Providence Health Plan Providence Health Assurance

The following changes will be effective on February 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
Calcium Acetate Tablet	Add to Commercial Formulary Effective: 01/01/2025	N/A
Febuxostat (Uloric) Tablet	• Commercial Dynamic: Down tier generic to Tier 3 • Medicaid: Add generic to formulary	N/A
Chenodiol (Chenodal) Tablet	Remove from Medicaid formulary Effective: 03/01/2025	Chenodal
Cholic acid (Cholbam) Capsule	Remove from Medicaid formulary Effective: 03/01/2025	Medications For Rare Indications
Teduglutide (Gattex) Kit	Remove from Commercial and Medicaid formularies	Gattex
Daprodustat (Jesduvroq) Tablet	Remove from Commercial and Medicaid formularies	Jesduvroq, Vafseo
Linaclotide (Linzess) Capsule	Add to Commercial Formulary, Retire prior authorization Effective: 01/01/2025	N/A
Obeticholic acid (Ocaliva) Tablet	Remove from Commercial and Medicaid formularies	Primary Biliary Cholangitis Agents
Granisetron (Sancuso) Patch TDWK	Remove from Commercial and Medicaid formularies	N/A

Avacopan (Tavneos) Capsule	Add to Commercial Formulary, Prior Authorization, Quantity Limit (6 capsules per day)	Tavneos
Budesonide (Uceris) 9 mg Tab DR/ER	• Commercial: Add Quantity Limit (one tablet per day) • Medicaid: Remove from formulary and add Quantity Limit (one tablet per day) Effective: 03/01/2025	Uceris
Erlotinib **Lapatinib** **dasatinib**	Down-tier generics to Tier 5 (with Prior Authorization) for Commercial	Anti-Cancer Medications - Self-Administered

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Anti-Cancer Medications – Self-Administered	☒ Commercial ☒ Medicaid	Will require trial of imatinib before coverage of nilotinib (Tasigna®) and dasatinib (Sprycel®) will be authorized. This will apply to new starts only.
Acute Hereditary Angioedema Therapy	☒ Commercial ☒ Medicaid	Updated age restrictions language to require age be appropriate based on FDA approved indication. Updated quantity limit for icatibant to allow treatment for two exacerbations per month. Per package insert, may administer up to three doses per 24 hours.
Adakveo	☒ Commercial ☒ Medicaid	Removed Oxbryta® under exclusion since the drug has been withdrawn from the market. Added Endari® under exclusion criteria to prevent combination use.
Alinia	☒ Commercial ☒ Medicaid	Updated oral suspension quantity limit to allow for three days of treatment per package insert.
Chenodal	☒ Commercial ☒ Medicaid	Added requirement for radiolucent stones in well-opacifying gallbladders, and clarifide when patients are considered not a candidate for surgery.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Constipation Agents	☒ Commercial ☐ Medicaid	Updated age restrictions language to require age be appropriate based on FDA approved indication. Retired prior authorization on Linzess® and added it as preferred therapy on formulary (non-preferred drugs on the policy will require trial of Linzess®). Step through Amitiza (lubiprostone) for IBS-C only applies for patients 18 years and older assigned female at birth due to FDA labeling.
Constipation Agents – Medicaid	☐ Commercial ☒ Medicaid	Added criteria for reauthorization criteria, updated ICD-10 code list of non-covered diagnosis codes to include functional constipation as they are also considered unfunded diagnoses.
Gene Therapies for Hemoglobin Disorders	☒ Commercial ☒ Medicaid	Added note that additional genotypes will be considered on a case-by-case basis based on disease severity for sickle cell disease to meet compliance for value based agreement.
Givlaari	☒ Commercial ☒ Medicaid	Updated active disease definition to include four or more porphyria attacks within a year (in addition to two or more within the past six months). This aligns with expert opinion statement from American Gastroenterological Association. Added for reauthorization that dosing must align with FDA-labeling.
Hemlibra	☒ Commercial ☒ Medicaid	Added criteria requiring the dose and frequency align with FDA labeling.
Hepatitis C - Direct Acting Antivirals	☒ Commercial ☒ Medicaid	Allow coverage of generic Epclusa in solid organ transplant setting per AASLD guideline.
Jesduvroq, Vafseo	☒ Commercial ☒ Medicaid	Updated prescriber restrictions to allow hematologist. Updated duration of approval to align with Erythropoietin Stimulating Agents clinical policy.
Livtencity	☒ Commercial ☒ Medicaid	Updated criteria to require failure of one antiviral or intolerance/contraindication to all other listed antivirals.
Lotronex	☒ Commercial ☒ Medicaid	Removed information on REMS program in prescriber restrictions and position statement as this is no longer required, increased initial authorization duration to 12 months, removed requirement that patient is female due to low risk of inappropriate utilization and low likelihood of males continuing on therapy if they are approved due to decreased efficacy in this population.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Medications For Rare Indications	☒ Commercial ☒ Medicaid	For Cerdelga, add requirement for metabolic status of poor, intermediate, or extensive 2D6 metabolizer. For Galafold, updated diagnosis requirement to an amenable galactosidase alpha (GLA) gene variant. For Sohonos, required initial clinical scores. For Xolremdi, required initial labs.
Prevymis	☒ Commercial ☒ Medicaid	Updated age restriction as medication is now approved down to those 6 months of age for hematopoietic stem cell transplantation (HSCT) and 12 years of age for kidney transplant recipients. Clarified that coverage requests for HSCT greater than 100 days post transplantation requires documentation the member is at high risk for late cytomegalovirus infection.
Primary Biliary Cholangitis Agents	☒ Commercial ☒ Medicaid	Updated initial auth from four to six months to allow more time to assess response.
Reblozyl, Rytelo	☒ Commercial ☒ Medicaid	Clarified definition of transfusion-dependent anemia for beta-thalassemia.
Tavneos	☒ Commercial ☒ Medicaid	Coverage duration clarified.
Thrombocytopenia Medications	☒ Commercial ☒ Medicaid	For Immune Thrombocytopenia (ITP), removed rituximab as trial/failure option; For Severe aplastic anemia (AA), added requirement for combination or previous use of standard immunosuppressive therapy; For Chronic Liver Disease, removed requirement for when to start therapy; For continuation of ITP and AA, remove requirement for attestation of medical necessity; Added quantity limits to Doptelet and Promacta. Effective 03/01/2025
Uceris	☒ Commercial ☒ Medicaid	Removed tablet from Medicaid formulary and added quantity limit for tablet. Effective 03/01/2025

