Pharmacy and Therapeutics (P&T) Committee Meeting Record

Date: October 18, 2019

Time: 9:00 a.m. – 3:00 p.m. **Location:** Idaho Medicaid, 3232 Elder Street, Boise, Idaho, Conference Room D

Moderator: Magni Hamso, MD

Committee Members Present: Magni Hamso, MD, Chair; Tami Eide, PharmD; Andrei Rudyi, PharmD; Paul Driver, PharmD; David Calley, PharmD; Joseph Weatherly, DO; Jeffery Johnson, PA, PharmD; Perry Brown, Jr., MD.

Committee Members Absent: Nicole Chopski, PharmD

Others Present: Sarah Martinez, PharmD, Magellan Health Services; Chris Johnson, PharmD, Division of Medicaid; Jane Gennrich, PharmD, Division of Medicaid; Suzanne Fox, Division of Medicaid; Wendy Estrellado, Division of Medicaid; Mark England, PharmD, Magellan Medicaid Administration.

AGENDA ITEMS	PRESENTER	OUTCOME/ACTIONS
CALL TO ORDER	*Magni Hamso, MD*	*Dr. Hamso called the meeting to order.*
Committee Business		
➢ *Roll Call*	*Magni Hamso, MD*	Dr. Hamso completed the roll call and welcomed the P&T Committee members.
➢ *Reading of Mission and Confidentiality Statements*	*Magni Hamso, MD*	Dr. Hamso read the Mission and Confidentiality Statements.
➢ *Approval of Minutes from May 17, 2019 Meeting*	*Magni Hamso, MD*	The May 17, 2019 minutes were reviewed. The minutes were approved without any changes.
Overview of Support Act State Plan Amendment Requirements	*Tami Eide, PharmD Division of Medicaid*	**Overview of Support Act State Plan Amendment Requirements** Dr. Eide reviewed CMS Guidance for Medicaid DUR Provisions included in Section 1004 of the Support Act or the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatments for Patients and Communities Act. She did an overview of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act and its intent to reduce opioid

		related fraud, misuse and abuse. She noted that it is also known as the SUPPORT for Patients and Communities Act or SUPPORT Act. Section 1004 of the act is specific to State Medicaid Drug Utilization Review (DUR) Programs. Strategies included were required to be implemented by October 1, 2019. A report will be conveyed by CMS to Congress based on information from each states' fiscal year 2020 DUR Reports. All states are required to submit a State Plan Amendment to CMS by December 31, 2019 documenting how they will comply with the requirements. Requirements to be implemented include: 1. **Safety Edits** which CMS interprets to be prospective drug review activities which identify potential problems at point of sale. These engage patients and prescribers about possible opioid abuse and overdose risk at time of dispensing and may require pharmacists to take further action to resolve before the prescription is dispensed. 2. **Claims Review Automated Processes** which CMS interprets as retrospective drug use review and includes additional examination of claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. Specific Claims Review Requirements are as follows. Those with a red check indicate which ones are already in place by Idaho Medicaid. • Safety edits including early, duplicate and quantity limits o State identifies the limits and restrictions ✓ • Maximum Daily Morphine Milligram equivalents (MME) Safety Edits o Must include a MME threshold amount ✓ • Concurrent Utilization Alerts o Opioids and benzodiazepines o Opioids and antipsychotics The concurrent utilization alerts are required to be done as retrospective review but may also be done through prospective (ProDUR) alerts. Dr. Eide noted that hospice or palliative care patients; cancer treatment patients and long-term care facility residents are permitted patient exclusions from the claims review requirements. States may elect to voluntarily include these patient groups.

