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 Formulary Maintenance

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

- **Calquence (acalabrutinib) 100 mg tablets —** Setup to mirror formulary coverage of the capsule at the preferred brand/specialty tier and will require a prior authorization to prescriber specialty (oncologist or hematologist) and indication, a quantity limit of two tablets per day, and split fill/limited distribution where applicable.
- **Dual Orexin Receptor Antagonists (Dayvigo, Belsomra, Quviviq) —** Changed from not-covered to a preferred or non-preferred generic with quantity limit.
- **Rosuvastatin (Crestor equiv.) 5, 10, 20, 40 mg tablets —** Quantity limit removed.
- **Self-injectables (estradiol valerate, testosterone enanthate, ketorolac tromethamine, methylprednisolone SS, dexamethasone sodium phosphate, Solu-Cortef) —** Changed from not-covered to a preferred or non-preferred generic coverage with quantity limit.

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

- **Albuterol inhalers (albuterol HFA 6.7 g & 8.5 g) —** Addition of quantity limit and preferred generic products to formulary.
- **Branded contraceptive agents without generics —** Moving branded products (with no generic alterative) that are currently not covered or on the non-preferred brand tier to $0 to prevent any possible non-compliance. Branded products with a directly interchangeable generic product available on formulary will remain not covered because the generic is already covered at $0.
- **Combigan (brimonidine tartrate/timolol maleate) 0.2%/0.5% ophthalmic solution —** Brand product will be removed from formulary and generic product will move to the non-preferred generic tier.
- **Epiduo Forte (adapalene/benzoyl peroxide) 0.3/2.5% gel —** Removal of the brand product from formulary and add the generic product at the non-preferred generic tier, still retaining the standard prior authorization requirements for acne products to prevent off-label cosmetic use.
- **Female condoms —** Addition of quantity limit of 12 condoms/fill.

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- **Linzess (linaclotide) 72, 145, & 290 mcg capsules —** Addition to formulary at the non-preferred brand tier, a quantity limit, and prior authorization for indication and a trial of plecanatide.
- **Male condoms —** Adding coverage of $0 copay and quantity limit of 12 condoms/fill.
- **Phexxi (lactic acid/citric acid/ potassium bitartrate) 1.8/1/0.4% gel —** Adding coverage of $0 copay and quantity limit.
- **Rozlytrek (entrectinib) 100 mg & 200 mg capsules —** Removal of Split-fill.

Effective for dates of service on and after January 1, 2023:

- **Soliqua (insulin glargine and lixisenatide) 100 units and 33 mcg per mL injection —** removal of prior authorization requirement.
- **Xultophy (insulin degludec and liraglutide) 100 units and 3.6 mg per mL injection —** removal of prior authorization requirement.
- **Koselugo (selumetinib) 10 mg capsules —** Quantity limit change to 8 capsulers per day.
- **Ocaliva (obeticholic acid) 5 & 10 mg tablets —** Addition of RxCents edits for savings.

Pharmacy Drug New or Expanded Formulations

Effective for dates of service on and after December 1, 2022

- **Imbruvica (ibrutinib) 70 mg/mL oral suspension —** Moved from not-covered to prior authorization and quantity limit.
- **Orkambi (lumacaftor/ivacaftor) 75 mg/94 mg oral granules —** Addition of prior authorization and quantity limit of two packets per day.
- **Pheburane (sodium phenylbutyrate) 483 mg/gram oral pellets —** Moved from not-covered to placement at the preferred brand tier or specialty tier.
- **Tadliq (tadalafil) 20 mg/5 mL oral suspension —** Moved from not-covered to prior authorization applicable only to those nine years and older. For those nine years and older, prior authorization criteria will restrict use to those with a diagnosis of PAH who are unable to use the tablets.
- **Zonisade (zonisamide) 100 mg/5 mL oral suspension —** Moved from not-covered to prior authorization applicable only to those nine years and older.

