Providence Health Plan Providence Health Assurance

The following changes will be effective on January 1, 2025, 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
Diroximel fumarate (Vumerity) Capsule DR	Correction from August 2024 P&T: • Commercial: Remain on Formulary; not removed	Non-Preferred Fumarate Products
• **Sitagliptin (Januvia) Tablet** • **Sitagliptin/metformin (Janumet/Janumet XR) Tablet**	Correction from June 2024 P&T: • Commercial: Drugs were not moved to Tier 3, but remain on Tier 4	DPP-4 Inhibitors
Chlorzoxazone Tablet	Remove from Commercial and Medicaid formularies	N/A
Efavirenz/emtricit/tenofovr df (efavirenz-emtric-tenofov disop) 600-200 mg tablet	Commercial: Down tier from Tier 3 to Tier 2	N/A
Pomalidomide (Pomalyst) Capsule	Commercial: Down tier generic from Tier 6 to Tier 5	Anti-Cancer Medications - Self-Administered
Tretinoin 0.05% Gel (Gram)	Remove from Commercial and Medicaid formularies	N/A
Tociluzumab (Actemra) 162 mg/0.9 ml Disp Syring / Pen Inj	Removed from Commercial Formulary	Therapeutic Immunomodulators (TIMS) – Comm
Doxycycline hyclate 150 mg Tablet	• Add to Commercial Formulary, Tier 2 • Add to Medicaid Formulary	N/A
Hydrocortisone butyrate/emollient (Locoid Lipocream) Cream	• Add to Commercial Formulary, Tier 3 • Medicaid: Add to Formulary	N/A

Voclosporin (Lupkynis) Capsule	Remove from Medicaid formulary	Lupkynis
• **Abatacept (Orencia) Syringe / Auto Injct** • **Upadacitinib (Rinvoq/Rinvoq ER) tablet/solution** • **Golimumab (Simponi) Pen Injctr / Syringe** • **Ustekinumab (Stelara) Syringe / Vial** • **Tofacitinib citrate (Xeljanz/ Xeljanz XR) Solution / Tablet**	Remove from Medicaid formulary	Therapeutic Immunomodulators (TIMS) – Medicaid
Prednisone (Rayos) Tablet DR	Add to Medicaid formulary	New Medications and Formulations without Established Benefit
Desoximetasone Topical Spray	• Add to Commercial Formulary, Tier 2 • Add to Medicaid Formulary	New Medications and Formulations without Established Benefit
Inebilizumab-cdon (Uplizna) Vial	Add to Medicaid formulary with Prior Authorization	Uplizna
Bepotastine besilate (Bepreve) Drops	Add to Commercial formulary with prior authorization	Bepreve, Zerviate
Cetirizine hcl (Zerviate) Droperette	Add to Commercial Formulary, Tier 4, Prior Authorization	Bepreve, Zerviate
Testosterone undecanoate (Jatenzo) Capsule	Add to Commercial Formulary, Tier 4	Hormone Replacement Therapy
Epinephrine Auto Injectors	Commercial/Medicaid: Change Quantity Limit to one 2-pack (2 pens) per 30 days	N/A
Vedolizumab (Entyvio) pen injector	Add to Commercial formulary as preferred product: Formulary, Tier 5, Prior Authorization, Quantity Limit (1.36 mL per 28 days)	Therapeutic Immunomodulators (TIMS) – Comm
Adalimumab-adaz (Hymrioz®)	Add low list price products to Commercial formulary as preferred biosimilar:	Therapeutic Immunomodulators (TIMS) – Comm

	Formulary, Tier 5, Prior Authorization, Quantity Limit (two injections per 28 days)	
Adalimumab-aaty Autoinjkit / Syringekit	Add low list price products to Commercial formulary as preferred biosimilar: Formulary, Tier 5, Prior Authorization, Quantity Limit (two injections per 28 days)	Therapeutic Immunomodulators (TIMS) – Comm
Mirikizumab-mrkz (Omvoh) Pen Injctr / Syringe	Add to Commercial formulary as preferred product: Tier 5, Prior Authorization, Quantity Limit (2 mL per 28 days)	Therapeutic Immunomodulators (TIMS) – Comm
Deucravacitinib (Sotyktu) Tablet	Down-tier for Commercial as preferred product: Formulary, Tier 5, Prior Authorization, Quantity Limit (1 tablet per day)	Therapeutic Immunomodulators (TIMS) – Comm
Sacubitril/valsartan (Entresto Sprinkle®) pellet capsule	Non-formulary for Commercial and Medicaid with Quantity Limit (eight capsules per day)	N/A
Balsalazide 750 mg (Colazal)	Commercial: Up tier generic to Tier 4	N/A
• **Mesalamine (Canasa) 1000 mg Suppositories** • **Mesalamine (Lialda DR) 1.2-gram Tablets**	Commercial: Down tier generic from Tier 4 to Tier 3	N/A
Mesalamine (Apriso ER) 0.375 g	Commercial: Up tier brand to Tier 4	N/A
• **Mesalamine (Pentasa) 500 mg ER Capsules** • **Mesalamine (Asacol HD) 800 mg DR Tablets**	Remove from Commercial formulary	N/A
Mesalamine (Pentasa) 250 mg ER capsules	Remove from Commercial formulary; Update quantity limit to 16 capsules per day	N/A
Sulfasalazine (Azulfidine Entab) 500 mg EC	Commercial: Down tier generic from tier 3 to tier 2	N/A

