SPECIAL eBULLETIN

APRIL 2018

SECOND QUARTER 2018 UPDATE

CHANGES TO THE HIGHMARK DRUG FORMULARIES

Following is the Second Quarter 2018 update to the Highmark Drug Formularies and pharmaceutical management procedures. The formularies and pharmaceutical management procedures are updated on a quarterly basis, and the following changes reflect the decisions made in January 2018 by our Pharmacy and Therapeutics Committee. These updates are effective on the dates noted throughout this document.

Please reference the guide below to navigate this communication:

Section I. Highmark Commercial and Healthcare Reform Formularies

A. Changes to the Highmark Comprehensive Formulary and the Highmark Comprehensive Healthcare Reform Formulary
B. Changes to the Highmark Delaware Healthcare Reform Progressive Formulary
C. Updates to the Pharmacy Utilization Management Programs
    1. Prior Authorization Program
    2. Managed Prescription Drug Coverage (MRxC) Program
    3. Quantity Level Limit (QLL) Programs

As an added convenience, you can also search our drug formularies and view utilization management policies on the Provider Resource Center (accessible via NaviNet® or our website). Click the Pharmacy Program/Formularies link from the menu on the left

National Select Formulary – Select Commercial Plans
July 2018

Effective July 1, 2018, there will be a new formulary available for select Commercial self-funded (ASO) plans. The new formulary, called the **National Select Formulary**, will be an incentive formulary with a non-formulary drug list to selectively manage products in therapeutic categories for which preferred alternatives are available.

If your patient(s) who are impacted by this change remain on any of the drugs not included on the National Select Formulary after the effective date, he or she will be responsible for the entire cost of the drug(s). If you feel there is a medical reason for your patient to continue to take the drug(s) rather than the alternatives, you may also submit a request for a coverage exception.

To ensure that your patients receive the maximum prescription drug coverage, please consider the available formulary drug options. A list of drugs included on the National Select Formulary will be available via the Provider Resource Center prior to July 1, 2018.

As a reminder, NaviNet can be used for any pharmacy authorization request. It saves you time, notifies you if a duplicate request has already been received by Highmark and confirms that the patient is a Highmark member with active pharmacy benefits.

We hope this information makes the transition easier for both you and your patient(s). Our goal, as always, is to work with you to help control the high cost of prescription drugs while maintaining high-quality patient care.

Market Watch Program – Select Commercial and Healthcare Reform Plans
July 2018

Effective July 1, 2018, there will be a new program offering for Select Commercial and Healthcare Reform Plans. The Market Watch Program is designed to help manage prescription drug costs by making select new to market drugs, high cost-low value drugs, and prescription drugs with an over-the-counter (OTC) equivalent non-formulary. Your patient(s) may be subject to any or all of the below market watch drug lists, dependent on their benefit design.

High Cost Low Value Program – High cost products with limited clinical value will be non-formulary under this program. Patients with this program will have coverage of equally efficacious and more cost effective therapies. Examples may include: Vimovo (esomeprazole; naproxen), Duexis (famotidine; ibuprofen) and Glumetza (metformin ER).

New to Market Program – Targeted new medications and dosage forms included within the New to Market drug program will be non-formulary upon initial market launch, and will allow Highmark to review the clinical efficacy, safety and value of the new product. Targeted

products will include newly approved medications where another cost-effective drug already exists to treat the same condition and works in a similar fashion.

Rx Drugs with OTC Equivalents Program – The FDA occasionally approves existing prescription drugs to be available without a prescription, also known as "Over-the-Counter" or 'OTC'. When the OTC version provides cost savings, the prescription version will no longer be covered under the prescription benefit, however the member will be able to purchase the medication over-the-counter. Examples may include: Prilosec, Nexium, Flonase, Zyrtec.

If your patient(s) who are impacted by this change remain on any of the drugs included in the Market Watch Program after the effective date, he or she will be responsible for the entire cost of the drug(s). If you feel there is a medical reason for your patient to continue to take the drug(s) rather than the alternatives, you may also submit a request for a coverage exception.

To ensure that your patients receive the maximum prescription drug coverage, please consider the available formulary drug options. A list of drugs included in the Market Watch Program will be available via the Provider Resource Center prior to July 1, 2018.

As a reminder, NaviNet can be used for any pharmacy authorization request. It saves you time, notifies you if a duplicate request has already been received by Highmark and confirms that the patient is a Highmark member with active pharmacy benefits.