Pharmacy Drug Prior Authorization Form Updates

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

- **Benlysta (belimumab) & Saphnelo (anifrolumab) —** Updated steroid requirement criteria on prior authorization.
- **Braftovi (encorafenib) & Mektovi (binimetinib) —** Addition of criteria for encorafenib to be used in combination with either cetuximab or panitumumab for colorectal cancer.
- **Prolia (denosumab) —** Added bisphosphonate step for oncology related indications, updated 'daily steroid use' requirement, and added continuation criteria to prior authorization form.
- **Strensiq (asfotase alfa) —** Updated prior authorization documentation criteria for: removal of prescribing "in consultation," as this complex disease state must be managed by an endocrinologist; removal of the "pediatric" specialist restriction, as an adult endocrinologist may continue to treat patients with pediatric-onset disease; required documentation of vitamin B6-dependent seizures, rachitic chest deformity causing respiratory problems, bowed arms/legs, or failure to thrive prior to the age of 18; required documentation from radiographic imaging reports demonstrating infantile rickets, alveolar bone loss, craniosynostosis, or other evidence of hypophosphatasia prior to the age of 18 rather than a checkbox that imaging supports the diagnosis; and requiring documentation of the PLP level, rather than a checkbox to indicate elevated levels.

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

- **Esbriet (pirfenidone) —** Update diagnosis criteria to allow use of transbronchial lung cryobiopsy.
- **Khapzory (levoleucovorin) & Fusilev (levoleucovorin) —** Update body surface area (BSA) requirements to only require for metastatic colon cancer diagnosis or NCCN supported indications.
- **Ofev (nintedanib) —** Updated diagnosis criteria to allow use of transbronchial lung cryobiopsy (for immune thrombocytopenia (ITP) and clarify mycophenolate requirement (for systemic scleroderma Interstitial lung disease (SSc-ILD)).
- **Promacta (eltrombopag olamine) & Nplate (romiplostim) —** Update prescriber requirement for immune thrombocytopenia from hematology specialist to hematologist.
- **Stelara (ustekinumab) —** Updated weight requirement. Weight submission will no longer be required 45 mg dose requests

when used for plaque psoriasis treatment or when used for psoriatic arthritis treatment with or without co-morbid moderate-to-severe plaque psoriasis. Additionally, we will now require confirmation that a member has co-morbid plaque-psoriasis (along with a provided weight > 100 kg) for approval of 90 mg dosing for a member with psoriatic arthritis.

Effective for dates of service on and after January 1, 2023:

- **Descovy (emtricitabine/ tenofovir alafenamide) —** Criteria addition for severe adverse events (AE) other than bone or renal AE.
- **Ofev (nintedanib) —** Addition of a step through pirfenidone for idiopathic pulmonary fibrosis (IPF) indication. Also alignment of progressive pulmonary fibrosis criteria with guidelines.

Pharmacy Drug New Indications

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

- **Nubeqa (darolutamide) 300 mg tablets —** New indication for use, in combination with docetaxel, for the treatment of metastatic hormone-sensitive prostate cancer.
- **Opzelura (ruxolitinib) 1.5% cream —** New indication for treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older.

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

- **Myfembree (relugolix/ estradiol/norethindrone acetate) 40/1/5 mg tablets —** New indication added including same criteria used for Orilissa (elagolix) which includes diagnosis of endometriosis or cyclic pelvic pain suspected to be related to endometriosis, prescribed by an OB/GYN or women's health specialist, trials of both an NSAID and hormonal contraceptive, and no known osteoporosis for the patient. Approval will be limited to 24 months without renewal as FDA-approval specifically limits therapy to that duration due to risk of continued and potentially irreversible bone loss with use of relugolix.
- **Orkambi (lumacaftor/ivacaftor) 75 mg/94 mg, 100 mg/125 mg, 150 mg/188 mg oral granules —** Updated age expansion.
- **Pemazyre (pemigatinib) 4.5, 9, & 13.5 mg tablets —** New indication added for the treatment of adults with relapsed or refractory myeloid/lymphoid neoplasm (MLNs) with a fibroblast growth factor receptor 1 (FGFR1) rearrangement. This will require prescription by an oncologist or hematologist, appropriate diagnosis, and documentation of an FGFR1 rearrangement.
- **Retevmo (selpercatinib) 40 mg & 80 mg capsules —** New indication to include solid tumors, and to update the non-small cell lung cancer (NSCLC) indication to include those with locally advanced NSCLC.

