred with both lixisenatide and insulin glargine (4)

WARNINGS AND PRECAUTIONS

- *Anaphylaxis and serious hypersensitivity reactions*: can occur with either of the components in SOLIQUA 100/33. Instruct patients to discontinue if a reaction occurs and promptly seek medical attention. (5.1)
- *Pancreatitis*: Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed. (5.2)
- *Never share* a SOLIQUA 100/33 prefilled pen between patients, even if the needle is changed. (5.3)
- *Hyperglycemia or hypoglycemia with changes in SOLIQUA 100/33 regimen:* Carry out under close medical supervision. (5.4)
- *Overdose due to Medication errors*: SOLIQUA 100/33 contains two drugs. Instruct patients to always check the label before each injection since accidental mix-ups with insulin-containing products can occur. Do not exceed the maximum dose or use with other GLP-1 receptor agonists. (5.5)
- *Hypoglycemia:* May be life-threatening. Increase frequency of glucose monitoring with changes to: insulin dosage, coadministered glucose lowering medications, meal pattern, physical activity; and in patients with renal or hepatic impairment and hypoglycemia unawareness. (5.6)
- *Acute Kidney Injury*: Monitor renal function in patients with renal impairment and in patients with severe GI adverse reactions. Use is not recommended in patients with end-stage renal disease (5.7)
- *Immunogenicity*: Patients may develop antibodies to insulin glargine and lixisenatide. If there is worsening glycemic control or failure to achieve targeted glycemic control, significant injection-site reactions or allergic reactions, alternative antidiabetic therapy should be considered. (5.8)
- *Hypokalemia*: May be life-threatening. Monitor potassium levels in patients at risk of hypokalemia and treat if indicated. (5.9)
- *Fluid retention and heart failure with use of thiazolidinediones (TZDs)*: Observe for signs and symptoms of heart failure; consider dosage reduction or discontinuation if heart failure occurs. (5.10)
- *Macrovascular Outcomes*: Clinical studies have not shown macrovascular risk reduction with SOLIQUA 100/33. (5.11)

ADVERSE REACTIONS

Adverse reactions commonly associated with SOLIQUA 100/33 include hypoglycemia, allergic reactions, nausea, nasopharyngitis, diarrhea, upper respiratory tract infection, headache. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact sanofi- aventis at 1-800-633-1610 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- *Drugs that affect glucose metabolism:* Adjustment of SOLIQUA 100/33 dosage may be needed; closely monitor blood glucose. (7.1)
- *Antiadrenergic Drugs* (e.g., beta-blockers, clonidine, guanethidine, and reserpine): Hypoglycemia signs and symptoms may be reduced. (7.1)
- *Effects of delayed gastric emptying on oral medications:* Lixisenatide delays gastric emptying which may impact absorption of concomitantly administered oral medications. Oral contraceptives and other medications such as antibiotics and acetaminophen should be taken at least 1 hour prior to SOLIQUA 100/33 administration or 11 hours after. (7.2)

USE IN SPECIFIC POPULATIONS

- *Pregnancy*: SOLIQUA 100/33 should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. (8.1)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 11/2016

FULL PRESCRIBING INFORMATION: CONTENTS*

AFSTYLA®
(generic name) formulation

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	ADVATE®, KOGENATE FS®, KOVALTRY®, NOVOEIGHT®, NUWIQ®, RECOMBINATE®, XYNTHA® (antihemophilic factor [recombinant]) & others
FDA Approval	May 26, 2016
Therapeutic Class	Antihemophilic Agent; prolonged half-life recombinant factor VIII concentrate, single chain
Indications and Usage	For use in adults and children with hemophilia A for on-demand treatment & control of bleeding episodes, routine prophylaxis to reduce the frequency of bleeding episodes, and perioperative management of bleeding; not indicated for von Willebrand disease
Dosing	***Forms & Strengths:*** lyophilized powder, single use 250, 500, 1000, 1500, 2000, or 3000 International Unit (IU) vials ***Administration:*** For intravenous use after reconstitution only – adults: 20-50 IU/kg; children: 30-50 IU/kg; median twice weekly dose was 35 IU/kg for people of all ages & 30-32 IU/kg when given three times a week ***Adjustments:*** Many, see package insert
Safety	***Contraindications:*** Hypersensitivity reactions ***Warnings:*** Neutralizing antibodies, monitoring lab tests ***Adverse Reactions:*** dizziness and hypersensitivity (>0.5%)
Key Points	First and only single-chain product for hemophilia A, specifically designed for long-lasting protection from bleeds with twice-weekly dosing available. Strong safety profile with no inhibitors observed and clinical trial prophylaxis data showing a median annualized spontaneous bleeding rate (AsBR) of 0.00.
Treatment Guidelines	The treatment of hemophilia may involve prophylaxis, management of bleeding episodes, treatment of factor VIII (FVIII) inhibitors, and treatment and rehabilitation of hemophilia synovitis. Use of factor replacement products and other medications, including pain medications, is typically required.
Place in Therapy	Provides an additional prolonged half-life clotting factor product to patients suffering with hemophilia A.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use AFSTYLA safely and effectively. See full prescribing information for AFSTYLA.

AFSTYLA®, Antihemophilic Factor (Recombinant), Single Chain
For Intravenous Injection, Powder and Solvent for Injection
Initial U.S. Approval: 2016

----------DOSAGE AND ADMINISTRATION----------
Dosage Forms and Strengths (3) 3/2017

----------INDICATIONS AND USAGE----------
AFSTYLA®, Antihemophilic Factor (Recombinant), Single Chain, is a recombinant, antihemophilic factor indicated in adults and children with hemophilia A (congenital Factor VIII deficiency) for:

- On-demand treatment and control of bleeding episodes,
- Routine prophylaxis to reduce the frequency of bleeding episodes,
- Perioperative management of bleeding.

Limitation of Use
AFSTYLA is not indicated for the treatment of von Willebrand disease (1).

----------DOSAGE AND ADMINISTRATION----------
For intravenous use after reconstitution only.

- Each vial of AFSTYLA is labeled with the amount of recombinant Factor VIII in international units (IU or unit). One unit per kilogram body weight will raise the Factor VIII level by 2 IU/dL. (2.1)
- Plasma Factor VIII levels can be monitored using either a chromogenic assay or a one-stage clotting assay – routinely used in US clinical laboratories. **If the one-stage clotting assay is used, multiply the result by a conversion factor of 2 to determine the patient's Factor VIII activity level.** (**2.1**, **5.3**)

Calculating Required Dose: (2.1)

Dose (IU) = Body Weight (kg) x Desired Factor VIII Rise (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL)

Routine Prophylaxis: (2.1)

- Adults and adolescents (≥12 years): The recommended starting regimen is 20 to 50 IU per kg of AFSTYLA administered 2 to 3 times weekly.
- Children (<12 years): The recommended starting regimen is 30 to 50 IU per kg of AFSTYLA administered 2 to 3 times weekly. More frequent or higher doses may be required in children <12 years of age to account for the higher clearance in this age group.
- The regimen may be adjusted based on patient response.

Perioperative Management: (2.1)

- Ensure the appropriate Factor VIII activity level is achieved and maintained.

----------DOSAGE FORMS AND STRENGTHS----------
AFSTYLA is available as a white or slightly yellow lyophilized powder supplied in single-use vials containing nominally 250, 500, 1000, 1500, 2000, 2500 or 3000 International Units (IU). (3)

----------CONTRAINDICATIONS----------
Do not use in patients who have had life-threatening hypersensitivity reactions, including anaphylaxis to AFSTYLA or its excipients, or hamster proteins. (4)

----------WARNINGS AND PRECAUTIONS----------

- Hypersensitivity reactions, including anaphylaxis, are possible. Should symptoms occur, immediately discontinue AFSTYLA and administer appropriate treatment. (5.1)
- Development of Factor VIII neutralizing antibodies (inhibitors) can occur. If expected plasma Factor VIII activity levels are not attained, or if bleeding is not controlled with an appropriate dose, perform an assay that measures Factor VIII inhibitor concentration. (5.2)
- If the one-stage clotting assay is used, multiply the result by a conversion factor of 2 to determine the patient's Factor VIII activity level. (5.3)

----------ADVERSE REACTIONS----------
The most common adverse reactions reported in clinical trials (>0.5% of subjects) were dizziness and hypersensitivity. (6)

To report SUSPECTED ADVERSE REACTIONS, contact the CSL Behring Pharmacovigilance Department at 1-866-915-6958 or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch***.**

----------USE IN SPECIFIC POPULATIONS----------

- Pediatric: Clearance (based on per kg body weight) is higher in pediatric patients 0 to <12 years of age. Higher and/or more frequent dosing may be needed. (8.4)

See 17 for Patient Counseling Information and FDA-approved Patient Labeling.

Revised: 4/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*** Sections or subsections omitted from the full prescribing information are not listed**

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

SPECIALTY GUIDELINE MANAGEMENT

FACTOR VIII CONCENTRATES

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

Table: Factor VIII Concentrates and Covered Uses

Brand	Generic	FDA-Approved Indication(s)	Compendial Indication(s)
Recombinant Factor VIII Concentrates			
Advate	antihemophilic factor [recombinant]	Hemophilia A	Acquired Hemophilia A
Kogenate FS	antihemophilic factor [recombinant]	Hemophilia A	Acquired Hemophilia A
Kovaltry	antihemophilic factor [recombinant]	Hemophilia A	
Novoeight	antihemophilic factor [recombinant]	Hemophilia A	
Nuwiq	antihemophilic factor [recombinant]	Hemophilia A	
Recombinate	antihemophilic factor [recombinant]	Hemophilia A	Acquired Hemophilia A
Xyntha	antihemophilic factor [recombinant]	Hemophilia A	Acquired Hemophilia A
Prolonged Half-life Recombinant Factor VIII Concentrate			
Afstyla	antihemophilic factor [recombinant], single chain	Hemophilia A	
Human Plasma-Derived Factor VIII Concentrates			
Hemofil M **Monoclate-P**	antihemophilic factor [human] monoclonal antibody purified	Hemophilia A	Acquired Hemophilia A
Human Plasma-Derived Factor VIII Concentrates That Contain Von Willebrand Factor			
Alphanate **Humate-P**	antihemophilic factor/von Willebrand factor complex [human]	Hemophilia A, von Willebrand Disease	Acquired Hemophilia A, Acquired von Willebrand Syndrome
Koate	antihemophilic factor [human]	Hemophilia A	Acquired Hemophilia A, von Willebrand Disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Hemophilia A

Indefinite authorization of Advate, Adynovate, Afstyla, Alphanate, Eloctate, Helixate FS, Hemofil M, Humate-P, Koate, Kogenate FS, Kovaltry, Monoclate-P, Novoeight, Nuwiq, Recombinate or Xyntha may be granted for treatment of hemophilia A when either of the following criteria is met:

1. Member has mild disease (see Appendix A) and has had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin (see Appendix B).
2. Member has moderate to severe disease (see Appendix A).

B. Von Willebrand Disease

Indefinite authorization of Alphanate, Humate-P or Koate may be granted for treatment of vWD when any of the following criteria is met:

1. Member has type 1, 2A, 2M, or 2N vWD and has had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin (see Appendix B).
2. Member has type 2B or type 3 vWD.

C. Acquired Hemophilia A

Indefinite authorization of Advate, Alphanate, Helixate FS, Hemofil M, Humate-P, Koate, Kogenate FS, Monoclate-P, Recombinate or Xyntha or may be granted for treatment of acquired hemophilia A.

D. Acquired von Willebrand Syndrome

Indefinite authorization of Alphanate or Humate-P may be granted for treatment of acquired von Willebrand syndrome.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. APPENDICES

Appendix A: Classification of Hemophilia by Clotting Factor Level (% Activity) and Bleeding Episodes

Severity	Clotting Factor Level % activity*	Bleeding Episodes
Severe	<1%	Spontaneous bleeding episodes, predominantly into joints and muscles Severe bleeding with trauma, injury or surgery
Moderate	1% to 5%	Occasional spontaneous bleeding episodes Severe bleeding with trauma, injury or surgery
Mild	6% to 40%	Severe bleeding with serious injury, trauma or surgery

*Factor assay levels are required to determine the diagnosis and are of value in monitoring treatment response.

