Providence Health Plan Providence Health Assurance

The following changes will be effective on August 1, 2024, unless otherwise specified and apply to the following plans:

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

Formulary Changes

Drug Name	Formulary Status	Policy Name
Pirfenidone 267 mg Capsule	Add to formulary: • Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (6 capsules per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (6 capsules per day)	Esbriet, Ofev, Pirfenidone tablets
Pirfenidone (Esbriet) 267 mg and 534 mg Tablets	Remove from Commercial and Medicaid Formulary Effective 09/01/2024	Esbriet, Ofev, Pirfenidone tablets
• **Bempedoic acid (Nexletol) Tablet** • **Bempedoic acid/ezetimibe (Nexlizet) Tablet**	• Commercial: Add to Formulary, Tier 4 • Medicaid: Add to Formulary	Nexletol, Nexlizet
Mepolizumab (Nucala) Auto Injct / Syringe	Add to Medicaid formulary	IL-5 Inhibitors
Mepolizumab (Nucala) Vial	Remove from Commercial and Medicaid formulary (covered under the medical benefit with prior authorization)	IL-5 Inhibitors
• **Ciclesonide (Omnaris) Spray/Pump** • **Beclomethasone dipropionate (Qnasl) Spray**	Remove from Commercial formulary	N/A

• **Ciclesonide (Zetonna) Spray**		
• **Novolog/Novolog Mix** • **Novolin R, N, 70/30** • **Fiasp**	Added to Commercial Formulary, Tier 3 Effective 07/01/2024	N/A