Retired Medical Policies

- **Altuviiio**
- **Oxbryta – medication is no longer available**
- **Serotonin Antagonists Step Therapy Policy**

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New Drugs:

Drug Name	Recommendations	Policy Name
Donanemab-azbt (Kisunla) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Amyloid Monoclonal Antibodies
Xanomeline tart-trospium chlor (Cobenfy) Capsule	• Commercial: Formulary, Tier 4, Prior Authorization, Quantity Limit (2 capsules per day) • Medicaid: Non-Formulary	• Commercial: Antipsychotics • Medicaid: N/A
Afamitresgene autoleucel (Tecelra) Plast. Bag	• Commercial/Medicaid: Medical Benefit, Prior Authorization, Quantity Limit (1 dose per lifetime)	T-Cell Therapy
Arimoclomol citrate (Miplyffa) Capsule	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (3 capsules per day)	Medications for Rare Indications
Bexagliflozin (Brenzavvy) Tablet	• Commercial/Medicaid: Non-Formulary	N/A
Lazertinib mesylate (Lazcluze) Tablet	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 tablets per day for 80 mg; 1 tablet per day for 240 mg)	Anti-Cancer Medications – Self-administered
Lebrikizumab-lbkz (Ebglyss Pen) Pen Injctr	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 mL per 28 days)	Interleukin-13 Inhibitors
Seladelpar lysine (Livdelzi) Capsule	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 capsule per day)	Primary Biliary Cholangitis Agents
Tislelizumab-jsgr (Tevimbra) Vial	• Commercial/Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications Policy – Medical Benefit
Vorasidenib citrate (Voranigo) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (10 mg	Anti-Cancer Medications – Self-Administered

	tablets: 60 tablets per 30 days; 40 mg tablets: 30 tablets per 30 days) • Medicaid: Formulary, Prior Authorization, Quantity Limit (10 mg tablets: 60 tablets per 30 days; 40 mg tablets: 30 tablets per 30 days)	
Palopegteriparatide (Yorvipath) Pen Injector	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (2 pens per 28 days) • Medicaid: Formulary, Prior Authorization, Quantity Limit (2 pens per 28 days)	Yorvipath