Centene Pharmacy Therapeutics Committee
Therapeutic Class Matrix Summary Table 3Q18

| HGPI Therapeutic Class | Review Recommendation |
|---|---|
| 01 Penicillins | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 02 Cephalosporins | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 03 Macrolides | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 04 Tetracyclines | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 05 Fluoroquinolones | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 07 Aminoglycosides | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 08 Sulfonamides | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 09 Antimycobacterial Agents | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 11 Antifungals | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 12 Antivirals | The following changes to the clinical guidance for this drug class are recommended based on current recommendations from the American Association for the Study of Liver Diseases (AASLD) Guidelines for the treatment of chronic hepatitis B:<br>• Deletion of the following guidance<br>o Clinically important differences between Baraclude (entecavir) and Hepsera (adefovir) are not evident.<br>• Addition of the following guidance:<br>o For initial treatment of adults with immune-active chronic hepatitis B infection, it would be clinically appropriate to require a trial of pegylated interferon, entecavir, or tenofovir prior to lamivudine, telbivudine, and adefovir, but not vice versa.<br>o For initial treatment of adults with immune-active chronic hepatitis B infection, similar therapeutic outcomes are anticipated for pegylated interferon, entecavir, and tenofovir; therefore it would be clinically appropriate to provide equal access to all three agents or require a trial of one before the others. |
| 13 Antimalarials | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 14 Amebecides | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |

| | |
|---|---|
| 15 Anthelmintics | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 16 Antibiotics Misc. | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 22 Corticosteriods | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 23 Androgens | The following changes to the clinical guidance for this drug class are recommended based on current recommendations in available clinical practice guidelines:<br>• Testosterone formulations for hypogonadism:<br>o Reference to scrotal testosterone formulations is removed as they are no longer available in the U.S.<br>o Testosterone therapeutic alternatives:<br>• Oxandrolone is removed as a testosterone therapeutic alternative as its indications are not the same as those of testosterone - oxandrolone is indicated for weight gain promotion.<br>• Testosterone undecanoate (IM) is added as a testosterone therapeutic alternative as are testosterone transdermal gels Fortesta®, Testim® and Vogelxo®, generic testosterone transdermal solution, and testosterone buccal tablet Striant®. Equal access is recommended for all testosterone formulations.<br>• Nasal gel and subcutaneous pellets may be listed as therapeutic alternatives but should not be required for the following reasons:<br>▪ Nasal gel: relatively high brain testosterone found in mice when comparing nasal versus systemic formulations;<br>▪ Subcutaneous pellet: labeled dosing recommendations conflict with current guidelines.<br>o **Axiron brand is discontinued (generic is available - testosterone transdermal solution, 30 mg/actuation (90 mL).**<br>• Testosterone and DHEA therapy for women<br>o Testosterone therapy for postmenopausal sexual interest/arousal disorder in women is not recommended at this time given a relative lack of safety data and no FDA-approved androgen products (including testosterone) for this indication.<br>o The androgen, dehydroepiandrosterone (DHEA), currently has no role in the treatment of female sexual disorders although research is ongoing. |
| 24 Estrogens | The following changes to the clinical guidance for this drug class are recommended based on current recommendations in available clinical practice guidelines as summarized above: |

| | |
|---|---|
| | Menopausal Hormone Therapy (MHT):<br>• Vasomotor symptoms (VMS) with or without genitourinary atrophy:<br>o Given that transdermal patches are associated with a lower risk of venous thromboembolism (VTE) and stroke, it would be clinically appropriate to provide equal access to transdermal and oral formulations. Additionally, equal access should be given to estrogen-only and estrogen/progestin patches (e.g., estradiol, estrogen/levonorgestral, estrogen/norethindrone).<br>o Uterine protection:<br>• Estrogen therapy (oral, transdermal patch, topical, high-dose vaginal) must be combined, for uterine protection, with oral micronized progesterone (OMP), a progestin (medroxyprogesterone acetate [MPA - tablet], estrogen/progestin patch) or Duavee (estrogen and bazedoxifene [a selective estrogen receptor modifier [SERM]).<br>• Duavee may be preferred over OMP or MPA in cases where OMP or MPA are not tolerated or where there is an independent need for breast cancer prophylaxis. Therefore, it would be clinically appropriate to provide equal access to Duavee, OMP, and progestins (tablet or patch) for uterine protection.<br>o Therapeutic alternatives:<br>• Ogen is discontinued so is removed; CombiPatch is added as a representative estradiol/progestin (norethindrone) combination patch.<br>• Bioidentical hormones<br>o The use of custom-compounded bioidentical hormone therapy is not recommended given limited product quality control and lack of evidence that it is safe or effective.<br>• Postmenopausal osteoporosis (PMO):<br>o Estrogen therapy is no longer recommended for PMO but may be considered in select cases when other options are not tolerated. Therefore, it would be clinically appropriate to require a trial of non-estrogen therapy (e.g., bisphosphonates) prior to estrogen therapy for PMO. Since SERMs have the same cardiovascular risk as estrogens, they may be considered if there are additional indications for their use such as breast cancer prophylaxis or VSM in the case of Duavee's labeled indication. |
| 25 Contraceptives | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |
| 26 Progestins | The following changes to the clinical guidance for this drug class are recommended based on current recommendations in available clinical practice guidelines:<br>• Menopausal hormone therapy (MHT) |

