WY P&T Committee Meeting Minutes
Thursday, May 8, 2025
Cheyenne, WY and via Zoom
10 a.m – 1 p.m.

Members present: Tracie Caller, Melinda Carroll, Evan Crump, Scott Johnston, Layne Lash, Kristen Lovas, Krystal Massey, Robert Monger, Chris Mosier, Garry Needham, Danae Stampfli, Alyse Williams

Ex-officio: Cori Cooper, Melissa Hunter, Paul Johnson

Excused:

Guests: Collin Townsend, Matt Robison (CHC), Corwyn Moss (CHC), Melissa Mehle (CHC), Nikki Yost (CHC), Joe Sullivan (VRTX), Chad Duncan (VRTX), Tim Birner (Alkermes), Megan Penner (Indivior), Jessica Jay (VRTX), Eileen Zimmerman (Novartis), Aimee Redhair (Biogen), Marc Parker (VS Health Group), Rosalynde Finch (Biogen), Deb Guay (Gene), Stormy Cameron (Artia), Frank Del Real

Chris Mosier called the meeting to order at 10:00 a.m.

Introductions were made.

Approval of Minutes

The minutes of the February 13, 2025 meeting were approved.

Department of Health

A. Pharmacy Program Manager Report: The Department is conducting interviews next week to refill Sandra Deaver's position following her retirement. The new pharmacy system build is ongoing with a new go-live day in mid-December 2025.

B. Medical Director Report: Interim legislative topics will include maternity and AI in prior authorizations. The Governor has authorized an increase in maternity rates up to 100% of Medicare and increased home health rates for nursing services. We expect the home health rates to shorten hospital stays and result in a cost savings.

C. DUR Manager Report: Alyse Williams has been selected to fill the physician vacancy on the Committee.

Old Business:

There was no old business to be discussed.

Sublocade was moved up to accommodate physician schedules. Megan Penner (Indivior) provided public comment. The half-life is approximately 40 – 60 days. Steady state is reached at 3 – 5 doses, so typically around the 3-month timeframe. Although it takes 3 – 5 doses to reach steady state, appreciable plasma levels are seen before then. The initial dose occurs on day 1 following an oral dose to determine tolerability. A second dose can be given in the first month as early as 1 week later. After the second dose, the dosing

goes to monthly with at least 26 days between injections. If a patient is on 8 mg to 18 mg oral buprenorphine, they could start with 100 mg Sublocade. Patients have had success with both 100 mg and 300 mg dosages. Patients using injectable drugs tend to do better with the 300 mg dose. With the rapid initiation dosage, concomitant oral buprenorphine is not necessary. Previously, oral buprenorphine was being used in the first month. The buprenorphine blocks the kappa receptor which blocks the euphoric effect of the opioids. The naloxone in the oral medication is only active if injected, so blocks misuse of the medication. Brixadi has a one-week and a one-month indication. There is no data comparing the two. There is currently a study ongoing with the VA comparing the two.

Sublocade is currently deferred to the medical side for billing via physician buy and bill. Dr. Del Real was invited to participate in the discussion. He currently works with UW Family Practice in Casper. Family practice residents are being trained firsthand in the treatment of substance use disorder. They would like to use Sublocade in appropriate patients. It is more convenient for the patient and practitioner. It has advantages with compliance and diversion. They would like to do that in the jails though Medicaid would not be involved in these patients. As it stands now, it is difficult to convert to the long-acting injectable due to the buy and bill reimbursement method. He asks that we make it more accessible. They follow the label in terms of dosing. The rapid initiation has made it much easier. He rarely needs to do the second 300 mg dose in the first month. Maintenance dose is often reduced to the 100 mg. For some that is not adequate and they increase to the 300 mg. Compliance has been good for the most part. Some have pain at the injection site and switch back to oral. If they skip a month or two, do you go back to the 300 mg or continue with 100 mg? It depends on what they have been doing in between. If they had been using, would likely restart at the 300 mg. What if they have a positive urine screen for other opioids? First, they counsel them on the use. Recurrence is expected in some patients. They go over the cause of the abuse. A lot of these patients don't know what it's like to not be under the influence. Over time, this process seems to work. The data shows 80% recidivism in a year. Dr. Del Real feels that is pretty high. After a year, it is consistent with any other chronic illness which is about 67%. In the beginning he did supplement with the oral buprenorphine. He has not done that in a while. Not all patients are in counseling. It is not required as a part of receiving buprenorphine. They are encouraged and educated on the importance and usefulness. Studies that have been completed looking at success rates with and without counseling show no significant difference between the groups. They have not used Brixadi yet.

The REMS program only applies if the clinic is ordering it for general use. It does not apply if it is ordered specifically for one patient. The initial prior authorization would include both potential loading doses. For maintenance, the dosing would be approved as 100 mg. If the 100 mg dose isn't sufficient, an additional PA would be required for the 300 mg.