New Medical Drug Policies

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

AMVUTTRA (vutrisiran) MB2222

New medical policy created from September Pharmacy and Therapeutics Committee. Prior authorization is required and must be prescribed by or in consultation with a hematologist specialist.

ENJAYMO ® (sutimlimab) MB2223

New medical policy created from September Pharmacy and Therapeutics Committee. Prior authorization is required and must be prescribed by (or in consultation) with a hematologist specialist.

KANUMA IV (sebelipase alfa) MB2221

New medical policy. Prior authorization is required.

LEQVIO (inclisiran) MB2227

New medical policy created from September Pharmacy and Therapeutics Committee. Non-Covered policy and no prior authorization required must be prescribed by (or in consultation with) a cardiology specialist.

RETHYMIC (Allogenic processed thymus tissue-agdc) MB2226

New medical policy created from September Pharmacy and Therapeutics Committee. Prior authorization is required and must be prescribed by (or in consultation) with a specialist who specializes in the treatment of athymia.

TEZSPIRE (tezepelumab) MB2225

New medical policy created from September Pharmacy and Therapeutics Committee. Prior authorization is required and must be prescribed by or in consultation with an allergist, pulmonologist, or immunologist specialist.

VYVGART (efgartigmoid) MB2224

New medical policy created from September 2022 Pharmacy and Therapeutics Committee. Prior authorization is required and must be prescribed by or in consultation with a neurologist specialist.

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

HEMLIBRA (emicizumab) MB2228

New medical policy. Prior authorization is required and must be prescribed by, or in consultation with, a hematology specialist.

Effective for dates of service on and after January 1, 2023:

2023 Medicare Part B Step Therapy

Medicare Part B Step Therapy is a Medical Benefit Injectable policy for informational purposes only and does not constitute medical advice. This policy supplements Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals for the purpose of determining coverage under Medicare Part B medical benefits. This policy implements a prior authorization requirement for prescriptions or administrations of medical benefit drugs only. Changes to 2022 Part B Step Therapy and additional Part B Step Therapy treatments for 2023.

Effective for dates of service on and after January 1, 2023:

KYPROLIS (carfilzomib)

New Medical Policy and prior authorization is required.

Effective for dates of service on and after March 1, 2023

FIRAZYR (icatibant)

New medical policy. Prior authorization is required.

GAMIFANT (emapalumab-lzsg)

New medical policy. Prior authorization is required.

REVCOVI (elapegademase-lvlr)

New medical policy. Prior authorization is required

UPLIZNA (inebilizumab-cdon)

New Medical Policy and Prior Authorization is required.

Changes To Medical Drug Policy

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

Antihemophilia Factors IX MB2117

Addition of indication for routine prophylaxis to prevent or reduce the frequency of bleeding. Prior authorization is required and must be prescribed by or in consultation with a hematologist specialist.

BEOVU (brolucizumab) MB1944

New indication added for diabetic macular edema (DME). Prior authorization is not required.

EVENITY (romosozumab-aqqg) MB1940

Prior authorization is required and must be prescribed by (or in consultation) with an endocrinology or rheumatology specialist. Note: Prior authorization has been required for Medicare Advantage since January 1, 2022.

