The following changes will be effective on **October 1, 2018**, unless otherwise specified and apply to the following plans:

Individual and Family, Large/Small Groups (Commercial)
Health Share of Oregon/Providence (Medicaid)

Formulary Changes

Table Key: F = formulary, NF = non-formulary; PA = prior authorization; ST = step therapy; QL = quantity limit, N/A = not applicable (no changes)

Drug/Policy Name	Recommendation
Dextroamphetamine sulfate (Dexedrine®)	Commercial/Medicaid: Add quantity limit (2 capsules per day)
Sodium Phenylbutyrate (Buphenyl®) Tablet	Commercial/Medicaid: Add prior authorization (add to Orphan Drug policy) • 2019 Commercial: change from Specialty to Non-Preferred Specialty
Butorphanol Tartrate Vial	Medicaid: Change from Formulary to Non-Formulary and remove Prior Authorization
Glatiramer Acetate (Copaxone®/Glatopa®) Syringe	Commercial: Change Quantity Limit to 1 ml per day • 2019 Commercial: change from Specialty to Preferred specialty
Vancomycin HCL (Firvanq®) Soln Recon	New Strength: • Commercial: F, Preferred Brand • Medicaid: F
Ganirelix Acetate Syringe	• Commercial: Add PA (add to Infertility Medications policy) • Medicaid: Remove from Formulary
Lonhala Magnair Refill Vial-Neb	New product • Commercial/Medicaid: Medical Benefit

Midazolam HCL Vial	• Commercial: Add to Formulary, Non-Preferred Generic • Medicaid: Add to Formulary
Modafinil Tablet	Remove quantity limit

Tolvaptan (Samsca®) Tablet	• Commercial/Medicaid: Add PA
	  ○ Add to Tolvaptan policy
	  ○ 2019 Commercial: Change from specialty to Non-Preferred Specialty

Memantine HCL (Namenda® XR) Capsule SPR	Change formulary status as follows: • Commercial: Add to Formulary (non-preferred generic), Remove PA
Daclizumab (Zinbryta®) Syringe	Due to recall, drug is now Non-Formulary for all lines of business
Humalog®	Medicaid: remove from formulary

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Antidepressants	☒ Commercial ☐ Medicaid	Policy has been changed to step therapy, which will still require trial/intolerance/contraindication to two generic selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs).
Direct-Acting Anti-virals_Medicaid	☐ Commercial ☒ Medicaid	Removed age restrictions, as there is very low risk of inappropriate utilization in this population.
Hetlioz	☒ Commercial ☒ Medicaid	This policy has been modified to specify that member is totally blind (i.e. no light perception) since this medication is for non-24 and study criteria were for patients with no light perception. This criteria had previously read as, "member is blind."
Infertility and Related Medications	☒ Commercial ☐ Medicaid	Updated age restrictions to allow at high age when the patient is undergoing in-vitro fertilization
Kapvay	☒ Commercial ☒ Medicaid	Criteria 2C and 2D combined as they were redundant

Drug/Policy Name(s)	Plans Affected	Summary of Change
Lamictal ODT	☒ Commercial ☐ Medicaid	Criteria 2 has been removed to provide access to medications for those who are unable to chew and swallow (criteria 1). The policy will still require a FDA approve diagnosis but will NOT require members with seizures to either be established on the medication or try and fail immediate release lamotrigine, as members who cannot chew and swallow would not be able to try immediate-release lamotrigine.
Long-Acting Stimulant Medications Quantity Limit	☒ Commercial ☒ Medicaid	The criteria related to maximum recommended daily dose was removed, as some of the products do not have a maximum dose and the health plan received significant pushback from providers. The intention of the policy is to focus on lowering utilization of dosing more than once per day. Therefore, more than twice-daily dosing was added as an exclusion criterion.
Medical Nutrition_Commercial	☒ Commercial ☐ Medicaid	This policy has been renamed and modified to apply only to Commercial line of business. Criteria for eosinophilic gastrointestinal disorder has been merged under the umbrella of severe intestinal malabsorption to ease administration burden of differentiating between members in different states to satisfy regulatory requirements. Exclusion criteria has been simplified to reduce redundancy as well as leave room for coverage in cases of severe milk protein allergy
Medical Nutrition_Medicaid	☐ Commercial ☒ Medicaid	All nutrition criteria for Medicaid line of business was moved to this policy and it was renamed Medical Nutrition. It now includes enteral nutrition, oral nutrition for inborn errors of metabolism, and severe intestinal malabsorption. Criteria is the same as previous version except albumin requirement
Total Parental Nutrition_ Commercial/Medicaid	☒ Commercial ☒ Medicaid	Serum albumin requirement and total protein have been removed for measures of failing enteral nutrition, as they are not accurate measures of nutrition during acute events. It has been replaced with an assessment as to whether or not nutritional needs (75%) can be met with enteral+oral intake. Intradialytic parenteral nutrition (IDPN) has been specifically added for members on chronic dialysis with criteria to mimic TPN.
New Medications and Formulations without Established Benefit	☒ Commercial ☒ Medicaid	Added Nalocet® (oxycodone hcl/acetaminophen) 2.5-300 mg tablet to the policy as oxycodone hlc/acetaminophen 2.5-325 mg is available on formulary as a low cost generic. Add Gocrovi® (amantadine extended release capsule) to the policy as immediate-release formulations and extended-release tablets will be available on formulary at lower costs