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Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Bepreve, Zerviate	☒ Commercial ☐ Medicaid	Reactivated retired policy to meet required drug class counts for Commercial formularies. Effective: 11/01/2024
Camzyos	☒ Commercial ☒ Medicaid	Updated trial and failure criteria to align with updated guidelines. Policy now requires trial and failure of ONE of the following (instead of two): beta blockers or calcium channel blockers. Disopyramide removed from trial and failure options.
Complement Inhibitors	☒ Commercial ☒ Medicaid	Added required trial of Empaveli® (in addition to Ultomiris®) for Soliris and fabhalta for paroxysmal nocturnal hemoglobinuria (PHN). Defined reauthorization criteria for neuromyelitis optica spectrum disorder (NMOSD) as reduction in relapses.
Compounded Drugs	☒ Commercial ☒ Medicaid	Coverage criteria was clarified to ensure compounded medications are not being made to mimic FDA approved drugs, unless medical rationale is provided. This was added to combat issues with compounding providers using semaglutide to compound similar formulations of therapy (injections and oral use) to circumvent use of FDA approved products.
Continuous Glucose Monitors for Personal Use	☒ Commercial ☒ Medicaid	Criterion was added for coverage in patients with gestational diabetes (with or without inuslin use).
Enspryng	☒ Commercial ☒ Medicaid	Added requirement to rule out other diagnoses, reduced coverage duration for initial authorization to three months to align with similar medications, and clarified reauthorization requirement. For Medicaid, added prescriber restriction (neurologist) and trial/failure of rituximab.
FcRn Antagonists	☒ Commercial ☒ Medicaid	Added exclusions of combination treatment with other immunomodulatory biologic therapies (such as rituximab, Soliris, Ultomiris, Vyvgart, Rystiggo), Updated reauthorization criteria to require improvement for initial authorization and sustained improvement for subsequent reauthorizations.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Formulary and Quantity Limit Exceptions	☒ Commercial ☐ Medicaid	Criteria updated to clarify prior authorization criteria and formulary exception criteria must both be met for non-formulary reviews. Removed Medicaid from policy, as these requirements are outlined in separate Medical Necessity policy for Medicaid.
Hormone Replacement Therapy	☒ Commercial ☒ Medicaid	Kyzatrex® was removed from the prerequisite therapy requirements, as this product is only available as "cash pay" directly from the manufacturer and not eligible for insurance billing. Also clarified that compounded testosterone pellets are not covered as they are not FDA approved. Testopel® is the FDA approved pellet formulation. Effective: 11/01/2024
IL-5 Inhibitors	☒ Commercial ☒ Medicaid	Fasenra® and Nucala® will be preferred agents (over Cinqair®). For eosinophilic asthma, added criteria to allow coverage for corticosteroid-dependent patients. Updated prescriber restrictions to make more generalized. Minor updates to criteria for the indication of hypereosinophilic syndrome.
Interleukin-1 Inhibitors	☒ Commercial ☒ Medicaid	Added prescriber restrictions for Commercial to align with other insurers. For gout flares, added criteria that provider attests that repeat courses of corticosteroids are not appropriate per FDA indication and decreased coverage duration. For recurrent pericarditis, updated criteria to align with EULAR guideline that recommends NSAIDs or glucocorticoids PLUS colchicine.
Medically Infused Therapeutic Immunomodulators (Tims) – Comm	☒ Commercial ☐ Medicaid	Updated criteria for immune checkpoint inhibitor toxicity to align with NCCN guidelines, added criteria for non-radiographic axial spondyloarthritis and juvenile arthritis, removed criteria for systemic interstitial lung disease as only subcutaneous tocilizumab formulation is approved for this indication.
New Medications and Formulations without Established Benefit	☒ Commercial ☒ Medicaid	Removed obsolete medications. Removed several medications that will remain non-formulary. Coverage may be authorized for these medications if formulary alternatives are tried or deemed not appropriate.
Saphnelo	☒ Commercial ☒ Medicaid	Added nephrologist to prescriber restrictions.
Self-Administered Drugs (SAD) Policy	☒ Commercial ☒ Medicaid	Several drugs were added to this policy, requiring use of self-administered products. These include Bimzelx®, Wainua®, Omvoh®, Spevigo®, and ustekinumab biosimilars (Selarsdi®, Wezlana®, Pyzchiva®)

