Providence Health Plan Providence Health Assurance

The following changes will be effective on October 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
Adalimumab-RYVK (Simlandi) Autoinjkit	Preferred Humira® biosimilar for Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (Two injections per 28 days)	Therapeutic Immunomodulators (TIMS)
Adalimumab-atto (Amjevita) Auto Injct / Syringe	Remove Amjevita from Commercial formulary: Non-Formulary, Prior Authorization, Quantity Limit (Two injections per 28 days) Effective: 11/01/2024	Therapeutic Immunomodulators (TIMS)
Clomiphene citrate Tablet	• Commercial: Remove from Formulary, add Prior Authorization • Medicaid: Remove from Formulary Effective: 11/01/2024	• Commercial: Fertility and Related Medications • Medicaid: N/A
Levomilnacipran hcl (Fetzima) Cap SA 24H	Remove from Commercial formulary	N/A
Frovatriptan succinate (Frova) Tablet	Remove from Commercial formulary	N/A
Istradefylline (Nourianz) Tablet	Commercial: Up tier to Tier 6 Effective: 09/01/2024	N/A
Ramelteon (Rozerem) Tablet	Commercial Dynamic: Down tier generic to Tier 2	N/A
Vigabatrin (Sabril) Tablet	Commercial: Down tier generic to Tier 5	N/A
Vortioxetine hydrobromide (Trintellix) Tablet	Remove from Commercial formulary Effective: 11/01/2024	Antidepressants Step Therapy Policy

Ubrogepant (Ubrelvy) Tablet	Add to Medicaid formulary: Formulary, Prior Authorization, Quantity Limit (16 per 30 days)	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists
Ganaxolone (Ztalmy) Oral Susp	Remove from Commercial and Medicaid formularies: Non-Formulary, Prior Authorization, Quantity Limit (37 mL/day)	Medications for Rare Indications
Topiramate ER capsules (Trokendi XR)	Commercial/Medicaid: Add Quantity Limit (one capsule per day) Effective: 11/01/2024	New Medications and Formulations without Established Benefit
• **Votrient capsule and gel** • **Truvada** • **Afinitor** • **Targretin** • **Kuvan** • **Provigil** • **Tobi neb solution** • **Zoloft** • **Lexapro** • **Sutent** • **Adcirca**	Brand Name Formulations to be removed from the Commercial formulary (generics to remain on formulary) Effective: 11/01/2024	N/A
Abiraterone submicronized (Yonsa)	Remove from Commercial Formulary. Preferred product is generic abiraterone, which will be required prior to coverage of Yonsa Effective: 11/01/2024	Anti-Cancer Medications - Self-Administered

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Addyi	☒ Commercial ☒ Medicaid	Combined Addyi and Vyleesi into one policy, "Medications for Female Sexual Interest/Arousal Dysfunction." • Addyi: Added requirement for 6 months of diagnosis, quantity limit of one per day • Vylessi: change quantity limit to 1.2 per 28 days, • Decreased initial authorization to two months
Antiepileptic Medications Step Therapy Policy	☒ Commercial ☒ Medicaid	Updated quantity limit for Briviact to align with maximum dosing per FDA labeling
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists	☒ Commercial ☐ Medicaid	Added criteria to acute migraine indication to require evaluation of medication overuse headache and exclude concomitant use of CGRPs indicated for acute migraine. Added reauthorization criteria for cluster headache.
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists - Medicaid	☐ Commercial ☒ Medicaid	Updated prophylactic therapy trial and failure prerequisite drugs to allow a trial of three drugs from any class as outlined to align with the Oregon Health Authority (OHA). For acute migraines, added criteria to evaluate for medication overuse headache and require use of preferred acute CGRP (Ubrelvy) to align with OHA. Added criteria to exclude use of dual prophylactic CGRP therapy or dual acute migraine CGRP therapy due to lack of safety and efficacy data. Prescriber restrictions were updated to clarify intent of requiring a specialist consultation on initial review.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Dupixent	☒ Commercial ☐ Medicaid	Atopic Dermatitis: • Updated to allow as first line for patients with body surface area greater than 40%, • Require trial and failure of a topical corticosteroid and topical calcineurin inhibitor for body surface area of 10-40% with allowance to waive calcineurin if an oral immunosuppresant was tried, Asthma: • Updated diagnostic criteria • Decrease requirement for stable oral corticosteroid for steroid-dependence to four weeks, Reauthorization for Asthma and Nasal Polyps requires combination with standard maintenance therapy. Coverage Duration for Atopic Dermatitis reauthorization extended to long-term
Dupixent - Medicaid	☐ Commercial ☒ Medicaid	Split policy from Commercial policy Asthma: • Updated diagnostic criteria to align with OHA • Decrease requirement for stable oral corticosteroid for steroid-dependence to four weeks, • Align tried and failed therapy to adherence for 12 months • Reauthorization for asthma requires combination with maintenance therapy Atopic Dermatitis: • Added allowance for EPSDT (under 21 only needs to show the condition significantly impacts life and does not need to meet severity criteria) • Reauthorization increased to long-term Nasal polyps: aligned criteria with OHA for trial and failure of two courses of intranasal steroids for at least 12 to 26 weeks each Esophagitis: remove requirement for symptoms and weight; Prurigo Nodularis: • Remove requirement for itching for six weeks • Add EPSDT allowance

