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The following changes will be effective on **October 1, 2023**, unless otherwise specified and apply to the following plans:

Individual and Family, Large/Small Groups (Commercial)
Health Share of Oregon/Providence (Medicaid)

Special Announcement

Effective **July 1st 2023** two biosimilars were added to the Commercial formulary. There are now three different adalimumab products available for use:

- Humira® (adalimumab)
- Hadlima® (adalimumab-bwwd) syringe and PushTouch™ autoinjector
- Amjevita® (adalimumab-atto) syringe and SureClick® autoinjector*

The Food & Drug Administration (FDA) defines a biosimilar as a biological product that is highly similar to an existing biologic product.

*Only Amjevita® products made by the manufacturer Amgen are covered by the plan

Formulary Changes

Drug Name	Formulary Status	Policy Name
Diclofenac potassium Tablet	• Commercial: Add to Formulary • Medicaid: Add to Formulary	N/A
• **Codeine Phosphate/Guaifenesin 10-100mg/5mL, 20-200mg/10mL Liquid**	Remove from Commercial formulary, as available over-the-counter (OTC) Effective 11/1/2023	N/A

• **Pseudoephed/Codeine/Guaifen 30-10-100 Syrup**		
Levocarnitine Solution	• Commercial: Add to Formulary	N/A
Adthyza® (thyroid,Pork) Tablet	• Commercial: Add to Formulary • Medicaid: Add to Formulary	N/A
Methylphenidate Patch	Medicaid: Add to Formulary	N/A
Dextroamphetamine sulfate ER capsule	Remove from Medicaid formulary	N/A
Ongentys® (opicapone) Capsule	Commercial/Medicaid: Remove from Formulary add Quantity Limit (1 capsule per day) Effective 11/1/2023	N/A
Ramelteon Tablet	Medicaid: Add to formulary with Prior Authorization and Quantity Limit (1 tablet per day)	Insomnia Agents – Medicaid
Melatonin • **1 mg, 3 mg, 5 mg, Tablet** • **1 mg/ml Liquid**	Medicaid: Add to formulary for patients less than 21 years of age.	N/A
Vilazodone	Commercial: Retire step therapy; covered without restriction	N/A
Vyvanse® (lisdexamfetamine)	Remove from Medicaid formulary	N/A

