Summer 2023

Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights

Highlights of recent drug policy revisions, as well as any new drug policies approved by Dean Health Plan's Medical Policy Committee, are listed below. Drug policies are applicable to all Dean Health Plan 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 Dean Health Plan 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.

Policies regarding medical benefit medications may be found on deancare.com. From the home page, hover over **For Providers** located on the top, right of the screen and click **Pharmacy Services**. Under Current Drug Policies, click **See Library**.

Criteria for pharmacy benefit medications may be found on the prior authorization form located in the provider portal. Pharmacy benefit changes may be found on deancare.com. From the home page, hover over **For Providers** located on the top, right of the screen and click **Pharmacy Services**. Under Covered Drugs/Formulary, click **See Drug Formularies**. Select appropriate plan type and then benefit plan to open formulary document.

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

The Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights in this document are published alongside our quarterly newsletters on the Dean Health Plan Provider news page at deancare.com/providers/news. Please call the Customer Care Center at 800-279-1301 if you have questions about accessing our newsletters.

Pharmacy Drug Formulary Maintenance

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

- Colonoscopy bowel preps (Suprep Equiv, Clenpiq, Moviprep Equiv, Osmoprep, and Sutab).
  - Clenpiq: Moved to not covered.
  - Suprep Equiv & Moviprep Equiv: $0 cost share and addition of quantity limit.
  - Osmoprep: No change.
  - Sutab: No change.
- **Levalbuterol (Xopenex Equiv) 0.31, 0.63, 1.25 mg solution —** Moved from non-preferred brand to the non-preferred generic Tier.
- **Purixan (mercaptopurine) 20 mg/mL oral suspension —** Prior authorization required if 9 years or older, and moved to non-preferred brand.
- **Self-injectables (Depo-Medrol [methylprednisolone acetate inj] & Kenalog [triamcinolone acetonide inj]) —** Moved from not covered to generic, will be on the preferred generic tier and branded products will be on the non-preferred brand tier.
- **Spiriva Respimat (tiotropium) 1.25 mcg/actuation inhaler —** Addition of Symbicort to Step Therapy criteria.
- **Topical acyclovir products (5% cream & 5% ointment [Zovirax equiv])**
  - **Cream (O/Y):** Moved to not covered
  - **Ointment (Y):** Moved to Preferred Generic
  - **Ointment (O):** Moved to Non-preferred brand

Effective for dates of service on and after May 15, 2023:

- **COVID-19 Vaccines —** Added to the flu and standard vaccine list.
- **COVID-19 Testing Kits —** Removed from formulary to over the counter (OTC) and moved to the Excluded Tier.
- **COVID-19 Therapeutics (Paxlovid [nirmatrelvir/ritonavir] & Lagevrio [molnupiravir]) —** Moved to preferred brand and quantity limit added.

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

- **Atorvaliq (atorvastatin) 20 mg/5 mL oral suspension —** Moved from not covered to non-preferred brand and prior authorization added for members 9 years of age and older.

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- **Cleocin (clindamycin) 100 mg vaginal suppository —** Quantity **limit added (3 suppositories/fill).**
- **Clindesse (clindamycin) 2% vaginal cream —** Quantity limit added (1 applicator/fill).
- **Combination products:**
  - **Amlodipine/Valsartan/ Hydrochlorothiazide tabs —** Moved from non-preferred generic to not covered.
  - **Amlodipine/Atorvastatin tabs —** Moved from Tier 2 to not covered.
  - **Amitriptyline/Chlordiazepoxide tabs —** Moved from preferred generic to not covered.
  - **Dutasteride/Tamsulosin caps —** Moved from Tier 2 to not covered.
- **FloLipid (simvastatin) 20 mg/5 mL & 40 mg/5 mL oral suspension —** Moved from not covered to non-preferred brand and prior authorization added for members 9 years of age and older.
- **Konvomep (omeprazole and sodium bicarbonate) 2 mg/84 mg per mL oral suspension —** Moved to not covered.
- **Lumakras (sotorasib) 320 mg tablets —** Covered at the preferred brand or specialty tier with prior authorization, split fill, and a quantity limit of 3 tablets per day.
- **Orenitram (treprostinil) 0.125 & 0.25 mg extended-release tablets —** Continue to be not covered.
- **Oxybutynin 2.5 mg tablets —** Continue to be not covered.
- **Pradaxa (dabigatran) 20, 30, 40, 50, 110, & 150 mg oral pellet packs —** Moved to not covered.
- **Tezspire (tezepelumab) 210 mg/1.91 mL single-dose pen —** Moved from not covered to preferred brand or specialty tier with prior authorization, mandatory specialty pharmacy, and a quantity limit of 1 pen, per 28 days.
- **Votrient (pazopanib) 200 mg tablets —** Removal of age requirement from prior authorization and quantity limited added.
- **Xaciato (clindamycin) 2% vaginal gel —** Moved to not covered.