		3. <u>Program to Monitor Antipsychotic Mediations by Children</u>. • Report annually on activities carried out on individuals < 18 years old generally, and children in foster care specifically ✓ **4. <u>Fraud and Abuse Identification Requirements</u>** • The state must have in place a process that identifies potential fraud or abuse of controlled substances for individuals (i.e. participants), enrolled prescribers and dispensing pharmacies. Mechanisms that can be used include use of the PDMP, lock-in programs and use of data analytics. State Plan Amendment (SPA) requirements must specify implementation of these DUR requirements including claims review limitations, monitoring of antipsychotic medications by children and fraud and abuse identification. It was noted that the State will need to report annually the percent of prescribers that are checking the PDMP. The Committee discussed possible DUR activities that could include use of opioids in combination with both an antipsychotic and benzodiazepine and co-prescribing of either opioids plus benzodiazepines or opioids and antipsychotics by one prescriber. They also discussed exploring the possibility of locking in patients concurrently receiving opioids and benzodiazepines or opioids and antipsychotics.
Public Comment Period	*Magni Hamso, MD* *Suzanne Fox, Medicaid*	**<u>Public Comment Period</u>** There were not any speakers for the public testimony period this meeting.

Immunoglobulins: Clinical Evidence for Off-Label Use	*Wesley Lindsey, Pharm D* *Auburn University*	**<u>Immunoglobulins: Clinical Evidence for Off-Label Use</u>** Dr. Lindsey reviewed the Drug Effectiveness Review Project (DERP) report on Immunoglobulins: Clinical Evidence for Off-Label Use. The study explored the evidence for off-label use of these medications. Off-label indications included in the review were multiple sclerosis, myasthenia gravis, chronic inflammatory demyelinating polyneuropathy (CIDP) and Guillain-Barré Syndrome. These were the only off-label use conditions with evidence for use. The key questions for the review were: 1. Effectiveness of off-label use of intravenous and subcutaneous immunoglobulin 2. Impact of dose and duration of treatment 3. Harms of treatment 4. Characteristics of ongoing studies For multiple sclerosis, 4 studies were reviewed with 2 studies rated methodologically as fair and 2 studies rated as poor because of cross-over with incomplete washout. Clinical outcomes of interest evaluated included proportion of relapse-free patients, annualized relapse rate and time to first relapse. The quality of evidence was rated low in all studies. For myasthenia gravis, 3 studies in 5 publications were reviewed with 2 studies rated methodologically as fair and 1 study rated poor due to small sample size and the cross-over design used. Clinical outcomes of interest evaluated included the quantified myasthenia gravis score and the quantitative myasthenia gravis score. The quality of evidence was rated low in two of the studies and moderate in one as it included consistent findings and larger sample sizes. For CIDP, 4 studies in 10 publications were reviewed with 2 studies rated methodologically as fair, 1 rated as good, 1 rated as poor. The quality of evidence was rated as moderate based on large sample sizes and head to head comparison. For Guillain-Barré, 2 studies were reviewed with both rated good methodologically. The studies compared IVIG to plasma exchange or IVIG compared with or without plasma exchange. Clinical outcomes of interest were improvement by one or more grades on the functional scale. The quality of evidence was rated moderate. Dr. Lindsey noted that many of the included studies that showed statistically significant improvements did not demonstrate clinical significance.