Appendix B: Clinical Reasons For Not Utilizing Desmopressin in Patients with Hemophilia A and Type 1, 2A, 2N and 2M vWD

A. Age < 2 years
B. Pregnancy
C. Fluid/electrolyte imbalance
D. High risk for cardiovascular or cerebrovascular disease (especially the elderly)
E. Predisposition to thrombus formation
F. Trauma requiring surgery
G. Life-threatening bleed
H. Contraindication or intolerance to desmopressin
I. Severe type 1 von Willebrand disease

V. REFERENCES

1. Advate [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; May 2015.
2. Helixate FS [package insert]. Whippany, NJ: Bayer HealthCare LLC; May 2016.
3. Kogenate FS [package insert]. Whippany, NJ: Bayer HealthCare LLC; May 2016.
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5. Kogenate FS with Vial Adapter [package insert]. Whippany, NJ: Bayer HealthCare LLC; May 2016.
6. Kovaltry [package insert]. Whippany, NJ: Bayer Healthcare LLC; March 2016.
7. Novoeight [package insert]. Plainsboro, NJ: Novo Nordisk Inc., November 2016.
8. Nuwiq [package insert]. Hoboken, NJ: Octapharma USA, Inc., September 2015.
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17. Alphanate [package insert]. Los Angeles, CA: Grifols Biologicals Inc.; March 2015.
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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2017

Revision Information	10/1/17 – Afstyla Added

TRULANCE®
(plecanatide) tablets, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 3 – Non-preferred Brand
Formulary Alternatives	AMITIZA® (lubiprostone) and LINZESS® (linaclotide)
FDA Approval	January 19, 2017
Therapeutic Class	Guanylate cyclase-C (GC-C) agonist
Indications and Usage	Indicated in adults for the treatment of chronic idiopathic constipation (CIC)
Dosing	***Forms & Strengths:*** 3 mg tablets ***Administration:*** take with or without food; swallow whole; maybe crushed and mixed with applesauce or dissolved in water ***Adjustments:*** None
Safety	***Contraindications:*** use in patients less than 6 years of age due to the risk of serious dehydration; use in patients with known or suspected mechanical gastrointestinal obstruction ***Warnings:*** risk of serious dehydration in pediatric patients; severe diarrhea ***Adverse Reactions:*** diarrhea (≥2%)
Key Points	First drug designed to replicate the function of uroguanylin, a naturally occurring and endogenous human gastrointestinal (GI) peptide that is thought to stimulate fluid secretion which results in a stool consistency associated with more regular bowel function
Treatment Guidelines	Fiber supplements, laxatives (including polyethylene glycol [PEG], lactulose, sodium picosulfate, and bisacodyl), AMITIZA® (lubiprostone), and LINZESS® (linaclotide) have been given strong recommendations for the treatment of CIC by the American College of Gastroenterology (ACG) while noting the therapies may need to be tailored to the individual patient
Place in Therapy	Adds an additional once daily treatment option for adults with CIC

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use TRULANCE safely and effectively. See full prescribing information for TRULANCE.

TRULANCE (plecanatide) tablets, for oral use
Initial U.S. Approval: 2017

WARNING: RISK OF SERIOUS DEHYDRATION IN PEDIATRIC PATIENTS
See full prescribing information for complete boxed warning.

- **TRULANCE is contraindicated in patients less than 6 years of age; in young juvenile mice, plecanatide caused death due to dehydration. (4, 8.4)**
- **Avoid use of TRULANCE in patients 6 years to less than 18 years of age. (5.1, 8.4)**
- **The safety and effectiveness of TRULANCE have not been established in patients less than 18 years of age. (8.4)**

INDICATIONS AND USAGE

TRULANCE is a guanylate cyclase-C agonist indicated in adults for treatment of chronic idiopathic constipation (CIC). (1)

DOSAGE AND ADMINISTRATION

The recommended adult dosage of TRULANCE is 3 mg taken orally once daily. (2.1)

Administration Instructions (2.2):

- Take with or without food.
- Swallow tablets whole.
- For patients who have difficulty swallowing tablets whole or those with a nasogastric or gastric feeding tube, see full prescribing information with instructions for crushing the tablet and administering with applesauce or water.

DOSAGE FORMS AND STRENGTHS

Tablets: 3 mg (3)

CONTRAINDICATIONS

- Patients less than 6 years of age due to the risk of serious dehydration. (4, 5.1, 8.4)
- Patients with known or suspected mechanical gastrointestinal obstruction. (4)

WARNINGS AND PRECAUTIONS

Diarrhea: Patients may experience severe diarrhea. If severe diarrhea occurs, suspend dosing and rehydrate the patient. (5.2)

ADVERSE REACTIONS

Most common adverse reaction (≥2%) is diarrhea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Synergy Pharmaceuticals at 1-888-869-8869 or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch*.

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 01/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

TRULANCE
(plecanatide)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Trulance is indicated in adults for the treatment of chronic idiopathic constipation (CIC).

COVERAGE CRITERIA
Trulance (plecanatide) will be covered with prior authorization when the following criteria are met:
- The requested drug is being prescribed for the treatment of chronic idiopathic constipation (CIC).

REFERENCES

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POLICY IMPLEMENTATION/REVISION INFORMATION
Prior Authorization
Original Implementation Date: 10/1/2017

Revision Information	

TYMLOS®
(abaloparatide) injection, for subcutaneous use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	FORTEO® (teriparatide)
FDA Approval	April 28, 2017
Therapeutic Class	Parathyroid Hormone Analog
Indications and Usage	Treatment of postmenopausal women with osteoporosis at high risk for fracture.
Dosing	***Forms & Strengths:*** Injection: 3120 mcg/1.56 mL (2000 mcg/mL) in a single-patient-use prefilled pen. ***Administration:*** Recommended dose is 80 mcg subcutaneously in the abdomen once daily; patients should receive supplemental calcium and vitamin D if dietary intake is inadequate and should be seated to avoid symptoms of orthostatic hypotension. ***Adjustments:*** none
Safety	***Contraindications:*** none ***Warnings:*** Orthostatic Hypotension; Hypercalcemia; Hypercalciuria and Urolithiasis ***Adverse Reactions:*** The most common adverse reactions (incidence ≥2%) are hypercalciuria, dizziness, nausea, headache, palpitations, fatigue, upper abdominal pain and vertigo.
Key Points	First new anabolic treatment approved for postmenopausal women with osteoporosis in the United States in nearly 15 years.
Treatment Guidelines	Bisphosphonates are generally well tolerated and are considered first-line in the treatment of osteoporosis. Other treatment options include: selective estrogen-receptor modulators (SERMs), hormone therapy, parathyroid hormone, calcitonin, and denosumab. Calcium and vitamin D supplementation in noninstitutionalized postmenopausal women and premenopausal women is no longer recommended by USPSTF for primary prevention of bone fractures.
Place in Therapy	Provides an additional treatment option for postmenopausal women with osteoporosis

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use TYMLOS safely and effectively. See full prescribing information for TYMLOS.

TYMLOS™ (abaloparatide) injection, for subcutaneous use
Initial U.S. Approval: 2017

WARNING: RISK OF OSTEOSARCOMA
See full prescribing information for complete boxed warning.

- **Abaloparatide caused a dose-dependent increase in the incidence of osteosarcoma, a malignant bone tumor, in male and female rats. It is unknown whether TYMLOS will cause osteosarcoma in humans. (5.1, 13.1)**
- **Use of TYMLOS is not recommended in patients at increased risk for osteosarcoma. (5.1)**
- **Cumulative use of TYMLOS and parathyroid hormone analogs (e.g., teriparatide) for more than 2 years during a patient's lifetime is not recommended. (5.1)**

----------INDICATIONS AND USAGE----------
TYMLOS is a human parathyroid hormone related peptide [PTHrP(1-34)] analog indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture. (1)

----------DOSAGE AND ADMINISTRATION----------
- Recommended dose is 80 mcg subcutaneously once daily; patients should receive supplemental calcium and vitamin D if dietary intake is inadequate. (2.1)
- Administer as a subcutaneous injection into periumbilical region of abdomen. (2.2)
- Administer initially where the patient can sit or lie down in case symptoms of orthostatic hypotension occur. (2.2, 5.2)

----------DOSAGE FORMS AND STRENGTHS----------
Injection: 3120 mcg/1.56 mL (2000 mcg/mL) in a single-patient-use prefilled pen. The prefilled pen delivers 30 daily doses of 80 mcg abaloparatide in 40 mcL of sterile, clear, colorless solution. (3)

----------CONTRAINDICATIONS----------
None (4)

----------WARNINGS AND PRECAUTIONS----------
- Orthostatic Hypotension: Instruct patients to sit or lie down if symptoms develop after dose administration. (5.2)
- Hypercalcemia: Avoid use in patients with pre-existing hypercalcemia and those known to have an underlying hypercalcemic disorder, such as primary hyperparathyroidism. (5.3)
- Hypercalciuria and Urolithiasis: Monitor urine calcium if preexisting hypercalciuria or active urolithiasis are suspected. (5.4)

----------ADVERSE REACTIONS----------
The most common adverse reactions (incidence ≥2%) are hypercalciuria, dizziness, nausea, headache, palpitations, fatigue, upper abdominal pain and vertigo. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Radius Health, Inc. at 1-855-672-3487 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 04/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

SPECIALTY GUIDELINE MANAGEMENT

TYMLOS™ (abaloparatide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Tymlos is indicated for the treatment postmenopausal women with osteoporosis at high risk for fracture defined as history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Osteoporosis in Postmenopausal women
Authorization of a lifetime total of 24 months for parathyroid hormone analogs (e.g., abaloparatide or teriparatide) may be granted to postmenopausal members with osteoporosis when ANY of the following criteria are met:

1. Member has a history of fragility fractures, OR
2. Member has a pre-treatment T-score of ≤ -2.5 and meets ANY of the following criteria:
    a. Member has indicators of higher fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores, or increased fall risk), OR
    b. Member has failed prior treatment with or is intolerant to previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents)

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

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POLICY IMPLEMENTATION/REVISION INFORMATION
Prior Authorization
Original Implementation Date: 10/1/2017

Revision Information	

RHOFADE®
(oxymetazoline hydrochloride) cream, for topical use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 3 – Non-preferred Brand
Formulary Alternatives	MIRVASO® (brimonidine)
FDA Approval	January 19, 2017
Therapeutic Class	Alpha$_{1A}$ adrenoceptor agonist
Indications and Usage	The topical treatment of persistent facial erythema associated with rosacea in adults
Dosing	***Forms & Strengths:*** Cream: 1% ***Administration:*** Apply a pea-sized amount once daily in a thin layer to cover the entire face avoiding eyes and lips ***Adjustments:*** None
Safety	***Contraindications:*** None ***Warnings:*** May impact blood pressure; use in caution with cerebral or coronary insufficiency, Raynaud's, thromboangiitis, obliterans, scleroderma, or Sjögren's syndrome; narrow-angle glaucoma ***Adverse Reactions:*** application site dermatitis, worsening inflammatory lesions of rosacea, application site pruritis, application site erythema, and application site pain
Key Points	First and only alpha$_{1A}$ adrenoceptor agonist approved for persistent facial erythema associated with rosacea in adults; 18% of study participants met the treatment goal of 2-grade improvement on the Clinician Erythema Assessment scale;
Treatment Guidelines	Use of a mild and non-abrasive cleanser, sunscreen, cosmetics for cover up, and the use of topical brimonidine or oxymetazoline can be used in conjunction with identifying and avoiding potential rosacea triggers
Place in Therapy	Adds an alternative option for treating persistent facial erythema associated with rosacea in adults

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use RHOFADE™ topical cream safely and effectively. See full prescribing information for RHOFADE™ topical cream.

