Providence Health Plan | Providence Health Assurance

The following changes will be effective on **February 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
Pirfenidone (Esbriet) Capsule	Non-preferred agent. Remove from formulary, add Quantity Limit (three tablets per day) Effective: 03/01/2023	Esbriet/Ofev
Pirfenidone tablet	Add quantity limit of three tablets per day Effective: 03/01/2023	Esbriet/Ofev
• **BRAND Epclusa® tablets and pellet packets**	Remove from Commercial and Medicaid formularies Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals
• **BRAND Harvoni® tablets and pellet packets**	Remove from Commercial and Medicaid formularies Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals
Elbasvir/Grazoprevir (Zepatier) Tablet	Non-preferred agents; remove from Commercial formulary Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals
Glecaprevir/Pibrentasvir (Mavyret) Pellet Pack	Remove from Medicaid formulary Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals
Ombita/Paritap/Ritonavir/ Dasabuvir (Viekira Pak)	Non-preferred agents; remove from Commercial formulary Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals
Sofosbuvir (Sovaldi) Pellet Pack and Tablet	Non-preferred agents; remove from Commercial formulary Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals

Drug Name	Formulary Status	Policy Name
Sofosbuvir/Velpatas/ Voxilaprevir (Vosevi) Tablet	Non-preferred agent • Commercial: Change from Tier 5 to Tier 6 • Medicaid: Remove from Formulary Effective: 01/01/2023	Hepatitis C - Direct Acting Antivirals
Sodium thiosulfate (Pedmark) Vial	Add prior authorization	Injectable Anti-Cancer Medications
Bismuth subcitrate/ metronidazole/tetracycline (Pylera) capsule	Add Quantity Limit for Commercial: 120 capsules per 28 days	N/A
Dexlansoprazole (Dexilant) Cap DR MP	Remove from Commercial formulary	N/A
Ketoconazole (Nizoral) Tablet	Add to Commercial Formulary	N/A
Omeprazole/amoxicillin / rifabutin (Talicia) capsule	Add to Commercial Formulary: Tier 4, Quantity Limit 168 capsules per 28 days	N/A
Omeprazole/clarithromycin / amoxicillin (Omeclamox) capsule	Change Commercial formulary status: Tier 4 (from Tier 3), add Quantity Limit (One pack per 28 days)	N/A
Patiromer Calcium Sorbitex (Veltassa) Powder Pack	Retire prior authorization and add to formulary for Commercial and Medicaid	N/A
Propranolol hcl (Hemangeol) Solution	Commercial: Add to Formulary, Tier 4, Specialty	N/A
Sodium chloride for inhalation (Nebusal) VialNeb	Add to formulary • Commercial: Tier 4 • Medicaid: Formulary	N/A
Sodium Zirconium Cyclosilicate (Lokelma) Powd Pack	Retire prior authorization and add to formulary: • Commercial: Tier 3 • Medicaid: Formulary	N/A
Sevelamer Carbonate Powder Pack	Add Step Therapy for Commercial and Medicaid Effective: 03/01/2023	Phosphate Binders Step Therapy Policy
Avatrombopag maleate (Doptelet) Tablet	Remove from Medicaid formulary	Thrombocytopenia Medications
Lusutrombopag (Mulpleta) Tablet	Remove from Medicaid formulary	Thrombocytopenia Medications

