NEW JERSEY DRUG UTILIZATION REVIEW BOARD
VIRTUAL PLATFORM

October 28, 2020

http://www.state.nj.us/humanservices/dmahs/boards/durb/

AGENDA

I. Call to order in accordance with New Jersey Open Public Meeting Act

II. Roll Call

III. Review of meeting transcript for July 15, 2020 meeting (URL)

IV. Review of draft meeting summary for July 15, 2020 meeting (pages 2-9)

V. Secretary's report (page 10)

VI. Old Business
- A. United Healthcare medically necessary claims report
- B. Review of buprenorphine utilization for pain (page 11)
- C. Addendum to Calcitonin Gene-Related Peptide (CGRP) antagonists products protocol (pages 12-14)

VII. New Business
- A. Proposed protocol for Vimizim® (elosulfase alfa) [pages 15-16]
- B. Proposed protocol for Naglazyme® (galsulfase) [pages 17-18]
- C. Proposed protocol for Mepsevii® (vestronidase alfa-vjbk) [pages 19-20]

VIII. Draft of DURB Annual Report for SFY 2020 (Board members only)

IX. A. Informational Highlights/Reports
1. DXC Technology/NJ HMO 1st Quarter 2020 Prior Authorization Report (pages 21-22)
2. Summary of DURB Action Items (pages 23-24)
3. (a) DHS, DHSS and MCO Programs Top Drugs Report (by amount paid and by category) [URL]
   (b) Physician-administered/Antiviral drugs by amount paid [URL]

B. Medication information:
1. FAQs for Pharmacists on Naloxone Co-Prescribing
   https://www.njconsumeraffairs.gov/COVID19/Documents/DCA-AO-2020-08.pdf
2. FDA Updates and Press Announcements on NDMA in Metformin
   https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-and-press-announcements-ndma-metformin
3. The Latest Research on COVID-19 Treatments and Medications in the Pipeline
   https://www.goodrx.com/blog/coronavirus-treatments-on-the-way/

X. Referenced Materials:
1. Update to Spravato (esketamine) approved protocol (July 2020) [pages 25-26]
2. Update to Cryopyrin-Associated Periodic Syndromes (CAPS) products approved protocol (July 2020) [pages 27-30]
3. Update to Calcitonin Gene-Related Peptide (CGRP) antagonists products approved protocol (April 2019) [pages 31-32]

July 15, 2020 DURB Meeting Summary (Draft)

Issue	Action	Notes
Roll Call		Present: Dr. Swee, Dr. Gochfeld, Dr. Marcus, Ms. Olson, Dr. Barberio, Dr. Gooen, Dr. Moynihan, Dr. Lind (ex-officio) Unable to attend: Mr. Schafer
Review of Minutes	Approved	Minutes from January 22, 2020 meeting was reviewed and approved. The approved meeting summary will also be posted on the DURB website at: http://nj.gov/humanservices/dmahs/boards/durb/meeting/index.html
Secretary's Report		Awaiting commissioners' signatures for the following DURB-recommended protocols for July 2019: a. Hereditary angioedema (HAE) products b. Urea cycle disorder products c. Chelating agents used in the treatment of Wilson's disease, Cystinuria, and severe, active rheumatoid arthritis d. Zolgensma® (onasemnogene abeparvovec-xioi) For October 2019: a. Hereditary transthyretin-mediated amyloidosis (ATTR) products b. Elaprase® (idursulfase) c. Gaucher disease products d. Cablivi® (caplacizumab-yhdp) For January 2020: a. Fabry disease products b. Lambert-Eaton Myasthenic Syndrome products c. Strensiq®(asfotase) Also outstanding for signatures: DURB Annual Report for SFY 2019 Dr. Swee wondered if the pandemic was the reason for the delay in signing of these protocols. Dr. Emenike responded that he could see the pandemic affecting the January protocols and the annual report but had no explanation for the earlier protocols, July and October, 2019. The DHS commissioner had a concern about the Zolgensma protocol but that was being resolved through the Medical Director's

July 15, 2020 DURB Meeting Summary (Draft)

Issue	Action	Notes
		office. Dr. Lind informed the Board that he sent a reminder about the outstanding protocols to the Commissioner's office so they are aware of the situation. He is working with the Commissioner's office to resolve the issues. - Regarding a concern raised by Dr. Marcus at the previous meeting about cystic fibrosis drugs payments, Mr. Vaccaro, informed the Board that the Department of Health has a cystic fibrosis program that processes claims under a generic identifier for recipients. That could explain why the claims are not showing up in the top drugs report. - Dr. Sandra Moore, a member of the Board resigned recently. Her resignation letter was forwarded to Lynn Koch, the State's boards reappointment, appointment coordinator.
Old Business		
A. United Healthcare Clinical Criteria Not Met (CCNM) report		The Board reviewed a report from United Healthcare (UHC) which addressed a previous request from the Board concerning their high clinical criteria not met (CCNM) category on the denials report. Dr. Odebiyi, with UHC explained that they follow the State's protocol and claims that do not meet the threshold are denied for CCNM. Dr. Swee requested that UHC provide some examples of these denials to ensure that the plan's interpretation of "medically necessary" claims is the same as the prescriber's interpretation. Regarding Dr. Marcus' concern about non-FDA approved indications, Dr. Odebiyi explained that they have peer-to-peer conversations between the Plan's medical director and the physicians which usually results in terms that is best for the patient. She will provide examples of these reviews, decisions at the next meeting.
B. Amerigroup Clinical Criteria		Dr. Levi with Amerigroup explained that most of the plan's denials in this category are due to step therapy for drugs like proton pump inhibitors and are resolved by reaching out to the prescriber when necessary.

July 15, 2020 DURB Meeting Summary (Draft)

Issue	Action	Notes
Not Met (CCNM) report		
C. Horizon resolution rate for CCNM and non-formulary drugs PA requests		The Board reviewed a report from Horizon which had updated their previous number for CCNM from 4, 484 to 2,493 after double checking their data.
D. Addendum to Dupixent® (dupilumab) protocol	Approved	The Board reviewed an addendum for dupilumab protocol which was approved in April 2019. The update was the removal of criterion #7 (Patient will not use Dupixent® concomitantly with other biologics [e.g., Nucala (mepolizumab), Xolair (omalizumab), Rituxan (rituximab), etc. indicated for atopic dermatitis]). None of the products listed is indicated for atopic dermatitis. The Board recommended the addendum. Dr. Gooen enquired why other indications for dupilumab were not included in the addendum. She was informed that for now, the addendum addressed previous approval (atopic dermatitis) and other indications will be reviewed at a future date if necessary.
E. Addendum to Emflaza® (deflazacort) protocol	Approved	The Board reviewed an addendum for deflazacort protocol which was approved in August 2017. The updates were changes to criterion #2 (The patient is ≥ 5 years of age) which was changed to: the patient is ≥ 2 years of age according to new guidelines. And, criterion for #3 (Inadequate response, intolerance, or contraindication to a 6 month trial of prednisone at the optimal dose of 0.75 mg/kg/day). This was changed to: Patient has had a 3 month trial of prednisone at the optimal dose of 0.75mg/kg/day unless the patient has experienced an inadequate response, intolerance, or has a contraindication to therapy (intolerance includes, but is not limited to weight gain, behavioral disturbance, growth

