Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights

Highlights of recent drug policy revisions, as well as any new drug policies approved by WellFirst Health Medical Policy Committee, are listed below. *Drug policies are applicable to all WellFirst Health products, unless directly specified within the policy.* NOTE: All changes to the policies may not be reflected in the written highlights below. **We encourage all prescribers to review the current policies.**

All drugs with documented WellFirst Health policies must be prior authorized, unless otherwise noted in the policy. Please note that most drugs noted below and with policies require specialists to prescribe and request authorization.

To view WellFirst Health pharmacy medical benefit policies, visit wellfirstbenefits.com ➤ select the Providers link at the top of the web page ➤ Pharmacy Services. From the Pharmacy services for health care providers page, click the See library link located under the Current policies section.

Criteria for pharmacy benefit medications may be found on the associated prior authorization form located in the Prescriber Portal.

Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar.

Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights are published alongside our quarterly newsletters. The Summer 2022 Provider News is published on the WellFirst Health Provider news page at wellfirstbenefits.com/providers/news. Please call the Customer Care Center at **866-514-4194** if you have questions about accessing our newsletters.

Pharmacy Drug Prior Authorization Form Updates

Effective for dates of service on and after March 1, 2022:

- Zydelig (idelalisib) — Two indications were voluntarily withdrawn by the manufacturer and will be removed from the prior authorization form.

Effective for dates of service on and after April 1, 2022:

- Cimzia (certolizumab pegol) — Addition of another step therapy option of Skyrizi that can be counted as one of the trialed drugs (need to try 2).
- Orencia (abatacept) — Addition of another step therapy option of Skyrizi that can be counted as one of the trialed drugs (need to try 2).
- Fetzima (levomilnacipran) — Removal of psychiatrist requirement as a prescriber.

Effective for dates of service on and after May 1, 2022:

- Dupixent (dupilumab) injection — restrict combination use.
- Afinitor/Afinitor Disperz (everolimus) tablets — step requirement for advanced renal cell carcinoma (aRCC) and diagnosis update under advanced hormone receptor positive (HR+), HER2-negative breast cancer.
- Nucala (mepolizumab) injection — allowing additional age expansion for self-administration for six to eleven year olds.
- Sporanox (itraconazole) oral solution — boxed warning update for congestive heart failure (CHF), additional coverage determination criteria for Esophageal candidiasis and Oropharyngeal candidiasis, and additional recommendation for treatment options.
- Infliximab products injection — updates to preferred product criteria.
- Methyltestoterone 10 mg capsules — update to prior authorization criteria.

Effective for dates of service on and after June 1, 2022:

- Corlanor (ivabradine) — Added criteria for inappropriate sinus tachycardia or postural orthostatic tachycardia syndrome.
- Hepatitis C Updates (Epclusa, Harvoni, Mavyret, Vosevi, Zepatier) — The updates include: 1) a removal of the specialist name box 2) HCV-RNA levels to be written in, rather than additional lab reports sent and allowing for levels from the prior 6 months 3) Removing most prior treatments as guidelines consider patients treated with older HCV drugs as being

treatment-naïve 4) removal of the genotype requirement for Mavyret and Epclusa in most situations as it does not change the approval duration. There are other minor updates to criteria to improve standardization.

- Humira (adalimumab) & Stelara (ustekinumab) — removal of the traditional DMARD step from criteria and a weight to be provided for pediatric ulcerative colitis approvals so that an appropriate quantity limit of 4 injections per month may be applied in these situations.
- Promacta (eltrombopag), Doptelet (avatrombopag), & Tavalisse (fostamatinib) — Added continuation criteria for immune thrombocytopenia.
- Topical androgen products — Update to continuation criteria with removal of lab value requirement and adding provider attestation.
- Viibryd (vilazodone) – Removal of psychiatrist requirement from prior authorization.

Pharmacy Drug New Indications

Effective for dates of service on and after April 1, 2022:

- Cosentyx (secukinumab) 75, 150, & 300 mg subcutaneous injection - Secukinumab recently received a new indication for active enthesitis-related arthritis (ERA) in patients four years of age and older. Secukinumab also received an age expansion for psoriatic arthritis (PsA) in patients two years of age and older, previously indicated in only adults. The new indications will be added to the prior authorization form.
- Otezla (apremilast) 10, 20 & 30 mg tablets — updated indication to be added to prior authorization.
- Oxbryta (voxelotor) 300 mg tablet — Recently voxelotor received an age expansion from 12 years old to 4 years old. The new age expansion will be added to prior authorization forms.
- Rinvoq (upadacitinib) 15 & 30 mg tablets — new indication to be added to prior authorization.
- Skyrizi (risankizumab) 150 mg/mL subcutaneous injection — Received a new indication for the treatment of adults with active psoriatic arthritis (PsA). The PsA indication will be added to the PA form as a preferred agent for the treatment of PsA. Forms will also be updated for the non-preferred PsA agents to add risankizumab to the list of preferred alternatives that could be tried (certolizumab and abatacept; also, secukinumab for the Extended formularies).
- Solosec (secnidazole) 2-gram packet — Secnidazole recently received an age expansion down to 12 years of age for the treatment of bacterial vaginosis in female patients and for the treatment of trichomoniasis, previously only approved in adults. Currently, there is no age listed as part of the prior authorization criteria and therefore, this is informational only.
- TIM for plaque psoriasis updates (Humira, Enbrel, Skyrizi, Stelara, Taltz, Tremfya) injections — Updated to reflect step requirements.

Effective for dates of service on and after June 1, 2022:

- Fintepla (fenfluramine) 2.2 mg/mL oral solution — Fenfluramine has received a new indication for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients ≥ 2 years of age. This new indication will be added to the PA form. Criteria will require a diagnosis of LGS, prescription by a neurologist, trial/failure of at least 1 other AED, and not to be used as monotherapy.
- Lynparza (olaparib) 100 & 150 mg tablets — Olaparib with the adjuvant treatment of germline, BRCA-mutated (gBRCAm), HER2 negative (HER2-), high-risk early breast cancer in patients who have been treated with prior neoadjuvant or adjuvant chemotherapy.
- Rinvoq (upadacitinib) 15, 30 & 45 mg tablets — Treatment of adult patients with moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to one or more TNF blockers. An initial 8-week coverage period requiring prescribing by a gastroenterology specialist, diagnosis of moderately to severely active UC, and trial of Humira. Continuation will be permitted on an annual basis requiring continued prescribing by a gastroenterology specialist, and attestation of significant improvement with supporting documentation.

New Medical Drug Policies

Effective for dates of service on and after April 1, 2022:

IV Lidocaine and Ketamine for Chronic Pain MB2203

New Medical Policy created from March Pharmacy and Therapeutics Committee. Not a covered service and no prior authorization required.

SAPHNELO-anifrolumab MB2205

New Medical Policy created from March Pharmacy and Therapeutics (P&T) Committee. Allows only for Rhuematology specialists, and only require SLEDAI-2K score. J Code update from J3590 and C9086 to J0491. Prior Authorization is required and is restricted to rheumatology prescribers.

TIVDAK-tisotumab MB2207

New Medical Policy created from March Pharmacy and Therapeutics (P&T) Committee. Allows one or more prior therapy options and J code update from J999 to J9273. Prior authorization is required and is restricted to oncology prescribers.

Effective for dates of service on and after July 1, 2022:

PEPAXTO-melphalan flufenamide MB2204

Removed from overarching oncology policy per Medically Administered Products Committee (MAPC) removal of coverage. Prior authorization is required and is restricted to oncology prescribers.

RYBREVANT-amivantamab-vmjw MB2200

New Pharmacy and Therapeutics (P&T) committee approved drug for treatment of locally advanced or metastatic non–small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations. Prior authorization is required and is restricted to Oncologist or Hematologist specialists.

SIGNIFOR LAR-pasireotide MB2201

New Pharmacy and Therapeutics (P&T) Committee approved drug for treatment of Acromegaly. Prior authorization is required and is restricted to endocrinologist specialists.

Site of Service MB2206

New policy for select specialty drugs authorization requests, as listed in section titled "Drugs in Scope," to be administered in a hospital outpatient setting and may be directed to a preferred alternative site of care, such as home infusion provider or a physician office. Prior authorization is required.

SOMATULINE (lanreotide) depot MB2202

New Pharmacy and Therapeutics (P&T) Committee drug for treatment of gastrointestinal and pancreatic neuroendocrine tumors (GEP-NETs) and carcinoid syndrome. Prior authorization is required and is restricted to endocrinologist, oncologist, or gastroenterologist specialists.

Effective for dates of service on and after August 1, 2022:

Subcutaneous Immune Globulin (SCIG) MB 2208

New policy for subcutaneous immune globulin products and treatment criteria. Prior authorization is required.