RHOFADE™ (oxymetazoline hydrochloride) cream, for topical use
Initial U.S. Approval: 1964

----------INDICATIONS AND USAGE----------
RHOFADE™ is an alpha$_{1A}$ adrenoceptor agonist indicated for the topical treatment of persistent facial erythema associated with rosacea in adults. (1)

----------DOSAGE AND ADMINISTRATION----------
- Not for oral, ophthalmic, or intravaginal use. (2)
- Prime pump bottle before initial use and discard product from first three pumps. (2)
- Apply a pea-sized amount once daily in a thin layer to cover the entire face (forehead, nose, each cheek, and chin) avoiding the eyes and lips. (2)
- Wash hands after application. (2)

----------DOSAGE FORMS AND STRENGTHS----------
Cream, 1%. Each gram of cream contains 10 mg (1%) oxymetazoline hydrochloride, equivalent to 8.8 mg (0.88%) of oxymetazoline free base. (3)

----------CONTRAINDICATIONS----------
- None. (4)

----------WARNINGS AND PRECAUTIONS----------
- Alpha-adrenergic agonists as a class may impact blood pressure. Advise patients with cardiovascular disease, orthostatic hypotension, and/or uncontrolled hypertension or hypotension to seek medical care if their condition worsens. (5.1)
- Use with caution in patients with cerebral or coronary insufficiency, Raynaud's phenomenon, thromboangiitis obliterans, scleroderma, or Sjögren's syndrome and advise patients to seek medical care if signs and symptoms of potentiation of vascular insufficiency develop. (5.2)
- Advise patients to seek immediate medical care if signs and symptoms of acute narrow-angle glaucoma develop. (5.3)

----------ADVERSE REACTIONS----------
Most common adverse reactions (incidence $\geq$ 1%) are application site dermatitis, worsening inflammatory lesions of rosacea, application site pruritis, application site erythema, and application site pain. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Allergan at 1-800-433-8871 or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch.*

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 01/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

FINACEA
(azelaic acid)

MIRVASO
(brimonidine)

NORITATE
(metronidazole)

RHOFADE
(oxymetazoline hydrochloride)

SOOLANTRA
(ivermectin)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Finacea
Finacea (azelaic acid), is indicated for topical treatment of inflammatory papules and pustules of mild to moderate rosacea.

Mirvaso
Mirvaso (brimonidine) is indicated for the topical treatment of persistent (non-transient) erythema of rosacea in adults 18 years of age or older.
.

Noritate
Noritate (metronidazole) is indicated for the topical treatment of inflammatory lesions and erythema of rosacea.

Rhofade
Rhofade (oxymetazoline) is indicated for the topical treatment of persistent facial erythema associated with rosacea in adults.

Soolantra
Soolantra (ivermectin) is indicated for the treatment of inflammatory lesions of rosacea.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of rosacea.

REFERENCES

1. Noritate [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; March 2015.
2. Mirvaso [package insert]. Fort Worth, TX: Galderma Labs; October 2015
3. Finacea [package insert]. Morristown, NJ: Intendis Inc., April 2011.
4. Rhofade [package insert]. Irvine, CA: Allergan; January 2017.
5. Soolantra [package insert]. Fort Worth, TX: Galderma Labs; February 2016.
6. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2016.
7. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2016.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 10/1/2017

Revision Information	

RUBRACA®
(rucaparib) tablets, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	LYNPARZA® (olaparib)
FDA Approval	December 19, 2016: accelerated approval, breakthrough therapy, priority review status, orphan drug designation
Therapeutic Class	Antineoplastic Agent, PARP Inhibitor
Indications and Usage	Treatment of patients with deleterious *BRCA* mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies.
Dosing	***Forms & Strengths:*** Tablets: 200 mg, 250 mg, and 300 mg ***Administration:*** Recommended dose is 600 mg orally twice daily with or without food; Continue treatment until disease progression or unacceptable toxicity; For adverse reactions, consider interruption of treatment or dose reduction ***Adjustments:*** Advise women not to breastfeed
Safety	***Contraindications:*** none ***Warnings:*** Myelodysplastic Syndrome/Acute Myeloid Leukemia can occur so monitor patients for hematological toxicity at baseline and monthly thereafter. Discontinue if MDS/AML is confirmed; Embryo-Fetal Toxicity ***Adverse Reactions:*** Most common adverse reactions (≥ 20%) were nausea, fatigue (including asthenia), vomiting, anemia, abdominal pain, dysgeusia, constipation, decreased appetite, diarrhea, thrombocytopenia, and dyspnea
Key Points	Rubraca is the first FDA-approved PARP therapy to treat both germline and somatic *BRCA*-mutated tumors.
Treatment Guidelines	Surgery and debulking, followed by carboplatin and paclitaxel is typically the first-line option for ovarian cancer. For recurrent cancers, more surgery is recommended possibly along with more chemo. Treatment with targeted drugs at this point can be helpful. Bevacizemab (Avastin®) may be given with chemo. A PARP inhibitor drug such as olaparib (Lynparza), rucaparib (Rubraca), or niraparib (Zejula) may also be an option at some point. In addition, some patients benefit from hormonal treatment with drugs like anastrozole, letrozole, or tamoxifen. High-dose chemotherapy with stem cell rescue (sometimes known as stem cell transplant) has been used for women with recurrent or persistent ovarian cancer.
Place in Therapy	Provides an additional treatment option to patients with deleterious BRCA mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies.

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use RUBRACA safely and effectively. See full prescribing information for RUBRACA.

RUBRACA™ (rucaparib) tablets, for oral use
Initial U.S. Approval: 2016

----------INDICATIONS AND USAGE----------

RUBRACA is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated as monotherapy for the treatment of patients with deleterious *BRCA* mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies. Select patients for therapy based on an FDA-approved companion diagnostic for RUBRACA. (1, 2.1)

This indication is approved under accelerated approval based on objective response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. (1, 14)

----------DOSAGE AND ADMINISTRATION----------

- Recommended dose is 600 mg orally twice daily with or without food. (2.2)
- Continue treatment until disease progression or unacceptable toxicity. (2.2)
- For adverse reactions, consider interruption of treatment or dose reduction. (2.3)

----------DOSAGE FORMS AND STRENGTHS----------

Tablets: 200 mg, 250 mg, and 300 mg (3)

----------CONTRAINDICATIONS----------

None. (4)

----------WARNINGS AND PRECAUTIONS----------

- Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML): MDS/AML occurred in patients exposed to RUBRACA, including one fatal event of AML. Monitor patients for hematological toxicity at baseline and monthly thereafter. Discontinue if MDS/AML is confirmed. (5.1)
- Embryo-Fetal Toxicity: RUBRACA can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception. (5.2, 8.1, 8.3)

----------ADVERSE REACTIONS----------

- Most common adverse reactions (≥ 20%) were nausea, fatigue (including asthenia), vomiting, anemia, abdominal pain, dysgeusia, constipation, decreased appetite, diarrhea, thrombocytopenia, and dyspnea. (6.1)
- Most common laboratory abnormalities (≥ 35%) were increase in creatinine, increase in ALT, increase in AST, decrease in hemoglobin, decrease in lymphocytes, increase in cholesterol, decrease in platelets, and decrease in absolute neutrophil count. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Clovis Oncology, Inc. at 1-844-258-7662 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----------USE IN SPECIFIC POPULATIONS----------

- Lactation: Advise women not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 2/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

SPECIALTY GUIDELINE MANAGEMENT

RUBRACA (rucaparib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Rubraca is indicated as monotherapy for the treatment of patients with deleterious BRCA mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies. Select patients for therapy based on an FDA-approved companion diagnostic for Rubraca.

This indication is approved under accelerated approval based on objective response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for treatment of advanced ovarian cancer when all of the following criteria are met:

A. Tumor has deleterious BRCA mutation (germline, somatic or both) as detected by an FDA-approved companion diagnostic test
B. Rubraca will be given as monotherapy
C. Member has received two or more prior chemotherapies

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Rubraca [package insert]. Boulder, CO: Clovis Oncology, Inc.; December 2016.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization
Original Implementation Date: 10/1/2017

Revision Information	

RYDAPT®
(midostaurin) capsules, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	None
FDA Approval	April 28, 2017; Breakthrough Therapy, Orphan Drug, Priority Review
Therapeutic Class	Antineoplastic Agent, Tyrosine Kinase Inhibitor, FLT3 Inhibitor
Indications and Usage	Adult patients with newly diagnosed acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation & aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)
Dosing	***Forms & Strengths:*** 25 mg capsules ***Administration:*** AML: 50 mg orally twice daily with food; ASM, SM-AHN, and MCL: 100 mg orally twice daily with food ***Adjustments:*** None
Safety	***Contraindications:*** Hypersensitivity to midostaurin or any of the excipients ***Warnings:*** Embryo-fetal toxicity; pulmonary toxicity
Key Points	FLT3 testing is required before RYDAPT® can be administered. First and only approved therapy for three types of SM collectively known as advanced SM, a group of ultra-rare, life-threatening conditions as well as newly diagnosed FLT3-mutated AML.
Treatment Guidelines	Induction & consolidation treatment with cytarabine and the anthracycline drugs (such as daunorubicin (daunomycin), idarubicin, and mitoxantrone) ± cladribine; Targeted therapies (midostaurin); Leukapheresis if needed; radiation if needed; non-myeloablative stem cell transplant (mini-transplant)
Place in Therapy	Use as a treatment option for FLT3 AML, ASM, SM-AHN, or MCL.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use RYDAPT safely and effectively. See full prescribing information for RYDAPT.

RYDAPT® (midostaurin) capsules, for oral use
Initial U.S. Approval: 2017

----------INDICATIONS AND USAGE----------

RYDAPT is a kinase inhibitor indicated for the treatment of adult patients with:

- Newly diagnosed acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation (1.1).

  Limitations of Use:

  RYDAPT is not indicated as a single-agent induction therapy for the treatment of patients with AML.
- Aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL). (1.2)

----------DOSAGE AND ADMINISTRATION----------

- AML: 50 mg orally twice daily with food. (2.1, 2.2, 2.4)
- ASM, SM-AHN, and MCL: 100 mg orally twice daily with food. (2.3, 2.4)

----------DOSAGE FORMS AND STRENGTHS----------

Capsules: 25 mg (3)

----------CONTRAINDICATIONS----------

Hypersensitivity to midostaurin or any of the excipients (4)

----------WARNINGS AND PRECAUTIONS----------

- Embryo-fetal Toxicity: RYDAPT may cause fetal harm when administered to a pregnant woman. Advise of the potential risk to a fetus. (5.1, 8.1).
- Pulmonary Toxicity: Monitor for symptoms of interstitial lung disease or pneumonitis. Discontinue RYDAPT in patients with signs or symptoms of pulmonary toxicity. Fatal cases have occurred. (5.2)

----------ADVERSE REACTIONS----------

- AML: The most common adverse reactions (≥ 20%) were febrile neutropenia, nausea, mucositis, vomiting, headache, petechiae, musculoskeletal pain, epistaxis, device-related infection, hyperglycemia, and upper respiratory tract infection. (6.1)
- ASM, SM-AHN, or MCL: The most common adverse reactions (≥ 20%) were nausea, vomiting, diarrhea, edema, musculoskeletal pain, abdominal pain, fatigue, upper respiratory tract infection, constipation, pyrexia, headache, and dyspnea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Novartis Pharmaceuticals Corporation at 1-888-669-6682 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----------DRUG INTERACTIONS----------

- Strong CYP3A4 Inhibitors: Strong CYP3A4 inhibitors may increase exposure to midostaurin and its active metabolites. Consider alternative therapies that do not strongly inhibit CYP3A4 or monitor for increased risk of adverse reactions. (7.1)
- Strong CYP3A4 Inducers: Avoid concomitant use as strong CYP3A4 inducers decrease exposure to midostaurin and its active metabolites. (7.1)

----------USE IN SPECIFIC POPULATIONS----------

Lactation: Advise females not to breastfeed (8.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 4/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

SPECIALTY GUIDELINE MANAGEMENT

RYDAPT (midostaurin)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

A. Rydapt is indicated, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy, for the treatment of adult patients with newly diagnosed acute myeloid leukemia (AML) who are FLT3 mutation-positive, as detected by a FDA approved test.

   Limitations of Use: Rydapt is not indicated as a single-agent induction therapy for the treatment of patients with AML.

B. Rydapt is indicated for the treatment of adult patients with aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Acute Myeloid Leukemia (AML)

Authorization of 12 months may be granted to adult members for the treatment of newly diagnosed FLT3 mutation-positive AML when Rydapt is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.

B. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with associated hematological neoplasm (SM-AHN), and Mast Cell Leukemia (MCL)

Authorization of 12 months may be granted to adult members for the treatment of ASM, SM-AHN, or MCL.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Rydapt [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2017.
2. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Acute Myeloid Leukemia. Version 1.2017. http://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed April 28, 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION
Prior Authorization
Original Implementation Date: 10/1/2017

Revision Information	

VRAYLAR®
(cariprazine) capsules, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 3 – Non-preferred Brand
Formulary Alternatives	Aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone
FDA Approval	September 17, 2015
Therapeutic Class	Atypical Antipsychotic
Indications and Usage	Indicated for the treatment of schizophrenia and for the acute treatment of manic or mixed episodes associated with bipolar I disorder
Dosing	***Forms & Strengths:*** Capsules: 1.5 mg, 3 mg, 4.5 mg, and 6 mg ***Administration:*** once daily with or without food ***Adjustments:*** None
Safety	***Contraindications:*** known hypersensitivity to VRAYLAR ***Warnings:*** Cerebrovascular adverse reactions in elderly patient with dementia-related psychosis, Neuroleptic malignant syndrome, Tardive dyskinesia, Late-occurring adverse reactions, Metabolic changes, Orthostatic hypotension ***Adverse Reactions:*** extrapyramidal symptoms, akathisia, dyspepsia, vomiting, somnolence, and restlessness ***Drug Interactions:*** Strong CYP3A4 inhibitors: reduce VRAYLAR dosage by half; CYP3A4 inducers: do not recommend use with VRAYLAR
Key Points	Long half-life compared to other atypical antipsychotics; No significant QT prolongation, low weight gain and lipid and glucose changes are similar to placebo
Treatment Guidelines	*Schizophrenia:* second-generation (atypical) antipsychotics – with the exception of clozapine – are the agents of choice for first-line treatment of schizophrenia because they are associated with fewer extrapyramidal symptoms than first-generation (typical) antipsychotics. Stage 2 would be to change to another atypical or typical, stage 3 clozapine would be used and thereafter combination therapy would be tried with or without electroconvulsive therapy and a mood stabilizer. *Bipolar I Disorder:* For patients' naïve to antimanic medication, a first-line antimanic agent such as lithium carbonate should be chosen. In addition to lithium salts, divalproex, carbamazepine, and most of the atypical antipsychotics are all FDA-approved treatments. While these agents are all effective as monotherapy, some analysis suggests that a combination of an atypical and either lithium or divalproex is the most effective treatment.
Place in Therapy	Adds an additional treatment option for bipolar I disorder & schizophrenia

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use VRAYLAR safely and effectively. See full prescribing information for VRAYLAR.

VRAYLAR® (cariprazine) capsules, for oral use
Initial U.S. Approval: 2015

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS
***See full prescribing information for complete boxed warning*.**
- **Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.**
- **VRAYLAR is not approved for the treatment of patients with - dementia-related psychosis. (5.1)**

----------RECENT MAJOR CHANGES----------
Warnings and Precautions (5.9) 2/2017

----------INDICATIONS AND USAGE----------
VRAYLAR is an atypical antipsychotic indicated for the:
- Treatment of schizophrenia (1)
- Acute treatment of manic or mixed episodes associated with bipolar I disorder (1)

----------DOSAGE AND ADMINISTRATION----------
- Administer VRAYLAR once daily with or without food (2)

	Starting Dose	Recommended Dose
Schizophrenia (2.2)	1.5 mg/day	1.5 mg to 6 mg/day
Bipolar Mania (2.3)	1.5 mg/day	3 mg to 6 mg/day

- Doses above 6 mg daily do not confer significant benefit but increased the risk of dose-related adverse reactions.

----------DOSAGE FORMS AND STRENGTHS----------
Capsules: 1.5 mg, 3 mg, 4.5 mg, and 6 mg (3)

----------CONTRAINDICATIONS----------
Known hypersensitivity to VRAYLAR (4)

----------WARNINGS AND PRECAUTIONS----------
- *Cerebrovascular Adverse Reactions in Elderly Patients with Dementia-Related Psychosis:* Increased incidence of cerebrovascular adverse reactions (e.g., stroke, transient ischemic attack) (5.2)
- *Neuroleptic Malignant Syndrome:* Manage with immediate discontinuation and close monitoring (5.3)
- *Tardive Dyskinesia*: Discontinue if appropriate (5.4)
- *Late-Occurring Adverse Reactions:* Because of VRAYLAR's long half-life, monitor for adverse reactions and patient response for several weeks after starting VRAYLAR and with each dosage change (5.5)
- *Metabolic Changes*: Monitor for hyperglycemia/diabetes mellitus, dyslipidemia and weight gain (5.6)
- *Orthostatic Hypotension*: Monitor heart rate and blood pressure and warn patients with known cardiovascular or cerebrovascular disease, and risk of dehydration or syncope (5.8)

----------ADVERSE REACTIONS----------
Most common adverse reactions (incidence ≥ 5% and at least twice the rate of placebo) were (6.1):
- Schizophrenia: extrapyramidal symptoms and akathisia
- Bipolar mania: extrapyramidal symptoms, akathisia, dyspepsia, vomiting, somnolence, and restlessness

To report SUSPECTED ADVERSE REACTIONS, contact Allergan at 1-800-433-8871or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----------DRUG INTERACTIONS----------
- Strong CYP3A4 inhibitors: reduce VRAYLAR dosage by half (2.4, 7.1)
- CYP3A4 inducers: do not recommend use with VRAYLAR (2.4, 7.1)

----------USE IN SPECIFIC POPULATIONS----------
- *Pregnancy:* May cause extrapyramidal and/or withdrawal symptoms in neonates with third trimester exposure (8.1)

See 17 for PATIENT COUNSELING INFORMATION

Revised: 2/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed

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North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	**ATYPICAL ANTIPSYCHOTICS**
BRAND NAME (generic)	**FANAPT (iloperidone)** **REXULTI (brexpiprazole)** **SAPHRIS (asenapine)** **VRAYLAR (cariprazine)**

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Fanapt

Fanapt tablets are indicated for the treatment of adults with schizophrenia. Efficacy was established in two short-term (4- and 6-week) placebo- and active-controlled studies of adult patients with schizophrenia. When deciding among the alternative treatments available for this condition, the prescriber should consider the finding that Fanapt is associated with prolongation of the QTc interval. Prolongation of the QTc interval is associated in some other drugs with the ability to cause torsade de pointes-type arrhythmia, a potentially fatal polymorphic ventricular tachycardia which can result in sudden death. In many cases this would lead to the conclusion that other drugs should be tried first. Whether Fanapt will cause torsade de pointes or increase the rate of sudden death is not yet known. Patients must be titrated to an effective dose of Fanapt. Thus, control of symptoms may be delayed during the first 1 to 2 weeks of treatment compared to some other antipsychotic drugs that do not require a similar titration. Prescribers should be mindful of this delay when selecting an antipsychotic drug for the treatment of schizophrenia. The effectiveness of Fanapt in long-term use, that is, for more than 6 weeks, has not been systematically evaluated in controlled trials. Therefore, the physician who elects to use Fanapt for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Rexulti

Rexulti is indicated for:

- Adjunctive treatment of major depressive disorder (MDD)
- Treatment of schizophrenia

Saphris

Saphris is indicated for:

- Schizophrenia
- Acute treatment of manic or mixed episodes associated with Bipolar I disorder as monotherapy or adjunctive treatment to lithium or valproate
- Maintenance monotherapy treatment in Bipolar I disorder

Vraylar

- Treatment of schizophrenia.
- Acute treatment of manic or mixed episodes associated with Bipolar I disorder.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- Fanapt is being prescribed for the treatment of an adult with schizophrenia

OR

- Rexulti is being prescribed for any of the following: A) Adjunctive treatment of major depressive disorder (MDD), B) Treatment of schizophrenia

OR

- Saphris is being prescribed for any of the following: A) Schizophrenia, B) Acute treatment of manic or mixed episodes associated with Bipolar I disorder as monotherapy or adjunctive treatment to lithium or valproate, C) Maintenance monotherapy treatment in Bipolar I disorder

OR

- Vraylar is being prescribed for any of the following: A) Treatment of schizophrenia, B) Acute treatment of manic or mixed episodes associated with Bipolar I disorder.

  AND
- The patient experienced an inadequate treatment response, intolerance, or contraindication to Latuda or Seroquel XR

  AND
- The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone

  AND
- The patient does not have dementia-related psychosis

REFERENCES

1. Fanapt [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation: April 2014.
2. Rexulti [package insert]. Rockville, MD: Otsuka America Pharmaceutical, Inc.; August 2015.
3. Saphris [package insert]. Irvine, CA: Allergan USA Inc.; February 2017.
4. Vraylar [package insert]. Parsippany, NJ: Actavis Pharma, Inc.; September 2015
5. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed May 2016.
6. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed May 2016.
7. Dixon, L., Perkins, D. et.al. Guideline Watch (September 2009): Practice Guideline for the Treatment of Patients with Schizophrenia. American Psychiatric Association.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 10/1/2017

Revision Information	

BINDER DIVIDER

“Utilization Management”

Utilization Management, New Policies Effective 10/1/2017

Policy Name	*Policy Type*
Albenza®, Biltricide®, Emverm® Limit Policy	Quantity Limit; Post Limit Prior Authorization
Ciclopirox Topical Solution 8% Policy	Initial Prior Authorization
Elidel® Policy	Initial Prior Authorization
Protopic® Policy	Initial Prior Authorization
Soriatane® Policy	Initial Prior Authorization
Prudoxin®, Zonalon® Policy	Initial Step Therapy with Quantity Limit; Post Step Therapy Prior Authorization with Quantity Limit
Sitavig® Policy	Initial Step Therapy; Post Step Therapy Prior Authorization
Cuprimine®, Syprine® Policy	Initial Step Therapy; Post Step Therapy Prior Authorization
Voltaren® Gel Policy	Initial Prior Authorization
Lidoderm® Policy	Initial Prior Authorization with Quantity Limit

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

ALBENZA
(albendazole)

BILTRICIDE
(praziquantel)

EMVERM
(mebendazole)

Status: CVS Caremark Criteria
Type: Quantity Limit, Post Limit Prior Authorization ***Ref # 1583-H, 1586-J***

POLICY

FDA-APPROVED INDICATIONS

Albenza

Neurocysticercosis

Albenza is indicated for the treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, Taenia solium.

Hydatid Disease

Albenza is indicated for the treatment of cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, Echinococcus granulosus.

Biltricide

Biltricide is indicated for the treatment of infections due to: all species of schistosoma (for example, Schistosoma mekongi, Schistosoma japonicum, Schistosoma mansoni and Schistosoma hematobium), and infections due to the liver flukes, Clonorchis sinensis/Opisthorchis viverrini (approval of this indication was based on studies in which the two species were not differentiated).

Emverm

Emverm (mebendazole) chewable tablet, USP is indicated for the treatment of Enterobius vermicularis (pinworm), Trichuris trichiura (whipworm), Ascaris lumbricoides (common roundworm), Ancylostoma duodenale (common hookworm), Necator americanus (American hookworm) in single or mixed infections.

Efficacy varies as a function of such factors as preexisting diarrhea and gastrointestinal transit time, degree of infection, and helminth strains.

LIMIT CRITERIA

Drug	Quantities to approve*
Albenza (albendazole)	336 tablets per 365 days
Biltricide (praziquantel)	24 tablets per 365 days
Emverm (mebendazole)	12 tablets per 365 days

** This drug is indicated for short-term acute use; therefore, the mail limit will be the same as the retail limit.*

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The infection has been confirmed by a diagnostic or laboratory test (e.g. imaging scans, blood, stool, or urine test)

AND

- The request is for mebendazole (Emverm) for a second course of therapy in the past year at a dose up to 2 tablets per day for two 3 day treatments for any of the following: A) Enterobius vermicularis (pinworm), B) Trichuris trichiura (whipworm), C) Ascaris lumbricoides (common roundworm), D) Ancylostoma duodenale (common hookworm), E) Necator americanus (American hookworm)

  OR

- The request is for albendazole (Albenza) for the treatment of Hydatid Disease for a second course of therapy in the past year at a dose up to 4 tablets per day for three 28-day cycles with 14-day free intervals

  OR

- The request is for praziquantel (Biltricide) for the treatment of schistosomiasis, clonorchiasis, or opisthorchiasis for any of the following: A) a quantity up to 36 tablets, B) a second day or course of therapy in the past year

Quantity Limits apply.
Emverm (mebendazole): 12 tablets per 365 days
Albenza (albendazole): 336 tablets per 365 days
Biltricide (praziquantel): 72 tablets per 365 days

REFERENCES

1. Albenza [package insert]. Horsham, PA: Amedra Pharmaceuticals LLC; June 2015.
2. Biltricide [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; February 2014.
3. Emverm [package insert]. Horsham, PA: Amedra Pharmaceuticals LLC; December 2015.
4. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed January 2017.
5. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed January 2017.
6. U.S. FDA Approves Vermox Chewable (Mebendazole) For Treatment of Children and Adults With Roundworm and Whipworm Infections. Available at: http://www.janssen.com/us-fda-approves-vermoxtm-chewable-mebendazole-treatment-children-and-adults-roundworm-and-whipworm. Accessed February 2017.
7. Parasites - Schistosomiasis. Available at: https://www.cdc.gov/dpdx/schistosomiasis/index.html. Accessed April 2017.
8. Parasites - Clonorchiasishttps://www.cdc.gov/dpdx/clonorchiasis/index.html. Accessed April 2017.
9. Parasites - Opisthorchis Infection. Available at: https://www.cdc.gov/parasites/opisthorchis/health_professionals/index.html. Accessed April 2017.
10. Parasites - Echinococcosis. Available at: https://www.cdc.gov/parasites/echinococcosis/. Accessed April 2017.
11. Parasites - Cysticercosis https://www.cdc.gov/parasites/cysticercosis// Accessed April 2017.