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July 15, 2020 DURB Meeting Summary (Draft)

Issue	Action	Notes
F. Addendum to PCSK9 inhibitors	Approved	restriction, pubertal delay, and vertebral fractures). The purpose of the change is to reduce trial period with prednisone. The Board reviewed an addendum for proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors. The change was the addition of a criterion that allows use for secondary prevention to the products, Praluent (alirocumab) and evolocumab (Repatha) according to recent guidelines. That criterion is: To reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease. The purpose is to increase access.
New Business		
(A) Proposed protocol for Varubi® (rolapitant)	Approved	The Board reviewed a proposed protocol for rolapitant, a product indicated for use in combination with other antiemetic agents in adults for the prevention of nausea and vomiting associated with chemotherapy. Dr. Gooen suggested the addition of alert from the FDA regarding allergic reaction to the product including that for patients allergic to soybean oil. Ms. Olson commented that the product will likely be rarely used and will be with strict chemo protocols when used. The Board approved and recommended the protocol.
(B) Proposed protocol for Vyondys 53® (golodirsen)	Approved	The Board reviewed a proposed protocol for golodirsen, a product indicated for the treatment of Duchenne muscular dystrophy (DMD). Dr. Swee raised concern about how patients renal function will be monitored as stated in one of the criteria. He was informed that a medical necessity form will be sent to prescribers to obtain baseline renal function test and follow ups after that. The Board approved and recommended the protocol.
(C) Proposed protocol for Cryopyrin-Associated Periodic Syndromes (CAPS) products	Approved pending addition of off-label language	The Board reviewed a proposed protocol for Cryopyrin-Associated Periodic Syndromes (CAPS) products which include rilonacept (Arcalyst®), canakinumab (Ilaris®) and anakinra (Kineret®). Dr. Moynihan, expressed some concern conveyed to her by some immunologists and geneticists who requested flexibility in the eligible age used in the treatment guidelines. She wanted the flexibility verbiage to be included in the protocol. She was informed that such off-label use would have

July 15, 2020 DURB Meeting Summary (Draft)

Issue	Action	Notes
		to be discussed with the prescribers on a case-by-case basis but not necessarily written into the protocol. Dr. Swee requested that a language informing prescribers that the flexibility is available would be welcome. Dr. Emenike promised to discuss with the MCO team and agree on appropriate language. Mr. Currie, director of pharmacy at Horizon informed the Board that since there is no distinct off-label policy developing one could be considered. The Board approved and recommended the protocol pending addition of such language.
(D) Proposed protocol for Spravato® (esketamine)	Approved pending update of step therapy trial duration	The Board reviewed a proposed protocol for esketamine nasal spray, a product indicated for use in treatment-resistant depression in conjunction with an oral antidepressant. Dr. Gochfeld informed the Board that the current protocol was much more user friendly than the one sent to her to review in April. She however wondered why there was no criterion requiring use or consultation with a psychiatrist or a mental health nurse practitioner. Dr. Swee pointed out that access to psychiatrists for the Medicaid population was limited making it more difficult for patients. The Board requested that criterion #3 which requires documentation of failure or intolerance for at least "4 weeks" each to at least 2 antidepressants (prior to using esketamine) be changed to "3 weeks" to give the prescriber more flexibility. The Board approved and recommended the protocol pending the change in duration of trial period. Dr. Gochfeld abstained from the vote.
Proposed Newsletter on Medication-Assisted Treatment (MAT)	Approved	The Board reviewed a proposed educational newsletter on medication-assisted treatment (MAT). The purpose of the newsletter is to explain the benefits and risks associated with the MAT program medications and address the issues surrounding requests to remove prior authorization for these medications. Dr. Marcus questioned a recommendation by a Substance Abuse and Mental Health Services Administration (SAMHSA) consensus panel (mentioned in the newsletter) that it is prudent to transition patients who require long-term treatment from buprenorphine to buprenorphine/naloxone after induction. He argued that the presence of naloxone was to deter abuse via injection and therefore encouraged

July 15, 2020 DURB Meeting Summary (Draft)

<table>
<tr><th>Issue</th><th>Action</th><th>Notes</th></tr>
<tr><td>Top (25) Drugs Utilization Review (2017-2019)</td><td></td><td>that it be used when appropriate for pain. Dr. Emenike pointed out that for the purpose of the newsletter, buprenorphine by itself is discouraged for long-term maintenance therapy in MAT. Buprenorphine/naloxone which is indicated only for substance abuse treatment is encouraged. Dr. Hanna informed the Board that in practice there was not much claims for buprenorphine/naloxone for pain but rather buprenorphine is being used more in those situations. Dr. Marcus requested that a utilization review of buprenorphine for pain to ensure there is no diversion.

Top 25 drugs used during the period of 2019 and 2019 was included in the packet.</td></tr>
<tr><td>Informational Highlights/Reports</td><td></td><td></td></tr>
<tr><td>1. Fee-for-Service/MCO Prior Authorization Report

7</td><td>Continue to monitor.</td><td>The Board reviewed prior authorization (PA) denial report comparing all MCO plans including FFS for the 4th quarter of 2019.
There were no comments regarding the report.
Percentage of prior authorization requests relative to total claims and denials associated with the PAs are listed below:

<table>
<tr><th>Plan</th><th>(%) PA Requests of claims</th><th>Denial (%)</th></tr>
<tr><td>FFS</td><td>0.6</td><td>14</td></tr>
<tr><td>Aetna</td><td>0.5</td><td>41</td></tr>
<tr><td>Amerigroup</td><td>0.7</td><td>30</td></tr>
<tr><td>Horizon</td><td>0.9</td><td>41</td></tr>
<tr><td>UHC</td><td>1</td><td>57</td></tr>
<tr><td>WellCare</td><td>0.6</td><td>47</td></tr>
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</td></tr>
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July 15, 2020 DURB Meeting Summary (Draft)

Issue	Action	Notes
Medication Information: 1. Protocol for the use of investigational drugs for the treatment of COVID-19 2. Reversal of Protocol for the treatment of COVID-19 3. Coronavirus (COVID-19) treatment Hub (URL)		Protocol introduced in March 2020 as guidance for the use of hydroxychloroquine (HCQ), chloroquine (CQ), and lopinavir-ritonavir (Kaletra®) was included in the packet. The FDA reversed its emergency use authorization (EUA) for HCQ in June 2020. The reversal of the above protocol was introduced as an addendum. A link with information to most recent COVID-19 treatments and updates was included in the packet.
2. Summary of DURB Actions/Recommendations		The Board reviewed a summary of actions from previous meetings (October 2019 thru January 2020).

