The following changes will be effective on **August 1, 2021**, 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	Recommendation	Policy Name
Azelastine HCL Spray/Pump	• Commercial: Formulary • Medicaid: Non-Formulary, Prior Authorization	• Commercial: N/A • Medicaid: Intranasal Allergy Medications
Mannitol (Bronchitol) Cap w/Dev	New route (Inhalation), dosage form (Cap w/dev), and strength (40mg); Non-formulary	N/A
Cefixime Susp Recon	Add to Medicaid formulary EFFECTIVE: 07/01/2021	N/A
Cyclophosphamide Tablet	Returning drug; • Commercial: Formulary • Medicaid: Formulary	N/A
Desloratadine Tablet	• Medicaid: Add Prior Authorization, keep Non-Formulary	Second and Third generation antihistamines - Medicaid
Levetiracetam (Elepsia XR)Tab ER 24H	New strengths (1000 mg, 1500 mg); • Commercial/Medicaid: Non-Formulary, Prior Authorization	Commercial/Medicaid: New Medications and Formulations without Established Benefit
Loteprednol etabonate (Lotemax) 0.5% Oint	• Remove brand from Medicaid formulary EFFECTIVE: 09/01/2021	N/A
Loteprednol etabonate (Lotemax SM) 0.38% Drops Gel	• Remove brand from Commercial and Medicaid formularies EFFECTIVE: 09/01/2021	N/A

Drug Name	Recommendation	Policy Name
Loteprednol etabonate 0.5% Drops Gel and Drops Susp	• Commercial: Add to Formulary • Medicaid: Remove from Formulary EFFECTIVE: 09/01/2021	N/A
Siponimod (Mayzent) Tab DS PK	• Commercial: Formulary, Specialty • Medicaid: Formulary, Specialty	N/A
Oxycodone HCL/acetaminophen (Prolate) Solution	New strength (10mg-300mg/5ml); • Commercial/Medicaid: Non-Formulary, Quantity Limit (90 MME)	N/A
Ursodiol (Reltone) Capsule	New strengths (200mg, 400mg); Non-Formulary	N/A
Lanreotide acetate (Somatuline Depot) Syringe	Add Prior Authorization EFFECTIVE: 09/01/2021	Somastatin Analogs
Solifenacin succinate (Vesicare LS) Oral Susp	New dosage form (susp) and strength (5mg/5ml); • Non-Formulary	N/A
Zileuton (Zyflo) Tablet	• Commercial/Medicaid: Non-Formulary, Prior Authorization	• Commercial/Medicaid: Zyflo CR
Azelaic acid cream (Azelex) Cream	Remove from Commercial formulary	N/A
Azilsartan medoxomil (Edarbi) Tablet **Azilsartan med/chlorthalidone (Edarbyclor) Tablet**	Remove from Commercial formulary EFFECTIVE: 09/01/2021	N/A
Calcipotriene/ betamethasone (Taclonex Scalp) Suspension	• Add to Medicaid formulary	Enstilar, Taclonex, Taclonex Scalp
Tafluprost/PF (Zioptan) Droperette	• Commercial: Formulary, Step Therapy, Quantity Limit (1 droperette per day) • Medicaid: Non-Formulary, Step Therapy, Quantity Limit (1 droperette per day)	Anti-Glaucoma Agents Step Therapy

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Alpha-1 Proteinase Inhibitors	☒ Commercial ☒ Medicaid	Changed initial authorization to one year. Added positive response to therapy as reauthorization criteria. Removed phenotype SZ as high risk for low levels of serum alpha-1 antitrypsin (ATT) and development of lung disease as evidence is mixed (i.e., SZ phenotype must provide documentation of low levels of AAT).
Benlysta	☒ Commercial ☒ Medicaid	Addition of concurrent use of Lupkynis to the exclusion criteria.
Bepreve, Lastacaft, Pazeo, Zerviate	☒ Commercial ☐ Medicaid	Changed covered uses to all medically-accepted indications. Removed Pazeo from policy as product is to be discontinued. Product will remain non-formulary.
Botulinum Toxin	☒ Commercial ☒ Medicaid	Criteria were added to establish medical necessity criteria for the use of Botox® in combination with prophylactic calcitonin gene related peptide (CGRP) receptor antagonists. Additionally added reauthorization criteria for successful response to Botox® for migraine prophylaxis.
Buprenorphine	☒ Commercial ☐ Medicaid	Prior Authorization removed for commercial lines of business due to regulatory requirements.
Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists for Migraine Prophylaxis - Medicaid	☐ Commercial ☒ Medicaid	Criteria were updated to align with criteria approved by the Oregon Health Authority.
Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists for Migraine Prophylaxis	☒ Commercial ☐ Medicaid	Updated criteria to allow for coverage of combination of botulinum toxin and CGRPs for prophylaxis when medically necessary. Removed prescriber restrictions for chronic migraine.