Drug/Policy Name(s)	Plans Affected	Summary of Change
Sylvant	☒ Commercial ☒ Medicaid	Updated coverage duration to call out off-label uses will require case-by-case review since use in some indications may be used for short duration (such as one-time use for CAR-T related toxicities).
Therapeutic Immunomodulators (TIMS) - Comm	☒ Commercial ☐ Medicaid	Updated prescriber restrictions and preferred drugs to align with cost-positioning contracts.
Therapeutic Immunomodulators (TIMS) – Medicaid	☐ Commercial ☒ Medicaid	Updated criteria to align with Oregon Health Authority (OHA). Specifically, reauthorization criteria for atopic dermatitis and hidradenitis suppurativa were updated. Removed criteria for polymyalgia rheumatica as OHA does not have disease specific criteria. Updated immune checkpoint inhibitor criteria to encompass all related toxicities as outlined by NCCN guidelines.
Transthyretin (TTR) Lowering Agents	☒ Commercial ☒ Medicaid	Added criteria for requiring baseline platelet count to be >100 x 109/L for Tegsedi®
Trientine	☒ Commercial ☒ Medicaid	Clarified that if approved, only the generic 250 mg capsule will be covered and that brand-name Syprine® will require additional criteria for approval if requested over the generic formulation.
Uplizna	☒ Commercial ☒ Medicaid	Added requirement to rule out other diagnoses and for trial/failure of Enspryng (in addition to rituximab). Added prescriber requirement and trial/failure of rituximab to Medicaid criteria. Reduced coverage duration for initial to 3 months, clarify reauthorization requirement.
Weight Management Medications	☒ Commercial ☐ Medicaid	Updated criteria to align with new indication for Wegovy® for reducing cardiovascular risk in obesity. This medication/indication continues to only be covered for groups with weight loss benefit only.
Weight Management Medications – Medicaid	☐ Commercial ☒ Medicaid	Updated criteria to align with the Oregon Health Authority coverage criteria.
Xiaflex	☒ Commercial ☒ Medicaid	For Dupuytren's Contracture: removed tabletop test requirement. For Peyronie's disease: removed documentation of functional impairment, counseling

Drug/Policy Name(s)	Plans Affected	Summary of Change
		requirements, and some exclusions that posed operational challenges for review (such as calcified plaque/significant pain/proximal plaque).
Xolair	☒ Commercial ☒ Medicaid	Updates were made to prescriber restrictions. Effective: 11/01/2024

Retired Medical Policies

- **Korsuva**

New Drugs:

Drug Name	Recommendations	Policy Name
Aprocitentan (Tryvio) Tablets	• Commercial/Medicaid: Non-formulary, Prior Authorization, Quantity Limit (1 tablet per day)	Therapies for Resistant Hypertension
Atidarsagene autotemcel (Lenmeldy) Plast. Bag	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Lenmeldy
Crovalimab-akkz (Piasky) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Complement Inhibitors
Elafibranor (Iqirvo) Tablet	• Commercial/Medicaid: Non-formulary, Prior Authorization, Quantity Limit (1 tablet per day)	Primary Biliary Cholangitis Agents
Ensifentrine (Ohtuvayre) Ampul-Neb	• Commercial/Medicaid: Non-formulary, Prior Authorization, Quantity Limit (2 ampules per day)	Ohtuvayre
Fidanacogene elaparvovec-dzkt (Beqvez) Kit and Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (1 administration per lifetime)	Gene Therapy for Hemophilia

Givinostat hydrochloride (Duvyzat) Oral Susp	• Commercial/Medicaid: Non-formulary, Prior Authorization, Quantity Limit (420 mL per 30 days)	Duvystat
Imetelstat sodium (Rytelo) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Reblozyl, Rytelo
Mavorixafor (Xolremdi) Capsule	• Commercial/Medicaid: Non-formulary, Prior Authorization, Quantity Limit (4 capsules per day)	Medications for Rare Indications
Sofpironium bromide (Sofdra) Gel with Pump	• Commercial/Medicaid: Non-formulary, Prior Authorization, Quantity Limit (1 bottle per 30 days)	Hyperhidrosis Agents
Tarlatamab-dlle (Imdelltra) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications - Medical Benefit
Vadadustat (Vafseo) Tablet	• Commercial/Medicaid: Non-formulary, Prior Authorization	Jesduvroq, Vafseo