July 15, 2020 DURB Meeting Summary (Draft)

<table>
<tr><th>Issue</th><th>Action</th><th>Notes</th></tr>
<tr><td>3. DHS/DHSS/MCO Programs Top Drugs Report</td><td></td><td>Top drugs report for January 2020 (FFS)/December 2019 (MCOs) was provided for review.

Reported drug expenditures:
<table>
<tr><th>Plan</th><th>Month Reported</th><th>Top Drugs</th><th>Total</th></tr>
<tr><td>FFS</td><td>January 2020</td><td>$13,077,495</td><td>$14,122,318</td></tr>
<tr><td>MCOs</td><td>December 2019</td><td>$80,037,005</td><td>$115,417,402</td></tr>
</table></td></tr>
<tr><td>4. Medication Information</td><td></td><td>Medical information was presented which provided a link to metformin ER recall updates.</td></tr>
<tr><td>Follow up items:</td><td></td><td>- United Healthcare will provide examples to explain their process for determining clinical criteria not met (CCNM) category
- The State will work with the MCOs to develop an additional language to be inserted into the CAPs protocol or to be used for off-label use in protocols
- The State will provide a report on the utilization of buprenorphine for pain</td></tr>
</table>

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NEW JERSEY DRUG UTILIZATION REVIEW BOARD
QUAKERBRIDGE PLAZA, BUILDING 7, Rooms 200 ABC

October 28, 2020

Secretary's Report:

1. All the protocols recommended by the Board from July 2019 through January 2020 have been signed off by the Commissioners of NJ Department of Human Services and Department of Health. The Commissioners have also signed off on the Board's annual report for SFY 2019. Protocols recommended by the Board are listed within the "Summary of DURB Actions" found on the NJ DURB website.

2. DURB Annual Report for SFY 2020 (July 1, 2019 – June 30, 2020)

3. Proposed dates for 2021 DURB meetings:
   Wednesday, January 20
   Wednesday, April 21
   Wednesday, July 14
   Wednesday, October 20

4. Update on board members reappointment/replacement.

Buprenorphine Utilization Report for the Period 2018-2019

October 2020

During review of a Medication Assisted Treatment (MAT) newsletter at the July 2020 meeting, the Board requested a review of buprenorphine utilization in pain management. There was concern that this product may be subject to diversion when used long-term for pain.
The table below is a breakdown of use for different diagnosis.

YEAR	DIAGNOSIS	RECIPIENTS	% OF TOTAL	AVERAGE DAYS
2018	Substance Use Disorder	320	14.8%	167
2018	Pain	156	7.2%	146
2018	Miscellaneous	424	19.5%	157
2018	No Diagnosis Code	1	0.0%	168
2018	No Medical Claims by Prescriber	1,595	73.5%	191
2018	**UNDUPLICATED TOTAL**	**2,169**	**100.0%**	**180**
2019	Substance Use Disorder	548	18.9%	156
2019	Pain	250	8.6%	130
2019	Miscellaneous	646	22.3%	146
2019	No Medical Claims by Prescriber	1,959	67.5%	168
2019	**UNDUPLICATED TOTAL**	**2,903**	**100.0%**	**159**

Report Detail:

Shows primary diagnosis on medical claims in 12 months prior to pharmacy claims.
Includes FFS & MCO claims; excludes PAAD, SG, and claims with Part D or TPL.
Does not include pharmacy claims for Suboxone-type drugs (buprenorphine HCl/naloxone HCl).
Percentages don't add to 100% because some patients had more than one type of diagnosis

Protocol for Calcitonin Gene-Related Peptide (CGRP) Antagonists for Preventative Treatment of Migraines

Approved April 2019

Updated October 2020

Addendum:

1. Addition of recently FDA-approved product in the class (Vyepti) – April 2020
2. Modified criteria for initiating treatment with monoclonal antibodies to Calcitonin Gene- Related Peptide or its receptor
   Source: American Headache Society Position Statement On Integrating New Migraine Treatments Into Clinical Practice. Headache. 2019;59:1-18. Available at:
   https://headachejournal.onlinelibrary.wiley.com/doi/10.1111/head.13456

Aimovig® (erenumab)
Ajovy® (fremanezumab)
Emgality® (galcanezumab)
Vyepti® (eptinezumab)

Background:
Calcitonin gene-related peptide (CGRP) is a neuropeptide believed to be directly involved in the pathophysiologic processes underlying migraine. CGRP antagonists for prevention of episodic and chronic migraine have provided another treatment option for migraine patients. Although comparative studies between traditional prophylaxis treatments are not available, treatment with these products have been shown to be efficacious. However, the long-term effects, particularly regarding the cardiovascular risks, are still unknown as well as the exact mode of action of the antibodies.

Criteria for approval:

1. Patient is 18 years of age or older; **AND**

2. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

3. Medication-Overuse Headaches (MOH, aka: drug-induced headache, medication-misuse headache, rebound headache) have been evaluated and addressed as follows (a and b):
   a. Patient has been evaluated for MOHs, defined as having 15 or more headache days per month in a patient who regularly overuses drugs (i and/or ii):
      i. Use of non-opioid analgesic (e.g., acetaminophen, non-steroidal anti-inflammatory drug [NSAID], acetylsalicylic acid] for 15 or more days per month for more than 3 months
      ii. Use of any other drugs for acute/symptomatic treatment of headaches for 10 or more days per month for more than 3 months
   b. For patients with MOH, the patient continues to have migraines despite discontinuing the overuse of drugs taken for acute and/or symptomatic treatment of headaches

   AND

4. The member must also meet all of the following:
    a. The patient meets at least one of the following:
        i. Patient has 4 or more migraine days per month **OR**
        ii. The migraine attacks significantly interfere with the patient's daily routines despite acute migraine treatment **OR**
        iii. The patient has contraindications to all acute migraine treatment [e.g., acetaminophen, aspirin, generic Cataflam (diclofenac), generic Voltaren (diclofenac), generic Motrin (ibuprofen), generic Advil (ibuprofen), generic Naprosyn (naproxen), generic Ansaid (flurbiprofen), generic Orudis (ketoprofen), generic Excedrin (acetaminophen/aspirin/caffeine), sumatriptan, rizatriptan/rizatriptan orally disintegrating tablet (ODT), naratriptan, Generic Cafergot (ergotamine/caffeine), Generic Migranal (Dihydroergotamine nasal spray)] **OR**
        iv. The patient was overusing acute migraine treatment [defined as 10 or more days per month for ergot derivatives, triptans, opioids, combination analgesics, and a combination of drugs from different classes that are not individually overused OR 15 or more days per month for nonopioid analgesics, acetaminophen, and NSAIDs (including aspirin)] **OR**
        v. The patient has tried and failed or had intolerance with acute migraine treatment **OR**
        vi. Patient has hemiplegic migraine, migraine with brainstem aura, migraine with prolonged aura, and those who have previously experienced a migrainous infarction

