November 2022 DUR Board Meeting Minutes

Date: November 9, 2022

Members Present: Barnhill, Blank, Brown, Caldwell, McGrane, Nauts, Putsch, Stone

Members Absent: Anglim, Blake, Jost

Others Present: Katie Hawkins, Shannon Sexauer, Dani Feist, (DPHHS); Artis, Bahny, Erickson, Miranda (MPQH); and representatives from the pharmaceutical industry.

Public Comment:

- Rochelle Yang, Teva – Austedo®
- Desiree Crevecoeur-MacPhail, Hikma Community Health - Kloxxado®

Meeting Minute Review: The meeting minutes from the September 21, 2022 Drug Utilization Review Board Meeting were approved as written.

Department Update: No Department update.

Board Discussion

1. **Drug Criteria Review:**

A. Auvelity® (dextromethorphan/bupropion 45/105mg extended release)

Initial Coverage Criteria

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of major depressive disorder
- Member has had a trial (8 weeks duration) and had an inadequate response, intolerance, or contraindication to two preferred agents with different mechanisms of action in the Novel Antidepressant category on the Preferred Drug List (PDL)
- Prescriber attests to the following:
    - Prescriber has discussed with the member the boxed warning regarding risk of suicidal thoughts and behaviors with this medication
    - Member will not take a Monoamine Oxidase Inhibitor within 14 days of Auvelity®
    - Member does not have:
        - a seizure disorder **OR**
        - a diagnosis of bulimia or anorexia nervosa **OR**
        - a diagnosis of severe hepatic or severe renal impairment **AND**
    - Member has not abruptly discontinued alcohol, benzodiazepines, barbiturates, or antiepileptic medications
    - Member's risk for abuse or misuse is assessed prior to initiating treatment and will be assessed periodically while on therapy (Auvelity® is not a scheduled medication and in clinical studies did not indicate drug seeking behavior, however, the active drugs in Auvelity® independently have reports of misuse)

- **Limitations:**
    - Maximum daily dose is limited to 2 tablets
    - Initial approval duration will be granted for 6 weeks

Renewal Coverage Criteria

Member must meet all the following criteria:

- Member has documentation of positive clinical response to therapy as demonstrated by a reduction in symptom severity compared to the baseline depression assessment utilizing the same rating scale
- **Limitations:**
    - Maximum daily dose is limited to 2 tablets
    - Renewal approval duration will be granted for 1 year

B. Hyftor® (sirolimus topical gel 0.2%)

Initial Coverage Criteria

Member must meet all the following criteria:

- Member must be 6 years of age or older
- Member must have a diagnosis of facial angiofibroma associated with tuberous sclerosis
- Member has 3 or more angiofibromas on the face that impair eyesight, bleed spontaneously or cause functional impairment
- Prescriber attests to the following:
    - No occlusive dressings will be used
    - Provider has discussed vaccination protocol with patient
    - Monitoring for adverse reactions due to an increase in systemic exposure of sirolimus will be done if used in conjunction with a CYP3A4 inhibitor
    - Provider has discussed with both male and female patients the risk of infertility as well as fetal harm if used during pregnancy
- **Limitations:**
    - Maximum quantity allowed:
        - Members 6-11 years of age are limited to 2 tubes every month
        - Members 12 years of age and older are limited to 2 tubes every 25 days
    - Initial approval duration will be granted for 12 weeks

Renewal Coverage Criteria

Member must meet all of the following criteria:

- Member has documentation of positive clinical response to therapy as noted by the reduction in size and redness of facial angiofibroma and decrease in physical impairment compared to baseline
- **Limitations:**
    - Maximum quantity allowed:
        - Members 6-11 years of age are limited to 2 tubes every month
        - Members 12 years of age and older are limited to 2 tubes every 25 days
    - Renewal approval duration will be granted for 1 year

C. Sotyktu® (deucravacitinib)

Initial Coverage Criteria

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of moderate to severe plaque psoriasis
- Must be prescribed by, or in consult with, an appropriate specialist (dermatologist, rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly authorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Provider attests that member **will not** use Sotyktu® concomitantly with other biologics
- **Limitations:**
    - Maximum daily dose is limited to 1 tablet
    - Initial approval duration will be granted for 16 weeks

Renewal Coverage Criteria

Member must meet all of the following criteria:

- Member has documentation of positive clinical response to therapy (e.g., reduction in body surface area involvement, reduction in severity index using a scoring tool)
- Annual specialist consult provided if prescriber not a specialist
- Provider attests that member **will not** use Sotyktu® concomitantly with other biologics
- **Limitations:**
    - Maximum daily dose is limited to 1 tablet
    - Renewal approval duration will be granted for 1 year

D. Ztalmy® (ganaxolone)

Initial Coverage Criteria

Member must meet all the following criteria:

- Member must be 2 years of age or older
- Member has a diagnosis of a pathogenic or likely pathogenic mutation in the CDKL5 gene
- Must be prescribed by, or in consult with, an appropriate specialist (neurologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Seizures are inadequately controlled by trial of at least 2 other conventional antiepileptic therapies
- **Limitations:**
    - Maximum quantity allowed:
        - Members weighing 28 kg or less: Maximum of 63 mg/kg/day
        - Members weighing more than 28 kg: Maximum of 1800 mg per day
        - Product available as 50 mg/ml suspension in 110 ml bottles
    - Initial approval duration will be granted for 4 months

Renewal Coverage Criteria

Member must meet all of the following criteria:

- Member has documentation of positive clinical response to therapy showing a decreased number of seizures compared to baseline
- Annual specialist consult provided if prescriber not a specialist
- Members who do not meet criteria for renewal will be tapered as abrupt discontinuation is not recommended.
- **Limitations:**
    - Maximum quantity allowed:
        - Members weighing 28 kg or less: Maximum of 63 mg/kg/day
        - Members weighing more than 28 kg: Maximum of 1800 mg per day
        - Product available as 50 mg/ml suspension in 110 ml bottles
    - Renewal approval duration will be granted for 1 year

E. Kloxxado® (naloxone HCl)

After discussion, the Board recommended that Kloxxado® be allowed when there is an availability issue for the preferred alternative. If member needs high dose naloxone therapy, duplicate Narcan® doses should be dispensed. The Board also requested that an educational piece be created to send to providers who frequently request Kloxxado® over the preferred alternatives.

F. Discussion on CF medications to make criteria and PA forms consistent

The existing criteria for CF medications have remained the same. Below are the updates that were provided to the Board documenting recent updates to the criteria documents in order to make all forms consistent and up to date.

1. Age change for Orkambi® which now allows for members 1 year of age and older
2. Specialist requirement added to Kalydeco®
3. Compliance verification wording updated on all PA forms & criteria documents (see below for updated language):
    - Verification of compliance will be made via Medicaid paid claims data. If non-compliance is determined, the reauthorization time frame may be reduced to allow time for the provider to address member compliance.

G. Dupixent® (dupilumab) for Prurigo Nodularis

Initial Coverage Criteria

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a confirmed diagnosis, by microscopic examination of lesion or biopsy, of prurigo nodularis
- Must be prescribed by, or in consult with, an appropriate specialist (dermatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Member has a Worst Itch Numerical Rating Scale (WI-NRS) of $\geq$7 points (0-10 scale)

- Member has 20 or more nodular lesions
- Provider attests that member **will not** use Dupixent® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 2 x 300 mg syringes (loading dose) and 1 x 300 mg syringe every other week for maintenance therapy
    - Initial coverage authorization will be granted for 6 months

Renewal Coverage Criteria

Member must meet all the following criteria:

- Member has documentation of positive clinical response to therapy by:
    - reduction in number and severity of nodules **OR**
    - reduction from baseline WI-NRS score by ≥4 points
- Annual specialist consult provided if prescriber not a specialist
- Provider attests that member **will not** use Dupixent® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 300 mg every other week for maintenance
    - Renewal authorization will be granted for 1 year

H. Skyrizi® (risankizumab-rzaa)

Initial Coverage Criteria

Active Psoriatic Arthritis:

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of psoriatic arthritis
- Must be prescribed by, or in consult with, an appropriate specialist (rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection
    - The member will avoid the use of live vaccines
- Provider attests that member **will not** use Skyrizi® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 150 mg given at week 0, week 4, and every 12 weeks thereafter
    - Initial approval duration will be granted for 3 doses (weeks 0, 4, and 16).
        - Update required prior to dose at 28 weeks

Moderate to Severe Plaque Psoriasis:

Member must meet all of the following criteria:

