The following changes will be effective on **August 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
Fluticasone propionate/ salmeterol (Advair HFA) HFA AER AD	Remove from Medicaid formulary Effective 09/01/2022	N/A
Atomoxetine hcl Capsule	Down-tier for Commercial: Formulary, Tier 2 Effective 07/01/2022	N/A
Cabozantinib s-malate (Cabometyx) Tablet	Add quantity limit (1 capsule per day) to Commercial and Medicaid Effective 09/01/2022	N/A
Dextroamphetamine-amphet er Cap ER 24H	Down-tier for Commercial: Formulary, Tier 2, Quantity Limit (5, 10, 15, 30 mg - 1 capsule per day) (20 mg – 2 capsules per day) Effective 07/01/2022	Long-acting Stimulants Quantity Limit
• **Methylphenidate ER Tablet ER** • **Methylphenidate HCL CD CPBP**	Down tier for Commercial Cost-Based; Tier 2, Quantity Limit (1 tablet per day) Effective 07/01/2022	N/A
Ergotamine tartrate/caffeine (Migergot) Supp.Rect	Remove from Commercial and Medicaid formularies Effective 09/01/2022	N/A
Insulin glargine-yfgn [Semglee (YFGN)] Cartridge/Vial	Remove Brand Semglee from Medicaid formulary Effective 09/01/2022	N/A
Almotriptan malate Tablet	Remove from Commercial formulary	N/A

Drug Name	Formulary Status	Policy Name
	Effective 09/01/2022	
Frovatriptan succinate Tablet	Remove from Commercial and Medicaid formularies Effective 09/01/2022	N/A
Everolimus disperz (Afinitor Disperz) Tablet	Remove from Commercial and Medicaid formularies Effective 09/01/2022	Oral Anti-Cancer Medications

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Anti-Glaucoma Agents	☒ Commercial ☒ Medicaid	Changed wording on covered uses from N/A to all medically accepted indications not otherwise excluded from the benefit.
Benlysta	☒ Commercial ☒ Medicaid	Updated policy so new members established on therapy do not need to meet initial criteria.
CFTR Modulators	☒ Commercial ☒ Medicaid	Age restrictions updated to meet FDA approved indications.
Disposable Insulin Pumps	☒ Commercial ☒ Medicaid	V-go and the new Omnipod 5 were added to this policy. V-go will require use of Omnipod prior to coverage.

Dupixent	☒ Commercial
	☒ Medicaid
		Updated criteria to align with contract requirements
		• For atopic dermatitis:
		  ○ Diagnostic criteria were updated to align with the Oregon Health Authority
		  ○ Updated prerequisite therapy to allow for either trial of systemic immunosuppressants or trial of BOTH topical steroids and topical calcineurin inhibitors
		• For asthma:
		  ○ Diagnostic criteria for eosinophilic asthma were updated to include more definitions