Rituximab Products MB9847

New indication added for Riabni for use in adults with moderately or severely active rheumatoid arthritis who have had an inadequate response to one or more TNF antagonist therapies. Prior authorization is required and must be prescribed by (or in consultation) with a rheumatology, transplant, hematology, neurology, dermatology, ENT, nephrology, or oncology specialist.

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

BENLYSTA (belimumab) MB1820

New step-through of corticosteroids and removal of the diagnosis criteria in the renewal conditions. Prior authorization is required and must be prescribed by (or in consultation) with a rheumatologist, dermatologist, or nephrologist specialist.

BREYANZI (lisocabtagene maraleucel) MB2209

Oncology criteria alignment with Magellan. Prior authorization is required.

EVENITY (romosozumab-aqqg) MB1940

Language alignment with Magellan and additional option to bypass step therapy of bisphosphonates and/or Prolia (denosumab). Prior authorization is required and must be prescribed by or in consultation with an endocrinology or rheumatology specialist.

FASENRA (benralizumab) MB1813

Addition of step requirement for asthma and minor wording changes. Prior authorization is required and must be prescribed by or in consultation with a pulmonology, allergy, and immunology specialist.

IMFINZI (durvalumab) MB1828

New indication added for locally advanced or metastatic billary tract cancer (BTC). Prior authorization is required and must be prescribed by (or in consultation) with an oncologist specialist.

Immune Globulin (IVIG) MB9423

Addition of HCPCS codes for Asceniv, Gamunex-C, Gammagard liquid, Gammaked, and Panzyga. Prior authorization is required. Approval of Asceniv requires documentation of a failed trial or contraindication of all other immune globulin products.

Immune Globulin (SCIG) MB2208

Update to quantity limit for Cutaquig and addition of references. Prior authorization is required.

Medically Administered Oncology Products MB2112

Addition of hematologist as a prescribing specialist. Prior authorization is required and must be prescribed by (or in consultation) with an oncologist or hematologist specialist.

NUCALA (mepolizumab) MB9914

Change in step requirement for asthma, indication addition for chronic sinusitis with nasal polyps, and minor word changes. Prior authorization is required. Eosinophilic asthma: Prescribed by, or in consultation with a Pulmonologist, Immunologist, or Allergist specialist. Chronic rhinosinusitis with nasal polyps: Prescribed by, or in consultation with an otolaryngologist, immunologist, or allergist specialist. Eosinophilic granulomatosis with polyangitis (EGPA): Prescribed by, or in consultation with a Pulmonologist, Immunologist, Allergist, or Rheumatologist specialist. Hyperesosinophilic syndrome (HES): Prescribed by, or in consultation with a pulmonologist, immunologist, allergist, rheumatologist, gastroenterologist, hematologist, or other specialist experienced with diagnosis.

ONPATTRO (patisiran) MB1838

Oncology criteria alignment with Magellan. Prior authorization is required.

PROLIA-XGEVA (denosumab) MB9409

Criteria addition of taking a daily dose of prednisone >2.5 mg daily. Prior authorization is required and must be prescribed by (or in consultation) with an oncology, rheumatology, internal medicine, family medicine, orthopedic surgery, or endocrinology specialist.

SAPHNELO (anifrolumab-fnia) MB2205

Criteria addition defining moderate to severe Systemic Lupus Erythematosus (SLE) and additional options for continuation approval. Prior authorization is required and requires prescribing or consultation with a rheumatology specialist.

XOLAIR (omalizumab) MB9309

Changed step requirement to include: either an inhaled corticosteroid (ICS) with one additional asthma controller medication or maximally tolerated inhaled corticosteroid/ long-acting beta agonist (ICS/ LABA) combination product, and other minor word changes. Prior authorization is required and must be prescribed by (or in consultation) with an allergy, pulmonary, immunology, otolaryngologist, or dermatology specialist.