Drug/Policy Name(s)	Plans Affected	Summary of Change
CFTR Modulators	☒ Commercial ☒ Medicaid	• Added quantity limit of two granule packets per day for Orkambi. This was already attached to the product but not listed on the policy.
Corlanor	☒ Commercial ☒ Medicaid	The policy criteria was updated to include a relatively new indication for pediatric patients with heart failure due to dilated cardiomyopathy (DCM).
Daliresp	☒ Commercial ☒ Medicaid	Remove provider restriction and exclusion criteria for hepatic impairment. Add trial duration to be at least 60 days. Add option to allow for coverage without trial of ICS in combination with LAMA/LABA in patients with low likelihood of response (blood eosinophils less than 100 cells/microliter) to align with the Global initiative for chronic Obstructive Lung Disease (GOLD) guidelines. Changed reauthorization duration to lifetime.
Enstilar, Taclonex, Taclonex Scalp, Wynzora	☒ Commercial ☒ Medicaid	Added ointment formulation as an option for trial and failure criteria of calcipotriene. In addition, updated trial and failure of betamethasone to high potency steroid to allow for other formulations that may be better suited for scalp application (e.g., clobetasol solution/shampoo).
Esbriet, Ofev	☒ Commercial ☒ Medicaid	Change initial and reauthorization duration to one year; updated idiopathic pulmonary fibrosis (IPF) diagnosis criteria to include option for biopsy supported probably or indeterminate UIP on HRCT to better align with the American Thoracic Society IPF diagnosis guidelines.
Gonadotropin Releasing Hormone Agonists	☐ Commercial ☒ Medicaid	HealthShare of Oregon has decided to prefer Vantas® (histrelin acetate 50 mg implant) for providing transgender services.
IL-5 Inhibitors	☒ Commercial ☒ Medicaid	For eosinophilic asthma changed drugs to be required prior to authorization to align with FDA labeling and study population in approval trials. Updated authorization duration for eosinophilic granulomatosis with polyangiitis and hyperesosinophilic syndrome to 12 months and changed reauthorization for asthma to until no longer eligible with the plan.
Infertility and Related Medications	☒ Commercial ☐ Medicaid	Updated criteria to assess that the medications are being used for a covered benefit (infertility treatments are not covered for many plans). Additionally, preferred products have been chosen and will be required before coverage of non-preferred therapies.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Injectable Anti-Cancer Medications	☒ Commercial ☒ Medicaid	Policy was updated to clarify non-preferred and preferred trastuzumab and bevacizumab products.
Juxtapid	☒ Commercial ☒ Medicaid	Update criteria to align with new therapy for homozygous familial hypercholesterolemia (HoFH) called evinocumab.
Ketorolac Intramuscular Injection	☒ Commercial ☒ Medicaid	Updated policy to clarify that the five day limit is per treatment course.
Krystexxa	☒ Commercial ☒ Medicaid	Updated the criteria to align with the 2020 American College of Rheumatology Guideline for the Management of Gout. This medication is recommended to be used only in patients that have failed other urate lowering therapy and continue to have symptomatic chronic gout.
Lumigan Step Therapy	☒ Commercial ☒ Medicaid	Renamed policy to Anti-Glaucoma Agents and added Vyzulta and Zioptan to the policy.
Luxturna	☒ Commercial ☒ Medicaid	Updated authorization duration from four weeks to 12 weeks to reduce repeat requests if treatment was not able to occur right away. Still one treatment course per eye per lifetime.
Medically Infused Therapeutic Immunomodulators	☒ Commercial ☐ Medicaid	Updated age restrictions to clarify that coverage is only approved for patients within the FDA label.
Nexletol, Nexlizet	☒ Commercial ☒ Medicaid	Clarified language around statin intolerance, added option for endocrinologist or lipid specialist as prescriber as may be the class for familial hypercholesterolemia, changed initial authorization to one year.
Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors	☒ Commercial ☒ Medicaid	Removed the brand name Avastin® from the policy criteria as there are now biosimilar products. Policy now uses the generic name bevacizumab only as all compounded bevacizumab products will count toward trial and failure.
Oxaydo	☒ Commercial ☒ Medicaid	Added criteria to require a least one non-opioid therapy prior to approval unless request is for active cancer pain. Increased initial authorization from six months to one year. Update quantity limit section to refer to the maximum allowable opioid dose policy.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Oxymorphone (Opana)	☒ Commercial ☒ Medicaid	Updated criteria to require trial failure of IR morphine sulfate and oxycodone for all indications (previously was not required for active cancer pain. Increased reauthorization length to lifetime. Update quantity limit section to reflect cumulative dose policy.
Pediatric Analgesics	☒ Commercial ☒ Medicaid	Update criteria to require trial of an over the counter cough and cold product if the requesting a product for cough.
Pulmonary Arterial Hypertension	☒ Commercial ☒ Medicaid	Updated FDA indication of Tyvaso for pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) to improve exercise ability.
Reyvow	☒ Commercial ☒ Medicaid	Added history of hemiplegic or basilar migraine as a contraindication to the use of triptans. Increased quantity limit of 100 mg tablets to eight per month (200 mg max per headache, max four headaches per month).
Rituximab	☒ Commercial ☒ Medicaid	Policy was updated to clarify non-preferred and preferred rituximab products.
Soliris	☒ Commercial ☒ Medicaid	Removed requirement for genetic testing and prior use of plasma therapy for complement mediated hemolytic uremic syndrome. Kidney Disease - improving global outcomes (KDIGO) recommend all patients with a clinical diagnosis of atypical HUS be eligible for treatment with a complement inhibitor and genetic testing should not delay treatment. 50-70% of participants in approval trials had confirmed genetic mutation. KDIGO states all patients with clinical diagnosis should be eligible for eculizumab with plasma therapy as alternative.
Tafamidis	☒ Commercial ☒ Medicaid	Update initial authorization duration to one year as study endpoints assessed after 30 months. Remove requirement of documented baseline 6-minute walk test or Kansas City Cardiomyopathy Questionnaire-Overall Summary.
Therapeutic Immunomodulators	☒ Commercial ☒ Medicaid	Updated age restrictions to clarify that coverage is only approved for patients within the FDA label.
Xhance	☒ Commercial ☒ Medicaid	Updated duration of approval and added reauthorization criteria to assess response to therapy.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Xolair	☒ Commercial ☒ Medicaid	Added new indication for nasal polyps. Policy criteria aligned closely with Dupixent criteria for nasal polyps. Increased reauthorization duration of urticaria to lifetime. For asthma, added medium dose ICS (in addition to high dose ICS) with a long-acting inhaled beta2-agonist as required prior medication therapy requirements to align with the Global Initiative for Asthma (GINA) 2021 updated guidelines.
Zinplava	☒ Commercial ☒ Medicaid	Added requirement patient is on standard of care antibiotics for reauthorization.