        AND

    b. The patient must meet at least one of the following prior therapy criteria (i-iii):
        i. Patient has experienced therapeutic failure after at least 30 days of therapy OR documented intolerance to at least two of the following (1-6):
            1. One of these Beta-blockers: metoprolol, propranolol, timolol, atenolol, nadolol
            2. Divalproex sodium/sodium valproate
            3. Generic Topamax
            4. One of these Tricyclic Antidepressants: amitriptyline, nortriptyline
            5. One of these Serotonin-Norepinephrine Reuptake Inhibitor: venlafaxine, duloxetine
            6. One of these Triptans (only when used for prevention of menstrual associated migraines): frovatriptan, naratriptan, zolmitriptan **OR**
        ii. The patient has chronic migraines AND has failed at least 2 quarterly injections (6 months) of OnabotulinumtoxinA **OR**
        iii. The patient has contraindications to all of the above medications (i. and ii.)

        AND

    c. The patient will only be receiving one CGRP inhibitor indicated for the preventative treatment of migraines

Continuation of therapy:

1. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

2. The patient must also meet all of the following:
    a. The patient has had an improvement in migraine prevention (reduction of migraine days/hours/frequency, reduction in acute abortive migraine medications/pain/level of disability, increase in functional capacity) compared to baseline **AND**
    b. The patient will only be receiving one CGRP inhibitor indicated for the preventative treatment of migraines

References:

1. Aimovig® [package insert]. Amgen Inc. Thousand Oaks, CA 91320. May 2018.
2. Ajovy® [package insert]. Teva Pharmaceuticals USA, Inc. North Wales, PA 19454. September 2018.
3. Emgality® [package insert]. Eli Lilly and Company. Indianapolis, IN 46285. September 2018.
4. Vyepti® [package insert]. Lundbeck Seattle BioPharmaceuticals, Inc. WA 98011. February 2020.
5. Clinical Pharmacology® Gold Standard Series [Internet database]. Tampa FL. Elsevier 2016. Updated periodically
6. Giamberardino MA, Affaitati G, Costantini R et al. Calcitonin gene-related peptide receptor as a novel target for the management of people with episodic migraine: current evidence and safety profile of erenumab. J Pain Res. 2017 Dec 8;10:2751-2760
7. Estemalik E, Tepper S. Preventive treatment in migraine and the new US guidelines. Neuropsychiatric Dis Treat. 2013;9:709–720.
8. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. Headache. 2019;59:1-18. Available at: https://headachejournal.onlinelibrary.wiley.com/doi/10.1111/head.13456
9. International Headache Society (IHS); Headache Classification Committee. The International Classification of Headache Disorders, 3rd edition. Available at: https://www.ichd-3.org/

Proposed Protocol for Vimizim® (elosulfase alfa)

October 2020

Background:
Mucopolysaccharidosis (MPS) IVA or Morquio A syndrome is an autosomal recessive lysosomal storage disorder (LSD) caused by deficiency of the N-acetylgalactosamine-6-sulfatase (GALNS) enzyme, which impairs lysosomal degradation of keratan sulphate and chondroitin-6-sulphate.

***Vimizim** is a hydrolytic lysosomal glycosaminoglycan (GAG)-specific enzyme indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome)*

Criteria for approval:

1. Patient has a diagnosis of Mucopolysaccharidosis IV type A (MPS IVA, Morquio A syndrome); **AND**

2. Diagnosis has been confirmed by one of the following:
   a. Genetic testing; **OR**
   b. Absence or deficiency in N-acetylgalactosamine 6-sulfatase (GALNS) enzyme activity; **AND**

3. At least one of the following baseline testing has been completed and will be used to assess response to therapy:
   a. Endurance test [i.e., Distance walked in six minutes (6-MWT) or Timed 25-foot walk (T25FW)]; **OR**
   b. Pulmonary test [i.e., Forced vital capacity (FVC), Forced expiration volume in 1 second (FEV_1), or Maximal voluntary ventilation (MVV)]; **AND**

4. Documented clinical signs and symptoms of Morquio A syndrome (e.g., kyphoscoliosis, pectus carinatum, knee deformity, etc.)

5. Patient does not have any contraindication(s) to the requested medication; **AND**

6. Medication is being prescribed by or in consultation with an endocrinologist, geneticist, metabolic disorders specialist, or an expert in the disease state; **AND**

7. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

8. Weight must be received for drugs that have weight-based dosing.

9. Vimizim will be administered under the supervision of a healthcare professional with the capability to manage anaphylaxis.

Continuation of therapy:

1. Patient has responded to treatment as demonstrated by an improvement and/or stabilization compared to baseline in at least one of the following:
    a. Endurance test [e.g., Distance walked in six minutes (6-MWT), Rate of stair climbing in three minutes (3-MSCT), or Timed 25-foot walk (T25-FW)]; **OR**
    b. Pulmonary test [e.g., Forced vital capacity (FVC), Forced expiration volume in 1 second (FEV_1), or Maximal voluntary ventilation (MVV)]; **AND**

2. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

3. For dose increase requests, weight must be received for drugs that have weight-based dosing.

Note: Vimizim has a black box warning:

Life-threatening anaphylactic reactions have occurred in some patients during Vimizim infusions. Anaphylaxis, presenting as cough, erythema, throat tightness, urticaria, flushing, cyanosis, hypotension, rash, dyspnea, chest discomfort, and gastrointestinal symptoms in conjunction with urticaria, have been reported to occur during infusions, regardless of duration of the course of treatment.
Closely observe patients during and after Vimizim administration and be prepared to manage anaphylaxis.

Patients with acute respiratory illness may be at risk of serious acute exacerbation of their respiratory compromise due to hypersensitivity reactions, and require additional monitoring

References:
1. Vimizim [Product information]. BioMarin Pharmaceutical Inc. Novato, CA; 12/2019.
2. Jones S, et al. Mucopolysaccharidoses: Clinical features and diagnosis. UpToDate. From: https://www.uptodate.com (Accessed on May 6, 2020.)
3. Genetics Home Reference. U.S. National Library of Medicine. Mucopolysaccharidosis type IV. From: https://ghr.nlm.nih.gov/condition/mucopolysaccharidosis-type-iv (Accessed on May 6, 2020)
4. Vimizim [Website]. BioMarin Pharmaceutical Inc. From: https://www.vimizim.com/about-vimizim/how-vimizim-can-help. (Accessed on May 6, 2020).
5. Akyol MU et al. Recommendations for the management of MPS IVA: systematic evidence- and consensus-based guidance. Orphanet Journal of Rare Diseases volume 14: 137. 2019. (Accessed on August 26, 2020)
6. National Organization for Rare Disorders. Mucopolysaccharidosis IV. Available at: https://rarediseases.org/rare-diseases/morquio-syndrome/ (Accessed on September 18, 2020)

Proposed Protocol for Naglazyme® (galsulfase)

October 2020

Background:
Mucopolysaccharidosis VI (MPS VI) is a very rare autosomal recessive disorder caused by mutations in the arylsulfatase B (ARSB) gene, which lead to deficient activity of the lysosomal enzyme ASB. This enzyme is important for the breakdown of the glycosaminoglycans (GAGs) dermatan sulfate and chondroitin sulfate, which accumulate in body tissues and organs of MPS VI patients.