We hope this information makes the transition easier for both you and your patient. Our goal, as always, is to work with you to help control the high cost of prescription drugs while maintaining high-quality patient care.

Important Drug Safety Updates

Clopidogrel Tablets USP, 75 mg by International Laboratories: Recall – Product Mislabeling
On January 10, 2018, International Laboratories LLC announced a voluntary recall of Clopidogrel Tablets 75 mg, packaged in bottles of 30 tablets (NDC# 54458-888-16, Lot Number 117099A), to the consumer level due to mislabeling. The product is labeled as Clopidogrel Tablets 75 mg but may contain Clopidogrel Tablets 75 mg or Simvastatin Tablets 10 mg. Unintended consumption of simvastatin may result in adverse events associated with its use, such as myopathy, and cause fetal harm in pregnant women. Missed doses of clopidogrel may increase the risk of heart attack and stroke which may be life threatening. Adverse events or side effects related to the use of this product should be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Varubi (rolapitant) Injectable Emulsion: Health Care Provider Letter – Anaphylaxis and Other Serious Hypersensitivity Reactions
On January 16, 2018, the FDA announced that anaphylaxis, anaphylactic shock, and other serious hypersensitivity reactions have been reported in the postmarketing setting, some requiring hospitalization, during or soon after the infusion of Varubi (rolapitant) injectable emulsion. Health care professionals must be vigilant for signs of hypersensitivity or anaphylaxis in all patients receiving Varubi (rolapitant) injectable emulsion, both during and following its administration. Adverse events or side effects related to the use of this product should be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Imodium (loperamide) for Over-the-Counter Use: Drug Safety Communication – FDA Limits Packaging To Encourage Safe Use
On January 30, 2018, the FDA announced working with manufacturers to foster safe use of the over-the counter (OTC) anti-diarrhea drug, loperamide, by using blister packs or other single dose packaging and to limit the number of doses in a package. This is the result of receiving reports of serious heart problems and deaths with much higher than the recommended doses of loperamide among people who are intentionally misusing or abusing the product, despite the addition of a warning to the medicine label and a previous communication. Health care professionals should be aware that using much higher than recommended doses of loperamide can result in serious cardiac adverse events, including QT interval prolongation, torsades de pointes or other ventricular arrhythmias, syncope, and cardiac arrest. Adverse events or side effects related to the use of this product should be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Ocaliva (obeticholic acid): Drug Safety Communication – Boxed Warning Added To Highlight Correct Dosing
On February 1, 2018, the FDA announced a warning that Ocaliva (obeticholic acid) has been incorrectly dosed daily instead of weekly in patients with moderate to severe primary biliary cholangitis (PBC), a rare chronic liver disease, increasing the risk of serious liver injury. The FDA is adding a new Boxed Warning to highlight this information in the prescribing information of the drug label, in addition to requiring a Medication Guide for patients to inform them about this issue. Health

care professionals should follow the Ocaliva dosing regimen in the drug label, which is based on calculating a Child-Pugh score in PBC patients with suspected liver cirrhosis before treatment to determine their specific classification and starting dosage. Adverse events or side effects related to the use of this product should be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Acyclovir 400mg Tablets by Apace Packaging: Recall – Product Mix-up
On February 13, 2018, Apace Packaging LLC announced a voluntary recall of one lot of Acyclovir Tablet, 400 mg, 50 ct Unit Dose (NDC# 50268-061-15, Lot Number 19900), to the retail level. These products have been recalled due to a product mix-up. A small number of blister cards containing Acyclovir Tablets 400 mg may potentially also include Torsemide 20 mg Tablets. Adverse events or side effects related to the use of this product should be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Clarithromycin (Biaxin): Drug Safety Communication – Potential Increased Risk of Heart Problems or Death in Patients With Heart Disease
On February 22, 2018, the FDA advised caution before prescribing the antibiotic clarithromycin (Biaxin) to patients with heart disease because of a potential increased risk of heart problems or death that can occur years later. Health care professionals should be aware of these significant risks and weigh the benefits and risks of clarithromycin before prescribing it to any patient, particularly in patients with heart disease, even if it is prescribed for short periods. In such cases, health care professionals are recommended to consider using other available antibiotics. Adverse events or side effects related to the use of this product should be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Highmark Formulary Update – April 2018