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Prior Authorization

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PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	**CICLOPIROX TOPICAL SOLUTION 8%**
BRAND NAME (generic)	**CICLODAN KIT (ciclopirox topical solution 8% moisturizer)** **CNL8 NAIL KIT (ciclopirox topical solution 8% nail lacquer remover swabs / emery board)** **PEDIPIROX -4 NAIL KIT (ciclopirox topical solution 8% nail lacquer removal pads / nail file / with or without foot powder)** **PENLAC NAIL LACQUER (ciclopirox topical solution 8%)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATION

Ciclopirox topical solution, 8%, as a component of a comprehensive management program, is indicated as topical treatment in immunocompetent patients with mild to moderate onychomycosis of fingernails and toenails without lunula involvement, due to *Trichophyton rubrum*. The comprehensive management program includes removal of the unattached, infected nails as frequently as monthly, by a health care professional who has special competence in the diagnosis and treatment of nail disorders, including minor nail procedures.

- No studies have been conducted to determine whether ciclopirox might reduce the effectiveness of systemic antifungal agents for onychomycosis. Therefore, the concomitant use of 8% ciclopirox topical solution and systemic antifungal agents for onychomycosis is not recommended.
- Ciclopirox topical solution, 8%, should be used only under medical supervision as described above.
- The effectiveness and safety of Ciclopirox topical solution, 8%, in the following populations has not been studied. The clinical trials with use of Ciclopirox topical solution, 8%, excluded patients who: were pregnant or nursing, planned to become pregnant, had a history of immunosuppression (e.g., extensive, persistent, or unusual distribution of dermatomycoses, extensive seborrheic dermatitis, recent or recurring herpes zoster, or persistent herpes simplex), were HIV seropositive, received organ transplant, required medication to control epilepsy, were insulin dependent diabetics or had diabetic neuropathy. Patients with severe plantar (moccasin) tinea pedis were also excluded.
- The safety and efficacy of using Ciclopirox topical solution, 8%, daily for greater than 48 weeks have not been established.

COVERAGE CRITERIA

Ciclopirox topical solution 8% will be covered with prior authorization when the following criteria are met:

- The patient has a fungal infection of the nail due to dermatophytes
  AND
- The diagnosis has been confirmed with a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)

AND

- The patient has experienced an inadequate treatment response, intolerance, or contraindication to an oral antifungal therapy (e.g., terbinafine, itraconazole)

REFERENCES

1. Ciclodan Kit [package insert]. Fairfield, NJ: Medimetriks Pharmaceutical, Inc.; January 2011.
2. CNL8 Nail Kit [package insert]. Charleston, SC: Innocutis Holdings LLC; December 2007.
3. Pedipirox Kit [package insert]. Amityville, NY: Hi-Tech Pharmacal Co., Inc.; June 2011.
4. Penlac Nail Lacquer [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; November 2012.
5. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed May 2016.
6. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed May 2016.
7. Elewski BE, Rich,P, Pollak R, et al. Efinaconazole 10% solution in the treatment of toenail onychomycosis: Two phase III multicenter randomized, double-blind studies. J Am Acad Dermatol 2013;68:600-8.
8. Westerberg, DP, Voyack MJ. Onychomycosis: Current Trends in Diagnosis and Treatment. American Family Physician 2013;88(11):762-70.

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PRIOR AUTHORIZATION CRITERIA

BRAND NAME	**ELIDEL**
(generic)	**(pimecrolimus)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Elidel is indicated as second-line therapy for the short-term and noncontinuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

Elidel is not indicated for use in children less than 2 years of age.

Compendial Use:
Psoriasis on the face, genitals, or skin folds. [3,5,6]
Vitiligo on the head or neck.[2,3,8,9]

COVERAGE CRITERIA

- Elidel (pimecrolimus) will be covered with prior authorization when the following criteria are met:
  - The patient is 2 years of age or older
    AND
    - Elidel is being prescribed for short-term or noncontinuous chronic use for one of the following: psoriasis on the face, genitals, or skin folds, or vitiligo on the head or neck
      OR
    - Elidel is being prescribed for short-term or noncontinuous chronic use for mild to moderate atopic dermatitis (eczema)
      AND
      - Elidel will be used on the face, body skin folds, genital area, armpit, or around the eyes
        OR
      - The patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical steroid)

OR

  - The patient is less than 2 years of age
    AND
    - Elidel is being prescribed for short-term or noncontinuous chronic use for one of the following: psoriasis on the face, genitals, or skin folds, vitiligo on the head or neck
      OR
    - Elidel is being prescribed for short-term or noncontinuous chronic use for mild to moderate atopic dermatitis (eczema)

REFERENCES

1. Elidel [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; August 2014.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2016.

3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2016.
4. Berke R, Singh A, et al. Atopic Dermatitis: An Overview. *American Family Physician*. July 2012; 86(1): 35-42.
5. Gribetz C, Ling M, Lebwohl M, et al, Pimecrolimus cream 1% in the treatment of intertriginous psoriasis: A double-blind, randomized study. *J Am Acad Dermatol.* 2004; 51:731-8.
6. Menter A, Korman N, et al. Guidelines of Care for the Management of Psoriasis and Psoriatic Arthritis. *J Am Acad Dermatol*. 2009; 60: 643-59.)
7. Topical Corticosteroids. *Drug Facts and Comparisons.* Facts & Comparisons [database online]. St. Louis, MO: Wolters Kluwer Health Inc; 2014. Accessed March 2016.
8. Taieb A, Alomar M, et al. Guidelines for the Management of Vitiligo: The European Dermatology Forum Consensus. *The British Journal of Dermatology.* 2013;168(1):5-19.
9. Bordere AC, Lambert J, et al. Current and Emerging Therapy for the Management of Vitiligo. *Clinical, Cosmetic, and Investigational Dermatology.* 2009:2 15-25.

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PRIOR AUTHORIZATION CRITERIA

BRAND NAME	**PROTOPIC**
(generic)	**(tacrolimus)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Protopic Ointment, both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated as *second-line therapy* for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable.

Protopic ointment is not indicated for children younger than 2 years of age.

Compendial Use:
Psoriasis on the face, genitals, or skin folds. [3,5,6]
Vitiligo on the head or neck.[2,3,8,9]

COVERAGE CRITERIA

- Protopic (tacrolimus) will be covered with prior authorization when the following criteria are met:
  - For Protopic (tacrolimus) 0.1% ointment, the patient is 16 years of age or older

  AND
  - Protopic (tacrolimus) is being prescribed for short-term or noncontinuous chronic use for one of the following: psoriasis on the face, genitals, or skin folds or vitiligo on the head or neck

  OR
  - Protopic (tacrolimus) is being prescribed for short-term or noncontinuous chronic use for moderate to severe atopic dermatitis (eczema)

    AND
    - Protopic (tacrolimus) will be used on the face, body skin folds, genital area, armpit, or around the eyes

      OR
    - The patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical steroid)

OR
  - For Protopic (tacrolimus) 0.03% ointment, the patient is 2 years of age or older

  AND
  - Protopic (tacrolimus) is being prescribed for short-term or noncontinuous chronic use for one of the following: psoriasis on the face, genitals, or skin folds or vitiligo on the head or neck

    OR
  - Protopic (tacrolimus) is being prescribed for short-term or noncontinuous chronic use for moderate to severe atopic dermatitis (eczema)

    AND
    - Protopic (tacrolimus) will be used on the face, body skin folds, genital area, armpit, or around the eyes

      OR

- The patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical steroid)

REFERENCES

1. Protopic [package insert]. Deerfield, IL: Astellas Pharma US, Inc.; May 2012.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2016.
4. Berke R, Singh A, et al. Atopic Dermatitis: An Overview. *American Family Physician*. July 2012; 86(1): 35-42.
5. Lebwohl M, Freeman AK, Chapman S, et al. Tacrolimus ointment is effective for facial and intertriginous psoriasis. *J Am Acad Dermatol.* 2004; 51:723-30.
6. Menter A, Korman N, et al. Guidelines of Care for the Management of Psoriasis and Psoriatic Arthritis. *J Am Acad Dermatol*. 2009; 60: 643-59.)
7. Topical Corticosteroids. *Drug Facts and Comparisons.* Facts & Comparisons [database online]. St. Louis, MO: Wolters Kluwer Health Inc; 2014. Accessed March 2016.
8. Taieb A, Alomar M, et al. Guidelines for the Management of Vitiligo: The European Dermatology Forum Consensus. *The British Journal of Dermatology.* 2013;168(1):5-19.
9. Bordere AC, Lambert J, et al. Current and Emerging Therapy for the Management of Vitiligo. *Clinical, Cosmetic, and Investigational Dermatology.* 2009:2 15-25.

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PRIOR AUTHORIZATION CRITERIA

BRAND NAME	**SORIATANE**
(generic)	**(acitretin)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Soriatane is indicated for the treatment of severe psoriasis in adults. Because of significant adverse effects associated with its use, Soriatane should be prescribed only by those knowledgeable in the systemic use of retinoids. In females of reproductive potential, Soriatane should be reserved for non-pregnant patients who are unresponsive to other therapies or whose clinical condition contraindicates the use of other treatments.

Most patients experience relapse of psoriasis after discontinuing therapy. Subsequent courses, when clinically indicated, have produced efficacy results similar to the initial course of therapy.

Compendial Use
Prevention of non-melanoma skin cancers in high risk individuals[3,4]

COVERAGE CRITERIA
Soriatane will be covered with prior authorization when the following criteria are met:

- The patient does not have any of the following: A) Severely impaired liver or kidney function, B) Chronic abnormally elevated blood lipid values, C) Concomitant use of methotrexate or tetracycline

AND

- The patient has a diagnosis of severe psoriasis OR the requested drug is being prescribed for the prevention of non-melanoma skin cancers in a high risk individual

AND

- If the patient is able to bear children then the patient and/or guardian signed a Patient Agreement/Informed Consent (e.g., Do Your P.A.R.T) which includes confirmation of 2 negative pregnancy tests

REFERENCES

1. Soriatane [package insert]. Research Triangle Park, NC: Stiefel Laboratories, Inc.; May 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2016.
4. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Squamous Cell Skin Cancer. V.1.2016. Available at: http://www.nccn.org/professionals/physician_gls/pdf/squamous.pdf. Accessed June 2016.
5. Hardin J, Mydlarski PR. Systemic retinoids: chemoprevention of skin cancer in transplant recipients. *Skin Therapy Lett*. 2010 Jul-Aug; 15:1-4. Available at: http://www.skintherapyletter.com/2010/15.7/1.html. Accessed June 2016.

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STEP THERAPY CRITERIA

BRAND NAME
(generic)

PRUDOXIN
(doxepin)

ZONALON
(doxepin)

Type: Initial Step Therapy with Quantity Limit;
Post Step Therapy Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS
Prudoxin and Zonalon are indicated for the short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus.

INITIAL STEP THERAPY with QUANTITY LIMIT*
If the patient has filled a prescription for at least a 7 day supply of a generic topical corticosteroid **AND** at least a 7 day supply of topical tacrolimus (Protopic) or Elidel (pimecrolimus) within the past 120 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.* If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

*If the patient meets the initial step therapy criteria, then the initial limit criteria will apply. If the patient is requesting more than the initial quantity limit the claim will reject with a message indicating that a PA is required.

***INITIAL LIMIT CRITERIA**

Drug	**1 Month Limit* and 3 Month Limit***
Prudoxin (doxepin)	90 grams/25 days
Zonalon (doxepin)	90 grams/25 days

** This drug is indicated for short-term acute use; therefore, the 1 month, 3 month, retail, and mail limits will be the same.*
**The limit criteria apply to both brand and generic, if available.*

COVERAGE CRITERIA

Doxepin 5% cream (Prudoxin, Zonalon) will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for short-term (up to 8 days) management of moderate pruritus in an adult patient with atopic dermatitis or lichen simplex chronicus
- The patient has experienced an inadequate response to a topical corticosteroid or topical tacrolimus (Protopic) or pimecrolimus (Elidel)

Quantity limits apply.