| | |
|---|---|
| | • Estrogen therapy (oral, transdermal patch, topical) for women with an intact uterus must be combined with uterine protection.<br>o As uterine protection, oral micronized progesterone (OMP) has a more favorable cardiovascular/breast cancer profile relative to progestins (medroxyprogesterone acetate [MPA - tablet], estrogen/progestin patch) and a more favorable cardiovascular profile relative to Duavee. Therefore, it is recommended that equal access be provided to progestins (MPA and estrogen/progestin patches), Duavee and OMP.<br>• Endometriosis<br>• Norethindrone acetate's place in therapy for endometriosis treatment is clarified as follows:<br>o For mild to moderate pelvic pain due to endometriosis in the absence of evidence of an endometrioma, continuous contraceptives (and/or NSAIDS) are considered first-line therapy. There are no data to support the superiority of one contraceptive over another; however, for women who cannot or chose not to use estrogen therapy, initial therapy with oral norethindrone (contraceptive) is preferred. If symptom relief is inadequate, norethindrone may be switched to non-contraceptive progestins (norethindrone acetate or MPA [IM]); accordingly, equal access is recommended for all three agents for endometriosis.<br>• Estrogen/progestin products<br>o Discussion regarding estrogen/progestin combination products is moved to GPI 24: Estrogens.<br>• Bioidentical hormone products<br>o The use of custom-compounded bioidentical hormone therapy is not recommended for addition to the formulary given limited product quality control and lack of evidence that it is safe or effective.<br>• Makena<br>o Clinical guidance is updated to reflect equal clinical preference for Makena and its compounded formulation. |
| 27 Antidiabetics | The following changes to the clinical guidance for this drug class are recommended based on current recommendation in the 2018 American Diabetes Association treatment guidelines:<br>• Revision of existing guidance is to be aligned with the following:<br>o For patients with HbA1c < 9%, it would be clinically appropriate to require a trial of metformin prior to initiation of either DPP-4 inhibitors or GLP-1 agonists.<br>o For patients with HbA1c ≥ 9%, it would be clinically appropriate to require concurrent use of metformin and either DPP-4 inhibitors or GLP-1 agonists.<br>o It would be clinically appropriate to provide equal access to all DPP-4 inhibitors or require a trial of one before the others.<br>o It would be clinically appropriate to provide equal access to all GLP-1 agonists. |

| | |
|---|---|
| | ○ For patients without ASCVD, it would be clinically appropriate to require a trial of one GLP-1 agonist before the others or vice versa.<br>○ It would be clinically appropriate to provide equal access to GLP-1 agonists, DPP-4 inhibitors, SGLT2 inhibitors, sulfonylureas, and thiazolidinediones.<br>• Addition of the following guidance:<br>○ For patients with personal or family history of medullary thyroid carcinoma, or Multiple Endocrine Neoplasia syndrome type 2, it would not be clinically appropriate to require a trial of Bydureon®, Tanzeum, Trulicity®, Ozempic®, Victoza®, and Xultophy® prior to initiation of Adlyxin, Byetta®, or Soliqua® because of the risk of thyroid C-cell tumors.<br>○ It would be clinically appropriate to provide equal access to all GLP-1 agonists.<br>○ For patients with ASCVD, it would be clinically appropriate to require a trial of Victoza prior to initiation of any other GLP-1 agonist, but not vice versa because Victoza is the only GLP-1 agonist with a labeled indication for reducing cardiovascular risk.<br>○ For patients with baseline HbA1c ≥ 10%, it would be clinically appropriate to require concurrent use of metformin and insulin, with or without a GLP-1 agonist, DPP-4 inhibitor, SGLT2 inhibitor, sulfonylurea, and thiazolidinedione.<br>• Removal of the following guidance where present:<br>○ It would be clinically appropriate to require a trial of one of the following agents before the others or vice versa if metformin is failed or contraindicated: GLP-1 agonists, DPP-4 inhibitors, SGLT2 inhibitors, sulfonylureas, and thiazolidinediones. |
| 28 Thyroid Agents | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 29 Oxytocics | Based on the available clinical evidence, there are no utilization management recommendations to be made at this time. |
| 30 Endocrine and Metabolic Agents Misc | No changes to the clinical guidance for this drug class are recommended based on the review of available clinical practice guidelines. |