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Antiepileptic Medications Step Therapy Policy	☒ Commercial ☒ Medicaid	Changed policy from Step Therapy to Prior Authorization policy, requiring FDA approved indication for all requests.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Botulinum Toxin	☒ Commercial ☒ Medicaid	Added criteria for reauthorization to ensure response to therapy. For chronic anal fissures, removing requirement related to surgery as the guidelines from the American College of Gastroenterology and the American Society of Colon and Rectal Surgeons recommend that botulinum toxin can be used second line after topical therapies and prior to surgery. For severe axillary hyperhidrosis, clarified topical agent that must be tried is aluminum chloride hexahydrate (Drysol. For overactive bladder in adults and neurologic detrusor overactivity, added beta-3 adrenoceptor agonist (e.g., mirabegron) as option for pharmaceutical trial and failure. Removed all "experimental and investigational" wording and replaced with "not considered medically necessary". Added criteria for evaluation of off-label uses.
Calcitonin Gene-Related Peptide Receptor Antagonists	☒ Commercial ☐ Medicaid	Clarified language for quantity limit requests for acute migraine treatment to require documentation of use of any migraine prophylactic therapy. Quantity limit added to Vyepti.
Calcitonin Gene-Related Peptide Receptor Antagonists - Medicaid	☐ Commercial ☒ Medicaid	Updated criteria to align with Oregon Health Authority guidance. Specifically, removed history of cluster headache frequency and confirmation of specific number of headache reduction on reauthorization. Removed exclusion criteria as it is outlined in initial criteria. Clarified language for quantity limit requests for acute migraine treatment to require documentation of use of any migraine prophylactic therapy.
Diabetic Durable Medical Equipment (DME)	☒ Commercial ☒ Medicaid	Removed restriction on test strips for users of continuous glucose monitors.
Diacomit	☒ Commercial ☒ Medicaid	Updated coverage duration for initial authorization to 12 months and removed prerequisite therapy criteria.
Epidiolex	☒ Commercial ☒ Medicaid	Updated coverage duration for initial authorization to 12 months. Reduced requirement of prerequisites therapies to one agent for Dravet syndrome and tuberous sclerosis complex.
Fintepla	☒ Commercial ☒ Medicaid	Updated coverage duration for initial authorization to 12 months.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Infusion Therapy Site of Care	☒ Commercial ☐ Medicaid	Several drugs were added to the mandatory site of care list.
Insomnia Agents – Medicaid	☐ Commercial ☒ Medicaid	Added ramelteon as another preferred medication to align with Oregon Health Authority preferred drug list. Coverage of non-preferred therapy requires trial of generic ramelteon and either generic zopiclone or generic eszopiclone. Clarified that melatonin will not be covered for adults 21 years of age and older.
Long Acting Opioids	☒ Commercial ☒ Medicaid	Clarified requirement of around-the-clock short-acting opioid therapy prior to approval of long-acting opioid therapy. Also clarified definition of established on therapy and requirements for patients switching to a different long-acting opioid product.
Long-Acting Stimulant Medications Quantity Limit	☐ Commercial ☒ Medicaid	Policy was updated to include Medicaid and Medicaid specific provider restriction for Quantity Limits was added and allowance for continuation of established patients for up to 90 days to allow time for consult with mental health provider.
Maximum Allowable Opioid Dose - Comm	☒ Commercial ☐ Medicaid	Added requirement that patients have been provided with prescription for naloxone when established on doses exceeding 90 milligram morphine equivalents.
Narcolepsy Agents	☒ Commercial ☒ Medicaid	Updated narcolepsy criteria to clarify that if requesting medication for the treatment of excessive daytime sleepiness (even in those with a history of cataplexy), trial of prerequisite and preferred agents still applies. Treatment of cataplexy in narcolepsy does not require trial of modafinil/armodafinil, stimulant or Sunosi®. Added new extended release drug formulation of sodium oxybate (Lumryz®) to policy in parity with Xyrem® and Xywav®. Added criteria for when coverage of combination therapy with Sunosi® and other agents would be considered. Added new extended release drug formulation of sodium oxybate (Lumryz®) to policy in parity with Xyrem® and Xywav®.
PCSK9 Inhibitors - Commercial	☒ Commercial ☐ Medicaid	Updated policy that only provider attestation is required (instead of "documented evidence") of previous statin use.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Pediatric Analgesics	☒ Commercial ☐ Medicaid	Clarified wording that for commercial members all over-the-counter (OTC) formulations, even those that are placed on prescription-only status as required by state or local laws, are a benefit exclusion.
Qudexy XR, Trokendi XR	☒ Commercial ☒ Medicaid	Removed prescriber restrictions from migraine therapy criteria to align with other migraine therapy policies (such as CGRP antagonists).
Rebyota	☒ Commercial ☒ Medicaid	Renaming policy to include all fecal microbiota agents. Updated policy criteria to align with FDA label and clinical trials of both Vowst and Rebyota.
Reyvow	☒ Commercial ☒ Medicaid	Updated trial and failure criteria to only require a trial of two oral formulary triptans to align with Oregon Health Authority guidance and current Calcitonin Gene-Related Peptide Antagonist policies.
Savella	☒ Commercial ☐ Medicaid	Added criteria for patients established on therapy.
SGLT-2 Inhibitors - Medicaid	☐ Commercial ☒ Medicaid	Added criteria for coverage of non-preferred therapy, ertugliflozin, for type 2 diabetes.
Spravato	☒ Commercial ☒ Medicaid	Limit coverage duration for Major Depressive Disorder with Acute Suicidal Ideation to four weeks with no reauthorization. Patients using for this specific indication will have to meet criteria for treatment-resistant depression for continuation of therapy.
Therapeutic Immunomodulators	☒ Commercial ☒ Medicaid	Several Humira® (adalimumab) biosimilar products launched and have been added to the policy as either preferred [Amjevita® (standard list price) and Hadlima®] or non-preferred.
VMAT2 Inhibitors	☒ Commercial ☒ Medicaid	Added Austedo XR® (deutetrabenazine extended-release) to the policy with quantity limitations. Removed reference to reserpine in the exclusion criteria, as this drug is banned in the U.S.. Minor update to diagnostic criteria related to genetic testing.
Ztalmy	☒ Commercial ☒ Medicaid	Updated coverage duration for initial authorization to 12 months. Reduced requirement of prerequisites therapies to one agent and removed adjunct therapy requirement.

Retired Medical Policies

- **Long-Acting Stimulant Medications – Medicaid:** Policy was retired and criteria related to quantity limitations was added to Commercial policy. Non-preferred therapy requests will be reviewed according to the formulary exception policy.
- **Ongentys Step Therapy Policy:** Policy retired and drug removed from the formulary due to very low utilization and low risk of inappropriate use.

New Drugs:

Drug Name	Recommendations	Policy Name
Omidubicel-onlv (Omisirge) Plast. Bag	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Omisirge
Retifanlimab-dlwr (Zynyz) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (20ml per 28 days)	Oral Anti-Cancer Medications
Epcoritamab-bysp (Epkinly) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Injectable Anti-cancer Medications
Sparsentan (Filspari) Tablet	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (2 tablets per day)	Filspari
Trientine tetrahydrochloride (Cuvrior) Tablet	• Commercial/Medicaid: Non-Formulary, Prior Authorization	Trientine
Leniolisib phosphate (Joenja) Tablet	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 tablets per day)	Medications For Rare Indications
Tofersen (Qalsody) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Qalsody
Fecal microbiota, spores, live-brpk (Vowst)	• Commercial/Medicaid: Non-Formulary, Prior Authorization	Fecal Microbiota Agents

Zavegepant hcl (Zavzpret) Spray	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (8 units per 30 days)	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists
Beremagene geperpavec-svdt (Vyjuvek) Gel (ML)	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (4 vials [10ml] per 28 days)	Vyjuvek