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

- **Inhaled corticosteroids:**
  - **Arnuity Ellipta —** Moved to Preferred Brand
  - **Asmanex —** Moved to Preferred Brand
  - **Asmanex HFA —** Moved to Preferred Brand
  - **Flovent HFA (brand) —** Moved to Preferred Brand
  - **Flovent Diskus —** Moved to Preferred Brand
  - **Flovent HFA (AG) —** No change

Pharmacy Drug New Indications

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

- **Cibinqo (abrocitinib) 50, 100, & 200 mg tablets —** Prior authorization criterion updated to the FDA-approved age updated to 12 years of age.
- **Mekinist (trametinib) 0.5 mg & 2 mg tablets —** Addition of new indication treatment of pediatric patients 1 year and older with low-grade glioma with a BRAF V600E mutation who require systemic therapy.
- **Tafinlar (dabrafenib) 50 & 75 mg capsules —** Addition of new indication treatment of pediatric patients 1 year and older with low-grade glioma with a BRAF V600E mutation who requires systemic therapy.

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

- **Kevzara (sarilumab) 150 mg/1.14 mL & 200 mg/1.14 mL injections —** Added indication to prior authorization. Added indication requiring an appropriate diagnosis, prescription by or in consultation with a rheumatologist, and that a trial of a corticosteroid was ineffective or that the patient was unable to tolerate steroid taper to ≤ 5 mg prednisone equivalent/day.
- **Qulipta (atogepant) 60 mg tablets —** No change.
- **Imbruvica (ibrutinib) 420 mg/560 mg TAB, 70 MG/140 MG CAP, & SUSP –** Indication withdrawal for use in patients with mantle cell lymphoma (MCL) who have received ≥ 1 prior therapy and with marginal zone lymphoma (MZL) who require systemic therapy and have received ≥ 1 prior anti-CD20-based therapy.
- **Trikafta (elexacaftor/tezacaftor/ ivacaftor) 100/50/75 mg & 80/40/60 mg oral granules —** Update the prior authorization to now include children ≥ 2 years of age.

Pharmacy Drug New or Expanded Formulations

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

- **Erleada (apalutamide) 240 mg tablet —** Moved to preferred brand or specialty tier with prior authorization, quantity limit, and mandatory specialty pharmacy.

- **Takhzyro (lanadelumab) 150 mg/1 mL prefilled syringe —** Moved to preferred brand or specialty tier with prior authorization, quantity limit, and limited distribution.

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

- **Gralise (gabapentin) 450, 750, & 900 mg tablets —** Moved to not covered.
- **Mircera (epoetin beta) 120 mcg/0.3 mL syringe —** Moved to not covered.
- **Primidone 125 mg tablets —** Moved to not covered.
- **Tirosint (levothyroxine) 37.5, 44, & 62.5 mcg capsules —** Moved to not covered.
- **Trikafta (elexacaftor/tezacaftor/ivacaftor) 100/50/75 mg & 80/40/60 mg oral granules —** Will be covered on the preferred brand/specialty tier with a prior authorization requirement to mirror the tablets, and will include children ≥ 2 years of age with a quantity limit of 2 packets per day.

Pharmacy Drug Prior Authorization Form Updates

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

- **Strensiq (asfotase alfa) —** Addition of continuation criteria allow for a number of potential demonstrations of improvement with therapy, and correctly diagnosed with hypophosphatasia patients should not have difficulty demonstrating improvement and continuing therapy. Also implementing an attestation that the requested dose is less than 9 mg/kg weekly for perinatal/infantile-onset disease and 6 mg/kg weekly for juvenile-onset disease.

New Medical Benefit Drug Policies

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

- **Continuous Blood Glucose MB2302 —** New medical policy and no prior authorization required.

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

- **MAPD CGM —** New medical policy following CMS National Coverage Determinations (NCD) and Local Coverage Determination (LCD) guidelines.

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

- **ADSTILADRIN (nadofaragene firadenovec-vncg) —** New medical policy and prior authorization is required.
- **BRIUMVI (ublituximab-xiiy) —** New medical policy and prior authorization is required.
- **ILUMYA (tildrakizumab-asmn) —** New medical policy and prior authorization is required.
- **LUNSUMIO (mosunetuzumab-axgb) —** New medical policy and prior authorization is required.

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

- **LAMZEDE (velmanase-alfa-tycv) —** New medical policy and prior authorization is required.

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

- **SYFOVRE (pegcetacoplan) —** New medical policy and prior authorization is required.
- **ZYNYZ (retifanlimab-dlwr) —** New medical policy and prior authorization is required.

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

- **SPRAVATO (esketamine) —** New medical policy and prior authorization is required.
- **SPRAVATO (esketamine) —** New pharmacy policy and prior authorization is required.

Changes to Medical Benefit Drug Policies

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

Medicare Part B Step Therapy MB2011

Policy updated with additional step therapy drugs missed originally.

Oncology Policies with Magellan Rx (MRx)

The medical benefit drug policy documents for the drugs listed below will be updated and accessible via the "Medical Oncology Drugs" link on the Dean Health Medical Management web page.