SECTION I. Highmark Commercial and Healthcare Reform Formularies

A. Changes to the Highmark Comprehensive Formulary and the Highmark Comprehensive Healthcare Reform Formulary

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. Please note that the Highmark Comprehensive Closed/Incentive Formulary is a complete subset of the Open Formulary; therefore, all medications added to the Comprehensive Closed/Incentive Formulary are also added to the Open Formulary. These updates are effective on the dates noted throughout this document. For your convenience, you can search the following formularies online:

Highmark Comprehensive Formulary:
(https://client.formularynavigator.com/Search.aspx?siteCode=8103967260)
Highmark Comprehensive Healthcare Reform Formulary:
(https://client.formularynavigator.com/Search.aspx?siteCode=4906449921)

Highmark is happy to inform you that Table 1 includes products that have been added to the formulary. Adding products to the formulary may mean lower copays or coinsurance rates for members. By adding products to the formulary, Highmark hopes to promote adherence to maintenance products and improve the overall health of our members.

Table 1. Products Added
(All products added to the formulary effective March 16, 2018, unless otherwise noted.)

Brand Name	Generic Name	Comments
Juluca	dolutegravir/rilpivirine	New two-drug combination indicated as a complete regimen for the treatment of HIV-1 infection in adults.
Clenpiq	sodium picosulfate, magnesium oxide, and anhydrous citric acid	New dosage form (ready-to-use oral solution) indicated for cleansing of the colon as a preparation for colonoscopy in adults.
Siklos*	hydroxyurea	New dosage form and strength (100 mg tablet and functionally triple-scored 1,000 mg tablet) indicated to reduce the frequency of painful crises and the need for blood transfusions in pediatric patients, 2 years of age and older, with sickle cell anemia with recurrent moderate to severe painful crises.

* Effective date to be determined.
Coverage may be contingent upon plan benefits.

Table 2. Products Not Added**

Brand Name	Generic Name	Preferred Alternatives
Vyzulta	latanoprostene bunod	latanoprost, bimatoprost
Tekturna oral pellets*	aliskiren	lisinorpril, enalapril, losartan

Brand Name	Generic Name	Preferred Alternatives
Heplisav-B	hepatitis B vaccine (recombinant), adjuvanted	Provider discretion
Abilify MyCite*	aripiprazole tablet with sensor	olanzapine, quetiapine, risperidone
Prevymis oral tablet	letermovir	valacyclovir, acyclovir
Ozempic	semaglutide	Trulicity, Victoza
Admelog	insulin lispro	Humalog, Novolog
Xepi*	ozenoxacin	mupirocin ointment
Rhopressa*	netarsudil	latanoprost, timolol
Lonhala Magnair*	glycopyrrolate	Spiriva
Steglatro	ertugliflozin	Invokana, Jardiance
Steglujan	ertugliflozin/sitaglitpin	Glyxambi
Segluromet	ertugliflozin/metformin	Invokamet, Synjardy
Macrilen*	macimorelin	Provider discretion
Prexxartan*	valsartan	losartan, valsartan
Hemlibra	emicizumab	Provider discretion

Coverage may be contingent upon plan benefits.
*Effective date to be determined.
Physicians may request coverage of these products using the Prescription Drug Medication Request Form, which can be accessed online in Highmark's Provider Resource Center; under **Forms, select **Miscellaneous Forms**, and select the form titled **Request for Non-Formulary Drug Coverage**.

Table 3. Additions to the Specialty Tier Copay Option

Note: The specialty tier does not apply to Highmark Delaware Healthcare Reform members; see Highmark Delaware's online Provider Resource Center and access the **Pharmacy Program/Formularies** link for details on the formularies and formulary options that apply to Highmark Delaware Healthcare Reform members.

(Effective upon completion of internal review and implementation unless otherwise noted.)

Brand Name	Generic Name
Prevymis oral tablet	letermovir
Hemlibra	emicizumab

Table 4. Products to be Removed or Shifted to Higher Tier — Effective July 1, 2018

Brand name	Generic Name	Preferred Alternatives
All commercial & healthcare reform comprehensive products		
Aczone	dapsone	dapsone
Lexiva	fosamprenavir calcium	fosamprenavir calcium
Lialda	mesalamine	mesalamine
Reyataz	atazanavir sulfate	atazanavir sulfate
Sustiva	efavirenz	efavirenz
Tamiflu suspension	oseltamivir phosphate	oseltamivir phosphate
Viread 300 mg tablet	tenofovir disoproxil fumarate	tenofovir disoproxil fumarate

B. Changes to the Highmark Delaware Healthcare Reform Progressive Formulary

Table 1. Formulary Updates for Highmark Delaware Select Healthcare Reform Individual Plans (All products added to the formulary effective date March 16, 2018, unless otherwise noted.)