Changes To Medical Drug Policy

Effective for dates of service on and after March 1, 2022:

Epoetin Alfa Products MB9715

Removed preferred product designation for Retacrit during planned shortages in 2022. This requirement will be reinstated once the planned shortage has resolved. Prior authorization is required and is restricted to oncology, infectious disease, hematology or nephrology prescribers.

Effective for dates of service on and after April 1, 2022:

ACTEMRA-IV-tocilizumab MB9405

Removed indications that are not appropriate for IV formulation. Prior authorization is required and is restricted to a rheumatology prescriber.

BENLYSTA-belimumab MB1820

Addition of anti-smith antibodies as option for confirmation of diagnosis. Prior authorization is required and is restricted to a rheumatologist, dermatologist, or nephrologist prescriber.

Botulinum Toxin MB9020

Prior authorization requirement is no longer required. Post service claim edits per medical policy criteria remain. Also, clarification for Xeomin dosing limit of in cervical dystonia over 83 days. Addition of pediatric indication for upper limb spasticity along with addition of language to Botox to allow for concurrent use with calcitonin gene-related peptid's (CGRP) in refractory cases

Epoetin Alfa Products MB9715

Addition of allowing Epogen to preferred product. Prior authorization is required and is restricted to oncology, infectious disease, hematology or nephrology prescribers.

LUMIZYME, Myozyme-alglucosidase alfa, Nexviazyme-avalglucosidase alfa MB2107

J Code update for Nexviazyme from J3590 and C9085 to J0219. Prior authorization is required and is restricted to a medical geneticist or other prescriber specialized in the treatment of Pompe disease.

MAPD Insulin Pump Policy MB2122

Statement clarification added regarding Omnipod under Part D only. Prior authorization is required and is restricted to oncology prescribers.

Medically Administered Oncology Products MB2112

J code update for Zynlonta from J9999 and C9084 to J9359. Prior authorization is required and is restricted to oncology prescribers.

ZINPLAVA-bezlotoxumab MB1815

Removal of requirement of previous treatment with vancomycin or fidaxomicin. Prior authorization is required and is restricted to an infectious disease or gastroenterology prescriber.

Effective for dates of service on and after May 1, 2022:

Antihemophilia Factors and Clotting Factors MB1802

Addition of indication for Vonvedi. Prior authorization is required and is restricted to a hematologist prescriber.

Antihemophilia Factors VIII MB2116

Addition of indication von Willebrand disease for Humate-P and Alphanate. Prior authorization is required and is restricted to a hematologist prescriber.

EVENITY-romosozumab-aqqg MB1940

Policy criteria update including difference of Step B therapy treatments with oral medications and Prolia. Additional requirement added of having diagnosis of osteoporosis and taking Calcium with Vitamin D pills. Prior authorization is required and is restricted to an endocrinology or rheumatology prescriber.

FABRAZYME-agalsidase MB9300

Policy criteria update. Prior authorization is required and is restricted to a medical geneticist or other prescriber specialized in the treatment of Fabry disease.

OPDIVO-nivoluma MB1844

Policy criteria updated with 2 new indications for treatment for Non-small cell lung cancer (NSCLC): along with 3 different categories for treatment options. Prior authorization is required and is restricted to an oncologist or hematologist prescriber.

MAPD Medicare Step B Therapy MB2011

Updated Step B policy to add the multiple sclerosis (MS) (Ocrevus, Tysabri, Lemtrada) step therapies that have been approved through commercial Medical policies. Prior authorization is required.

Parenteral Iron Products MB2134

Addition of Triferic and Triferic AVNU as non-preferred drug options. Prior authorization is required.

SPRAVATO-esketamine MB1921

Criteria removal of electroconvulsive therapy (ECT) for both indications. For major depressive disorder (MDD) added criteria that member would need to be on antidepressants plus need some type of psychological / behavioral counseling. Prior authorization is required and is restricted to a psychiatrist prescriber.

Effective for dates of service on and after June 1, 2022:

ACTEMRA IV-tocilizumab MB9405

New indication for Giant cell arteritis. Prior authorization is required and is restricted to a rheumatology specialist.

ADUHELM-aducanumab MB2128

Removal of Medicare product from the policy because of new National Coverage Criteria for Medicare. All other products will continue with non-covered service and no prior authorization required.

ALDURAZYME-laronidase MB9940

Addition of criteria for baseline values and continuation criteria of documented reduction of urinary glycosaminoglycan (uGAG) levels and one other beneficial response from baseline values. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis I.

