Providence Health Plan Providence Health Assurance

The following changes will be effective on June 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
Humira (adalimumab)	Remove from Commercial formulary Effective: 8/1/2025	Therapeutic Immunomodulators (TIMS)
Stelara (ustekinumab)	Remove from Commercial formulary Effective: 7/1/2025	Therapeutic Immunomodulators (TIMS)I
• **Lantus 100/ml Vial** • **Lantus Solostar, Basaglar Kwikpen U-100 100/ml (3) Insulin Pen**	Add brand Lantus to Medicaid formulary Effective: 3/1/2025	N/A
Nitrofurantoin 25 mg/5 ml Oral Susp	• Commercial: Formulary, Tier 2 • Medicaid: Formulary	N/A
• **Tafamidis (Vyndamax) Capsule** • **Tafamidis meglumine (Vyndaqel) Capsule**	Commercial: Change from Tier 6 to Tier 5	Tafamidis
Corticotropin (Acthar Selfject) Pen Injctr	Remove from Medicaid formulary	HP Acthar Gel
• **Semaglutide (Ozempic) Pen Injector** • **Semaglutide (Rybelsus) Tablet**	Remove from Medicaid formulary (non-preferred products on the preferred drug list)	GIP and GLP-1 Receptor Agonists
Sitagliptin (Zituvio) Tablet	• Commercial: Add to Formulary, Tier 2, Quantity Limit (1 tablet per day)	N/A

	• Medicaid: Add to Formulary, Quantity Limit (1 tablet per day)	
• **Vraylar (cariprazine) capsule** • **Rexulti (brexpiprazole) tablet** • **Lybalvi (olanzapine/samidorphan) tablet** • **Cobenfy (xanomeline/trospium chloride) capsule**	Commercial: Move to Tier 3 (from Tier 4), Prior Authorization and Quantity Limits continue to apply	Antipsychotics
Tesamorelin acetate (Egrifta SV) Vial	Remove from Commercial and Medicaid formularies	N/A

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Anti-Cancer Medications - Medical Benefit	☒ Commercial ☒ Medicaid	Step criteria added to policy for bortezomib (Boruzu) requests to step through bortezomib (Velcade) due to similar efficacy/safety, but higher cost of Boruzu.
Anti-Cancer Medications - Self-Administered	☒ Commercial ☒ Medicaid	Added exception to Ibrance criteria (requiring step therapy) when used with Itovebi in alignment with FDA labeling.
Antipsychotics	☒ Commercial ☐ Medicaid	Updated criteria to only require trial and failure of one atypical antipsychotic prior to coverage. Added additional criteria for Fanapt® to require an additional trial of two brand atypical antipsychotic agents.
Disposable Insulin Pumps	☒ Commercial ☒ Medicaid	Preferred pumps (Ominpod) will now automatically process at point-of-sale with history of claims for rapid- or short-acting insulin claims.
DPP-4 Inhibitors Step Therapy Policy	☒ Commercial ☒ Medicaid	Criteria were updated to prefer any generic DPP-4 inhibitor prior to coverage of branded products. Added quantity limits and an exclusion for use in combination with GLP-1 therapies (such as semaglutide). Effective: 7/1/2025