Note: Effective January 1, 2018, this Progressive Formulary applies to select Individual Healthcare Reform plans in Delaware. See Highmark Delaware's online Provider Resource Center and access the **Pharmacy Program/Formularies** link for details on the formularies and formulary options that apply to Highmark Delaware members. For your convenience, you may search the formulary online at: https://client.formularynavigator.com/Search.aspx?siteCode=3597426829

Brand Name	Generic Name	Tier**	Comments/Preferred Alternatives
Items listed below are preferred products			
Juluca	dolutegravir/rilpivirine	3-Preferred Brand	New two-drug combination indicated as a complete regimen for the treatment of HIV-1 infection in adults.
Siklos*	hydroxyurea	3-Preferred Brand	New dosage form and strength (100 mg tablet and functionally triple-scored 1,000 mg tablet) indicated to reduce the frequency of painful crises and the need for blood transfusions in pediatric patients, 2 years of age and older, with sickle cell anemia with recurrent moderate to severe painful crises.
Items listed below are non-preferred products			
Vyzulta	latanoprostene bunod	4-Non-preferred Brand	latanoprost, bimatoprost
Tekturna oral pellets*	aliskiren	4-Non-preferred Brand	lisinorpril, enalapril, losartan
Heplisav-B	hepatitis B vaccine (recombinant), adjuvanted	4-Non-preferred Brand	Provider discretion
Abilify MyCite*	aripiprazole tablet with sensor	4-Non-preferred Brand	olanzapine, quetiapine, risperidone
Ozempic	semaglutide	4-Non-preferred Brand	Trulicity, Victoza
Clenpiq	sodium picosulfate, magnesium oxide, and anhydrous citric acid	4-Non-preferred Brand	Suprep
Admelog	insulin lispro	4-Non-preferred Brand	Humalog, Novolog
Xepi*	ozenoxacin	4-Non-preferred Brand	mupirocin ointment
Rhopressa*	netarsudil	4-Non-preferred Brand	latanoprost, timolol
Lonhala Magnair*	glycopyrrolate	4-Non-preferred Brand	Spiriva
Steglatro	ertugliflozin	4-Non-preferred Brand	Invokana, Jardiance

Steglujan	ertugliflozin/sitaglitpin	4-Non-preferred Brand	Glyxambi
Segluromet	ertugliflozin/metformin	4-Non-preferred Brand	Invokamet, Synjardy
Macrilen*	macimorelin	4-Non-preferred Brand	Provider discretion
Prexxartan*	valsartan	4-Non-preferred Brand	losartan, valsartan
Hemlibra	emicizumab	4-Non-preferred Brand	Provider discretion
Prevymis oral tablet	letermovir	4-Non-preferred Brand	valacyclovir, acyclovir

Coverage may be contingent upon plan benefits.
*Effective date to be determined.
Tier 1: Preferred generic drugs; **Tier 2:** Non-preferred generic drugs; **Tier 3:** Preferred brand drugs, **Tier 4:** Non-preferred brand drugs.

Table 2. Products to be Removed or Shifted to Higher Tier – Effective July 1, 2018

Brand Name	Generic Name	Preferred Alternatives
Only healthcare reform progressive products		
Viread	tenofovir disoproxil fumarate	tenofovir disoproxil fumarate
All commercial & healthcare reform progressive products		
Sustiva	efavirenz	efavirenz
Tamiflu	oseltamivir phosphate	oseltamivir phosphate