***Naglazyme** is indicated for patients with Mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome).*

Criteria for approval:

1. Patient has a diagnosis of Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome); **AND**

2. Diagnosis has been confirmed by one of the following:
    a. Detection of mutations in the arylsulfatase B (ARSB) gene
    b. Absence or deficient activity of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) in leukocytes or fibroblasts; **AND**

3. At least one of the following baseline tests have been completed and will be used to assess response to therapy:
    a. Urinary glycosaminoglycan (uGAG) levels; **OR**
    b. Endurance test [e.g., Distance walked in six minutes (6-MWT) or Timed 25-foot walk (T25FW), 3-minute stair-climb test]; **OR**
    c. Pulmonary test [e.g., Forced vital capacity (FVC), Forced expiration volume in 1 second (FEV_1)]; **AND**

4. Documented clinical signs and symptoms of the disease (e.g., kyphoscoliosis, pectus carinatum, gait disturbance, reduced pulmonary function, etc.)

5. Patient does not have any contraindication(s) to the requested medication; **AND**

6. Medication is being prescribed by or in consultation with an endocrinologist, geneticist, metabolic disorders specialist, or an expert in the disease state; **AND**

7. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

8. Weight must be received for drugs that have weight-based dosing.

Continuation of therapy:

1. Patient has responded to treatment as demonstrated by an improvement and/or stabilization compared to baseline in at least one of the following:
    a. Improved endurance test [e.g., Distance walked in six minutes (6-MWT) or Timed 25-foot walk (T25FW), 3-minute stair-climb test]; **OR**
    b. Improved pulmonary function [e.g., Forced vital capacity (FVC), Forced expiration volume in 1 second (FEV1)]; **OR**
    c. Reduction in urinary GAG levels; **AND**

2. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

3. For dose increase requests, weight must be received for drugs that have weight-based dosing.

References:

1. Naglazyme [Product information]. BioMarin Pharmaceutical Inc. Novato, CA; 12/2019.
2. Jones S, et al. Mucopolysaccharidoses: Clinical features and diagnosis. UpToDate. From: https://www.uptodate.com (Accessed on May 5, 2020.)
3. Giugliani R, Harmatz P, Wraith JE. Management guidelines for mucopolysaccharidosis VI. Pediatrics. 2007;120:405-418
4. Giugliani, R, Lampe, C, Guffon, N. Natural history and galsulfase treatment in mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome) – 10-year follow-up of patients who previously participated in an MPS VI survey study. Am J Med Genet A. 2014;164A(8):1953–1964.
5. Akyol, M.U., Alden, T.D., Amartino, H. et al. Recommendations for the management of MPS VI: systematic evidence- and consensus-based guidance. Orphanet J Rare Dis 14, 118 (2019). https://doi.org/10.1186/s13023-019-1080-y
6. Dafne D G Horovitz , Tatiana S P C Magalhães, Angelina Acosta, et al. Enzyme replacement therapy with galsulfase in 34 children younger than five years of age with MPS VI. Mol Genet Metab. 2013 May;109(1):62-9. doi: 10.1016/j.ymgme.2013.02.014. Epub 2013 Mar 5.
7. Vairo F et al. Diagnostic and treatment strategies in mucopolysaccharidosis VI. Appl Clin Genet. 2015; 8: 245–255.

Proposed Protocol for Mepsevii® (vestronidase alfa-vjbk)

October 2020

Background:
Mucopolysaccharidosis VII (MPS VII, Sly syndrome) is caused by mutations in the gene encoding the beta-glucuronidase (GUS) enzyme, located on chromosome 7q11.21. Beta-glucuronidase enzyme deficiency causes glycosaminoglycans (GAGs) to accumulate in cells throughout the body. Vestronidase alfa is a recombinant human lysosomal beta glucuronidase intended to provide exogenous GUS enzyme for uptake into cellular lysosomes.

***Mepsevii** is a recombinant human lysosomal beta glucuronidase indicated in pediatric and adult patients for the treatment of Mucopolysaccharidosis VII (MPS VII, Sly syndrome).*

Criteria for approval:

1. Patient has a documented diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome); **AND**

2. Diagnosis has been confirmed by one of the following:
    a. Detection of mutations in the beta-glucuronidase (GUSB) gene
    b. Beta-glucuronidase (GUS) enzyme deficiency in peripheral blood leukocytes or fibroblasts; **AND**

3. At least one of the following baseline testing has been completed and will be used to assess response to therapy: Six minute walk test (6MWT), motor function [e.g., Bruininks-Oseretsky Test of Motor Proficiency (BOT-2)], liver and/or spleen volume, urinary excretion of glycosaminoglycans (GAGs) such as chondroitin sulfate and dermatan sulfate, skeletal involvement, pulmonary function tests, shoulder flexion, visual acuity.

4. Patient does not have any contraindication(s) to the requested medication; **AND**

5. Medication is being prescribed by or in consultation with an endocrinologist, geneticist, metabolic disorders specialist, or an expert in the disease state; **AND**

6. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

7. Weight must be received for drugs that have weight-based dosing; **AND**

8. Mepsevii will be administered under the supervision of a healthcare professional with the capability to manage anaphylaxis.

Continuation of therapy:

1. Patient has responded to treatment compared to baseline as shown by at least one of the following:
    a. Stability or improvement in six-minute walk test (6MWT), motor function [e.g., Bruininks-Oseretsky Test of Motor Proficiency (BOT-2)], pulmonary function tests, shoulder flexion, visual acuity, and/or other motor functions; **OR**
    b. Reduction in liver and/or spleen volume; **OR**
    c. Reduction in urinary excretion of glycosaminoglycans (GAGs) such as chondroitin sulfate and dermatan sulfate; **OR**
    d. Stability of skeletal disease; **AND**

2. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence; **AND**

3. For dose increase requests, weight must be received for drugs that have weight-based dosing.

Note: Mepsevii has a black box warning:
Anaphylaxis has occurred with MEPSEVII administration, as early as the first dose, therefore appropriate medical support should be readily available when MEPSEVII is administered.
• Closely observe patients during and for 60 minutes after MEPSEVII infusion
• Immediately discontinue the MEPSEVII infusion if the patient experiences anaphylaxis

References:

