Pharmaceutical and Therapeutics Committee (P&T)

April 23, 2025

Location: Virtual only
Executive Session: 2:30pm - 3:30pm
Open Session: 3:30pm – 5:00pm
Charleston, WV 25301
(304) 558-1700

MINUTES

Committee Members Present:
Chris Terpening, PharmD, PhD
Charles Rohrbaugh, RPh
Krista Capehart, PharmD
Toni DiChiacchio, DNP
Michael Cheshire, DO
Scott Brown, RPh, Vice Chair
David Gloss, MD
Laura Davisson, MD
Brian Hardman, FNP-C
Schelley Schliesser, PharmD
John Bernabei, RPh (JJ)

Absent:
Philip Galapon, MD FAAFP, Chair
Mitzi Payne, MD
Krista Capehart, PharmD

Division of Medicaid Staff Present:
Vicki Cunningham, PharmD, MS, Director
Bill Hopkins, Operations Manager
Doug Sorvig, Data Analyst
Lori Moles, RPH Appeals Pharmacist
Gail Goodnight, RPH Rebate Pharmacist
Priya Shah, PharmD, DUR Coordinator
Kristen Boustany, PharmD

Contract Staff Present:
Change Healthcare/OptumRx
Joseph Bergondo, PharmD
Robert Capp, MD
Paige Clayton, PharmD
Chris Dolfi, PharmD

Other Contract / State Staff Present:

I. Call to Order

Scott Brown, Vice Chairman, called the meeting to order at 3:10 PM.

II. Welcome and Introductions

Scott Brown welcomed all present to the committee meeting. Committee members, Bureau of Medical Services staff, and Change Healthcare staff introduced themselves.

III. Housekeeping Items / Updates

A. Approval of the January 22, 2025, Meeting Minutes

The Committee moved to approve the January 22, 2025, Meeting Minutes, with the addition of the committee's discussion surrounding Anti-Obesity Class coverage on the statewide Preferred Drug List (PDL). All were in favor of revisions.

B. PDL Compliance / Generic Percent Report Updates

Joe Bergondo provided an explanation of the PDL Compliance and Generic Percent reports.

- Joe Bergondo reviewed the Generic Percent Report; overall generic utilization for Q4 2023 was 85.5%.
- Joe Bergondo reviewed the PDL Compliance Report; overall compliance for Q4 2023 was 92.8%.

IV. Public Comment

Public comments for this meeting were only accepted in writing. Written statements were provided to State and Committee members for review prior to this meeting and are available to the public on the State's website.

V. New Business

A. New Drug Reviews

i. Androgenic Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANDROGENIC AGENTS		
CLASS PA CRITERIA: A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.		
ANDRODERM (testosterone)CL/PA* ANDROGEL PUMP (testosterone)CL/PA* TESTIM (testosterone) testosterone cypionate vialCL/PA* testosterone enanthate vialCL/PA* testosterone gel 1.62%	ANDROGEL PACKETS (testosterone) ANDROID (methyltestosterone) AVEED (testosterone undecanoate) AZMIRO (testosterone cypionate) injection FORTESTA (testosterone) JATENZO (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone capsules NATESTO (testosterone) testosterone gel testosterone solution pump TESTRED (methyltestosterone) TLANDO (testosterone undecanoate) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

Scott Brown made a motion to approve the changes to the Androgenic Agents class as recommended; the motion was seconded by Charlie Rohrbaugh. All members were in favor and the motion was approved.

ii. Antihemophilia Factor Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIHEMOPHILIA FACTOR AGENTSCL/PA		
CLASS PA CRITERIA: All agents will require prior authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
NON-FACTOR REPLACEMENT		
	ALHEMO (concizumab-mtci) HYMPAVZI (marstacimab-hncg)	

Charlie Rohrbaugh made a motion to approve the changes to the Antihemophilia Factors Agents class; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

iii. Antiparkinson's Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIPARKINSON'S AGENTS		
CLASS PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding subclass before a non-preferred agent will be authorized.		
OTHER ANTIPARKINSON'S AGENTS		
amantadineAP* carbidopa/levodopa levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) Carbidopa CREXONT (carbidopa/levodopa) GOCOVRI ER (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARLODEL (bromocriptine) rasagiline RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) VYALEV (foscarbidopa/foslevodopa) injection XADAGO (safinamide) ZELAPAR (selegiline)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.

Charlie Rohrbaugh made a motion to approve the changes to the Antiparkinson's Agents class as recommended; the motion was seconded by Brian Hardman. All members were in favor and the motion was approved.

iv. Antipsychotics, Atypical and Combination

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

ANTIPSYCHOTICS, ATYPICAL AND COMBINATION

CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children six (6) years of age and younger will be reviewed by Medicaid's consultant psychiatrist.

Non-preferred agents require thirty (30) day trials of two (2) preferred Atypical Antipsychotics approved or medically accepted for the member's diagnosis or indication, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. When determining requests for non-preferred products, any trial utilizing a preferred agent whose dose or duration was limited due to adverse effects or clear lack of efficacy will be considered complete only if the agent was being taken within the FDA-approved therapeutic range.*

Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior authorization while the Medical Director reviews the request.

*According to manufacturer dosing recommendations.