C. Updates to the Pharmacy Utilization Management Programs

1. Prior Authorization Program

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Prexxartan (valsartan) – Commercial and Healthcare Reform	TBD	New policy created to ensure appropriate use for all FDA-approved indications (hypertension, heart failure [NYHA class II-IV], and stable left ventricular failure or left ventricular dysfunction following myocardial infarction) and requiring clinical documentation that patient is unable to swallow the tablet formulation, including valsartan tablets.
Xerese Cream (acyclovir; hydrocortisone) – Commercial	01/23/2018	New policy created to ensure appropriate use for FDA-approved indication (herpes labialis [cold sores]) and step through formulary antiviral agents such as acyclovir, valacyclovir, or acyclovir, or use of acyclovir 5% ointment and hydrocortisone 1% cream simultaneously.
Tekturna and Tekturna HCT(aliskiren) – Commercial	TBD	New policy created to ensure appropriate use for FDA-approved indication, treatment of hypertension, and to require trial of at least 3 generic antihypertensive medications, one of which must be an angiotensin-converting-enzyme inhibitor (ACEI) or an angiotensin II receptor blocker **(**ARB).
Luxturna (voretigene neparvovec-rzyl) – Commercial and Healthcare Reform	03/16/2018	New policy created to ensure appropriate utilization of this novel therapy for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy, aligned with its marketed use as a one-time gene therapy option for this

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		patient population.
Siklos (hydroxyurea) – Commercial and Healthcare Reform	TBD	New policy created to ensure appropriate use for the FDA-approved indication, of sickle cell anemia, in patients who are between 2 and 18 years of age.
Hemlibra (emicizumab) – Commercial and Healthcare Reform	02/17/2018	New policy created to ensure appropriate use for hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors, and to ensure there is documentation supporting prophylaxis management strategy and that member's weight has been provided.
Non-Preferred Erectile Dysfunction Medications – Commercial	TBD	New policy created to promote use of preferred generic product sildenafil citrate for the treatment of erectile dysfunction (ED) prior to utilizing Cialis, Levitra, Staxyn, Viagra, or Stendra.
Impoyz (clobetasol propionate) – Commercial and Healthcare Reform	03/16/2018	New policy created to ensure appropriate use for the treatment of moderate to severe plaque psoriasis in patients 18 years of age and older, and step through generic clobetasol propionate topical cream.
Hepatitis C Oral Therapy – Commercial and Healthcare Reform	01/01/2018	Policy revised to move Epclusa to the list of preferred agents and to remove all references to alternative preferred products. Preferred products now include: sofosbuvir/velpatasvir (Epclusa), ledipasvir/sofosbuvir (Harvoni), glecaprevir/pibrentasvir (Mavyret), and ombitasvir/paritaprevir/ritonavir/dasabuvir (Viekira Pak/XR) for Genotype 1 (GT1), sofosbuvir/velpatasvir (Epclusa) and glecaprevir/pibrentasvir (Mavyret) for GT2 and GT3, sofosbuvir/velpatasvir (Epclusa), ledipasvir/sofosbuvir (Harvoni), glecaprevir/pibrentasvir (Mavyret), and ombitasvir/paritaprevir/ritonavir (Technivie) for GT4, and sofosbuvir/velpatasvir (Epclusa), ledipasvir/sofosbuvir (Harvoni), and glecaprevir/pibrentasvir (Mavyret) for GT5 and GT6 for adults and ledipasvir/sofosbuvir (Harvoni) for pediatrics.
Dupixent (dupilumab) – Commercial and Healthcare Reform	02/17/2018	Policy revised to update initiation quantity limitation (QL) from 3 syringes to 4 syringes.
Intra-articular hyaluronan – Commercial and Healthcare Reform	TBD	Policy revised to update the list of preferred products, which now include Euflexxa, Durolane, GelSyn-3, and Supartz.
Idiopathic Pulmonary Fibrosis –Commercial and Healthcare Reform	02/17/2018	Policy revised to require that patient is a non-smoker or involved in smoking cessation, limit authorization to 12 months, and add reauthorization criteria for members responding to therapy and continuing to be non-smoking.
PCSK9 Inhibitors – Commercial and Healthcare Reform	02/17/2018	Policy revised to add new expanded indication for evolocumab (Repatha) for cardiovascular risk reduction in patients with established cardiovascular disease, and additional LDL-based approval criteria added for treated heterozygous familial hypercholesterolemia (HeFH) population. American College of