REFERENCES

1. Prudoxin [package insert]. Newtown, PA: Prestium Pharma, Inc.; February 2015.
2. Zonalon [package insert]. Newtown, PA: Prestium Pharma, Inc.; October 2014.
3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2016.
4. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2016.
5. Eichenfield L, Tom W, Berger T, et al. Guidelines of Care for the Management of Atopic Dermatitis Section 2. Management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol* 2014;71:116-32. Available at: https://www.aad.org/practice-tools/quality-care/clinical-guidelines/atopic-dermatitis/. Accessed December 2016.
6. Elidel [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; August 2014.
7. Protopic [package insert]. Parsippany, NJ: LEO Pharma. Inc.; June 2016.

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STEP THERAPY CRITERIA

BRAND NAME
(generic)

SITAVIG
(acyclovir buccal tablet)

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Sitavig is indicated for the treatment of recurrent herpes labialis (cold sores) in immunocompetent adults.

COVERAGE CRITERIA
Sitavig will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of recurrent herpes labialis (cold sores) in an immunocompetent adult

AND

- The patient has experienced an inadequate treatment response, intolerance or contraindication to a generic oral antiviral medication (e.g., acyclovir, famciclovir, valacyclovir)

AND

- The patient does not require use of MORE than 2 tablets of Sitavig (acyclovir buccal tablets) per month

Quantity Limits apply.
2 tablets/25 days

REFERENCES

1. Sitavig [package insert]. Angers, France: Farméa; April 2013.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed December 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed December 2016.
4. Cernik C, Gallina K et al. The Treatment of Herpes Simplex Infections – An Evidence-Based Review. *Arch Intern Med*. 2008; 168(11):1137-1144.
5. Usatine RP, Tinitigan R. Nongenital Herpes Simplex Virus. *Am Fam Physician*. 2010; 82(9):1075-1082.

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STEP THERAPY CRITERIA

DRUG CLASS	**ROSACEA PRODUCTS (BRAND PRODUCTS ONLY)**
BRAND NAME (generic)	**METROCREAM (metronidazole)**
	METROGEL TOPICAL (metronidazole)
	ORACEA (doxycycline)
	ROSADAN (metronidazole)

Status: CVS Caremark Criteria
Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Metrocream
Metrocream (metronidazole topical cream) Topical Cream is indicated for topical application in the treatment of inflammatory papules and pustules of rosacea.

Metrogel Topical
Metrogel (metronidazole) Gel, 1% is indicated for the topical treatment of inflammatory lesions of rosacea.

Oracea
Oracea (doxycycline) is indicated for the treatment of only inflammatory lesions (papules and pustules) of rosacea in adult patients.

Limitation of Use
This formulation of doxycycline has not been evaluated in the treatment or prevention of infections.
Efficacy of ORACEA beyond 16 weeks and safety beyond 9 months has not been established.

Rosadan
Rosadan (metronidazole) Topical Cream and Gel are indicated for topical application in the treatment of inflammatory papules and pustules of rosacea.

INITIAL STEP THERAPY

If the patient has filled a prescription for a 30 day supply of generic topical metronidazole or generic doxycycline within the past 120 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of rosacea.
  AND
- The patient has had an inadequate treatment response or intolerance after generic topical metronidazole or generic doxycycline.

Quantity Limit may apply.

REFERENCES.

1. Metrocream [package insert]. Fort Worth, TX; Galderma Labs, March 2011
2. Metrogel topical [package insert]. Fort Worth, TX: Galderma Labs; October 2011
3. Oracea [package insert]. Fort Worth, TX: Galderma Labs; December 2014
4. Rosadan [package insert]. Fairfield , NJ: Medimetircks, Inc.; April 2012
5. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2016.
6. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2016

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STEP THERAPY CRITERIA

BRAND NAME*
(generic)

CUPRIMINE
(penicillamine)

SYPRINE
(trientine)

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

** Drugs that are listed in the target drug box include both brand and generic and all dosages forms and strengths unless otherwise stated*

POLICY

FDA-APPROVED INDICATIONS

Cuprimine
Cuprimine is indicated in the treatment of Wilson's disease, cystinuria, and in patients with severe, active rheumatoid arthritis who have failed to respond to an adequate trial of conventional therapy. Available evidence suggests that Cuprimine is not of value in ankylosing spondylitis

Syprine
Syprine is indicated in the treatment of patients with Wilson's disease who are intolerant of penicillamine. Clinical experience with Syprine is limited and alternate dosing regimens have not been well-characterized; all endpoints in determining an individual patient's dose have not been well defined. Syprine and penicillamine cannot be considered interchangeable. Syprine should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects.

INITIAL STEP THERAPY

If the patient has filled a prescription for a 30 day supply of Depen within the past 180 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The request is for Cuprimine for the treatment of Wilson's disease, cystinuria, or in patients with severe, active rheumatoid arthritis who have failed to respond to an adequate trial of conventional therapy
  [Note: conventional therapy for rheumatoid arthritis may include disease-modifying antirheumatic drugs (DMARDs) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.]
  AND
- The patient has experienced a documented allergy to Depen (penicillamine)
  OR
- The request is for Syprine for the treatment of Wilson's disease
  AND
- The patient has experienced an inadequate treatment response or documented allergy to Depen (penicillamine)

REFERENCES

1. Cuprimine [package insert]. Bridgewater, NJ: Aton Pharma. Inc., a division of Valeant Pharmaceuticals North America LLC; November 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2017.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

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North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	**TOPICAL NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)**
BRAND NAME	**VOLTAREN GEL**
(generic)	**(diclofenac sodium topical gel 1%)**

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

** Drugs that are listed in the target drug box include both brand and generic and all dosages forms and strengths unless otherwise stated.*

POLICY

FDA-APPROVED INDICATIONS
Voltaren Gel is indicated for the relief of the pain of osteoarthritis of joints amenable to topical treatment, such as the knees and those of the hands.
Voltaren Gel has not been evaluated for use on the spine, hip, or shoulder.

LIMIT CRITERIA

Drug	1 Month Limit*	3 Month Limit*
Voltaren Gel diclofenac sodium topical gel 1%	500 grams/ 25 days	1500 grams / 75 days

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The patient does NOT have any of the following: A) History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs) OR B) Use of the requested drug in the setting of coronary artery bypass graft (CABG) surgery
  AND
- The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrist, and elbow
  AND
- The patient is unable to tolerate or is not a suitable candidate for oral nonsteroidal anti-inflammatory drug (NSAID) therapy (e.g., bleeding ulcer, etc.)
  AND
- The prescribed quantity falls within the manufacturer's published dosing guidelines

POST LIMIT QUANTITY FOR APPROVAL

Drug	1 Month Limit*	3 Month Limit*
Voltaren Gel diclofenac sodium topical gel 1%	1000 grams/ 25 days	3000 grams / 75 days

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

REFERENCES

1. Voltaren Gel [package insert]. Parsippany, NJ: Novartis Consumer Health, Inc.; April 2016.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2016.
4. Altman RD, Dreiser RL, Fisher CL, et al. Diclofenac Sodium Gel in Patients with Primary Hand Osteoarthritis: A Randomized, Double-blind, Placebo-controlled Trial. *J Rheumatol*. 2009; 36:1991-1999. doi: 10.3899/jrheum.081316.

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PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

LIDODERM
(lidocaine patch 5%)

Type: Initial Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS
Lidoderm is indicated for relief of pain associated with post-herpetic neuralgia. It should be applied only to **intact skin**.
Compendial Uses
Pain associated with diabetic neuropathy
Pain associated with cancer-related neuropathy

COVERAGE CRITERIA
Lidocaine patch will be covered with prior authorization when the following criteria are met:
- Lidocaine patch is being prescribed for any of the following:
  - Pain associated with post-herpetic neuralgia
  - Pain associated with diabetic neuropathy
  - Pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy]).

Quantity Limits apply.

REFERENCES

1. Lidoderm [package insert]. Chadds Ford, PA: Endo Pharmaceuticals Inc.; January 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed January 2017.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed January 2017.
4. Barbano RL, Herrmann DN, Hart-Gouleau S, et al: Effectiveness, tolerability, and impact on quality of life of the 5% lidocaine patch in diabetic polyneuropathy. Arch Neurol 2004; 61:914-918.
5. Dworkin RH, O'Connor AB, Backonja M, et al. Pharmacologic Management of Neuropathic Pain: Evidence-based Recommendations. *Pain* 2007;132(3):237-251.
6. National Comprehensive Cancer Network: Adult Cancer Pain V.2.2015. National Comprehensive Cancer Network. Fort Washington, PA. 2008. Available from URL: http://www.nccn.org/professionals/physician_gls/PDF/pain.pdf. Accessed January 2017.
7. Vadalouca A, Raptis E, Moka E, et al. Pharmacological Treatment of Neuropathic Cancer Pain: A Comprehensive Review of Current Literature. World Institute of Pain. *Pain Practice.* 2011; 12(3):219-251.

POLICY IMPLEMENTATION/REVISION INFORMATION
Prior Authorization
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Revision Information	

Utilization Management, Current Policies in Effect 1/1/2017

Policy Name	*Policy Type*
Daraprim® Policy	Initial Prior Authorization
Dificid® Policy	Initial Prior Authorization
Influenza Treatment Policy	Quantity Limit, Post Limit Prior Authorization
Grastek® Policy	Initial Prior Authorization
Oralair® Policy	Initial Prior Authorization
Ragwitek® Policy	Initial Prior Authorization
Solodyn®, Ximino® Policy	Initial Step Therapy; Post Step Therapy Prior Authorization
Restasis® Policy	Initial Prior Authorization
Testosterone Oral Policy	Initial Prior Authorization
Testosterone Policy	Initial Prior Authorization
Solaraze® Policy	Initial Prior Authorization

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BRAND NAME	**DARAPRIM**
(generic)	**(pyrimethamine)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Treatment of Toxoplasmosis

Daraprim is indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide, since synergism exists with this combination.

Treatment of Acute Malaria

Daraprim is also indicated for the treatment of acute malaria. It should not be used alone to treat acute malaria. Fast-acting schizonticides such as chloroquine or quinine are indicated and preferable for the treatment of acute malaria. However, conjoint use of Daraprim with a sulfonamide (e.g., sulfadoxine) will initiate transmission control and suppression of susceptible strains of plasmodia.

Chemoprophylaxis of Malaria

Daraprim is indicated for the chemoprophylaxis of malaria due to susceptible strains of plasmodia. However, resistance to pyrimethamine is prevalent worldwide. It is not suitable as a prophylactic agent for travelers to most areas.

Compendial Uses

Toxoplasmosis; Prophylaxis[2,3,4,5]
Pneumocystis jiroveci pneumonia; Prophylaxis[2,3,4]
Cystoisosporiasis[2,4,5]

COVERAGE CRITERIA

Daraprim will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of congenital toxoplasmosis in a pediatric patient

OR

- The requested drug is being prescribed for the treatment of toxoplasmosis

OR

- The patient has an intolerance or contraindication to sulfamethoxazole/trimethoprim AND the requested drug is being prescribed for any of the following: A) Toxoplasmosis prophylaxis B) Pneumocystis jiroveci pneumonia prophylaxis C) Cystoisosporiasis

OR

- The requested drug is being prescribed for the treatment or chemoprophylaxis of malaria

REFERENCES

1. Daraprim [package insert]. New York, NY: Turing Pharmaceuticals, LLC; October 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. February 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. February 2016.
4. Centers for Disease Control and Prevention, National Institutes of Health, HIV Medicine Association of the Infectious Diseases Society of America, et al: Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents: Recommendations from the CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR Recomm Rep 2009; 58 (RR4):1-207.
5. Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Department of Health and Human Services. Recommendations from the National Institutes of Health, Centers for Disease Control and Prevention, the HIV Medicine Association of the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society,

and the American Academy of Pediatrics. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/oi_guidelines_pediatrics.pdf. Accessed February 2016.

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BRAND NAME	**DIFICID**
(generic)	**(fidaxomicin)**

Type: Initial Prior Authorization

POLICY

FDA APPROVED INDICATIONS

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Dificid and other antibacterial drugs, Dificid should be used only to treat infections that are proven or strongly suspected to be caused by *Clostridium difficile (CDI)*.

Clostridium difficile-Associated Diarrhea

Dificid is a macrolide antibacterial drug indicated in adults (≥18 years of age) for treatment of *Clostridium difficile*-associated diarrhea (CDAD).