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Actinic Keratosis Agents	☒ Commercial ☐ Medicaid	Remove prior authorization on fluorouracil 4% cream (Tolak®) and removed prescriber restriction for treatment of genital warts.
Adbry	☒ Commercial ☒ Medicaid	For Commercial: Removed daily/twice daily application requirement for topicals For Medicaid: Clarified members needs trial of four weeks of prerequisite therapy.
Benlysta	☒ Commercial ☒ Medicaid	Simplified diagnostic criteria and updated prerequisite therapies based on the latest guideline updates. Removed the requirement to use standard therapy in reauthorization criteria based on provider feedback.
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists - Comm	☒ Commercial ☐ Medicaid	Removed exclusion of combination therapy for acute treatments, as the risk of exacerbating medication overuse headache has not been well established with CGRPs. This criterion has caused a lot of operational burden and member/provider dissatisfaction.
Camzyos	☒ Commercial ☒ Medicaid	Removed requirement for providing documentation/imaging to support diagnosis. Updated conventional therapy based on guideline recommendations.
Cibinqo	☒ Commercial ☒ Medicaid	For Commercial: Updated requirement of trial of upadacitinib (Rinvoq®) to dupilumab (Dupixent®) and removed daily/twice daily application requirement for topicals For Medicaid: Clarified members needs trial of four (4) weeks of prerequisite therapy.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Complement Inhibitors	☒ Commercial ☒ Medicaid	New policy combining criteria for Soliris®, Ultomiris®, and Empaveli®. Aligned criteria for all agents, updated exclusion to not allow with another complement inhibitor OR an Fc receptor antagonist. Soliris® will required use of more cost-effective agents for overlapping indications.
Corlanor	☒ Commercial ☒ Medicaid	Clarified definition of inappropriate sinus tachycardia and that postural orthostatic tachycardia syndrome should be ruled out. Slightly reworded crtieria for guideline directed medical therapy (intent did not change).
Denavir, Sitavig, Xerese, Zovirax	☒ Commercial ☒ Medicaid	Retired prior authorization on acyclovir 5% ointment. Removed references to Sitavig®, as this drug is no longer available on the market.
DPP-4 Inhibitors	☒ Commercial ☒ Medicaid	Changed policy to a step therapy policy; claims for non-preferred therapies will require trial of saxagliptin or alogliptin for coverage.
Esbriet, Ofev, Pirfenidone tablets	☒ Commercial ☒ Medicaid	Remove brand Esbriet and pirfenidone 267 mg and 534 tablets, as these drugs are non-preferred behind the pirfenidone 267 mg capsules.
Granulocyte-Colony Stimulating Factor (G-CSF) Policy	☒ Commercial ☒ Medicaid	New policy and preferred product strategy. Preferred pegfilgrastim products (Neulasta® and Fulphila®) will continue to be available without prior authorization. Non-preferred products will require prior authorization and use of preferred products. Effective 09/01/2024
Homozygous Familial Hypercholesterolemia (FH) Agents	☐ Commercial ☒ Medicaid	Updated policy language clarify dosage range for defining high-intensity statins.
IL-5 Inhibitors	☐ Commercial ☒ Medicaid	Updated diagnostic criteria to remove lab values measured while patient on high doses of steroids or oral steroids as it is presumed that eosinophilic level would be lower if on steroids.
Intranasal Allergy Medications – Medicaid	☐ Commercial ☒ Medicaid	Xhance was added to the policy and language around covered diagnosis was clarified.
Medications for Rare Indications	☒ Commercial ☒ Medicaid	Policy criteria for urea cycle disorders was updated to require use of Pheburane® (sodium phenylbutyrate pellets) prior to coverage of Ravicti® or Olpruva®.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Nexletol, Nexlizet	☒ Commercial ☒ Medicaid	1. Added new indication of cardiovascular risk reduction in both primary and secondary prevention, 2. Removed PCSK-9 inhibitors as a prerequisite, 3. Re-worded statin intolerance definition to align with our other policies such as PCSK-9 inhibitors.
Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors	☒ Commercial ☒ Medicaid	Changed preferred product strategy. Eyelea HD® will be non-preferred and Lucentis® (along with biosimilars Byooviz® and Cimerli®) will be preferred for the respective indications. Preferred agents do not require prior authorization.
Oxervate	☒ Commercial ☒ Medicaid	Reduced number of required failed conventional therapies.
• **PCSK9 Inhibitors – Commercial** • **PCSK9 Inhibitors - Medicaid**	☒ Commercial ☒ Medicaid	Updated age restriction criteria and new indication for Praluent.
Pulmonary Hypertension	☒ Commercial ☒ Medicaid	Clarified that pulmonary capillary wedge pressure/left ventricular end diastolic pressure is used for diagnosis of pulmonary arterial hypertension or WHO group 1 only. Removed criteria for brand Tracleer tablets and Letairis as these are reviewed using the brand over generic policy. Added exclusion of idiopathic pulmonary fibrosis for ambrisentan due to contraindication in package insert.
Second and Third Generation Antihistamines - Medicaid	☐ Commercial ☒ Medicaid	Updated criteria to add comorbid conditions for patients under age 21 to align with Oregon Health Authority.
Syfovre	☒ Commercial ☒ Medicaid	Rename policy to Geographic Atrophy Agents and add Izervay.
Tafamidis	☒ Commercial ☒ Medicaid	Clarified the need for documentation of New York Heart Association class. Updated concurrent drug exclusion criteria to include the two new drugs for transthyretin-mediated amyloidosis polyneuropathy.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Tezspire	☒ Commercial ☒ Medicaid	Clarified that coverage of medication when being administered by a healthcare provider would only be approved for short duration, as this medication is required to be self-administered. Clarified prescriber restrictions apply for initial and subsequent authorizations.
• **Therapeutic Immunomodulators** • **Therapeutic Immunomodulators - Medicaid**	☒ Commercial ☒ Medicaid	Added criteria for new self-administered vedolizumab (Entyvio®) product. Updated FDA indications for upadacitinib (Rinvoq®).
• **Topical Agents for Skin Conditions** • **Topical Agents for Skin Conditions - Medicaid**	☒ Commercial ☒ Medicaid	New policy combining criteria from multiple agents (Eucrisa®, Zoryve®, Wynzora®, Enstilar®, and Vtama®).
Upneeq	☒ Commercial ☒ Medicaid	Minor update to policy criteria for documentation of superior visual field deficit criteria listing Leicester Peripheral Field Test as an example of documentation.
Vascepa	☒ Commercial ☒ Medicaid	Updated wording surrounding statin use requirement to align with other policies requiring statin therapy. Intent to optimize statin therapy for ASCVD risk reduction has not changed.
Xdemvy	☒ Commercial ☒ Medicaid	Updated trial and failure meds based on the latest guideline updates.
Xolair	☒ Commercial ☒ Medicaid	Updated trial and failure duration for urticaria indication to align with the European Academy of Allergy and Clinical Immunology Guidelines. Criteria added for newly approved indication, IgE-mediated food allergy.