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		Cardiology (ACC) and National Lipid Association (NLA) guideline references updated to include the most current place in therapy recommendations for Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors.
Immune Globulin (Medical Injectable Policy) – Commercial and Healthcare Reform	02/17/2018	Policy revised to modify the duration of authorization from lifetime to 12 months. Administrative changes were also made to add the FDA indications and update of HCPCS code for immune globulin subcutaneous (human) (Cuvitru). Please note immune globulin (IG) products are covered under the medical benefit. Additional criteria may apply to the coverage of both preferred and non-preferred IG products under Highmark medical benefit.
Chronic Inflammatory Diseases –Commercial and Healthcare Reform	02/17/2018	Policy revised to include the expanded indication of psoriatic arthritis for ixekizumab (Taltz) and tofacitinib (Xeljanz, Xeljanz XR). Stelara (ustekinumab) added as one of the preferred agents for Crohn's disease. Policy also revised to include exceptions to the requirement for a trial of one nonbiologic DMARD (for rheumatoid arthritis, juvenile idiopathic arthritis, and psoriatic arthritis), phototherapy or systemic therapy (for plaque psoriasis), and two immunosuppressants (for Crohn's disease and ulcerative colitis). The exception would prevent a member from having to "step back" when a member has a previous trial of a biologic agent.
Vimpat (lacosamide) – Healthcare Reform	02/17/2018	Policy revised to include expanded indication for younger age population, thus modification of coverage for patients ≥4 years of age (previously indicated coverage for patients ≥17 years of age).
Kinase Inhibitors – Commercial and Healthcare Reform***	02/17/2018	Policy revised to split Commercial and Medicare policies; additionally, new expanded indications were added for the following agents: • vemurafenib (Zelboraf) for the treatment of patients with Erdheim-Chester Disease with BRAF V600 mutation • alectinib (Alecensa) for treatment of all patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) • dasatanib (Sprycel) for the treatment of pediatric patients with Ph+ CML in chronic phase • sunitinib (Sutent) as adjuvant treatment for adult patients at high risk of recurrent renal cell carcinoma following nephrectomy • bosutinib (Bosulif) for treatment of newly diagnosed chronic phase Ph+ CML • cabozantanib (Cabometyx) for treatment of all patients with advanced renal cell carcinoma • afatanib (Gilotrif) for first-line treatment of metastatic NSCLC in adults whose tumors have non-resistant

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		epidermal growth factor receptor (EGFR) mutations (i.e., exon 19 deletions, or exon 21 (L858R) substitution mutations, S768I, L861Q, G719X) as detected by an FDA-approved test • olaparib (Lynparza) for the treatment of patients with deleterious or suspected deleterious *gBRCAm*, human epidermal growth factor 2 (HER2)-negative metastatic breast cancer who have been previously treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting
Human Growth Hormone – Commercial and Healthcare Reform	02/17/2018	Policy revised to include macimorelin (Macrilen) as a growth hormone stimulation test option for diagnosis of adult growth hormone deficiency.
Procysbi (cysteamine bitartrate) – Commercial and Healthcare Reform	02/17/2018	Policy revised to include coverage in patients 1 year and older.

*All effective dates are tentative and subject to delay pending internal review or approval.
*** Cancer Chemotherapy Override Exception: An exception to select criteria within the respective policies may be made for members enrolled in a DE plan

2. Managed Prescription Drug Coverage (MRxC) Program

Policy Name	Policy Effective Date*	Updates and Automatic Approval Criteria**
Xepi (ozenoxacin) – Commercial and Healthcare Reform	TBD	New policy created to ensure appropriate use for the treatment of Impetigo due to *Staphylococcus aureus* or *Streptococcus pyogenes* in adults and pediatric patients 2 months of age and older. Policy criteria also include a requirement to step through generic mupirocin ointment.
Opioid Containing Cough and Cold Medications – Commercial and Healthcare Reform	3/8/2018	New policy created to restrict use of opioid containing cough and cold medications to adults. This is based on new requirements from the U.S. Food and Drug Administration (FDA), requiring safety labeling changes for prescription cough and cold medications containing codeine or hydrocodone to limit the use of these products to adults 18 years of age and older as the risks of these medicines outweigh their benefits in children younger than 18 years of age.
Non-Preferred Nasal Steroids – Commercial	TBD	New policy created to require step through two preferred generic nasal steroids, fluticasone propionate nasal spray and triamcinolone nasal spray, before Beconase AQ, Dymista, Flonase, Nasacort, Nasonex (mometasone furoate nasal spray), Omnaris, Qnasl, Rhinocort, Veramyst, or Zetonna are covered.