- Member must be 18 years of age or older

- Member must have a diagnosis of moderate to severe plaque psoriasis
- Must be prescribed by, or in consult with, an appropriate specialist (dermatologist, rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection
    - The member will avoid the use of live vaccines
- Provider attests that member **will not** use Skyrizi® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 150 mg given at week 0, week 4, and every 12 weeks thereafter
    - Initial approval duration will be granted for 3 doses (weeks 0, 4, and 16)
        - Update required prior to dose at 28 weeks

Moderately to Severely Active Crohn's Disease

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of moderately to severely active Crohn's disease
- Must be prescribed by, or in consult with, an appropriate specialist (gastroenterologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection
    - The member will avoid the use of live vaccines
    - Provider will monitor liver enzymes and bilirubin levels at baseline, during induction, and up to at least 12 weeks of treatment
- Provider attests that member **will not** use Skyrizi® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 600 mg IV at week 0, week 4, and week 8, then 180 mg or 360 mg Sub Q at week 12, then every 8 weeks thereafter
    - Initial approval duration will be granted for 4 doses (infusion weeks 0, 4, and 8, then injection week 12)
        - Update required prior to dose at 20 weeks

Renewal Coverage Criteria (applies to all diagnoses)

Member must meet all of the following criteria:

- Member has documentation of positive clinical response to therapy (reduction in the frequency and/or severity of symptoms and exacerbations)
- Annual specialist consult provided if prescriber not a specialist

- Provider attests that member **will not** use Skyrizi® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed:
        - Active Psoriatic Arthritis – 150 mg every 12 weeks
        - Moderate to Severe Plaque Psoriasis – 150 mg every 12 weeks
        - Crohn's Disease – 180 mg or 360 mg every 8 weeks
    - Renewal approval duration will be granted for 1 year

I. Stelara® (ustekinumab)

Initial Coverage Criteria

Moderate to Severe Plaque Psoriasis

Member must meet all of the following criteria:

- Member must be 6 years of age or older
- Member must have a diagnosis of moderate to severe plaque psoriasis
- Must be prescribed by, or in consult with, an appropriate specialist (dermatologist, rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection, malignancies, Posterior Reversible Encephalopathy Syndrome (PRES), and noninfectious pneumonia
- Provider attests that member **will not** use Stelara® concomitantly with other biologics
- **Limitations:**
    - In **adults with psoriasis** the subcutaneous dose is weight based:
        - ≤ 100 kg = 45 mg initially and 4 weeks later, then every 12 weeks
        - > 100 kg = 90 mg initially and 4 weeks later, then every 12 weeks
    - In **pediatric patients aged 6 to 17 with psoriasis** the subcutaneous dose is weight based:
        - < 60 kg = 0.75 mg/kg at week 0 and 4, then every 12 weeks
        - 60 - 100 kg = 45 mg at week 0 and 4, then every 12 weeks
        - > 100 kg = 90 mg at week 0 and 4, then every 12 weeks
    - Initial approval duration will be granted for 3 doses (weeks 0, 4, and 16)
        - Update required prior to dose at 28 weeks

Active Psoriatic Arthritis

Member must meet all of the following criteria:

- Member must be 6 years of age or older
- Member must have a diagnosis of psoriatic arthritis
- Must be prescribed by, or in consult with, an appropriate specialist (rheumatologist)

- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection, malignancies, Posterior Reversible Encephalopathy Syndrome (PRES), and noninfectious pneumonia
- Provider attests that member **will not** use Stelara® concomitantly with other biologics
- **Limitations:**
    - In **adults with psoriatic arthritis** the subcutaneous dose is weight based:
        - ≤ 100 kg = 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks
        - > 100 kg = 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks
    - In **pediatric patients aged 6 to 17 with psoriatic arthritis** the subcutaneous dose is weight based:
        - < 60 kg = 0.75 mg/kg at week 0 and 4, then every 12 weeks
        - ≥ 60 kg = 45 mg at week 0 and 4, then every 12 weeks
        - > 100 kg with co-existent moderate to severe plaque psoriasis = 90 mg at week 0 and 4, then every 12 weeks
    - Initial approval duration will be granted for 3 doses (weeks 0, 4, and 16)
        - Update required prior to dose at 28 weeks