		The committee concluded that treatment in Guillain-Barré had the best evidence but use over plasma exchange would depend on cost. The committee recommended that requests for off-label use for these four specific conditions be considered only from specialists for the specific condition being treated.
Drug Class Reviews and Committee Recommendations	*Sarah Martinez, PharmD* *Magellan Health Services*	**Drug Class Reviews and Committee Recommendations** Committee members were asked to base their recommendations for each drug class on the answers to the following questions: 1. Is there comparative evidence to support clinically significant differences in efficacy or effectiveness between agents? If yes, what are the differences? 2. Is there comparative evidence to support clinically significant differences in safety between agents? If yes, what are the differences? 3. Are there any agents that the committee feels strongly must be preferred or non-preferred? 4. Are there any recommendations for changes to PA requirements?
➢ *Immune Globulins*	*Sarah Martinez, PharmD*	**<u>Immune Globulins</u>** Dr. Martinez reported on two new products in this class: Cutaquig and Panzyga. Cutaquig is a subcutaneous immune globulin approved for the treatment of primary humoral immunodeficiency in adults and Panzyga is an intravenous Immune globulin approved for the treatment of primary humoral immunodeficiency in patients 2 years of age and older and for chronic immune thrombocytopenia in adults. Dosing, contraindications, warnings and adverse reactions were reviewed for both products. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between immune globulin products. The committee recommended that requests for use of these agents be from a specialist of the specific condition or documentation provided of consultation with said specialist. It was also recommended that language requiring such consultation be added to the prior authorization form.
➢ *Immunomodulators, Asthma*	*Sarah Martinez, PharmD*	**<u>Immunomodulators, Asthma</u>** There were no new products in this class. In product updates Dr. Martinez noted that Xolair is now available as 75mg and 150 mg single dose prefilled syringe formulations for administration by a health care professional for allergic asthma in patients ≥ 6 years of age and chronic idiopathic urticaria in patients ≥ 12 years of age. Nucala (mepolizumab) is now available in a 100mg/mL single dose, prefilled

		autoinjector or single-dose prefilled syringe to allow for self-administration or patient caregiver administration. Nucala previously required administration by a health care provider. Nucala is also now indicated for use as add-on maintenance treatment for patients with severe asthma of the eosinophilic phenotype in patients 6-11 years of age. It was previously approved for patients ≥ 12 years of age for this indication. Dr. Martinez also reviewed the 2019 Global Initiative for Asthma updated guidelines which recommend that all adults and adolescents with asthma receive an ICS-containing controller medication. She noted that due to the increased risk of severe exacerbations and asthma-related death, short-acting beta agonist (SABA) only treatment is no longer recommended. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Anti-Allergens, Oral*	*Sarah Martinez, PharmD*	**Anti-Allergens, Oral** Dr. Martinez reported that Oralair is now indicated in children 5 to 9 years of age as immunotherapy for the treatment of grass pollen-induced allergic rhinitis. Previously, it was approved only for use in persons 10 through 65 years of age. It was noted that Oralair is currently the only rebatable product and others will be removed from the PDL document. **Committee Recommendations** The committee concluded that rebatable agents should have clinical criteria to match their FDA approved indications.
➢ *Antihistamines, Minimally Sedating*	*Sarah Martinez, PharmD*	**Antihistamines, Minimally Sedating** Dr. Martinez reported no new products in this class and there is no recent information of significance in this class. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Immunomodulators, Atopic Dermatitis*	*Sarah Martinez, PharmD*	**Immunomodulators, Atopic Dermatitis** Dr. Martinez did a product update on new Dupixent indications beyond original approval for the treatment of adults with moderate to severe atopic dermatitis. Dupixent is now approved for the treatment of moderate to severe atopic dermatitis in patients 12 years of age and older whose disease has not been adequately controlled with topical prescription therapies or when

		those therapies are not advisable. It may be used with or without topical steroids for this indication. It is also approved for the add-on maintenance treatment of moderate to severe asthma in patients 12 years of age and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma and for the treatment of nasal polyps accompanied by chronic rhinosinusitis in adults. She reviewed the dosing for these new indications. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents in atopic dermatitis. The committee recommended that a prior authorization form specific for atopic dermatitis be developed.
➢ *Epinephrine, Self-Injected*	*Sarah Martinez, PharmD*	**Epinephrine, Self-Injected** Dr. Martinez reported on a new product, Symjepi available as 0.15mg/0.3 mL and 0.3mg/0.3 mL prefilled syringes. She noted that it is not an auto-injector and requires manual injection. **Committee Recommendations** The committee concluded that there was not comparative evidence to support clinically significant differences in efficacy, effectiveness, or safety between the preparations. They recommended that at least one auto-injector be preferred that is available in both pediatric and adult doses. They also recommended that the Department continue to allow product switches based on supply issues.
➢ *Intranasal Rhinitis Agents*	*Sarah Martinez, PharmD*	**Intranasal Rhinitis Agents** Dr. Martinez reported that there were no new products in this class and no recent information of significance. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.