Policy Name	Policy Effective Date*	Updates and Automatic Approval Criteria**
Vyzulta (latanoprostene bunod) –Commercial and Healthcare Reform	03/16/2018	New policy created to ensure appropriate use of latanoprostene bunod ophthalmic solution (Vyzulta) in patients with open-angle glaucoma or ocular hypertension, and step through two ophthalmic alternatives that lower intraocular pressure, one of which must be generic latanoprost. • Alternatives include prostaglandin analogs (i.e., Lumigan, latanoprost), ophthalmic beta blockers (i.e., timolol), alpha-adrenergic agonists (i.e., brimonidine), carbonic anhydrase inhibitors (i.e., Azopt, dorzolamide), and combination products of these classes (i.e., Combigan, Cosopt).
Rhopressa (netarsudil) – Commercial and Healthcare Reform	TBD	New policy created to ensure appropriate use of netarsudil ophthalmic solution (Rhopressa) in patients with open-angle glaucoma or ocular hypertension, and step through two ophthalmic alternatives that lower intraocular pressure, one of which must be generic latanoprost. • Alternatives include prostaglandin analogs (i.e., Lumigan, latanoprost), ophthalmic beta blockers (i.e., timolol), alpha-adrenergic agonists (i.e., brimonidine), carbonic anhydrase inhibitors (i.e., Azopt, dorzolamide), and combination products of these classes (i.e., Combigan, Cosopt).
Atypical Antipsychotics – Commercial and Healthcare Reform	03/01/2018	Policy revised to change the authorization duration from lifetime to 12 months.
Diabetic Blood Glucose Testing Products (blood glucose test strips) - Commercial	02/17/2018	Policy revised to change the authorization duration from lifetime to 12 months.
Non-Stimulant Treatment of ADHD/ADD – Commercial and Healthcare Reform	02/17/2018	Policy revised to include history of pheochromocytoma and narrow angle glaucoma as indications where a stimulant for attention-deficit/hyperactivity disorder (ADHD) would be contraindicated. The authorization duration was also changed from lifetime to 12 months.
Gralise (gabapentin) – Commercial and Healthcare Reform	02/17/2018	Policy revised to change the authorization duration from lifetime to 12 months.
Non-Preferred Sodium-Glucose Co-Transporter 2 Inhibitors – Healthcare Reform	03/16/2018	Policy revised to add ertugliflozin (Steglatro), ertugliflozin and sitagliptin (Steglujan) and ertugliflozin and metformin HCl (Segluromet) as non-preferred products. Policy ensures use for FDA-approved indication (type 2 diabetes mellitus) and step through both preferred agents, canagliflozin (Invokana, Invokamet or Invokamet XR) and empagliflozin (Jardiance, Synjardy or Synjardy XR).
Non-Preferred Glucagon-Like Peptide-1 Receptor Agonists –Commercial and Healthcare Reform	03/16/2018	Policy revised to add exenatide ER (Bydureon Bcise) and semaglutide (Ozempic) to the policy. Policy ensures appropriate use for FDA-approved indication, diagnosis of type 2 diabetes mellitus, and step through both of the preferred GLP-1 receptor agonists (dulaglutide [Trulicity] and liraglutide [Victoza]).

Policy Name	Policy Effective Date*	Updates and Automatic Approval Criteria**
Non-Preferred Dipeptidyl Peptidase IV Inhibitors – Commercial and Healthcare Reform	03/16/2018	Policy revised to add empagliflozin/linagliptin (Glyxambi) to the list of preferred products and add dapagliflozin/saxagliptin (Qtern) and ertugliflozin/sitagliptin (Steglujan) to non-preferred products. Patients must step through both of the preferred agents, sitagliptin (Januvia) and linagliptin (Tradjenta), for the non-preferred agents to be approved.
Beta Blocker Management – Commercial	02/09/2018	Policy revised to add carvedilol phosphate extended release (ER) to the list of non-preferred products. Please refer to the policy for additional details and to review the extensive list of preferred and non-preferred agents and corresponding approval criteria.
Trulance (plecanatide) – Commercial	02/21/2018	Policy revised to include the expanded indication for irritable bowel syndrome with constipation (IBS-C) in adults, requiring trial and failure of linaclotide (Linzess) and lubiprostone (Amitiza). Amitiza is only currently indicated for IBS-C in females. Males are only required to document therapeutic failure or intolerance to Linzess prior to approval of Trulance for IBS-C. The authorization duration was also changed from lifetime to 12 months.

*All effective dates are tentative and subject to delay pending internal review or approval.
**Standard prior authorization criteria will apply for members who do not meet the automatic approval criteria.