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Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Acute Hereditary Angioedema Therapy	☒ Commercial ☒ Medicaid	Policy criteria for patients established on the requested therapy has been updated to require trial and failure of generic icatibant for requests for brand Firazyr® requests.
Aemcolo	☒ Commercial ☒ Medicaid	Removed exclusion criteria to align policy with Oregon Health Authority criteria.
Albenza, Emverm	☒ Commercial ☒ Medicaid	Clarified that infectious disease specialist prescribing would only be required if laboratory confirmation of parasitic infection is not available.
Alinia	☒ Commercial ☒ Medicaid	Changed criteria for *C. parvum* infection to align with updated package labeling.
Chenodal	☒ Commercial ☒ Medicaid	Criteria updated to include dose optimization criteria. For Medicaid, gallstones without cholecystitis is undunded, so a requirement for evidence of cholecystitis was added.
Constipation Agents	☒ Commercial ☒ Medicaid	Updated criteria for chronic idiopathic constipation to resemble Rome IV diagnostic criteria more closely.
Empaveli	☒ Commercial ☒ Medicaid	For Paroxysmal Nocturnal Hemoglobinuria, added “increase or stabilization of hemoglobin levels” as option for successful response to therapy at reauthorization. Added criteria for patients switching from eculizumab (Soliris®) or ravulizumab-CWVZ (Ultomiris®)
Enjaymo	☒ Commercial ☒ Medicaid	Defined some of the criteria, added note that medications obtained as samples, coupons, other methods outside established health plan are not considered established on therapy.
Erythropoiesis Stimulating Agents (ESAs)	☒ Commercial ☒ Medicaid	Added Mircera to policy, removed exclusion of anemia due to treatment for hepatitis C.
Formulary and Quantity Limit Exceptions	☒ Commercial ☒ Medicaid	Added criteria for quantity limit reviews to allow for denials related to dose optimization.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Gattex	☒ Commercial ☒ Medicaid	Updated to allow patients established on therapy to get continued coverage if they have a documented response to therapy.
Hepatitis C - Direct Acting Antivirals	☒ Commercial ☒ Medicaid	Clarified preferred products for the Commercial line of business and that coverage of non-preferred regimens will require rationale for use over preferred formulary alternative regimens.
Hepatitis C - Direct Acting Antivirals - Medicaid	☒ Commercial ☒ Medicaid	Update criteria to align with Oregon Health Authority Risk Corridor requirements. Prior authorization be removed on preferred therapies for treatment naïve patients. Additionally, life expectancy and hep B requirements were removed.
Lotronex	☒ Commercial ☒ Medicaid	Re-worded criteria to clarify irritable bowel syndrome must be chronic (lasting at least six months) and not that severe symptom must have been occurring for at least six months.
Mepron	☒ Commercial ☒ Medicaid	Expand prescriber restriction to allow review by infectious disease specialist, pulmonologist, hematologist, and oncologist.
Ocaliva	☒ Commercial ☒ Medicaid	Increased trial duration for ursodiol from six months to 12 months.
Phosphate Binders Step Therapy Policy	☒ Commercial ☒ Medicaid	Sevelamer carbonate powder packets were added to the policy due to large discrepancies in cost between these and carbonate tablets.
Prevymis	☒ Commercial ☒ Medicaid	Updated criteria to align with FDA label and recommendations from the American Society for Transplantation and Cellular Therapy guideline. Retire prior authorization for Medicaid to align with Oregon Health Authority's preferred drug list.
Pyrukynd	☒ Commercial ☒ Medicaid	Changed criteria to initiation of therapy and for patients established on therapy, gave specific timeframes for documentation for patients established on therapy criteria.
Reblozyl	☒ Commercial ☒ Medicaid	Removed minimum hemoglobin requirement for beta-thalassemia, updated criteria for myelodysplastic syndrome to align with NCCN guidelines.
Self-Administered Drug (SAD) Exclusion Policy	☒ Commercial ☒ Medicaid	Drugs were added to the policy and criteria were clarified regarding prior history of anaphylaxis and appropriateness of medical administration for patients with needle phobia.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Soolantra Step Therapy Policy	☒ Commercial ☒ Medicaid	Remove specific strength from metronidazole prerequisite.
Tavneos	☒ Commercial ☒ Medicaid	Remove kidney and liver function criteria, remove cirrhosis as exclusion, remove requirement for reduction in glucocorticoid use from reauthorization criteria.
Thrombocytopenia Medications	☒ Commercial ☒ Medicaid	Updated criteria for hematopoietic syndrome of acute radiation syndrome to align with FDA label, added indication specific criteria for hepatitis C associated thrombocytopenia.
Ultomiris	☒ Commercial ☒ Medicaid	For Paroxysmal Nocturnal Hemoglobinuria, added "increase or stabilization of hemoglobin levels" as option for successful response to therapy at reauthorization. Also added criteria for patients switching from pegcetacoplan (Empaveli®). For generalized myasthenia gravis, added criteria for patients switching from eculizumab (Soliris®).
Xermelo	☒ Commercial ☒ Medicaid	Removed criteria requiring trial of short-acting somatostatin analogs and loperamide to align with National Comprehensive Cancer Network (NCCN) and North American Neuroendocrine Society (NANETS) guidelines. Changed requirement of 4+ bowel movements/day to "uncontrolled diarrhea."
Xifaxan	☒ Commercial ☒ Medicaid	Removed trial of loperamide for irritable bowel syndrome with diarrhea (IBS-D) to align with guidelines, changed maximum to three courses per rolling 6-month period.

Retired Medical Policies

- Ketoconazole Tablets – Due to low utilization and is similarly priced to other formulary generic antifungal medications such as fluconazole.
- Potassium Lowering Agents - Due low utilization and low risk of inappropriate utilization.
- Proton Pump Inhibitors Step Therapy Policy – All agents on this policy with be non-formulary and require trial of formulary agents prior to approval.
- Rukobia, Trogarzo – Due to low utilization and low risk of inappropriate utilization.

New Drugs:

Drug Name	Recommendations	Policy Name
Betibeglogene autotemcel (Zynteglo)	Medical benefit, Prior Authorization	Zynteglo
Sodium phenylbutyrate-taurursodiol (Relyvrio)	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (56 packets per 28 days) • Medicaid: Formulary, Specialty, Prior Authorization, Quantity Limit (56 packets per 28 days)	Relyvrio
Oteseconazole (Vivjoa) Capsule	Non-Formulary, Prior Authorization Quantity Limit (18 capsules per four months)	Antifungal Agents
Olipudase alfa-rpcp (Xenpozyme)	Medical benefit, Prior Authorization	Enzyme Replacement Therapy
Spesolimab-sbzo (Spevigo)	Medical benefit, Prior Authorization	Spevigo
Vutrisiran sodium (Amvuttra)	Medical benefit, Prior Authorization	Transthyretin (TTR) Lowering Agents