SINGLE INGREDIENT		
ABILIFY ASIMTUFII (aripiprazole) CL/PA	ABILIFY MYCITE (aripiprazole)	**The following criteria exceptions apply to the specified products:**
ABILIFY MAINTENA (aripiprazole)CL/PA	ABILIFY TABLETS (aripiprazole)	
aripiprazole tablets	ADASUVE (loxapine)	*Invega Hafyera may only be authorized after four (4) months treatment with Invega Sustenna or at least a one (1) three (3) month cycle with Invega Trinza.
ARISTADA (aripiprazole)CL/PA	aripiprazole ODT	
ARISTADA INITIO (aripiprazole)CL/PA	aripiprazole solution	**Invega Trinza will be authorized after four (4) months treatment with Invega Sustenna
asenapine sublingual tablets	CAPLYTA (lumateperone)	
clozapine	clozapine ODT	***Quetiapine 25 mg will be authorized:
INVEGA HAFYERA (paliperidone)CL/PA*	CLOZARIL (clozapine)	1. For a diagnosis of schizophrenia; **OR**
INVEGA SUSTENNA (paliperidone)CL/PA	COBENFY (xanomeline/trospium)	2. For a diagnosis of bipolar disorder; **OR**
INVEGA TRINZA (paliperidone)CL/PA**	ERZOFRI (paliperidone)	3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.
lurasidone	FANAPT (iloperidone)	**Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.**
olanzapine	GEODON (ziprasidone)	
olanzapine ODT	GEODON IM (ziprasidone)	****Patient must have had a positive response with olanzapine and experienced clinically significant weight gain (documentation must be provided) which necessitated
paliperidone ER	INVEGA ER (paliperidone)	
PERSERIS (risperidone)CL/PA	LATUDA (lurasidone)	
quetiapineAP for the 25 mg Tablet Only***	LYBALVI (olanzapine/samidorphan)****	
quetiapine ER	NUPLAZID (pimavanserin)*****	
RYKINDO (risperidone)	olanzapine IMCL/PA	
risperidone ODT, solution, tablets	olanzapine/fluoxetine	
VRAYLAR (cariprazine)******	OPIPZA (aripiprazole) film, soluble	
ziprasidone	REXULTI (brexpiprazole)	
	RISPERDAL (risperidone)	

Charlie Rohrbaugh made a motion to approve the changes to the Antipsychotics, Atypical and Combination class as recommended; the motion was seconded by Brian Hardman. All members were in favor and the motion was approved.

v. Cytokine and Cam Antagonists

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

CYTOKINE & CAM ANTAGONISTSCL/PA

CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis, unless one (1) of the exceptions on the PA form is present. *Patients stabilized for at least six (6) months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication AND a more cost-effective biosimilar product is not available). In cases where a biosimilar exists but is also non-preferred, the PA vendor shall advise the provider which product is the most cost-effective agent. All off-label requests require review by the Medical Director.* **Full PA criteria may be found on the PA Criteria page by clicking the link.**

OTHERS		
KINERET (anakinra) ORENCIA CLICKJECT, VIAL (abatacept) OTEZLA (apremilast) TALTZ (ixekizumab)* TYENNE (tocilizumab-aazg) XELJANZ (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) ACTEMRA SUBCUTANEOUS (tocilizumab) BIMZELX (bimekizumab-bkzx) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) OLTULFI (ustekinumab-aauz) PYZCHIVA (ustekinumab-ttwe) RINVOQ ER (upadacitinib)** SILIQ (brodalumab) SKYRIZI (risankizumab-rzaa) SOTYKTU (deucravacitinib) STELARA SUBCUTANEOUS (ustekinumab) STEQEYMA (ustekinumab-stba) TOFIDENCE (tocilizumab-bavi) TREMFYA (guselkumab) VELSIPITY (etrasimod) WEZLANA (ustekinumab-auub) XELJANZ XR (tofacitinib) YESINTEK (ustekinumab-kfce)	*Taltz will be authorized for treatment of plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of one (1) preferred Anti-TNF gent. **Full criteria for Rinvoq ER may be found on the PA Criteria page by clicking the hyperlink.

Charlie Rohrbaugh made a motion to approve the changes to the Antipsychotics, Atypical and Combination class as recommended; the motion was seconded by Brian Hardman. All members were in favor and the motion was approved.

vi. Immunomodulators, Atopic Dermatitis

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
IMMUNOMODULATORS, ATOPIC DERMATITIS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a medium-to-high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds.		
ADBRY (tralokinumab)* DUPIXENT (dupilumab)* ELIDEL (pimecrolimus) tacrolimus ointment	CIBINQO (abrocitinib)* EBGLYSS (lebrikizumab) EUCRISA (crisaborole)^P** NEMLUVIO (nemolizumab-ilto) OPZELURA CREAM (ruxolitinib)* pimecrolimus cream ZORYVE CREAM 0.15% (roflumilast)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink **Eucrisa requires a thirty (30) day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated.

Charlie Rohrbaugh made a motion to approve the changes to the Immunomodulators, Atopic Dermatitis class as recommended; the motion was seconded by Chris Terpening. All members were in favor and the motion was approved.

vii. Lipotropics, Other (non-statins)

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	apoC-III-DIRECTED ASO	
	TRYNGOLZA (olezarsen)	

Charlie Rohrbaugh made a motion to approve the changes to the Lipotropics, Other (non-statins) class as recommended; the motion was seconded by Brian Hardman. All members were in favor and the motion was approved.

viii. Obstructive Sleep Apnea Agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OBSTRUCTIVE SLEEP APNEA AGENTS		
CLASS PA CRITERIA:		
ZEPBOUND (tirzepatide)		

Schelley Schliesser made a motion to approve the changes to the Lipotropics, Other (non-statins) class as recommended; the motion was seconded by Charlie Rohrbaugh. All members were in favor and the motion was approved.

VI. Old Business

VII. Other Business

There was no other business discussed at this time.

VIII. Next Meeting

The next P&T Committee Meeting is scheduled for August 27, 2025, virtual meeting.

IX. Adjournment

The committee adjourned the meeting at 3:30pm.