3. Quantity Level Limit (QLL) Programs*

(Effective immediately upon completion of internal review and implementation, unless otherwise noted.)

Table 1. Quantity Level Limits – Quantity per Duration for Commercial and Healthcare Reform Plans

Drug Name	Retail Edit Limit	Mail Edit Limit
Prevymis (letermovir) oral tablet (all strengths)	100 tablets per 365 days	
Ozempic (semaglutide) all strengths	4 pens per 28 days	12 pens per 84 days
Xepi (ozenoxacin) all strengths*	1 pack per 5 days	
Lonhala Magnair (glycopyrrolate starter kit) all strengths*	1 starter kit per lifetime	
Lonhala Magnair (glycopyrrolate neb refill) all strengths*	1 refill kit per 30 days	3 refill kits per 90 days
Alunbrig (brigatinib) 90-180 mg dose pack	1 dose pack per 720 days	
Luxturna (Voretigene Neparvovec) 1.5X10EX[11]	One 0.5 mL vial per 720 days	
Hemlibra (emicizumab) 30 mg/mL in a single-dose vial	24 vials (24 mL) per 28 days	72 vials (72 mL) per 84 days
Hemlibra (emicizumab) 60 mg/0.4 mL in a single-dose vial	8 vials (3.2 mL) per 28 days	24 vials (9.6 mL) per 84 days
Hemlibra (emicizumab) 105 mg/0.7 mL in a single-dose via	8 vials (5.6 mL) per 28 days	24 vials (16.8 mL) per 84 days
Hemlibra (emicizumab) 150 mg/mL in a single-dose vial	8 vials (8 mL) per 28 days	24 vials (24 mL) per 84 days

Drug Name	Retail Edit Limit	Mail Edit Limit
Copaxone 20 mg	28 syringes per 28 days	84 syringes per 84 days
Copaxone 40 mg	12 syringes per 28 days	36 syringes per 84 days
Glatopa 20 mg	28 syringes per 28 days	84 syringes per 84 days
glatiramer acetate 20 mg*	28 syringes per 28 days	84 syringes per 84 days
glatiramer acetate 40 mg*	12 syringes per 28 days	36 syringes per 84 days

*Effective date to be determined.

Table 2. Quantity Level Limits – Quantity per Dispensing Event – Commercial and Healthcare Reform Plans

Drug Name	Retail Edit Limit	Mail Edit Limit
Vyzulta (latanoprostene bunod) all strengths	5 ml	15 ml
Rhopressa (netarsudil) all strengths*	5 ml	15 ml
Clenpiq (sodium picosulfate, magnesium oxide, and anhydrous citric acid) 10 mg-3.5 g-12 g	320 ml	

*Effective date to be determined.

Quantity per dispensing event limits the quantity of medication that can be dispensed per each fill. If the submitted day supply on a claim is 34 days or less, the retail limit will apply. If the submitted day supply on a claim is greater than 34 days, the mail limit will apply.

Table 3. Maximum Daily Quantity Limits – Commercial and Healthcare Reform Plans

Drug Name	Daily Limit
Tekturna (aliskiren) oral pellets (all strengths)	4 pellet capsules per day
Juluca (dolutegravir/rilpivirine) all strengths	1 tablet per day
Steglatro (ertugliflozin) all strengths	1 tablet per day
Steglujan (ertugliflozin/sitagliptin) all strengths	1 tablet per day
Segluromet (ertugliflozin/metformin) all strengths	2 tablets per day
Bosulif (bosutinib) 400 mg	1 tablet per day
Lyrica CR (pregabalin) all strengths	1 tablet per day
methylphenidate ER 72 mg	1 tablet per day
Alunbrig (brigatinib) 90 mg, 180 mg	1 tablet per day
Alunbrig (brigatinib) 30 mg	2 tablets per day
Xigduo XR (dapagliflozin; metformin) 2.5 mg/1000 mg	2 tablets per day
Prexxartan (valsartan) 4 mg/ml	320 mg (80 ml) per day

Members can receive up to the maximum day supply according to their benefits, but the daily limit must not be exceeded for each individual day.

Requests for coverage of select medications exceeding the defined quantity level limits may be submitted for clinical review. Maximum-day supply on certain medications may vary depending on member's benefit design.

All effective dates are tentative and subject to delay, pending internal review and implementation.