1. Mepsevii [Product information]. Ultragenyx Pharmaceutical Inc. Novato, CA; 12/2019.
2. "Mucopolysaccharidosis Type VII." NORD (National Organization for Rare Disorders), rarediseases.org/rare-diseases/sly-syndrome/.
3. "Mucopolysaccharidosis Type VII | Genetic And Rare Diseases Information Center (GARD) – An NCATS Program". Rarediseases.Info.Nih.Gov, 2019, https://rarediseases.info.nih.gov/diseases/7096/mucopolysaccharidosis-type-vii. Accessed 20 June 2020..
4. Clinicaltrials.gov. A Phase 3 Study of UX003 Recombinant Human Betaglucuronidase (rhGUS) Enzyme Replacement Therapy in Patients With Mucopolysaccharidosis Type 7 (MPS 7). NCT02230566. Available at: https://clinicaltrials.gov/ct2/show/NCT02230566
5. Clinicaltrials.gov. An Open-Label Phase 1/2 Study to Assess the Safety, Efficacy and Dose of Study Drug UX003 Recombinant Human Beta-glucuronidase (rhGUS) Enzyme Replacement Therapy in Patients With Mucopolysaccharidosis Type 7 (MPS 7). NCT01856218. Available at: https://clinicaltrials.gov/ct2/show/NCT01856218
6. National MPS Society. A guide to understanding MPS VII. Available at https://mpssociety.org/cms/wp-content/uploads/2017/04/MPS_VII_2008.pdf

2nd Quarter 2020 (April - June) Prior Authorization Denial Report

	FFS	Aetna	Amerigroup	Horizon	UHC	Wellcare
Total # of Enrolled Beneficiaries (June 2020)	**72,803**	**89,359**	**214,142**	**921,701**	**383,964**	**88,949**
Total # of Pharmacy Claims Processed	**1,444,710**	**395,279**	**474,354**	**2,808,731**	**980,008**	**293,830**
Total Prior Authorizations (PA) Requests	**7,897 (0.5%)**	**2,333 (0.6%)**	**5,547 (1.2%)**	**21,570 (0.8%)**	**6,239 (0.6%)**	**2,188 (0.7%)**
Denials	**980 (12%)**	**987 (42%)**	**1,662 (30%)**	**8,834 (41%)**	**3,337 (53%)**	**858 (39%)**
Breakdown of Denials*	**Totals**					
a. Clinical Criteria Not Met	261	887	1,595	1,849	710	657
b. Directed Intervention	66**			178a		24
Age Standard Exceeded	1					
First Fill	65					
c. Drug-Drug Interaction/Conflict	22					
d. Duration Exceeded						311
e. Early/Same Day refill	34					
f. Excessive Dose	63	9		98	219	311
g. Incomplete Information	20	39	22	3,078	62	33
h. Incorrect Day Supply	201					
i. Incorrect DOB/ID	33					
j. Mandatory Generic	39	18		89		33
k. Prescriber Decreased Dose	3					
l. Prescriber Denies Rx						
m. Med Discontinued by Prescriber	32					
n. Medicare Part D Wraparound						
o. Methadone Maintenance	5					
p. MNF Not Returned by Prescriber	18					
q. Multiple Pharmacies						
r. Multiple Prescribers						
s. No Diagnosis Provided						
t. No Suboxone Waiver Number						
u. OTC alternative available	13					
v. Prescriber Changed to OTC Product	6				1	
w. Therapeutic Duplication	164	7				
x. Unacceptable Diagnosis		27				
y. Other			45			201
z. Non-formulary				3,522	2,234	
aa. Non-covered benefit				198	112	
TOTAL DENIALS	**980**	**987**	**1,662**	**8,834 b**	**3,338 b**	**1,570 b**

* See attachment for explanation of categories for FFS

** Denial letters are not sent to the prescriber for FFS

*** Directed intervention includes denied with formulary alternatives

a. Not included in Denial Totals

b. Breakdown of total denials may exceed the total number of absolute denials due to authorization requests resulting in more than 1 captured denial category.

Explanation of Denial Categories

Category	Explanation	Example/Comment
Age Standard Exceeded	Patient's age does not meet criteria approved by the DURB	
APAP Dose Exceeded	Self explanatory	
Clinical Criteria Not Met	Claim does not meet criteria set by the DURB	Drug written for indication not approved by the DURB
Daily Quantity Exceeded	Quantity limits established by DURB exceeded	
Drug-Drug Interaction	Self explanatory	
Duration Exceeded	Duration limit established by DURB exceeded	Could be extended with provider's justifiable clinical request
Early/Same Day Refill	Self explanatory	
Excessive Dose	Dose exceeds reasonable therapeutic recommendation	
First Fill	First fill of HIV medications or high dose opioids	Labs are required for HIV medications. Prescribers are contacted for opioid naïve patients.
Incomplete Information	Prescriber did not provide requested information	Diagnosis/ICD-9, Lab values, Ht, Wt, e.t.c.
Incorrect Day Supply	Self explanatory	Ex. Fosamax 4 tabs for 4 days rather than 30.
Incorrect DOB/ID	Pharmacy has submitted claim using the wrong DOB or beneficiary ID#	
Mandatory Generic	Brand name requested without reasonable /clinical justification	Side effects with generic is a reason for exemption
Med Discontinued by Prescriber	Self explanatory	- change in therapy - Hgb >12.0 for ESA; provider denies refill request by pharmacy
Medicare Part D Wraparound	Paid for by Part D insurance if not on table	State provides 6-day window for appeal process
Methadone Maintenance	Request for narcotic/BNDZ for patient on MMT from another physician other than primary care giver	
MNF Not Returned by Prescriber	Prescriber did not return form with clinical or verification information required for continuation of therapy	- duplicate therapy by same prescriber - lab values, height/weight when required
Multiple Pharmacies	Patient presents script for similar drug to different pharmacies	"Pharmacy shoppers"
Multiple Prescribers	Patient goes to multiple providers for the same drug or similar drugs	"Doctor shoppers"
No Diagnosis Provided	Prescriber did not provide diagnosis required as part of approval criteria	Verification of diagnosis from prescriber's office will suffice.
No Suboxone Waiver #	Self explanatory	
No Verification	Prescriber did not confirm writing the prescription.	
OTC alternative available	Part of State FY 2010 Budget initiative – Prescription drug product not covered if OTC alternative is available.	- Medication is prescribed for symptomatic relief of cough and cold - OTC equivalent available
Prescriber Changed to OTC Product	Prescriber changed from prescription brand to OTC brand	- PPIs initiative - Non-sedating antihistamines initiative - Ophthalmic drops conversion initiative
Prescriber Decreased Dose	Self explanatory	Decrease from BID to QD dosing
Prescriber Denies RX	Prescriber denies writing prescription	Could be wrong info from pharmacy or fraud
Retinoid/Topical	Prescription used for cosmetic purposes	
Therapeutic Duplication	Requested drug belongs to the same therapeutic class as one on profile	Aciphex® and Nexium®
Unacceptable Diagnosis	Diagnosis provided does not meet criteria approved by the DURB	Some flexibility allowed with prescriber's input