Drug/Policy Name(s)	Plans Affected	Summary of Change
Fertility and Related Medications	☒ Commercial ☐ Medicaid	Clomiphene removed from policy as it will be reviewed as non-formulary (for medical necessity) to allow for coverage of compendial supported indications outside of fertility.
GIP and GLP-1 Receptor Agonists	☒ Commercial ☒ Medicaid	Removed trial and failure of metformin and clarified diagnostic criteria for type 2 diabetes (such as history of A1C >6.5%). Added exclusions for autoimmune diabetes and concomitant use with dipeptidyl peptidase-4 inhibitors and other GIP/GLP agonists. Effective: 5/1/2025
GnRH Antagonists	☒ Commercial ☒ Medicaid	Updated prerequisite therapy criteria, removed undiagnosed abnormal uterine bleeding exclusion, and added exclusion for using multiple therapies due to lack of evidence for long-term use.
Human Growth Hormones – Medicaid	☐ Commercial ☒ Medicaid	Updated growth hormone stimulation test requirements for diagnosing pediatrics growth hormone deficiency.
Infusion Therapy Site of Care	☒ Commercial ☐ Medicaid	Removed drugs from the policy: Camcevi, Eligard, Lupron Depot, and Fensolvi.
Kerendia	☒ Commercial ☒ Medicaid	Removed laboratory requirements and trial of sodium glucose co-transporter-2.
Medical Hormone Therapy Policy	☒ Commercial ☒ Medicaid	Added indication of delayed puberty for testosterone pellet (Testopel®) which may be covered after failure of testosterone enanthate.
Medical Nutrition – Commercial	☒ Commercial ☐ Medicaid	Removed exclusion for use of oral nutritional products, as if patients meet medical necessity criteria, coverage for any nutritional products would be allowed.
Medical Nutrition – Medicaid	☐ Commercial ☒ Medicaid	Updated Medicaid covered indications to include select physical and intellectual disabilities.
Palynziq	☒ Commercial ☒ Medicaid	Decreased reauthorization duration from long-term authorization (until no longer eligible with the plan, subject to formulary and/or benefit changes) to one year.
Self-Administered Drugs (SAD) Policy	☒ Commercial ☒ Medicaid	Several drugs added to this policy: Zymfentra, Takhzyro, Ebglyss, Nemluvio, Tryngolza, Yorvipath, Winrevair, Tofidence, Stegeyma, Entyvio Pen, and Zilbrysq.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Tolvaptan	☒ Commercial ☒ Medicaid	Revised diagnostic criteria for rapidly progressive disease per new 2025 KDIGO ADPKD guidelines.
Tzield	☒ Commercial ☒ Medicaid	Updated exclusion criteria as well as updated policy criteria to have more clear language and to align with Oregon Health Plan criteria.
Vaginal Progesterone Formulations	☒ Commercial ☒ Medicaid	Updated criteria for secondary amenorrhea to require a trial of formulary progestins approved for secondary amenorrhea (such as medroxyprogesterone, norethindrone).
Vijoice	☒ Commercial ☒ Medicaid	Simplified diagnostic criteria to require genetic mutation OR onset/overgrowth/spectrum of isolated features, clarified provider specialist options.
Yorvipath Policy	☒ Commercial ☒ Medicaid	Removed criteria requiring recent normal vitamin D and albumin-adjusted serum calcium levels, as patients who cannot achieve albumin-adjusted serum calcium greater than or equal to 7.8 mg/dL are those most likely to benefit from therapy.

Retired Medical Policies

- **Apidra**
- **Egrifta**
- **Revcovi**

New Drugs:

Drug Name	Recommendations	Policy Name
Acoramidis hcl (Attruby) Tablet	• Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (4 tablets per day)	Transthyretin (TTR) Stabilizing Agents

	• Medicaid: Formulary, Prior Authorization, Quantity Limit (4 tablets per day)	
Concizumab-mtci (Alhemo) Pen Injctr	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Tissue Factor Pathway Inhibitors 2
Crinecerfont (Crenessity) Capsule & Solution	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (50 mg and 100 mg capsules: 2 per day; 50 mg/mL solution: 2 mL per day)	Medications for Rare Indications
Datopotamab deruxtecan-dlnk (Datroway) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications – Medical Benefit
Eladocagene exuparvovec-tneq (Kebilidi) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (one treatment course per lifetime)	Medications for Rare Indications
Obecabtagene autoleucel (Aucatzyl) Plast. Bag	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (one administration per lifetime)	T-Cell Therapy
Olezarsen sodium (Tryngolza) Auto Injct	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (0.8 mL per 28 days)	Tryngolza
Suzetrigine (Journavx) Tablet	• Commercial: Non-Formulary, Prior Authorization, Quantity Limit (7 tablets per 75 days)	Journavx
Treosulfan (Grafapex) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications – Medical Benefit
• **Ustekinumab-aekn (Selarsdi) Syringe** • **Ustekinumab-aekn (Steqeyma) Syringe**	• Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (one dose every 84 days)	Therapeutic Immunomodulators (TIMS)

	• Medicaid: Formulary, Specialty, Prior Authorization, Quantity Limit (one dose every 84 days) Effective 7/1/25	
• **Ustekinumab-auub (Wezlana) Syringe/Vial** • **Ustekinumab-aauz (Otulfi) Syringe** • **Ustekinumab-ttwe (Pyzchiva) Syringe** • **Ustekinumab (“unbranded” Stelara) Syringe & Vial**	Commercial/Medicaid: Non-Formulary, Specialty, Prior Authorization, Quantity Limit (one dose every 84 days) Effective 7/1/25	Therapeutic Immunomodulators (TIMS)
Vanzacaftor calcium-tezacaftor-deutivacaftor (Alyftrek) Tablet	• Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (3 tablets per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (3 tablets per day)	CFTR Modulators
Zanidatamab-hrii (Ziihera) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications – Medical Benefit
Zenocutuzumab-zbco (Bizengri) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications – Medical Benefit