- ABRAXANE (paclitaxel protein bound particles)
- ADCETRIS (brentuximab vedotin)
- BAVENCIO (avelumab)
- BELEODAQ (belinostat)
- BEVACIZUMAB (Avastin, Mvasi, Zirabev, Alymsys, Velgezma)
- BLINCYTO (blinatumomab)
- CYRAMZA (ramucirumab)
- DARZALEX (daratumumab)
- DARZALEX FASPRO (daratumumab)
- ERBITUX (cetuximab)
- GAZYVA (obinutuzumab)

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- IMFINZI (durvalumab)
- JEMPERLI (dostarlimab-gxly)
- KEYTRUDA (pembrolizumab)
- LEVOLEUCOVORIN (Fusilev, Khapzory)
- LIBTAYO (cemipilimab-rwlc)
- MARGENZA (margetuximab-cmkb)
- OPDIVO (nivolumab)
- PEMETREXED (Alimta, Pemfexy)
- PERJETA (pertuzumab)
- RITUXIMAB IV
- RITUXIMAB SQ
- TECENTRIQ (atezolizumab)
- TIVDAK (tisotumab vedotin-tftv)
- TRASTUZUMAB IV
- TRODELVY (sacituzumab govitecan hziy)
- YERVOY (ipilimumab)
- YONDELIS (trabectedin)
- ZEPZELCA (lurbinectedin)
- ZYNLONTA (loncastuximab tesirine-lpyl)

SPEVIGO (spesolimab)

Added J Code J1747.

TECVAYLI (teclistamab-cqyv)

Added HCPCs Code C9333 and reference updates.

XENPOZYME (olipudase alfa)

Added J code J0218.

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

FIRAZYR (icatibant)

Criteria alignment with Navitus for covering products on both medical and pharmacy benefit side.

Effective for dates of service on and after May 26, 2023:

Oncology Policies with Magellan Rx (MRx)

The medical benefit drug policy documents for the drugs listed below will be updated and accessible via the "Medical Oncology Drugs" link on the Dean Health Plan Medical Management web page.

- AKYNZEO (fosnetupitant palonosetron)
- ALOXI (palonosetron)
- COSELA (trilaciclib)
- Colony Stimulating Factors – Pegfilgrastim
- Colony Stimulating Factors-Filgrastims
- ELZONRIS (tagraxofusp-erzs)
- ONIVYDE (irinotecan liposome)
- REBLOZYL (luspatercept-aamt)
- ROLVEDON (eflapegrastim-xnst)
- SANDOSTATIN LAR (octreotide suspension)
- SAPHNELO (anifrolumab-fnia)
- SUSTOL (granisteron extended release)
- ZYNTEGLO (betibeglogene autoemcel)

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

FLOLAN (epoprpstenol)-REMODULIN (Treprostinil) MB1934

Prior authorization requirement for Flolan and Veletri removed. Prior authorization is still required for Remodulin.

Oncology Policies with Magellan Rx (MRx)

The medical benefit drug policy documents for the drugs listed below will be updated and accessible via the "Medical Oncology Drugs" link on the Health Plan's Medical Management web page.

- PEDMARK (sodium thiosulfate)
- POTELIGEO (mogamulizumab-kpkc)
- SYLVANT (siltuximab)

Effective for dates of service on and after June 29, 2023:

Oncology Policies with Magellan Rx (MRx)

The medical benefit drug policy documents for the drugs listed below will be updated and accessible via the "Medical Oncology Drugs" link on the Health Plan's Medical Management web page.

- ARANESP (darbepoetin alfa)
- EPOETIN ALFA (Epogen, Procrit, Retacrit)
- FYARRO (sirolimus albumin bound)
- IMLYGI (talimogene laherparepvec)
- INFUGEM (gemcitabine)
- JELMYTO (mitomycin)
- KEYTRUDA (pembrolizumab)
- OPDUALAG (nivolumab-relatimab-rmbw)
- PADCEV (enfortumab vedotin ejfv)
- POLIVY (polatuzumab vedotin piiq)

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

Antihemophilia Factors VIII MB2116

Addition of product Altuviio.

ENJAYMO (sutimlimab-jome)

Added age requirement of 18 years or older, removed pediatric specialist restriction, updated renewal criteria, and changed approval period from 12 months to 6 months.

KRYSTEXXA (pegloticase)

Added age requirement of 18 years or older, minimum 3- month trial of only one treatment with maximally tolerated xanthine oxidase inhibitors or uricosuric agents, removed specialist requirement, and changed approval period from 12 months to 6 months.

TEZSPIRE (Tezepelumab)

Removed specialist requirement, updated renewal criteria, and changed approval period from 12 months to 6 months.

Retired Medical Benefit Drug Policies

Effective April 1, 2023:

- **BLENREP (belantamab mafodotin-blmf)**

Effective May 1, 2023:

- **MARQIBO (vincristine sulfate liposomal)**
- **MAPD 2135- Continuous Glucose Monitoring Supplies-Freestyle and Dexcom**