Retired Medical Policies

Policy Name	Summary of Change
Bepreve, Zerviate	Bepreve and Zerviate will be removed from the formulary and criteria for coverage is outlined in the “Formulary and Quantity Limit Exceptions” policy.

Corticosteroid and Vitamin D Analogues	Remove prior authorization for Taclonex and moved remaining drugs (Wynzora and Enstilar) to new policy "Topical Agents for Skin Conditions"
Empaveli	Drug moved to new combined “Complement Inhibitors” policy.
Eucrisa	Drugs were moved to new combined "Topical Agents for Skin Conditions" policy.
Intranasal Medications - Commercial	Policy retired due to low utilization- formulary nasal steroids include flunisolide, fluticasone, mometasone.
Izervay	Drug combined with Syfovre policy.
Opzelura	Drugs were moved to new combined "Topical Agents for Skin Conditions" policy.
Quantity Limits of Epinephrine Auto-Injector	Retire policy due to low utilization of policy, will continue to manage utilization with epinephrine quantity limit.
• **Soliris** • **Soliris Prior Authorization and Step Therapy Policy - Medicare Part B**	Drug moved to new combined “Complement Inhibitors” policy
• **Topical Antibiotics Step Therapy Policy**	Retired prior authorization due to low risk for inappropriate utilization
• **Ultomiris** • **Ultomiris Prior Authorization and Step Therapy Policy - Medicare Part B**	Drug moved to new combined “Complement Inhibitors” policy.
• **Verkazia**	Retired prior authorization. The medication is non-formulary and criteria for coverage is outlined in the “Formulary and Quantity Limit Exceptions” policy.
• **Verquvo**	Retire policy due to low risk of inappropriate use or over utilization. The medication is non-formulary and criteria for coverage is outlined in the “Formulary and Quantity Limit Exceptions” policy.
• **Vtama, Zoryve**	Drugs were moved to new policy "Topical Agents for Skin Conditions"
• **Xhance**	Retire Xhance policy due to low utilization. Other nasal steroids are available on formulary (such as fluticasone).

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New Drugs:

Drug Name	Recommendations	Policy Name
• **Exagamglogene autotemcel (Casgevy) Vial** • **Lovotibeglogene autotemcel (Lyfgenia) Plast. Bag**	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (One administration per lifetime)	Gene Therapies for Hemoglobin Disorders
Birch bark extract (Filsuvez) Gel (Gram)	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (23.4 gram/day [1 single-use tube per day])	Topical Agents for Epidermolysis Bullosa
Budesonide (Eohilia) Susp Packt	• Commercial/Medicaid: Non-Formulary, Quantity Limit (168 packets per 365 days)	N/A
Donislecel-jujn (Lantidra) Plast. Bag	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (3 infusions per lifetime)	Lantidra
Eplontersen sodium (Wainua) Auto Inject	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (One 45 mg syringe per 30 days) • Medicaid: Formulary, Tier 6, Quantity Limit (One 45 mg syringe per 30 days)	Transthyretin (TTR) Lowering Agents
Etrasimod arginine (Velsipity) Tablet	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 tablet per day)	Therapeutic Immunomodulators (TIMs)
Iptacopan hcl (Fabhalta) Capsule	• Commercial: Non-Formulary, Tier 6, Prior Authorization, Quantity Limit (2 capsules per day) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 capsules per day)	Complement Inhibitors

Lifileucel (Amtagvi) Plast. Bag	• Commercial/Medicaid: Medical Benefit, Prior Authorization	T-cell Therapy
Mirikizumab-mrkz (Omvoh) Pen Injctr - Vial	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 pens per 28 days)	Therapeutic Immunomodulators (TIMs)
Nedosiran sodium (Rivfloza) Syringe-Vial	• Commercial/Medicaid: Non-Formulary, Prior Authorization	Hyperoxaluria Agents
Taurolidine in heparin sodium (Defencath) Vial	• Commercial/Medicaid: Medical Benefit	N/A
Travoprost (Idose TR) Implant	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Ophthalmic Prostaglandin Implants
Vamorolone (Agamree) Oral Susp	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (7.5 mL (300 mg) per day)	Corticosteroids for Duchenne Muscular Dystrophy
Zilucoplan sodium (Zilbrysq) Syringe	• Commercial/Medicaid: Non-Formulary, Prior Authorization	Complement Inhibitors