Summary of DURB Recommendations

October 28, 2020

Meeting Date	Action Item	Status/DURB recommendation	Impact/Comments
All the protocols recommended by the Board from July 2019 through January 2020 have been signed off by the Commissioners of NJ Department of Human Services and Department of Health. The Commissioners have also signed off on the Board's annual report for SFY 2019. Protocols recommended by the Board are listed within the "Summary of DURB Actions" found on the NJ DURB website.			
July 2020	Protocol for Varubi (rolapitant)	- The Board recommended the approval of the protocol	
	Protocol for Vyondys 53 (golodirsen)	- The Board recommended the approval of the protocol	
	Protocol for Cryopyrin-associated periodic syndromes (CAPS) products	- The Board recommended approval of the protocol after including a language that allows off-label use	This update will be included in the body of the protocol
	Protocol for Spravato (esketamine)	- The Board recommended approval of the protocol after changing the step therapy requirement from 4 weeks each to 3 weeks each	This update will be included in the body of the protocol The Division is working with the Department to move forward outstanding requests for approval by the Commissioner. Protocols recommended by the Board from July 2019 through July 2020 are under consideration, as well as the DURB Annual Report for 2019. Protocols recommended by the Board are listed within the "Summary of DURB Actions" found on the NJ DURB website.
January 2020	Protocol for Fabry disease products	- The Board recommended the approval of the protocol	
	Protocol for Lambert-Eaton Myasthenic Syndrome (LEMS) products	- The Board recommended the approval of the protocol	
	Protocol for Strensiq® (asfotase)	- The Board recommended the approval of the protocol	

Summary of DURB Recommendations

Meeting Date	Action Item	Status/DURB recommendation	Impact/Comments
October 2019	Protocol for hereditary transthyretin-mediated amyloidosis (hATTR)	- The Board recommended the approval of the protocol with addition of the requirement for prescription to be written by or in consultation with a specialist in the treatment of aTTR	This update will be included in the final copy of the protocol
	Protocol for Elaprase® (idursulfase)	- The Board recommended the approval of the protocol	
	Protocol for Gaucher disease products	- The Board recommended the approval of the protocol with a change: delete the criterion that requires a patient to be intolerant to enzyme replacement therapy to qualify for substrate replacement therapy	This update will be included in the final copy of the protocol
	Protocol for Cablivi® (caplacizumab-yhdp)	- The Board recommended the approval of the protocol	
July 2019	Protocol for Hereditary Angioedema drugs	- The Board recommended the approval of the protocol	
	Protocol for Urea Cycle Disorder drugs	- The Board recommended the approval of the protocol pending input from a geneticist	Protocol will be updated with geneticist's recommendations.
	Protocol for Chelating products used in Wilson disease, cystinuria and rheumatoid arthritis	- The Board recommended the approval of this protocol with some changes in the title	Protocol will be updated with the Board's recommendation.
	Protocol for onasemnogene abeparvovec-xioi (Zolgensma®)	- The Board reviewed and recommended the protocol with some changes in specialties	Protocol will be updated with the Board's recommendation.

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Protocol for Spravato® (esketamine) Nasal Spray

Approved July 2020

Background:
Spravato is a non-competitive N-methyl D-aspartate (NMDA) receptor antagonist indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults.

Criteria for approval:

1. Patient is 18 years of age or older
2. Patient has been diagnosed with treatment-resistant depression
3. There is documentation showing that the patient had therapeutic failure or had an intolerance for at least 3 weeks each to at least two (2) antidepressants unless the patient has contraindications to all antidepressants.
4. Patient must use Spravato nasal spray in conjunction with an oral antidepressant therapy
5. Spravato will be administered under the supervision of a healthcare provider and the patient will be monitored for at least 2 hours after administration
6. Patient has been assessed and determined not to be at risk for abuse and misuse of Spravato
7. Patient has no contraindications to therapy:
    a. Patient has no aneurysmal vascular disease (including in the brain, chest, abdominal aorta, arms and legs) or arteriovenous malformation, or history of bleeding in the brain
8. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs (Lexicomp), national guidelines, or other peer-reviewed evidence

Continuation of therapy:

1. Documentation showing the patient responded to therapy demonstrated by an improvement from baseline in the Montgomery-Asberg Depression Rating Scale (MADRS)
2. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Lexi-Drugs, national guidelines, or other peer-reviewed evidence

Warning: Because of the risks of serious adverse outcomes resulting from sedation, dissociation, and abuse and misuse, SPRAVATO is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the SPRAVATO REMS

References:

1. Spravato [package insert]. Janssen Pharmaceuticals, Inc., Titusville, NJ 08560. March 2019
2. Clinical Pharmacology® Gold Standard Series [Internet database]. Tampa FL. Elsevier 2018. Updated periodically
3. Canuso C, Singh J, et al: Efficacy and Safety of Intranasal Esketamine for the Rapid Reduction of Symptoms of Depression and Suicidality in Patients at Imminent Risk for Suicide: Results of a Double-Blind, Randomized, Placebo-Controlled Study. Am J Psychiatry. 2018. Accessed online on May 24, 2019 at: https://adaa.org/sites/default/files/Canuso-AJP-2018.pdf

Protocol for Cryopyrin-Associated Periodic Syndromes (CAPS) Products

Approved July 2020

Arcalyst® (rilonacept)
Ilaris® (canakinumab)
Kineret® (anakinra)

Background:
Three clinically overlapping, interleukin (IL) 1-associated, autoinflammatory disorders are known collectively as the cryopyrin-associated periodic syndromes (CAPS) or cryopyrinopathies: familial cold autoinflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), and neonatal-onset multisystem inflammatory disorder (NOMID, also known as chronic infantile neurologic cutaneous and articular [CINCA] syndrome).

***Arcalyst® (rilonacept)** is an interleukin-1blocker indicated for the treatment of CAPS, including FCAS and MWS in children 12 and older including:*
- *Familial Cold Autoinflammatory Syndrome (FCAS)*
- *Muscle-Wells Syndrome (MWS)*

***Ilaris® (canakinumab)** is an interleukin-1β blocker indicated for the treatment of:*
- *Cryopyrin-associated periodic syndromes (CAPS) in adults and children 4 years of age and older including:*
  - *Familial Cold Autoinflammatory Syndrome (FCAS)*
  - *Muckle-Wells Syndrome (MWS)*
- *Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) in adult and pediatric patients*
- *Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) in adults and pediatric patients*
- *Familial Mediterranean Fever (FMF) in adult and pediatric patients*
- *Active Systemic Juvenile Idiopathic Arthritis (SJIA)*

***Kineret® (anakinra)** is an interleukin-1 receptor antagonist indicated for the treatment of:*
- *Rheumatoid Arthritis (RA)*
- *Cryopyrin-associated periodic syndromes*
- *Patient has Schnitzler syndrome*
- *Patient has moderate to severe Hidradenitis Suppurativa (HS)*

