PROVIDENCE Health Plan

The following changes will be effective on **February 1, 2022**, 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
• **Dexlansoprazole (Dexilant)** • **Rabeprazole (Aciphex Sprinkle)** • **Esomeprazole strontium** • **Esomeprazole (Nexium) packet**	Remove prior authorization for Medicaid; these drugs will remain Non-formulary and still require authorization for use	N/A
Fidoxamicin (Dificid) 200 mg tablet	Step Therapy policy will be retired. Add quantity limit for Commercial and Medicaid: • Commercial: Formulary, Tier 4, Quantity Limit (20 tablet per 30 days • Medicaid: Formulary, Quantity Limit (20 tablet per 30 days	N/A
Fidoxamicin (Dificid) 40 mg/mL suspension	Step Therapy policy will be retired. Add quantity limit for Commercial and Medicaid: • Commercial: Formulary, Tier 4, Quantity Limit (136 mL per 30 days) • Medicaid: Formulary, Quantity Limit (136 mL per 30 days)	N/A
Hydroxychloroquine Sulfate Tablet	New strength; • Commercial/Medicare Part D: Formulary, Tier 2 • Medicaid: Formulary	N/A
Insulin Glargine-YFGN (Semglee (YFGN)) Vial	New entity; interchangeable biosimilar for Lantus® • Commercial: Formulary, Tier 3	N/A

	• Medicaid: Non-Formulary	
Insulin Glargine-YFGN Insulin Pen and vial	New entity; interchangeable biosimilar for Lantus® • Commercial: Formulary, Tier 3 • Medicaid: Formulary	N/A
Insulin glargine (Lantus)	Remove from Commercial formulary	N/A
Paliperidone Palmitate (Invega Hafyera) Syringe	New Dosing regimen and strengths (1560 mg/5 ml;1092 mg/3.5 ml); • Commercial/Medicaid: Medical Benefit	N/A
Lorazepam (Loreev XR) Cap ER 24h	New dosage form (Cap ER 24h); • Commercial/Medicaid: Non-Formulary	N/A
Dihydroergotamine Mesylate (Trudhesa) Spray/Pump	New strength; • Commercial/Medicaid: Non-Formulary, Quantity Limit (8 ml per 30 days)	N/A

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Acute Hereditary Angioedema Therapy	☒ Commercial ☒ Medicaid	Updated diagnostic criteria to align with recommendations from the United States Hereditary Angioedema Association (US HAEA) Medical Advisory Board Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.
Antifungal Agents	☒ Commercial ☒ Medicaid	Covered uses have been modified from all FDA approved indications to all FDA and some medically accepted indications, as policy covers some off-label indications.
Continuous Glucose Monitors (CGMs)	☒ Commercial ☒ Medicaid	CGMs have become a standard of care for patients with insulin-dependent diabetes according to the American Diabetes Association. To provide better access to these devices, the policy criteria was updated to allow coverage for patients on rapid-acting or short-acting insulin therapy. Effective 1/1/2022

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Drug/Policy Name(s)	Plans Affected	Summary of Change
Fertility and Related Medications	☒ Commercial ☒ Medicaid	Criteria were updated to clarify coverage requirements for non-preferred gonadotropins.
Formulary and Quantity Limit Exceptions	☒ Commercial ☒ Medicaid	A new clinical policy was created to improve transparency for how these exception requests are reviewed.
Hemlibra	☒ Commercial ☒ Medicaid	Updating reauthorization coverage duration to until no lonfer eligible with the plan.
Hepatitis C - Direct Acting Antivirals	☒ Commercial ☐ Medicaid	Removed prescriber restriction to improve access.
Hepatitis C - Direct Acting Antivirals – Medicaid	☐ Commercial ☒ Medicaid	Criteria updated to align with the Risk Corridor Medicaid's Fee-For-Service criteria.
Lotronex	☒ Commercial ☒ Medicaid	Criteria has been modified to align with the 2021 American College of Gastroenterology (ACG) Guideline for the management irritable bowel syndrome by removing requirement for anti-spasmodic agents.
Prophylactic Hereditary Angioedema Therapy	☒ Commercial ☒ Medicaid	Updated diagnostic criteria to align with recommendations from the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, extended-initial duration of approval to six months, recommend preferred agent (Takhyzro) with reauthorization criteria requiring dose de-escalation for stable patients, per the package insert.
Proton Pump Inhibitors	☒ Commercial ☐ Medicaid	Changed to step therapy program and removed requirement for specific doses of prerequisite therapy.
Reblozyl	☒ Commercial ☒ Medicaid	Added requirement of a hemoglobin less than 11 g/dL for both conditions since they are indicated for anemia. Updated the MDS criteria to align with current National Comprehensive Cancer Network (NCCN) guidelines.
Rukobia, Trogarzo	☒ Commercial ☒ Medicaid	Clarified Trogarzo is the only therapy on this policy that applies to Medicare part B.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Spravato	☒ Commercial ☒ Medicaid	To provide better access to this mediation, the prescriber restrictions were updated to include mental health nurse practitioners. In addition, other aspects of the criteria were updated to clarify the definition of treatment-resistant depression. The requirements for patients with suicidal ideation (SI) were updated to allow coverage with documentation of current SI with intent.
Ultomiris	☒ Commercial ☒ Medicaid	Removed age restriction for paroxysmal nocturnal hemoglobinuria to align with new FDA labelling. Removed requirement for genetic testing and prior use of plasma therapy for complement mediated hemolytic uremic syndrome. Kidney Disease - improving global outcomes (KDIGO) recommend all patients with a clinical diagnosis of atypical HUS be eligible for treatment with a complement inhibitor and genetic testing should not delay treatment. 50-70% of participants in approval trials had confirmed genetic mutation. This aligns with Soliris policy.
Viberzi	☒ Commercial ☒ Medicaid	Criteria has been modified to align with the 2021 ACG Guideline for the management irritable bowel syndrome.
Xifaxan	☒ Commercial ☒ Medicaid	Criteria has been modified to align with the 2021 ACG Guideline for the management irritable bowel syndrome.

Retired Medical Policies:

- Dificid Step Therapy

New Drugs:

Drug Name	Recommendation	Policy Name
Belzutifan (Welireg) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Oral Anti-Cancer Medications
Olanzapine-samidorphan malate (Lybalvi) Tablet	• Commercial: Formulary, Tier 4, Step Therapy • Medicaid: Covered by DMAP	Antipsychotics

Mobocertinib succinate (Exkivity) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Oral Anti-Cancer Medications
Tisotumab vedotin-tftv (Tivdak)	• Commercial: Medical, Prior Authorization • Medicaid: Medical, Prior Authorization	Injectable Anti-Cancer Agents
Odevixibat (Bylvay) Pellet	• Commercial: Non-Formulary, Prior Authorization, Quantity Limit (6 mg/day) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (6 mg/day)	Bylvay
Avalglucosidase alfa-ngpt (Nexviazyme) Vial	• Commercial: Medical, Prior Authorization • Medicaid: Medical, Prior Authorization	Enzyme Replacement Therapy