Providence Health Plan | Providence Health Assurance

The following changes will be effective on **January 1, 2023**, 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
Echothiophate iodide (Phospholine Iodide) Drops	Non-formulary for all lines of business	N/A
Ranolazine (Ranolazine ER) Tab ER 12h	Add to Medicaid formulary	N/A
Arnuity Ellipta (fluticasone furoate)	Remove From Medicaid formulary	N/A
Asmanex (mometasone furoate)	Remove From Medicaid formulary	N/A
Flovent Diskus (fluticasone propionate)	Remove From Medicaid formulary	N/A
Pulmicort Flexhaler (budesonide)	Remove From Medicaid formulary	N/A
Frovatriptan tablet	Add to Commercial formulary with Prior Authorization	Non-Preferred Triptans
Harvoni® brand name (90-400 mg) tablet **Epclusa® brand name (400-100 mg) tablet**	Remove from Commercial formulary	Hepatitis C - Direct Acting Antivirals
Reyvow (Lasmiditan)	Add to Commercial formulary: Tier 4, Prior Authorization, Quantity Limit: • 50 mg: 4 tablets per 30 days • 100 mg: 8 tablets per 30 days	Reyvow
Rhopressa (netarsudil)	Commercial: Add to Formulary, Tier 4, Step Therapy	Anti-Glaucoma Agents
Mylotarg (gemtuzumab ozogamicin)	Add Prior Authorization	Injectable Anti-Cancer Medications

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Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists – Medicaid	☐ Commercial ☒ Medicaid	Preferred products were updated to align with Oregon Health Authority. Quantity limits were added to align with FDA labeling.
Formulary and Quantity Limit Exceptions	☒ Commercial ☒ Medicaid	Updated language to require a minimum of four drug therapies tried, to include all drugs in the same therapeutic class if available.
Immune Gamma Globulin (IGG)	☒ Commercial ☒ Medicaid	Criteria were added for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections/pediatric acute-onset neuropsychiatric syndrome (PANDA/PANS).
Interleukin-1 Inhibitors	☒ Commercial ☒ Medicaid	• Added exclusion for combination therapy with biologics. • Updated Still's Disease criteria to align with clinical practice guidelines: Require trial of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs, such as naproxen, etodolac) instead of Disease-Modifying Antirheumatic Drugs (DMARDs, such as methotrexate) and Tumor Necrosis Factor Drug (anti-TNF's, such as adalimumab or Humira®) • Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Added requirement for the presence of symptoms. • Familial Mediterranean Fever: Added requirement for genetic confirmation
Medically Infused Therapeutic Immunomodulators	☒ Commercial ☐ Medicaid	New FDA indications for products were added. Certolizumab (Cimzia®) was added to this policy due to one formulation required to be administered by a healthcare professional.
New Medications and Formulations without Established Benefit	☒ Commercial ☒ Medicaid	The following drugs will be removed from this policy (will remain non-formulary for Commercial) and added Medicaid Long-Acting Stimulant Policy • Adhansia: • Adzenys ODT • Evekeo ODT •

Drug/Policy Name(s)	Plans Affected	Summary of Change
Non-Preferred Triptan Therapy	☒ Commercial ☐ Medicaid	Frovatriptan was added with prior authorization with requirement to try more cost-effective triptan therapies.
Oral Rinses	☒ Commercial ☒ Medicaid	Updated to no longer require a failure of other agents, as this would typically be used as adjunctive therapy.
Sylvant	☒ Commercial ☒ Medicaid	Requiring additional documentation that therapy will be used as a single agent to better align with cancer treatment guidelines from the National Comprehensive Cancer Network.
Therapeutic Immunomodulators (TIMs) - Commercial	☒ Commercial ☐ Medicaid	Criteria related to trial of preferred products for Crohn's disease were updated. Non-preferred therapies will be required to try adalimumab (Humira®) and one of the following: ustekinumab (Stelara®) or Risankizumab-rzaa (Skyrizi®). Additionally, baracitinib (Olumiant®) was recently approved for alopecia areata. This indication is considered a benefit exclusion and the policy was updated to reflect this.
Therapeutic Immunomodulators (TIMs) - Medicaid	☐ Commercial ☒ Medicaid	Criteria were added for the diagnosis of atopic dermatitis to align with the Oregon Health Authority. Additionally, baracitinib (Olumiant®) was recently approved for alopecia areata. This indication is not covered by the Oregon health Authority (considered “unfunded”).
Trientine	☒ Commercial ☒ Medicaid	Removed requirement of penicillamine trial. Policy ensures appropriate prescriber and indication for use
Vyleesi	☒ Commercial ☒ Medicaid	Removed prescriber restriction as this indication is most often evaluated by primary care providers. Added requirement for six months of symptoms and clarified approved diagnosis to include Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition new classification.

Retired Medical Policies

- Insomnia Agents (Commercial) – drugs will remain non-formulary

New Drugs:

Drug Name	Recommendations	Policy Name
Tirzepatide (Mounjaro) Pen Injctr	• Commercial: Non-Formulary, Step Therapy, Quantity Limit (2 mL per 28 days) • Medicaid: Non-Formulary, Step Therapy, Quantity Limit (2 mL per 28 days)	GLP-1 Receptor Agonists Step Therapy
Ganaxolone (Ztalmy) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (36 mL day) • Medicaid: Formulary, Specialty, Prior Authorization, Quantity Limit (36 mL day)	Ztalmy
Daridorexant hcl (Quviviq) Tablet	• Commercial: Non-Formulary, Quantity Limit (One tablet per day) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (One tablet per day)	Insomnia Agents - Medicaid
Vonoprazan Fumarate-Amoxicillin Trihydrate (Voquezna Dual Pak) Combo. Pkg	• Commercial/Medicaid: Non-Formulary	N/A
Tapinarof (Vtama) Cream (G)	• Commercial: Non-Formulary, Prior Authorization, Quantity Limit (60 grams (1 tube) every 30 days) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (60 grams (1 tube) every 30 days)	Vtama
Alpelisib (Vijoice) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit; [(50 mg/125 mg daily dose: one per day); (250 mg daily dose: two per day)] • Medicaid: Formulary, Prior Authorization, Quantity Limit; [(50 mg/125 mg daily dose: one per day); (250 mg daily dose: two per day)]	Vijoice
Donepezil hcl (Adlarity) Patch TDWK	• Commercial/Medicaid: Non-Formulary, Quantity Limit (Four patches per 28 days)	N/A