ZULRESSO (brexanolone) MB1939

Addition of age limit requirement (15 years or older) per updated FDA indication and addition of criteria for attestation that member would be monitored for excessive sedation or loss of consciousness, and pulse oximetry. Prior authorization is required and must be prescribed by (or in consultation) with a psychiatrist or an obstetrician-gynecologist specialist. Also, ZULRESSO must be prescribed by an MD and administered in a facility that is enrolled in the Risk Evaluation and Mitigation Strategy (REMS) program.

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

Antihemophilia Factors IX MB2117

Indication and quantity limit updates. Prior authorization is required and must be prescribed by (or in consultation) with a hematology specialist.

EVENITY (romosozumab) MB1940

Removal of specialist requirement. Prior Authorization is required.

FLOLAN-epoprpstenol-REMODULIN-treprostinil MB1934

Removal of prior authorization requirement and notation that only generic Remodulin (treprostinil) IV would be covered. Prior authorization is not required, generic Treprostinil will be covered, and Remmodulin will not be covered.

Immune Globulin (IVIG) MB9423

Formatting change and added compendia supported indication IgG subclass deficiency. Removal of Carimune NF as it is no longer available in the marketplace. Prior authorization is required. Approval of Asceniv requires documentation of a failed trial or contraindication of all other immune globulin products.

Infliximab Infusions MB9231

Removal of biosimilar Ixifi as it will not be marketed in U.S. Prior authorization is required and must be prescribed by dermatology, rheumatology, or gastroenterology specialist.

LUMIZYME (alglucosidase alfa), Nexviazyme (avalglucosidase alfa)

Removal of drug Myozyme from policy as drug is marketed in the U.S. as Lumizyme. Prior authorization is required and must be prescribed by, or in consultation with, a medical geneticist or other prescriber specialized in the treatment of Pompe DX.

OXLUMO® (lumasiran) MB2125

Addition of criteria to include plasma oxalate level as an option. Additional indication of lowering plasma oxalate in adult and pediatric patients. Prior authorization is required and must be prescribed by, or in consultation with, a nephrologist or urologist specialist.

Parenteral Iron Products MB2134

Removal of drugs Triferic/Triferic AVNU from policy as they are not necessary to include since they are only provided in dialysis centers. Prior authorization is required for non-preferred products: Injectafer and Monoferric. No prior authorization is required for preferred products: Venofer, INFeD, Ferrlecit, Feraheme.

Pegfilgrastim Products MB1808

New J-Code added to Drug FULNETRA, new code is C9399, J3590. Prior authorization is required for Neulasta, Neulasta OnPro, Nyvepria, Fylnetra, or Udenyca only and must be prescribed by, or in consultation with, a hematologist or oncologist specialist. No prior authorization is required for Fulphila or Ziextenzo.

SIGNIFOR LAR (PASIREORTIDE) MB2201

Prior authorization is required and must be prescribed by (or in consultation) with an endocrinologist specialist. Note: Prior authorization has been required for Medicare Advantage since July 1, 2022.

Somatuline (lanreotide) depot MB2202

Prior authorization is required and must be prescribed by, or in consultation with, an endocrinologist, oncologist, or gastroenterologist specialist. Note: Prior authorization has been required for Medicare Advantage since July 1, 2022.

VYVGART (efgartigmoid) MB2224

Removal of 'cold agglutinin disease' from drug criteria. Prior authorization is required and must be prescribed by a neurologist specialist.

VYZULTA (latanoprostene bunod)-RHOPRESSA (netarsudil) MB1847

Policy updated to reflect current status of formulary prostaglandin alternatives, while removing Travatan Z and replacing with generic travoprost.

Retired Medical Drug Policies

Effective December 1, 2022:

- **KORSUVA (difelikefalin) MB2213**
- **NULOJIX (belatacept) MB1937**
- **SINUVA (mometasone furoate) MB1833**
- **VISUDYNE (verteporfin) MB2114**
- **ZINPLAVA (bezlotoxumab) MB1815**
- **ZULRESSO (brexanolone) MB1939**