ARANESP-darbepoetin alpha MB9799

Reduction in approval timeframe to 45 days, refined approvable diagnosis code and covered ranges for hemoglobin (Hb) and hematocrit (Hct). Additional edits in comment section. Prior authorization is required and must be prescribed by, or in consultation with, an oncology, infectious disease, hematology, or nephrology prescriber.

Botulinum Toxin MB9020

Updated dosing limitation of 150 units per visit for migraine headaches to 155 units (8.10). No prior authorization is required.

CABENUVA-cabotegravir and rilpivirine MB2131

Removal of Medicare product from the policy. All other products require prior authorization.

ELAPRASE-idursulfase MB2105

Policy criteria including new requirements for lab values and baseline measurements for initial approval and additional continuation criteria (e.g., cognitive impairment requirement) and lab values. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis II.

ELELYSO-taliglucerase alfa MB2106

Policy criteria including clarifying use as single agent, requirement of complications applies to adults only, addition of national drug code (NDC) and references. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of Gaucher DX.

Epoetin Alfa Products MB9715

Policy criteria including reduction in approval timeframe to 45 days, refined approvable diagnosis and covered ranges for Hb and Hct. Also, additional edits added in the comment section. Prior authorization is required and is restricted to oncology, infectious disease, hematology or nephrology prescribers.

KEYTRUDA-pembrolizumab MB1812

New indication allowing use as a single agent in either microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), clarified in cutaneous squamous cell carcinoma that disease not be curable by surgery and disease not curable by radiation. Prior authorization is required and is restricted to an oncologist or hematologist specialist.

NAGLAZYME-galsulfase MB2108

Policy criteria including addition of baseline values and continuation criteria of documented reduction of uGAG levels and one other beneficial response from baseline values. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis VI.

VIMIZIM-elosulfase MB2109

Policy criteria including additional requirement for initial therapy (6-minute walk test) and clarification on what is needed to confirm diagnosis. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis IVA.

Effective for dates of service on and after July 1, 2022:

Epoetin Alfa Products MB9715

Addition of EPOGEN as a preferred product. Prior authorization is required and is restricted to an oncology, infectious disease, hematology, or nephrology prescribers.

Medically Administered Oncology Products MB2112

Removal of PEPAXTO product to its own medical policy. Prior authorization is required and is restricted to oncology prescribers.

SANDOSTATIN-octreotide MB1809

Policy updated for step through Sandostatin LAR prior to Signifor or Somatuline for Acromegaly, Neuroendocrine tumors and carcinoid tumors BUT not Cushing Disease. Prior authorization is required and is restricted to an endocrinologist, oncologist, or gastroenterologist specialist.

VYEPTI-eptinezumab MB2120

Policy updated for new Calcitonin Gene-Related Peptide (CGRP) inhibitor with using Botox and adding Sub-Q products to be used first. Prior authorization is required and is restricted to a neurologist specialist.

Effective for dates of service on and after August 1, 2022:

Intravenous Immune Globulin (IVIG) MB9423

Updated policy for intravenous immune globulin products and treatment criteria. Prior authorization is required.

ELZONRIS-tagraxofusp-erzs MB1905

Policy criteria updated. Prior authorization is required and must be prescribed by, or in consultation, with an oncologist or hematologist specialist.

Effective for dates of service on and after September 1, 2022:

KYMRIAH-tisagenlecleucel MB1822

Criteria update including separation of the B-Cell precursor for ALL Adult /children (slight difference for child having relapse after transplant or disease is refractory with two line of therapy or later relapse). Added measures for prescriber to attest diagnosis of the disease. Prior authorization is required and is restricted to oncology prescribers.

LUTATHERA-lutetium Lu 177 dotatate MB1823

Criteria update including carcinoid tumors and pheochromocytoma/ paraganglioma. Prior authorization is required and is restricted to oncology prescribers.

Pertuzumab Products MB9438

Criteria update including addition of adverse drug reaction (ADR), (Left ventricular ejection fraction [LVEF] monitoring), and addition of National Comprehensive Cancer Network (NCCN) 2A guidelines to policy with PERJETA vs PHESGO. Prior authorization is required and is restricted to oncology prescribers.

TECARTUS-brexucabtagene autoleucel MB2013

Universal criteria update. Prior authorization is required and is restricted to oncology prescribers.

YESCARTA-axicabtagene ciloleucel MB1829

Criteria update adding screening information, new indication for B-Cell Lymphoma with dosing requiring only 1 line of therapy versus 2 along with relapse within 12 months and AIDs related B-Cell Lymphoma, and criteria update for treatment prior to transplant and relapse. Prior authorization is required and is restricted to oncology prescribers.