Criteria for approval:

1. Medication is prescribed by or in consultation with a rheumatologist or physician experienced in the treatment of genetic disorders. For diagnosis of Hidradenitis Suppurativa the medication is prescribed by or in consultation with a dermatologist. For diagnosis of Schnitzler syndrome, the medication is prescribed by or in consultation with a rheumatologist, dermatologist, or immunologist **AND**

2. Medication will not be used in combination with any other biologic DMARD or Targeted Immune Modulator for the same diagnosis **AND**

3. Weight must be received for drugs that have weight-based dosing **AND**

4. Medication is prescribed in accordance with Food and Drug Administration (FDA) established indication and dosing regimens or in accordance with medically appropriate off-label indication and dosing according to American Hospital Formulary Service, Micromedex, Clinical Pharmacology, Lexi-Drugs, national guidelines, or other peer-reviewed evidence

For Arcalyst:

A. Patient is ≥ 12 years old **AND**
B. Patient has a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

For Ilaris: The member meets at least one of the following:

A. Patient has a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS) and meets the following criteria:
    1. Patient is ≥ 4 years old; **OR**

B. Patient has a confirmed diagnosis of Familial Mediterranean Fever (FMF) and meets the following criteria:
    1. For children 4 years or older, the patient has inadequate response to or is intolerant to colchicine; **OR**

C. Patient has a confirmed diagnosis of Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD); **OR**

D. Patient has a confirmed diagnosis of Tumor necrosis factor receptor associated periodic syndrome (TRAPS); **OR**

E. Patient has confirmed diagnosis of active systemic juvenile idiopathic arthritis (SJIA) and meets the following criteria:
    1. Patient is ≥ 2 years with SJIA **AND**
    2. For patients with active systemic features:

i. Unless contraindicated to all, patient has inadequate response to or is intolerant to systemic corticosteroids or non-steroidal anti-inflammatory drugs (NSAIDS) or methotrexate or leflunomide or anakinra (Kineret®) or tocilizumab (Actemra®) **OR**

3. For patients without active systemic features
    i. Unless contraindicated to all, patient has had an inadequate response to or is intolerant to one of the following:
        1. DMARD (i.e., methotrexate or leflunomide) plus anakinra
        2. DMARD (i.e., methotrexate or leflunomide) plus tocilizumab
        3. DMARD (i.e., methotrexate or leflunomide) plus TNF-α inhibitor (e.g., adalimumab, etanercept, infliximab)
        4. abatacept

For Kineret:

A. Member does not have known hypersensitivity to E coli-derived proteins **AND**

B. Patient has one of the following diagnoses:
    1. Patient has a diagnosis of Rheumatoid Arthritis (RA) and meets the following criteria:
        i. Patient is ≥ 18 years
        ii. Patient has moderately to severely active disease
        iii. Unless contraindicated to all, patient has had intolerance or an inadequate response to at least a 3-months trial of one of the following disease modifying antirheumatic drugs (DMARDs): Hydroxychloroquine, Leflunomide, Methotrexate, or Sulfasalazine; **OR**

    2. Patient has confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS):
        i. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) also known as chronic infantile neurologic cutaneous articular syndrome (CINCA); **OR**

    3. Patient has a diagnosis of Systemic Juvenile Idiopathic Arthritis (SJIA) defined as <u>one</u> of the following:
        i. Patients has active systemic features
            a. Unless contraindicated to all, patient has had an inadequate response to or is intolerant to systemic corticosteroids or non-steroidal anti-inflammatory drugs (NSAIDS) **OR**
        ii. Patients without active systemic features
            a. Unless contraindicated to all, patient has had an inadequate response to or is intolerant to methotrexate, leflunomide, non-steroidal anti-inflammatory drugs (NSAIDS), or intra-articular glucocorticosteroids **OR**

Protocol for Calcitonin Gene-Related Peptide (CGRP) Antagonists

Approved April 2019

Aimovig® (erenumab)
Ajovy® (fremanezumab)
Emgality® (galcanezumab)

Background:
Calcitonin gene-related peptide (CGRP) is a neuropeptide believed to be directly involved in the pathophysiologic processes underlying migraine. CGRP antagonists for prevention of episodic and chronic migraine have provided another treatment option for migraine patients. Although comparative studies between traditional prophylaxis treatments are not available, treatment with these products have been shown to be efficacious. However, the long-term effects, particularly regarding the cardiovascular risks, are still unknown as well as the exact mode of action of the antibodies.

Criteria for approval:

1. Patient is 18 years of age or older; **AND**

2. Patient has a confirmed diagnosis of episodic or chronic migraines

3. Patient has 4 or more migraine days per month (documentation of number of migraine days will be required)

4. Medication-Overuse Headaches (MOH, aka: drug-induced headache, medication-misuse headache, rebound headache) have been evaluated and addressed as follows (a and b):
   a. Patient has been evaluated for MOHs, defined as having 15 or more headache days per month in a patient who regularly overuses drugs (i and/or ii):
      i. Use of non-opioid analgesic (e.g., acetaminophen, non-steroidal anti-inflammatory drug [NSAID], acetylsalicylic acid) for 15 or more days per month for more than 3 months
      ii. Use of any other drugs for acute/symptomatic treatment of headaches for 10 or more days per month for more than 3 months
   b. For patients with MOH, the patient continues to have migraines despite discontinuing the overuse of drugs taken for acute and/or symptomatic treatment of headaches

5. Patient has documented adherence for at least **30 days** at generally accepted doses or documented intolerance to at least one drug in 3 different classes of the following OR has documented contraindications for all:
   a. Beta-blockers (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)
   b. Anticonvulsants (e.g., divalproex sodium, sodium valproate, generic Topamax)

c. Antidepressants (e.g., amitriptyline, venlafaxine)

d. Triptans (e.g., frovatriptan, naratriptan, zolmitriptan)

6. Medication will not be used in combination with another CGRP antagonist or inhibitor

References:

1. Aimovig® [package insert]. Amgen Inc. Thousand Oaks, CA 91320. May 2018.
2. Ajovy® [package insert]. Teva Pharmaceuticals USA, Inc. North Wales, PA 19454. September 2018.
3. Emgality® [package insert]. Eli Lilly and Company. Indianapolis, IN 46285. September 2018.
4. Clinical Pharmacology® Gold Standard Series [Internet database]. Tampa FL. Elsevier 2016. Updated periodically
5. Giamberardino MA, Affaitati G, Costantini R et al. Calcitonin gene-related peptide receptor as a novel target for the management of people with episodic migraine: current evidence and safety profile of erenumab. J Pain Res. 2017 Dec 8;10:2751-2760
6. Estemalik E. Tepper S. Preventive treatment in migraine and the new US guidelines. Neuropsychiatric Dis Treat. 2013;9:709–720.