➢ *Glucocorticoids, Inhaled*	*Sarah Martinez, PharmD*	**Glucocorticoids, Inhaled** Dr. Martinez reported that Dulera (mometasone furoate/formoterol fumarate) is now indicated for the maintenance treatment of asthma in pediatric patients 5 years of age and above (previously approved for patients older than 12 years of age). She also reported that Asmanex HFA (mometasone furoate) is now indicated for the maintenance treatment of asthma in patients 5 years of age and above (previously approved for patients older than 12 years of age). Dr. Martinez gave a review of the IMPACT study, a 52-week, multicenter, randomized, double-blind, parallel-group trial that compared the efficacy of Trelegy Ellipta (fluticasone/umeclidinium/vilanterol) with fixed-dose Breo Ellipta (fluticasone/vilanterol) and Anoro Ellipta (umeclidinium/vilanterol) in 10,355 patients with COPD and a history of ≥ 1 moderate or severe exacerbations in the prior year. The primary endpoint for this study was the annual rate of on-treatment moderate and severe exacerbations, defined as ≥ 2 major symptoms (e.g., dyspnea, sputum volume, sputum purulence) or worsening of a 1 major symptom combined with ≥ 1 minor symptom (e.g., sore throat, colds, fever without other cause, increased cough or wheezing) that required systemic corticosteroids and/or antibiotics (moderate) or resulted in hospitalization or death (severe). Trelegy Ellipta was preferred over its comparators with higher decreases in exacerbation rates and decreased risk of time to first exacerbation. A statistically significant difference was also seen favoring Trelegy Ellipta over Anoro Ellipta in annual rate of severe exacerbations; however, the difference was not statistically significant between Trelegy Ellipta and Breo Ellipta. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents. They did note possible better adherence with Trelegy Ellipta (fluticasone/umeclidinium/vilanterol).
➢ *Bronchodilators, Beta Agonists, Short-Acting*	*Sarah Martinez, PharmD*	**Bronchodilators, Beta Agonists, Short-Acting** Dr. Martinez reviewed the 2019 Global Initiative for Chronic Obstructive Lung Disease (GOLD) update and recommendations for initial therapy and follow-up treatment based on predominant treatable trait of either dyspnea or exacerbations. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.

➢ *Bronchodilators, Beta Agonists Long-Acting*	*Sarah Martinez, PharmD*	**Bronchodilators, Beta Agonists Long-Acting** There were no new products and no recent clinical information of significance to review in this class. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Leukotriene Modifiers*	*Sarah Martinez, PharmD*	**Leukotriene Modifiers** There were no new products and no recent clinical information of significance to review in this class. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *COPD Agents*	*Sarah Martinez, PharmD*	**COPD Agents** Dr. Martinez reported on one new product in this class: Yupelri (revefenacin) which is an anticholinergic approved for the maintenance treatment of patients with COPD. Dosing, contraindications, warnings, adverse events and clinical evaluations completed for market approval of this agent were reviewed. Dr. Martinez also reviewed the following 2019 Global Initiative for Chronic Obstructive Lung Disease (GOLD) update: • There is some evidence for use of triple therapy—ICS/LABA/LAMA—in patients with persistent breathlessness or exercise limitation. • If exacerbations still occur with triple therapy, then the oral phosphodiesterase 4 (PDE4) inhibitor roflumilast (Daliresp), which is indicated to decrease the frequency of exacerbations or worsening of symptoms of severe COPD, may be added in patients with FEV1 < 50% predicted and chronic bronchitis. • Long-term monotherapy with an ICS at any stage has been shown to be less effective than its use in combination with LABAs. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.