Drug/Policy Name(s)	Plans Affected	Summary of Change
Promacta	☒ Commercial ☒ Medicaid	Updated criterion for severe plastic anemia to state that patient is to have a platelet count of less than 30 x 109/L, removing the less than "or equal to"
Savella	☒ Commercial ☒ Medicaid	The coverage duration was change to align with other mental health medication policies. Coverage duration now states: "Authorization may be reviewed annually to assess continued medical necessity and effectiveness of medication."
Spinraza	☒ Commercial ☒ Medicaid	Initial and reauth duration was changed from 6 months to 12 months to allow for time for response. In the CHERISH study, some patients did not see improvement until after 6 months
Trelegy Ellipta	☒ Commercial ☒ Medicaid	• A trial duration of 60 days has been added for trial and failure criteria of a LAMA/LABA or LABA/ICS.
2nd and 3rd generation antihistamines_Medicaid	☐ Commercial ☒ Medicaid	Updated the coverage duration to one year for both initial and reauthorization. Changed criteria for non-preferred agents to trial and failure to the preferred agents
Aranesp, Epogen, Procrit	☒ Commercial ☒ Medicaid	Reworded criteria for clarification purposes
Bystolic, Byvalson	☒ Commercial ☒ Medicaid	Removed step requirement for Angiotensin Receptor Blocker (ARB) for Byvalson®, as this medication is more cost-effective than using the medications separately. Both Bystolic® and Byvalson® will be available after trial of two cardio-selective beta-blockers.
Immune Gamma Globulin	☒ Commercial ☒ Medicaid	Updated reauthorization criteria for dermatomyositis/polymyositis to require documented response to therapy only. Removed criterion related to corticosteroid use.
Increlex	☒ Commercial ☒ Medicaid	Added reauthorization criteria that continued approval will require evidence of open epiphyses
Intranasal Medications_Commercial	☒ Commercial ☐ Medicaid	Age restrictions were removed from policy due to low risk of inappropriate utilization.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Intranasal Medications_Medicaid	☐ Commercial ☒ Medicaid	The prior authorization on fluticasone nasal spray was removed due to the very low cost of this medication, despite possible utilization for below the line diagnoses (allergic rhinitis without other airway disease). Criteria was clarified to require trial of fluticasone nasal spray as preferred agent.
Korlym	☒ Commercial ☒ Medicaid	Reworded reauthorization criteria to indicate that patient must have improved OR stable (not AND) glucose tolerance
Myalept	☒ Commercial ☒ Medicaid	Clarified criteria for reauthorization and removed exlusion criteria, as it is already assessed through initial authorization criteria
Radicava	☒ Commercial ☒ Medicaid	The prescriber restriction has been clarified from prescribed by or in consultation with a neurologist to a neurologist with expertise in amyotrophic lateral sclerosis (ALS).
Relistor	☒ Commercial ☒ Medicaid	Updated the coverage duration to one year for both initial and reauthorization.
Sylvant	☒ Commercial ☒ Medicaid	Removed redundant prescriber restriction criteria
Triptan Step Policy	☒ Commercial ☒ Medicaid	Covered uses section was updated to reflect that there are no limitations to indication when a step therapy is in place.
Xifaxan	☒ Commercial ☒ Medicaid	Clarified coverage quantities for the various indications

New Medical Policies

Drug/Policy Name(s)	Plans Affected	Comments
Orphan Drugs (Medications for Rare Indications)	☒ Commercial ☒ Medicaid	Previously, the medications in this policy were not managed by prior authorization. This policy has been created for very high cost orphan drugs to ensure that these medications are being prescribed by specialists for the appropriate indication. Initial authorization will require documentation of clinical response.

Drug/Policy Name(s)	Plans Affected	Comments
Tolvaptan (Samsca® and Jynarque®)	☒ Commercial ☒ Medicaid	Criteria involves confirmation of diagnosis and prescriber restrictions
PCSK-9 Inhibitors_Medicaid	☐ Commercial ☒ Medicaid	Split out Medicaid as a separate policy. The coverage duration criteria was updated; initial reauthorization will require documented improvement in cholesterol levels and subsequent reauthorizations may be approved for lifetime

Retired Medical Policies

Drug/Policy Name(s)	Plans Affected	Comments
Zinbryta	☒ Commercial ☒ Medicaid	This medication was voluntarily withdrawn from the market by the manufacturer due to safety concerns.
Gocovir	☒ Commercial ☒ Medicaid	Drug was added to the "New Medications and Formulations without Established Benefit" policy
Namenda XR	☒ Commercial ☒ Medicaid	Policy will be retired for all lines of business due to availability of generic product.

New Drugs to Market

- **Burosumab-TWZA (Crysvita®) Vial**
  - Commercial/Medicaid: medical benefit, Prior Authorization
- **Erenumab-AOOE (Aimovig®) Auto Injct**
  - Commercial/Medicaid: Non-formulary, Prior Authorization
- **Recombinant factor XA injection (AndexXa®) Vial**
  - Commercial/Medicaid: medical benefit
- **Insulin Lispro (Admelog®)**
  - Commercial: Non-Formulary, Prior Authorization
  - Medicaid: Formulary
- **Tolvaptan (Jynarque®) Tablet**

- Commercial (2018): Formulary, Specialty, Prior Authorization
- Commercial (2019): Formulary, Non-Preferred Specialty, Prior Authorization
- Medicaid: Formulary, Specialty, Prior Authorization

- **Cocaine HCL (Goprelto®) Solution**
  - Commercial/ Medicaid: Medical Benefit
- **Amantadine Extended Release (Osmolex ER™) Tablet**
  - Commercial: Formulary, Non-Preferred Brand, Prior Authorization, Quantity Limit (1 tablet per day)
  - Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 tablet per day)