Moderately to Severely Active Ulcerative Colitis

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of moderately to severely active ulcerative colitis
- Must be prescribed by, or in consult with, an appropriate specialist (gastroenterologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection, malignancies, Posterior Reversible Encephalopathy Syndrome (PRES), and noninfectious pneumonia
- Provider attests that member **will not** use Stelara® concomitantly with other biologics
- **Limitations:**
    - IV infusion for initial dose for **ulcerative colitis**
        - Initial intravenous infusion of Stelara® is based on body weight at time of dosing
            - Up to 55 kg = 260 mg
            - > 55 kg to 85 kg = 390 mg

        - > 85 kg = 520 mg
    - Subcutaneous injection for maintenance in **ulcerative colitis**
        - 90 mg dose 8 weeks after initial IV dose, then every 8 weeks thereafter
    - Initial approval duration will be granted for 2 doses (infusion week 0, injection week 8)
        - Update required prior to dose at 16 weeks

Moderately to Severely Active Crohn's Disease

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of moderately to severely active Crohn's disease
- Must be prescribed by, or in consult with, an appropriate specialist (gastroenterologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection, malignancies, Posterior Reversible Encephalopathy Syndrome (PRES), and noninfectious pneumonia
- Provider attests that member **will not** use Stelara® concomitantly with other biologics
- **Limitations:**
    - IV infusion for initial dose for **Crohn's Disease**
        - Initial intravenous infusion of Stelara® is based on body weight at time of dosing
            - Up to 55 kg = 260 mg
            - > 55 kg to 85 kg = 390 mg
            - > 85 kg = 520 mg
    - Subcutaneous injection for maintenance in **Crohn's Disease**
        - 90 mg dose 8 weeks after initial IV dose, then every 8 weeks thereafter
    - Initial approval duration will be granted for 2 doses (infusion week 0, injection week 8)
        - Update required prior to injection at 16 weeks

Renewal Coverage Criteria (applies to all diagnoses)

Member must meet all of the following criteria:

- Member has documentation of positive clinical response to therapy (reduction in the frequency and/or severity of symptoms and exacerbations)
- Annual specialist consult provided if prescriber not a specialist
- Provider attests that member **will not** use Stelara® concomitantly with other biologics
- **Limitations:**
    - Maximum dose limit allowed:
        - **Moderate to Severe Plaque Psoriasis:**
            - In **adults with psoriasis** the subcutaneous dose is weight based:

        - ≤ 100 kg = 45 mg every 12 weeks
        - > 100 kg = 90 mg every 12 weeks
    - In **pediatric patients aged 6 to 17 with psoriasis** the subcutaneous dose is weight based:
        - < 60 kg = 0.75 mg/kg every 12 weeks
        - 60 – 100 kg = 45 mg every 12 weeks
        - > 100 kg = 90 mg every 12 weeks
- **Active Psoriatic Arthritis:**
    - In **adults with psoriatic arthritis** the subcutaneous dose is weight based:
        - ≤ 100 kg = 45 mg every 12 weeks
        - > 100 kg = 90 mg every 12 weeks
    - In **pediatric patients aged 6 to 17 with psoriatic arthritis** the subcutaneous dose is weight based:
        - < 60 kg = 0.75 mg/kg every 12 weeks
        - ≥ 60 kg = 45 mg every 12 weeks
        - > 100 kg with co-existent moderate to severe plaque psoriasis = 90 mg every 12 weeks
- **Moderately to Severely Active Ulcerative Colitis:**
    - 90 mg dose every 8 weeks
- **Moderately to Severely Active Crohn's Disease:**
    - 90 mg dose every 8 weeks
- Renewal approval duration will be granted for 1 year

J. Tremfya® (guselkumab)

Initial Coverage Criteria

Active Psoriatic Arthritis

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of psoriatic arthritis
- Must be prescribed by, or in consult with, an appropriate specialist (rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection
- Provider attests that member **will not** use Tremfya® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 100mg Sub Q at week 0, 4, and every 8 weeks thereafter
    - Initial authorization duration will be granted for 4 doses (weeks 0, 4, 12, and 20)
        - Update required prior to dose at 28 weeks

Moderate to Severe Plaque Psoriasis:

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of moderate to severe plaque psoriasis
- Must be prescribed by, or in consult with, an appropriate specialist (dermatologist, rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection
- Provider attests that member **will not** use Tremfya® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 100mg Sub Q at week 0, 4, and every 8 weeks thereafter
    - Initial authorization duration will be granted for 4 doses (weeks 0, 4, 12, and 20)
        - Update required prior to dose at 28 weeks

Renewal Coverage Criteria (applies to both diagnoses)

Member must meet all the following criteria:

- Member has documentation of positive clinical response to therapy (reduction in the frequency and/or severity of symptoms and exacerbations)
- Annual specialist consult provided if prescriber not a specialist
- Provider attests that member **will not** use Tremfya® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 100mg Sub Q every 8 weeks
    - Renewal approval duration will be granted for 1 year

K. Ilumya® (tildrakizumab-asmn)

Initial Coverage Criteria

Member must meet all the following criteria:

- Member must be 18 years of age or older
- Member must have a diagnosis of moderate to severe plaque psoriasis
- Must be prescribed by, or in consult with, an appropriate specialist (dermatologist, rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization
- Must have a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:

    - The member has been screened for TB prior to initiating treatment
    - The provider will monitor for active infection
- Provider attests that member **will not** use Ilumya® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 100mg Sub Q at week 0, 4, and every 12 weeks thereafter
    - Initial approval duration will be granted for 3 doses (weeks 0, 4, and 16)
        - Update required prior to dose at 28 weeks

Renewal Coverage Criteria

Member must meet all the following criteria:

- Member has documentation of positive clinical response to therapy (reduction in the frequency and/or severity of symptoms and exacerbations)
- Annual specialist consult provided if prescriber not a specialist
- Provider attests that member **will not** use Ilumya® concomitantly with other biologics
- **Limitations:**
    - Maximum dose allowed is 100mg Sub Q every 12 weeks
    - Renewal approval duration will be granted for 1 year

L. Austedo® (deutetrabenazine) – Suicidality Discussion

The Board approved the addition to the PA form documenting the concern of increased suicidality in members with Huntington's Chorea. The suicidality warning was removed from the criteria for Tardive Dyskinesia as the risk is only associated with the Huntington's diagnosis. Additionally, the Board requested that DPHHS and Mountain Pacific research the intersection of movement disorders and high dose stimulant prescriptions or stimulant use disorder. A review should be done to determine if benefit from an educational intervention could be realized. These findings will be brought back for Board discussion at a later date. The Board briefly reviewed the AIMS criteria but did not make any changes. They agreed to continue the current process of allowing case management staff to review cases, which do not meet AIMS criteria, on an individual basis for possible exceptions.

2. Preferred Drug List trial discussion (no additional criteria added):

- Trial requirements in classes with multiple MOAs
    - The Board approved the request to add requirements to the PDL stating that the member will need to fail 2 preferred products, with different MOA's, before a non-preferred therapy will be considered.

- Trial requirements in classes with combination products
    - The Board approved the request to require, and document on the PDL, that members must try a combination of preferred products with all requested MOAs prior to approval of a non-preferred dual or triple therapy product with the same MOA combination.

- Trial requirements for alternative dosage forms

- The Board approved the request to require clinical rationale for all alternative dosage forms and have this requirement documented on the PDL.

3. **Criteria removal discussion**

- Colchicine:
  - The Board approved the request to remove criteria for colchicine. Quantity limits (max of 3 per day) and PDL placement will be the only things enforced for these products.

4. **Report on gabapentin/pregabalin project implemented January 2022**

- Update tabled for future meeting

5. **Atypical Antipsychotics in Children criteria discussion**

- A Mountain Pacific Case Management Pharmacist gave a high-level overview of this program and provided a brief history on why this program was created and how the PA process has evolved over time.

- The Board reviewed and discussed the letter received by DPHHS that discussed concerns of the current program and requiring metabolic labs in pediatric children (currently under the age of 8 years old) when atypical antipsychotics are prescribed by fellowship trained pediatric psychiatrists.

- After discussion, the Board instructed DPHHS and Mountain Pacific to continue with current program requirements and to not make any changes at this time.

6. **Upcoming meeting dates:**

- 2023 PDL Meeting Dates: March 15, 2023, April 26, 2023, May 24, 2023
- 2023 DUR Board Meeting Dates: TBD

The next meeting will be TBD and in this same format. The meeting adjourned at 3:48pm.