➢ *Smoking Cessation*	*Sarah Martinez, PharmD*	**Smoking Cessation** There were no new products in this class. Dr. Martinez reviewed The ACC 2018 Expert Consensus Decision Pathway on Tobacco Cessation Treatment: • First-line pharmacotherapy for patients with stable cardiovascular disease (CVD) in an outpatient setting is varenicline (Chantix) or combination nicotine replacement therapy (NRT) which is comprised of a nicotine patch (Nicoderm CQ) plus nicotine gum (Nicorette), lozenge (Nicorette) or spray (Nicotrol NS), depending on patient preference. • Second-line therapy for patients with stable CVD consists of bupropion (Zyban) or a single NRT product. • If a single agent is not effective, the following combinations can be used; varenicline plus a single NRT, varenicline plus bupropion, or bupropion plus a single agent NRT. Dr. Martinez also noted as a product update that GlaxoSmithKline made a business decision to discontinue Zyban in July 2019. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Botulinum Toxins*	*Sarah Martinez, PharmD*	**Botulinum Toxins** There were no new products in this class. In product updates Dr. Martinez noted: • Botox (onabotulinumtoxin A) is now approved to treat upper limb spasticity in pediatric patients ≥ 2 years of age. It is not intended to substitute for standard of care rehabilitation regimens. • Myobloc (rimabotulinumtoxin B) is now approved for the treatment of chronic sialorrhea in adults. It was previously indicated for cervical dystonia. • Dysport (abobotulinumtoxin A) is now approved to treat upper limb spasticity in pediatric patients ≥ 2 years of age, excluding spasticity caused by cerebral palsy (was already approved for upper and lower limb spasticity in adults and lower limb spasticity in pediatric patients ≥ 2 years of age).

		Committee Recommendations The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents. The committee recommended adding language to the PA form specifying that two trial and failures of conventional therapy for diagnosis be required prior to use of botulinum toxins.
➢ *Cytokine/CAM Agents*	*Sarah Martinez, PharmD*	**<u>Cytokine/CAM Agents</u>** Dr. Martinez reviewed two new products in this class: Rinvoq (upadacitinib) and Skyrizi (risankizumab-rzaa). Rinvoq is a Janus kinase (JAK) inhibitor indicated for the treatment of adults with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to methotrexate. Skyrizi is an Interleukin-23 antagonist indicated for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. She reviewed dosing, contraindications, warnings, adverse events and clinical evaluations completed for market approval of these agents. In product updates Dr. Martinez noted: • Cimzia (certolizumab pegol) is now approved for the treatment of non-radiographic axial spondyloarthritis (nr-asXpA) in adults with objective signs of inflammation. • Inflectra (infliximab-dyyb) is now indicated to reduce the signs and symptoms as well as induce and maintain clinical remission in pediatric patients ≥ 6 years of age with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy. • Renflexis (infliximab-abda) is now indicated to reduce the signs and symptoms as well as induce and maintain clinical remission in pediatric patients ≥ 6 years of age with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy. • Otezla (apremilast) is now approved to treat adults with oral ulcers associated with Behçet's disease. • Taltz (ixekizumab) is now approved for the treatment of adults with ankylosing spondylitis. • Xeljanz and Xeljanz XR now have new boxed warnings for increased risk of blood clots and risk of death with the 10 mg twice daily dose (ulcerative colitis dose). This was based on interim data from an ongoing trial in patients with rheumatoid arthritis. • Actemra is now available in a 162 mg/0.9mL single-dose prefilled autoinjector (ACTPen) for subcutaneous administration. • Tremfya (guselkumab) is now available in a single-dose prefilled autoinjector (One-Press) for subcutaneous injection.