Drug/Policy Name(s)	Plans Affected	Summary of Change
Epidiolex	☐ Commercial ☒ Medicaid	Decreased trial criteria to one instead of two for Medicaid, for Lennox-Gastaut syndrome to align with OHA criteria.
Fintepla	☐ Commercial ☒ Medicaid	Added criteria requiring therapy to be adjunct based on guideline recommendations and OHA policy. Added criteria required echocardiogram screening for initial and reauthorization per package insert black box warning and to align with OHA. For Medicaid only: reduced prerequisite therapy criteria to one drug to align with OHA.
Firdapse	☐ Commercial ☒ Medicaid	Added criteria requiring baseline assessment of function to align with other insurers and OHA, updated reauthorization criteria to require improvement from baseline validated assessment scale.
Formulary and Quantity Limit Exceptions	☒ Commercial ☒ Medicaid	Criteria for brand name medications with formulary, generic alternatives were added to this policy.
Infusion Therapy Site of Care	☒ Commercial ☐ Medicaid	Several drugs were added to this policy that can be self-administered.
Insomnia Agents - Medicaid	☐ Commercial ☒ Medicaid	Prior authorization removed from flurazepam as no utilization of this drug. It will be reviewed as a non-formulary medication.
Krystexxa	☒ Commercial ☒ Medicaid	Add requirement for combination with methotrexate, increase duration of authorization from six months to 12 months for both initial and reauthorization.
Long-Acting Opioids	☒ Commercial ☒ Medicaid	Allowed for waiver of prerequisite therapy with long-acting morphine sulfate therapy for patients with metastatic cancer. Clarified requirement regarding prior short-acting opioid use. Added requirement for naloxone prescription.
Long-Acting Stimulant Medications Quantity Limit	☒ Commercial ☒ Medicaid	Add allowance for patients aging into a maximum dose.
Maximum Allowable Opioid Dose	☒ Commercial ☒ Medicaid	Updated coverage duration for chronic pain for initial authorization and reauthorization to both be one year.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Narcolepsy Agents	☒ Commercial ☒ Medicaid	Updated indication for Wakix for excessive daytime sleepiness (EDS) in pediatric patients six years and older. Added Wakix as a prerequisite for coverage of oxybate salts for children with EDS in narcolepsy. Added prerequisite therapy requirements for patients with cataplexy.
Nuedexta	☒ Commercial ☐ Medicaid	Added exclusion of complete atrioventricular block without implanted pacemaker/high risk of atrioventricular block to align with package insert.
Pediatric Analgesics	☒ Commercial ☒ Medicaid	Removing all non-formulary medications as no utilization. Review will default to non-formulary review process.
Qudexy XR, Trokendi XR	☒ Commercial ☒ Medicaid	Move Trokendi to New Medications and Formulations Without Established Benefit policy; Add Quantity Limit of one per day to Qudexy and Trokendi.
Reyvow	☒ Commercial ☒ Medicaid	Combined Cambia and Reyvow into “Acute migraine Medications policy”, added reauthorization criteria.
Spinraza	☒ Commercial ☒ Medicaid	Combined Spinraza, Evrysdi and Zolgensma into one policy, "Therapies for spinal muscular atrophy". Updated reauthorization for Spinraza/Evrysdi to "established on therapy".
Spravato	☒ Commercial ☐ Medicaid	Removed some exclusion criteria.
Strensiq	☒ Commercial ☒ Medicaid	Removed criteria for patients 18 years and older at time of request and age specific criteria on reauthorization to align with package label. Expanded prescriber restrictions to include any specialist in the area of perinatal or juvenile onset hypophosphatasia.
• **Tepezza** • **Tepezza Prior Authorization and Step Therapy Policy - Medicare Part B**	☒ Commercial ☒ Medicaid	Removed requirement for clinical activity score for active disease.
Therapeutic Immunomodulators (TIMS) – Commercial	☒ Commercial ☐ Medicaid	Preferred adalimumab biosimilar products were updated, as Simlandi® will replace Amjevita® as one of the preferred products. Tocilizumab-aazg (Tyenne®), a new biosimilar product, will be covered in parity with the innovator product Actemra®.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Topical Agents for Skin Conditions - Medicaid	☐ Commercial ☒ Medicaid	Changed to align with OHA criteria.
Triptan Quantity Limit	☒ Commercial ☒ Medicaid	Changed some quantity limits. Added combination with other acute migraine medications as exclusion criteria, reauthorization requires documentation that increased quantity is still necessary.
VMAT2 Inhibitors	☒ Commercial ☒ Medicaid	Update to quantity limits to reflect newly available dosage strengths, removed exclusion criteria that was a boxed warning only when used in Huntington's disease, updated re-authorization duration to reflect long-term use of these medications.