There was a motion and second to limit to indication in adults over age 18, with a maximum dose of 600 mg in the first month, followed by 100 mg per month. Oral buprenorphine would not be allowed concurrently. Brixadi cannot be used concurrently. All were in favor.

New Business

A. PA Criteria

1. Review existing criteria

i. Leqembi has new maintenance dosing. It is currently limited to 18 months. We need to remove Aduhelm from the PDL. Neurologists are hesitant with this drug at this time. The data shows amyloid clearance but no clinical outcomes. There is no strong data to support long-term maintenance. The Committee was not in favor of approving maintenance dosing at this time.

ii. Dupixent has a new indication for chronic spontaneous urticaria in patients who do not respond to antihistamines. This will be added as a covered indication on the ATCC.

iii. Nicotine replacement therapy has not been updated in a long time. Melinda asked that we add it to the agenda. The following dosing limits were proposed.

Product	Current Limits	Proposed Limits
Nicotine gum	735 pieces&/or 84 days/365	24 pieces/day, up to 84 days
Nicotine lozenges	735 pieces&/or 84 days/365	20 lozenges/day, up to 84 days
Nicotine Inhaler	8 packs &/or 84 days/365	No longer available in US
Nicotine nasal spray	8 packs &/or 84 days/365	40 mg/day, up to 84 days
Nicotine patch (7 mg)	14 patch &/or 14 days/365	84 days of any patch combination
Nicotine patch (14 mg)	14 patch &/or 14 days/365	84 days of any patch combination
Nicotine patch (21 mg)	42 patch &/or 42 days/365	84 days of any patch combination
Nicotine transdermal system	56 patch &/or 56 days/365	Refer to patches

There was a motion, second and all were in favor of the proposed nicotine replacement therapy. We will allow the combination of bupropion and nicotine replacement therapy.

2. New Drugs

i. Alhemo is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients $\geq$ 12 years of age with hemophilia A with factor VIII inhibitors and hemophilia B with factor IX inhibitors. There is no data regarding comparative safety and efficacy with other agents. There was a motion, second and all were in favor of limiting to indication and referring to the Department of Health for cost analysis.

ii. Journavx is indicated for the treatment of moderate to severe

acute pain in adults. Public comment was provided by Chad Duncan (Vertex). Richard Leslie (Wyoming Epilepsy Association) provided written comment prior to the meeting. Chad requests that it be added to the PDL with no steps and day supply limit of no less than 14 days. Ibuprofen was an option for all patients at 400 mg every six hours. The first does is two tablets, followed by one tablet every 12 hours. Additional studies will be completed in additional surgical procedures. Elderly patients will be studied as well. We currently limit opioids to seven days. Why would we not limit this to seven days? The opioid limit is related to the risk of addiction. Other pain relievers are not limited to seven days. Patients were dosed every 12 hours, not as needed. 85.4% of patients of suzetrigine patients asked for ibuprofen rescue. If the patient discontinues treatment and then needs to restart, do they need to do the loading dose again? They do not have that data.

The Committee is excited that there is a non-opioid available. Dr. Johnston is concerned that the data is poor with only 48 hours duration in the larger trials and one small 14-day open label study. We would like to see longer-term data. There was a motion and second and all were in favor of limiting to indication for up to 14 days of therapy and refer to the Department of Health for cost analysis. It will be allowed for opioid allergy and a history of substance use disorder.

iii. Onapgo is indicated for the treatment of motor fluctuations in patients with advanced Parkinson disease. We likely won't have a lot of patients on it. This would be used in the more severe patients. The levodopa continuous pump would be the preferred treatment at this time. A movement specialist will be coming to Cheyenne once a month. There is no comparative data with other approved agents. There was a motion, second and all were in favor of limiting to indication and referring to the Department of Health for cost analysis.

iv. Zunveyl is indicated for the treatment of mild to moderate dementia of Alzheimer disease. This medication has fewer gastrointestinal side effects than galantamine. These medications are used frequently, and patients do better behaviorally on them, indicating a clinical benefit. They are likely used more in Lewy body dementia than Alzheimer's. There is no comparative data with other approved agents. There was a motion, second and all were in favor of referring to the Department of Health for cost analysis.

v. Sofdra is indicated for topical treatment of primary axillary hyperhidrosis in adults and pediatric patients $\geq$ 9 years of age. The other topical agents aren't super effective. However, botox injections in the hands and feet are very painful. There is no comparative data with the other approved agents. There was a motion, second and all were in favor of referring to the Department of Health for cost analysis.

3. Determine need for criteria

i. Intrarosa is indicated for the treatment of genitourinary syndrome of menopause (vulvovaginal atrophy) with dyspareunia. It is generally reserved for patients who did not respond to nonhormonal therapies, vaginal estrogen, and have no contraindications to use. There was a motion, second and all were in favor of limiting to indication.

4. Physician Administered Drugs

i. There were no physician administered drugs to review.

Other: There was no other business to discuss.

There being no further business, the open portion of the meeting adjourned at 11:30 am and the Committee met in closed session.

Respectfully Submitted,

Aimee Lewis
WYDUR Manager