		Dr. Martinez reviewed several updated guidelines involving cytokine/CAM therapy. The American College of Rheumatology (ACR) and National Psoriasis Foundation (NPF) issued joint guidelines for psoriatic arthritis (PsA)which recommend a treat-to-target approach and TNFα inhibitors as first-line in patients with active PsA. They strongly recommend based on moderate-quality evidence preference of a TNFα inhibitor monoclonal antibody biologic over a TNFα inhibitor biologic soluble receptor biologic (e.g., etanercept) or an interleukin (IL)-17 inhibitor. They also recommend preference of an IL 12/23 inhibitor over an IL-17 inhibitor. For patients who are both oral small molecule and biologic treatment-naïve they recommend starting an oral small molecule (OSM) drug (e.g. Xeljanz, Otezla) over a TNFα inhibitor biologic in patients with active PsA and frequent serious infections. They also recommend against smoking. The American Academy of Dermatology (AAD) and the National Psoriasis Foundation (NPF) issued guidelines for the management and treatment of psoriasis, particularly in relation to comorbidities. Discontinuation of a tumor necrosis factor (TNF) inhibitor may be needed to resolve skin issues that arise following TNF inhibitor initiation. Interleukin-17 inhibitor therapy should be avoided with concurrent inflammatory bowel disease. The American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2019 update on the treatment of ankylosing spondylitis (AS) and nonradiographic axial spondyloarthritis (SpA) recommend similar treatment for AS and nonradiographic axial SpA. TNF antagonist are recommended as the first biologic with secukinumab (Cosentyx) or ixekizumab (Taltz) then recommended over a second TNF antagonist if the first does not produce a response. All the prior mentioned agents are recommended over tofacitinib (Xeljanz). Concurrent low-dose methotrexate with a TNF antagonist is not recommended. The guidelines also recommend against a strict treat-to-target strategy and recommend against discontinuing or tapering biologics in stable disease. They state that sulfasalazine provides an option for select patients who cannot take a TNF antagonist **Committee Recommendations** The committee concluded that there was evidence to support differences in efficacy, effectiveness or safety between the agents for their respective indications. The committee also recommended that Skyrizi (risankizumab) and Rimvog (upadacitinib) be considered for preferred status based on data showing improved outcomes. They recommended that Xeljanz/Xeljanz XR be non-preferred because of safety concerns and that they require trial

		and failure of at least 2 other agents. The committee also recommended that if a particular agent is recommended for a particular diagnosis, that trial and failure of a preferred drugs not indicated for that diagnosis not be required. They recommended changes to the PDL document and PA form to clarify use in specific diagnoses.
➢ *Ophthalmic Antibiotics*	*Sarah Martinez, PharmD*	**Ophthalmic Antibiotics** Dr. Martinez reported that there were no new products and no recent clinical information of significance in this class. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Ophthalmic Antibiotic/Steroid Combinations*	*Sarah Martinez, PharmD*	**Ophthalmic Antibiotic/Steroid Combinations** Dr. Martinez reported that there were no new products and no recent clinical information of significance in this class. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Ophthalmic Anti-Inflammatories, Immunomodulators*	*Sarah Martinez, PharmD*	**Ophthalmic Anti-Inflammatories, Immunomodulators** Dr. Martinez reported on one new product in this class, Cequa (cyclosporine ophthalmic solution) which is indicated to increase tear production in patients with keratoconjunctivitis sicca (dry eye). Dosing, contraindications, warnings and adverse reactions were reviewed. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
➢ *Ophthalmics for Allergic Conjunctivitis*	*Sarah Martinez, PharmD*	**Ophthalmics for Allergic Conjunctivitis** Dr. Martinez noted that Novartis has made a business decision to discontinue Emadine 0.05% ophthalmic solution. **Committee Recommendations** The committee concluded that the evidence did not support differences in efficacy, effectiveness or safety between the agents.
Other Committee Business	*Tami Eide, PharmD*	**Other Committee Business**

		The meeting adjourned at 3:00 p.m. Next meeting is scheduled for November 15, 2019.

Pharmacy and Therapeutics Committee Meeting
Public Comment

There were not any speakers for the public comment period this meeting.