COVERAGE CRITERIA

Dificid will be covered with prior authorization when the following criteria are met:

- The patient has the diagnosis of *Clostridium difficile*-associated diarrhea (CDAD) confirmed by a positive stool assay

AND

- The patient has any of the following:
  - a high risk of *Clostridium difficile* Infection (CDI) recurrence
  - a recurrent infection with *Clostridium difficile* after previous antibiotic therapy
  - requires additional medication to complete a 10 day course of Dificid therapy that was initiated in the hospital

OR

- The patient has experienced inadequate treatment response to metronidazole after a trial of at least 10 days OR has intolerance, contraindication to or is not a candidate for treatment with metronidazole (e.g., severe *Clostridium difficile* Infection [CDI], second recurrence) **AND** has experienced inadequate treatment response to Vancocin (vancomycin hydrochloride) after a trial of at least 7 days, OR has intolerance or contraindication to Vancocin (vancomycin hydrochloride)

REFERENCES

1. Dificid [package insert]. Lexington, MA: Cubist Pharmaceuticals US; May 2014.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed December 2015.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed December 2015.
4. Cohen SH, et al. Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). *Infect Control Hosp Epidemiol* 2010; 31(5):431-455.
5. Louie TJ, Miller MA, Mullane KM, et al. for the OPT-80-003 Clinical Study Group. Fidaxomicin versus Vancomycin for Clostridium difficile Infection. *NEJM*. February 3, 2011. 364:422-431.
6. Gould C, McDonald C. Bench-to-bedside review: Clostridium difficile colitis. *Critical Care* 2008;12: 203-211.
7. Cornely OA, Crook DW, Esposito R, et al: Fidaxomicin versus vancomycin for infection with Clostridium difficile in Europe, Canada, and the USA: a double-blind, non-inferiority, randomised controlled trial. *Lancet Infect Dis* 2012; 12(4):281-289.
8. Mullane K. Fidaxomicin in *Clostridium difficile* infection: latest evidence and clinical guidance. *Ther Adv Chronic Dis*. 2014 Mar; 5(2): 69–84.

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DRUG CLASS	**INFLUENZA TREATMENT & PREVENTION (NEURAMINIDASE INHIBITORS)**
BRAND NAME (generic)	**RELENZA (zanamivir)**
	TAMIFLU CAPSULES/SUSPENSION (oseltamivir)

Type: Quantity Limit, Post Limit Prior Authorization

POLICY

FDA APPROVED INDICATIONS

Relenza

Treatment of Influenza

Relenza Inhalation Powder is indicated for treatment of uncomplicated acute illness due to influenza A and B virus in adults and pediatric patients 7 years of age and older who have been symptomatic for no more than 2 days.

Prophylaxis of Influenza

Relenza is indicated for prophylaxis of influenza in adults and pediatric patients aged 5 years and older.

Important Limitations on Use of Relenza

Relenza is not recommended for treatment or prophylaxis of influenza in individuals with underlying airways disease (such as asthma or chronic obstructive pulmonary disease) due to risk of serious bronchospasm. Relenza has not been proven effective for treatment of influenza in individuals with underlying airways disease. Relenza has not been proven effective for prophylaxis of influenza in the nursing home setting.

Relenza is not a substitute for early influenza vaccination on an annual basis as recommended by the Centers for Disease Control's Immunization Practices Advisory Committee. Influenza viruses change over time. Emergence of resistance mutations could decrease drug effectiveness. Other factors (for example, changes in viral virulence) might also diminish clinical benefit of antiviral drugs. Prescribers should consider available information on influenza drug susceptibility patterns and treatment effects when deciding whether to use Relenza. There is no evidence for efficacy of Relenza in any illness caused by agents other than influenza virus A and B. Patients should be advised that the use of Relenza for treatment of influenza has not been shown to reduce the risk of transmission of influenza to others.

Tamiflu

Treatment of Influenza

Tamiflu is indicated for treatment of acute, uncomplicated illness due to influenza infection in patients 2 weeks of age and older who have been symptomatic for no more than 2 days.

Prophylaxis of Influenza

Tamiflu is indicated for the prophylaxis of influenza in patients 1 year and older.

Limitations of Use

The following points should be considered before initiating treatment or prophylaxis with Tamiflu:
Efficacy of Tamiflu in patients who begin treatment after 48 hours of symptoms has not been established. Tamiflu is not a substitute for early influenza vaccination on an annual basis as recommended by the Centers for Disease Control and

Prevention Advisory Committee on Immunization Practices. There is no evidence for efficacy of Tamiflu in any illness caused by agents other than influenza viruses Types A and B. Influenza viruses change over time. Emergence of resistance substitutions could decrease drug effectiveness. Other factors (for example, changes in viral virulence) might also diminish clinical benefit of antiviral drugs. Prescribers should consider available information on influenza drug susceptibility patterns and treatment effects when deciding whether to use Tamiflu.

LIMIT CRITERIA*

These limits accumulate together across all drugs and strengths up to the highest quantity listed depending on the order that the claims are processed.

1. The limit for Relenza is 40 blisters every 90 days.

2. The limit for Tamiflu is the following:

75 mg capsules:	14 capsules every 90 days
45 mg capsules:	14 capsules every 90 days
30 mg capsules:	28 capsules every 90 days
6 mg/mL suspension:	180 mL every 90 days

***These drugs are only indicated for short-term acute use and chronic use may not be appropriate, therefore the 3 month limit will be the same as the 1 month limit.**

COVERAGE CRITERIA

- Post quantity limits for Relenza will be covered with prior authorization when the following criteria are met:
  - Relenza is being prescribed for any of the following:
    - Treatment of a current infection with influenza A or B in a pregnant or critically/severely ill patient 7 years of age or older OR
    - Treatment of a current infection with influenza A or B in a patient 7 years of age or older with an onset of symptoms within the previous 48 hours (2 days) OR
    - Prevention of influenza A or B in a patient 5 years of age or older after being exposed to another person with influenza within the previous 36 hours (1.5 days) OR
    - Continuation of therapy for a patient currently using the drug for prevention of influenza A or B after exposure to a community outbreak OR
    - Prevention of influenza A or B in a patient 5 years of age or older who has been exposed to a community outbreak of influenza within the previous 5 days

OR

- Tamiflu will be covered with prior authorization when the following criteria are met:
  - Tamiflu is being prescribed for any of the following:
    - Continuation of therapy for a patient currently using the drug for prevention of influenza A or B after exposure to a community outbreak OR
    - Treatment of a current infection with influenza A or B in a pregnant or critically/severely ill patient 2 weeks of age or older OR
    - Treatment of a current infection with influenza A or B in a patient 2 weeks of age or older with an onset of symptoms within the previous 48 hours (2 days) OR
    - Prevention of influenza A or B in a patient 1 year of age or older following close contact with another person with influenza OR
    - Prevention of influenza A or B in a patient 1 year of age or older who has been exposed to a community outbreak of influenza

Quantity Limits apply.

POST LIMIT QUANTITY FOR APPROVAL

The post limit quantity chart below should be used to determine the quantity for approval for each prescribed medication.

Medication	Indication	Quantity Limit
Tamiflu	Continuation of therapy for a patient currently using the drug for prevention of influenza A or B after exposure to a community outbreak	6 months for a TOTAL quantity of: 28 Capsules of 75 mg or 45 mg OR 56 Capsules of 30 mg OR 360 mL Suspension
Tamiflu	-Treatment of a current infection with influenza A or B in a pregnant or critically/severely ill patient 2 weeks of age or older OR -Treatment of a current infection with influenza A or B in a patient 2 weeks of age or older with an onset of symptoms within the previous 48 hours (2 days) OR -Prevention of influenza A or B in a patient 1 year of age or older following close contact with another person with influenza	6 months for a TOTAL quantity of: 10 Capsules of 75 mg or 45 mg OR 20 Capsules of 30 mg OR 180 mL Suspension
Tamiflu	Prevention of influenza A or B in a patient 1 year of age or older who has been exposed to a community outbreak of influenza	6 months for a TOTAL quantity of: 42 Capsules of 75 mg or 45 mg OR 84 Capsules of 30 mg OR 540 mL Suspension
Relenza	-Treatment of a current infection with influenza A or B in a pregnant or critically/severely ill patient 7 years of age or older -Treatment of a current infection with influenza A or B in a patient 7 years of age or older with an onset of symptoms within the previous 48 hours (2 days) -Prevention of influenza A or B in a patient 5 years of age or older after being exposed to another person with influenza within the previous 36 hours (1.5 days) -Continuation of therapy for a patient currently using the drug for prevention of influenza A or B after exposure to a community outbreak	6 months for a TOTAL quantity of 20 Blisters
Relenza	Prevention of influenza A or B in a patient 5 years of age or older who has been exposed to a community outbreak of influenza within the previous 5 days	6 months for a TOTAL quantity of 60 Blisters

REFERENCES

1. Relenza [package insert]. Research Triangle Park, NC: GlaxoSmithKline; October 2013.
2. Tamiflu [package insert]. South San Francisco, CA: Genentech, Inc.; December 2014.
3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed December 2015.
4. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed December 2015.
5. 2015-2016 Influenza Antiviral Medications: Summary for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention; 2015. Available at: http://www.cdc.gov/flu/pdf/professionals/antivirals/antiviral-summary-clinician.pdf. Accessed December 2015.

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BRAND NAME	**GRASTEK**
(generic)	**(timothy grass pollen allergen extract)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Grastek is an allergen extract indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. Grastek is approved for use in persons 5 through 65 years of age.
Grastek is not indicated for the immediate relief of allergic symptoms.

COVERAGE CRITERIA

Grastek will be covered with prior authorization when the following criteria are met:

- Grastek is being prescribed for the treatment of grass pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for timothy grass pollen grass allergen extract.
  AND
- The patient does not have any of the following: severe, unstable or uncontrolled asthma, history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy, history of eosinophilic esophagitis, medical conditions that may reduce the ability of the patient to survive a serious allergic reaction or increase the risk of adverse reactions after epinephrine administration and not on any medication(s) that can inhibit or potentiate the effect of epinephrine
  AND
- The patient is being prescribed or made available an auto-injectable epinephrine
  AND
- Grastek is being prescribed by or in consultation with an allergist
  AND
- Treatment is being initiated at least 12 weeks prior to expected onset of grass pollen season
  AND
- For a patient currently on Grastek, patient must show a benefit from treatment (eg, reduction in symptoms of allergic rhinitis and conjunctivitis, decreased use of rescue medications such as antihistamines and nasal or oral corticosteroids).

REFERENCES

1. Grastek [package insert]. Whitehouse Station, NJ: Merck& Co., Inc.; February 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2016.
4. Agency for Healthcare Research and Quality. Allergen-Specific Immunotherapy for the Treatment of Allergic Rhinoconjunctivits and/or Asthma: Comparative Effectiveness Review. U.S. Department of Health and Human Services; 2013. http://www.effectivehealthcare.ahrq.gov/ehc/products/270/1427/Allergy-Asthma-Immunotherapy-130319.pdf. Accessed March 2016.
5. Wallace DV, Dykewicz MS. The diagnosis and management of rhinitis: an updated practice parameter. *J Allergy Clin Immunol.* 2008; 122(2): S1-S84.

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BRAND NAME	**ORALAIR**
(generic)	**(Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Oralair is an allergen extract indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product. Oralair is approved for use in persons 10 through 65 years of age. Oralair is not indicated for the immediate relief of allergy symptoms.

COVERAGE CRITERIA

Oralair will be covered with prior authorization when the following criteria are met:

- Oralair is being prescribed for the treatment of grass pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for any of the five grass species contained in this product.
  AND
- The patient does not have any of the following: severe, unstable or uncontrolled asthma, history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy, history of eosinophilic esophagitis, medical conditions that may reduce the ability of the patient to survive a serious allergic reaction or increase the risk of adverse reactions after epinephrine administration and not on any medication(s) that can inhibit or potentiate the effect of epinephrine
  AND
- The patient is being prescribed or made available an auto-injectable epinephrine
  AND
- Oralair is being prescribed by or in consultation with an allergist
  AND
- Treatment is being initiated at least 4 months prior to expected onset of grass pollen season
  AND
- For a patient currently receiving Oralair, patient must show benefit from Oralair treatment (eg, reduction in symptoms of allergic rhinitis and conjunctivitis, decreased use of rescue medications such as antihistamines and nasal or oral corticosteroids).

REFERENCES

1. Oralair [package insert]. Lenoir, NC: GREER Laboratories, Inc.; January 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2016.