Retired Medical Policies:

- Non-preferred angiotensin receptor blockers
- Octreotide injectables
- Azelaic acid Step Therapy

New Medical Policies:

- Somatostatin Analogs
- Zeposia

New Drugs:

Drug Name	Recommendation	Policy Name
Vericiguat (Verquvo®) Tablet	• Commercial: Non-Formulary, Prior Authorization • Medicaid: Non-Formulary, Prior Authorization	Verquvo
Trilaciclib dihydrochloride (Cosela®) Vial	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Injectable Anti-Cancer Medications Policy
Margetuximab-CMKB (Margenza) Vial	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Injectable Anti-Cancer Medications Policy

Melphalan flufenamide HCl (Pepaxto) Vial	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Injectable Anti-Cancer Medications
Umbralisib tosylate (Ukoniq) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Oral Anti-Cancer Medications
Tepotinib hcl (Tepmetko) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Oral Anti-Cancer Medications
Tivozanib HCL (Fotivda) Capsule	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Oral Anti-Cancer Medications
Idecabtagene vicleucel (Abecma) Plast. Bag	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	CAR-T
Evinacumab-dgnb (Evkeeza) Vial	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Evkeeza
Fosdenopterin hydrobromide (Nulibry) Vial	• Commercial: Medical benefit, Prior Authorization • Medicaid: Medical benefit, Prior Authorization	Nulibry
Voclosporin (Lupkynis) Capsule	• Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization	Lupkynis