Retired Medical Policies

Policy Name	Summary of Change
• **Nourianz** • **Rescue Medications for Epilepsy** • **Sabril**	Low risk of inappropriate utilization.
Ketorolac Intramuscular Injection	Utilization and safety concerns will be assessed with quantity limits.
• **Antidepressants Step Therapy Policy** • **Non-Preferred Triptan Therapy**	Drugs will be removed from the formulary. Criteria from "Formulary and Quantity Limit Exception" policy will apply.
• **Qalsody** • **Skysona** • **Spevigo** • **Ztalmy**	Moved to “Medications for Rare Indications” policy.
Relyvrio	Drug no longer available on the market to new patients.
Vyleesi	Combining with Addyi in the “Medications for Female Sexual Interest/Arousal Disorder” policy.
• **Evrysdi** • **Zolgensma**	Combined Spinraza, Evrysdi and Zolgensma into one policy, "Therapies for spinal muscular atrophy".
Cambia	Combined with Reyvow on new “Acute Migraine Medications” policy.

Brand Over Generic	Combined with the "Formulary and Quantity Limit Exception" policy.

New Drugs:

Drug Name	Recommendations	Policy Name
Sotatercept-csrk (Winrevair) Kit	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (1 kit per 21 days) • Medicaid: Formulary, Prior Authorization, Quantity Limit (1 kit per 21 days)	Pulmonary Hypertension
Danicopan (Voydeya) Tablet	• Commercial: Non-Formulary, Tier 6, Prior Authorization, Quantity Limit (6 tablets per day) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (6 tablets per day)	Complement Inhibitors
Immune globulin,gamma(igg)stwk (Alyglo) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Immune Gamma Globulin (IGG)
Melphalan hcl (Hepzato) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications - Medical Benefit
Nogapendekin alfa inbakic-pmln (Anktiva) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications - Medical Benefit
Resmetirom (Rezdiffra) Tablet	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 tablet per day)	Rezdiffra
Tovorafenib (Ojemda) Susp Recon and Tablet	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (Suspension: 96 mL per 28 days; Tablets: 24 per 28 days)	Anti-Cancer Medications – Self-Administered

	• Medicaid: Formulary, Prior Authorization, Quantity Limit (Suspension: 96 mL per 28 days; Tablets: 24 per 28 days)	