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North Carolina State Health Plan
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BRAND NAME	**RAGWITEK**
(generic)	**(short ragweed pollen allergen extract)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Ragwitek is an allergen extract indicated as immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for short ragweed pollen. Ragwitek is approved for use in persons 18 through 65 years of age. Ragwitek is not indicated for the immediate relief of allergic symptoms.

COVERAGE CRITERIA

DRUG will be covered with prior authorization when the following criteria are met:

- Ragwitek is being prescribed for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for short ragweed pollen.
  AND
- The patient does not have any of the following: severe, unstable or uncontrolled asthma, history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy, history of eosinophilic esophagitis, medical conditions that may reduce the ability of the patient to survive a serious allergic reaction or increase the risk of adverse reactions after epinephrine administration and not on any medication(s) that can inhibit or potentiate the effect of epinephrine
  AND
- The patient is being prescribed or made available an auto-injectable epinephrine
  AND
- Ragwitek is being prescribed by or in consultation with an allergist
  AND
- Treatment is being initiated at least 12 weeks prior to expected onset of ragweed pollen season
  AND
- For a patient currently receiving Ragwitek, patient must show benefit from Ragwitek treatment (eg, reduction in symptoms of allergic rhinitis and conjunctivitis, decreased use of rescue medications such as antihistamines and nasal or oral corticosteroids).

REFERENCES

1. Ragwitek [package insert]. Whitehouse Station, NJ: Merck& Co., Inc.; February 2015.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2016.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2016.
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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2017

Revision Information	

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

DRUG CLASS	**MINOCYCLINE EXTENDED-RELEASE BRAND ONLY**
BRAND NAME (generic)	**SOLODYN (brand only) (minocycline HCl extended-release tablets)**
	XIMINO (minocycline HCl extended-release capsules)

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

FDA-APPROVED INDICATION

Solodyn

Solodyn is indicated to treat only inflammatory lesions of non-nodular moderate to severe acne vulgaris in patients 12 years of age and older.

Ximino

Ximino is indicated to treat only inflammatory lesions of non-nodular moderate to severe acne vulgaris in patients 12 years of age and older.

Limitations of Use

Solodyn and Ximino did not demonstrate any effect on non-inflammatory acne lesions. Safety of Solodyn and Ximino has not been established beyond 12 weeks of use. This formulation of minocycline has not been evaluated in the treatment of infections.

To reduce the development of drug-resistant bacteria as well as to maintain the effectiveness of other antibacterial drugs, Solodyn and Ximino should be used only as indicated.

INITIAL STEP THERAPY

If the patient is 12 years of age or older **AND** has filled a prescription for a 30 day supply of generic minocycline extended-release OR minocycline OR doxycycline extended-release OR doxycycline within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested Solodyn or Ximino will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

Solodyn brand or Ximino will be covered with prior authorization when the following criteria are met:

- The patient is 12 years of age or older with a diagnosis of inflammatory, non-nodular moderate to severe acne vulgaris

AND

- The patient experienced an inadequate treatment response with generic minocycline extended-release or minocycline or doxycycline extended-release or doxycycline after a trial of at least 30 days

OR

- The patient experienced an intolerance, contraindication to or a potential drug interaction with generic minocycline extended-release or minocycline AND doxycycline extended-release or doxycycline that would prohibit a 30 day trial, AND
- The patient experienced an inadequate treatment response with tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, or azithromycin after a trial of at least 30 days

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

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North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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BRAND NAME	**RESTASIS**
(generic)	**(cyclosporine ophthalmic emulsion)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATION

Restasis is a topical immunomodulator indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.

COVERAGE CRITERIA

- Restasis will be covered with prior authorization when the following criteria are met:
  - Restasis is prescribed for chronic dry eyes as a result of keratoconjunctivitis sicca that has been confirmed by an optometrist or ophthalmologist in patient 16 years of age or older
    AND
  - Patient has tried and failed or been intolerant to artificial tears products
    AND
  - Patient will not be using ophthalmic anti-inflammatory drugs concurrently with Restasis

  OR
  - Patient will be using ophthalmic anti-inflammatory drugs concurrently with Restasis
    AND
  - The ophthalmic anti-inflammatory drugs will be used concurrently for a short period (2-4 weeks) while transitioning to monotherapy with Restasis

REFERENCES

1. Restasis [package insert]. Irvine, CA: Allergan, INC; June 2013.
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3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed November 2015.
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North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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DRUG CLASS	**TESTOSTERONE PRODUCTS – ORAL**
GENERIC NAME dosage form (brand/generic)	**METHYLTESTOSTERONE Oral**
	FLUOXYMESTERONE Oral

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Males

Androgens are indicated for replacement therapy in conditions associated with deficiency or absence of endogenous testosterone:

Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy.

Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. (Appropriate adrenal cortical and thyroid hormone replacement therapy are still necessary, however, and are actually of primary importance.)

If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sexual characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty.

Safety and efficacy of oral testosterone in men with “age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.

Androgens may be used to stimulate puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An X-ray of the hand and wrist to determine bone age should be obtained every 6 months to assess the effect of treatment on the epiphyseal centers.

Females

Androgens may be used secondarily in women with advancing inoperable metastatic (skeletal) mammary cancer who are 1 to 5 years postmenopausal. Primary goals of therapy in these women include ablation of the ovaries. Other methods of counteracting estrogen activity are adrenalectomy, hypophysectomy, and/or anti-estrogen therapy. This treatment has also been used in premenopausal women with breast cancer who have benefited from oophorectomy and are considered to have a hormone-responsive tumor. Judgment concerning androgen therapy should be made by an oncologist with expertise in this field.

COVERAGE CRITERIA

- Oral testosterone products will be covered with prior authorization when the following criteria are met:
  - The patient has tried and failed or is unable to tolerate one non-oral form of testosterone supplementation
  AND
  - The drug is being prescribed for inoperable metastatic breast cancer in a female patient who is 1 to 5 years postmenopausal AND the patient had an incomplete response to other therapy for metastatic breast cancer
  OR

- The drug is being prescribed for a pre-menopausal female patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor

OR

- The drug is being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) **OR**
- The drug is being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation)

AND

- The patient had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values

OR

- The drug is being prescribed for delayed puberty in a male patient

REFERENCES

1. Android [package insert]. Aliso Viejo, CA: Valeant Pharmaceuticals North America; April 2015.
2. Methitest [package insert]. Philadelphia, PA: Global Pharmaceutical Corporation; April 2015.
3. Testred [package insert]. Aliso Viejo, CA: Valeant Pharmaceuticals North America; April 2015.
4. Androxy [package insert]. Maple Grove, MN: Upsher-Smith Laboratories, Inc.; October 2014.
5. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed November 2015.
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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2017

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North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	**TESTOSTERONE PRODUCTS (BRAND AND GENERIC)**
BRAND NAME (generic)	**ANDRODERM (testosterone transdermal patch)** **ANDROGEL (testosterone topical gel)** **AXIRON (testosterone topical solution)** **DELATESTRYL (testosterone enanthate injection)** **DEPO-TESTOSTERONE (testosterone cypionate injection)** **FORTESTA (testosterone topical gel)** **NATESTO (testosterone nasal gel)** **STRIANT (testosterone mucoadhesive buccal system)** **TESTIM (testosterone topical gel)** **TESTOPEL (testosterone propionate implant pellets)** **(testosterone cream)** **(testosterone ointment)** **VOGELXO (testosterone topical gel)**

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Topical, buccal, nasal, implant, and injectable testosterone products are indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone.
Primary hypogonadism (congenital or acquired) - testicular failure due to conditions such as cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter Syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (FSH, LH) above the normal range.
Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but have gonadotropins in the normal or low range.

Limitations of Use
Safety and efficacy of topical, buccal, nasal, implant, and injectable testosterone products in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.

Safety and efficacy of topical, buccal, nasal, implant, and injectable testosterone products in males less than 18 years old have not been established.

Topical testosterone products may have different doses, strengths or application instructions that may result in different systemic exposure.

Delatestryl
Males
Delatestryl (Testosterone Enanthate Injection) is indicated for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone.
Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchiectomy.
Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. (Appropriate adrenal cortical and thyroid hormone replacement therapy are still necessary, however, and are actually of primary importance).
If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sexual characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty.
Safety and efficacy of Delatestryl in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.
Delayed puberty - Delatestryl (Testosterone Enanthate Injection) may be used to stimulate puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An X-ray of the hand and wrist to determine bone age should be obtained every six months to assess the effect of treatment on the epiphyseal centers.
Females
Metastatic Mammary Cancer - Delatestryl (Testosterone Enanthate Injection) may be used secondarily in women with advancing inoperable metastatic (skeletal) mammary cancer who are one to five years postmenopausal. Primary goals of therapy in these women include ablation of the ovaries. Other methods of counteracting estrogen activity are adrenalectomy, hypophysectomy, and/or anti-estrogen therapy. This treatment has also been used in pre-menopausal women with breast cancer who have benefited from oophorectomy and are considered to a have a hormone-responsive tumor. Judgment concerning androgen therapy should be made by an oncologist with expertise in this field.

Depo-Testosterone
Depo-Testosterone Injection is indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone.
Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchiectomy.

Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropic or LHRH deficiency, or pituitary- hypothalamic injury from tumors, trauma or radiation.
Safety and efficacy of Depo-Testosterone (testosterone cypionate) in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.

Compendial Uses
Gender Dysphoria in Female-to-Male transgender patients[13-14, 17-20]

Testopel
Males
Androgens are indicated for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone.
Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchiectomy.
Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropic LHRH deficiency, or pituitary - hypothalamic injury from tumors, trauma or radiation.
If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sex characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty.
Safety and efficacy of Testopel (testosterone pellets) in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.
Androgens may be used to stimulate puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An x-ray of the hand and wrist to determine bone age should be taken every 6 months to assess the effect of treatment on epiphyseal centers.

COVERAGE CRITERIA

- Testosterone products will be covered with prior authorization when the following criteria are met:
    - The requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]
      AND
        - Before the start of testosterone therapy, the patient has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values **OR**
        - For continuation of testosterone therapy: before the patient started testosterone therapy, the patient had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values

      OR
    - Delatestryl (testosterone enanthate injection) is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal AND the patient had an incomplete response to other therapy for metastatic breast cancer

      OR
    - Delatestryl (testosterone enanthate injection) is being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to a have a hormone-responsive tumor

      OR
    - Delatestryl (testosterone enanthate injection) or Testopel (testosterone propionate implant pellets) is being prescribed for delayed puberty

      OR
    - The requested drug is being prescribed for female-to-male gender reassignment in a patient who is 14 years of age or older and able to make an informed, mature decision to engage in therapy

REFERENCES

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2. Androgel 1% [package insert]. North Chicago, IL: Abbvie Inc; November 2016.
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19. Coleman E, Bockting W, Botzer M, et al. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. World Professional Association for Transgender Health. Last Updated 2012. Available at: https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf. Accessed February 2017.
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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

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North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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BRAND NAME	**SOLARAZE**
(generic)	**(diclofenac sodium gel, 3%)**

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Solaraze Gel is indicated for the topical treatment of actinic keratoses (AK). Sun avoidance is indicated during therapy.

COVERAGE CRITERIA
Solaraze will be covered with prior authorization when the following criteria are met:
- The patient has the diagnosis of actinic keratoses (AK)

REFERENCES

1. Solaraze [package insert]. Melville, NY: PharmaDerm; April 2016.
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BINDER DIVIDER

"Other Topics"

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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THE NC STATE HEALTH PLAN IS LOCATED IN THE LONGLEAF BUILDING

Directions to the State Health Plan from Downtown Raleigh

Take US-401 N / S. McDowell Street

Take the Wake Forest Road exit toward Atlantic Ave

Use the left 2 lanes to turn left onto Wake Forest Rd

Continue onto Atlantic Avenue

Cross Highwoods Boulevard and take the first or second right into the office complex.

Follow the signs to the Longleaf Building.

Street level/handicapped parking can be found on the opposite side of the building from where the flags are flying.

Directions to the State Health Plan from RDU Airport

Take I-40 East

Use the right 2 lanes to take exit 289 for Wade Avenue toward I-440/US-1 N

Continue onto Wade Avenue

Take exit onto 1-440E/US-1 N toward Wake Forest/Rocky Mt/Wilson

Take exit 11 to merge onto US-1 N/US-401 N/Capital Boulevard toward Wake Forest/Louisburg

Stay in the left lane and turn left at Highwoods Boulevard

Turn right on Atlantic Avenue and take the first or second right into the office complex.

Follow the signs to the Longleaf Building

Street level/handicapped parking can be found on the opposite side of the building from where the flags are flying