Drug/Policy Name(s)	Plans Affected	Summary of Change
		○ Updated requirement for an additional controller medication (on top of inhaled corticosteroid) to include a long-acting beta-2 agonists (LABA), leukotriene receptor antagonist, or long-acting muscarinic antagonist (LAMA) instead of only allowing a LABA. Effective 06/13/2022
Elidel, Protopic - Medicaid	☐ Commercial ☒ Medicaid	Added reauthorization criteria
Immune Gamma Globulin (IgG)	☒ Commercial ☒ Medicaid	Removed trial and failure of prophylactic antibiotics.
Intranasal Allergy Medications - Medicaid	☐ Commercial ☒ Medicaid	Updated covered uses section to clarify coverage based on the Oregon Health Services Commission listed on the Prioritized List of Health Care Services
Ketoconazole tablets	☒ Commercial ☒ Medicaid	Updated criteria to allow for coverage in endogenous Cushing's syndrome
Krystexxa	☒ Commercial ☒ Medicaid	Added language clarifying that maximum medically appropriate doses of xanthine oxidase and uricosuric agents must be tried.
Narcolepsy Agents	☒ Commercial ☒ Medicaid	Developed criteria for Xywav in the setting of idiopathic hypersomnia. Criteria aligns with the respected clinical trial, International Classification of Sleep Disorders guidance, and American Academy of Sleep Medicine treatment guidelines.
Nexletol, Nexlizet	☒ Commercial ☒ Medicaid	Removed provider restrictions
Non-Preferred Insulins	☒ Commercial ☒ Medicaid	Adding duration for required trial and failure of preferred insulins.
Oral Anti-Cancer Medications	☒ Commercial ☒ Medicaid	Criterion was added to establish medical necessity for everolimus tablets for oral suspension (generic for Afinitor Disperz®), as this formulation is only warranted in certain cases and is much more costly than the generic everolimus tablets (generic for Afinitor®). Additionally, quantity limits were added to support dose optimization.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Osteoanabolic Therapies	☒ Commercial ☒ Medicaid	Add criteria for use of teriparatide beyond two years based on new labeling.
PCSK9 Inhibitors	☒ Commercial ☒ Medicaid	Removed provider restrictions
Pulmonary Arterial Hypertension	☒ Commercial ☒ Medicaid	1. Updated diagnosis criteria for mPAP from 25 mmHg to greater than or equal to 20 mmHg to align with current recommendations from the 6th World Symposium on Pulmonary Hypertension Task Force. 2. Changed authorization to until no longer eligible with the plan.
Reyvow	☒ Commercial ☒ Medicaid	Updated initial criteria to include "intolerance of two triptan entities," separated trial and failure requirements by line of business, and removed prescriber requirements to align with other anti-migraine drug therapy policies (e.g., CGRP).
Scenesse	☒ Commercial ☒ Medicaid	Updated diagnostic criteria to align with The Porphyrias Consortium that notes "the diagnosis of EPP/XLP is established biochemically by demonstrating increased protoporphyrin in red blood cells, with a predominance of metal-free protoporphyrin rather than zinc protoporphyrin."
Soliris	☒ Commercial ☒ Medicaid	For neuromyelitis optica spectrum disorder (NMOSD) will require trial of rituximab and an additional therapy (Enspryng or Uplizna) prior to approval of Soliris. Changed based on high cost of Soliris and feedback from expert opinion.
Tafamidis	☒ Commercial ☒ Medicaid	Clarified wording surrounding reauthorization criteria. Need to provide documentation of positive response but specific criteria (such as 6-minute walk test) not required.
Therapeutic Immunomodulators – Comm	☒ Commercial ☐ Medicaid	Criteria were updated to reflect new FDA approved indications. Effective 6/13/2022
Therapeutic Immunomodulators – Medicaid	☐ Commercial ☒ Medicaid	Vedolizumab (Entyvio®) was added as a co-preferred agent with infliximab biosimilars (Renflexis® and Inflectra®) for Crohn's disease Effective 7/1/2022
Triptan Quantity Limit	☒ Commercial ☒ Medicaid	Updated initial criteria to allow a Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist as a trial option.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Vascepa	☒ Commercial ☒ Medicaid	Atherosclerotic cardiovascular disease (ASCVD) low density lipoprotein (LDL) requirement or less than or equal to 100 mg/dL has been removed from policy criteria to align with Oregon Health Authority prior authorization policy.
VEGF Inhibitors	☒ Commercial ☒ Medicaid	Aflibercept (Eylea® and ranibizumab-nuna (Byooviz®) will no longer require prior authorization. Other non-preferred products will require trial of 1) bevacizumab and 2) aflibercept (Eylea®) or ranibizumab-nuna (Byooviz®)

Retired Medical Policies:

- Koselugo – combined with to Oral Anti-Cancer Medications policy
- Sublingual Immunotherapy with Allergen-specific Pollen Extracts (SLIT) – due to appropriate utilization
- Dihydroergotamine – due to low utilization of medications
- Northera - due to low risk of overutilization and generic availability
- Triptans Step Therapy – cost-effective agents are on the formulary and more costly agents will be removed from the formulary (frovatriptan and almotriptan)

New Drugs:

Drug Name	Recommendation	Policy Name
Faricimab-svoa (Vabysmo®) **Ranibizumab (Susvimo) Vial**	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	VEGF inhibitors
Tebentafusp-tebn (Kimmtrak)	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Injectable Anti-cancer Agents

Nivolumab-Relatlimab-rmbw (Opdualag)		
Ciltacabtagene autoleucel (Carvykti)	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	CAR-T
Pacritinib citrate (Vonjo) Capsule	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Oral Anti-cancer Agents
Nivolumab-Relatlimab-rmbw (Opdualag)	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	
Tezepelumab-ekko (Tezspire)	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Tezspire
Levoketoconazole (Recorlev) Tablet	• Commercial: Non-Formulary, Prior Authorization • Medicaid: Non-Formulary, Prior Authorization	Pituitary Disorder Therapies
Sutimlimab-jome (Enjaymo)	• Commercial: Non-Formulary, Prior Authorization • Medicaid: Non-Formulary, Prior Authorization	Enjaymo
Mitapivat sulfate (Pyrukynd)	• Commercial: Formulary, Tier 5, Prior Authorization • Medicaid: Formulary, Prior Authorization	Pyrukynd
Plasminogen, human-tvmh (Ryplazim)	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Ryplazim
Thymus tissue-agdc (Rethymic)	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Rethymic