

New Provider-Administered (Medical) Drug Policies

Effective July 1, 2019, Blue Cross and Blue Shield of Alabama will transition comprehensive provider-administered (medical) drug management to Magellan Rx Management. As part of this transition, all medical drug policies, both oncology and non-oncology, will be maintained by Magellan Rx. While AIM Specialty Health will continue to perform precertification reviews for oncology drugs based on these new policies, Magellan Rx will begin performing precertification reviews for non-oncology drugs on July 1, 2019.

Draft policies affected by this transition are available and open for comment on our website AlabamaBlue.com/providers/policies. Navigate to the draft policies page for the following policy types:

- Blue Advantage® Provider-Administered Drug Policies (Excluding Oncology)
- Blue Advantage Provider-Administered Oncology Drug Policies
- Provider-Administered Drug Policies (Excluding Oncology)
- Provider-Administered Oncology Drug Policies

Please be sure to review all policies posted prior to July 1, 2019, when the new criteria will be used for the Provider-Administered Drug Program precertification reviews.

Provider-Administered Precertification Drug List

| | | | | |
|--------------|-------------------|------------|-----------------|-------------|
| Abraxane* | Cuvitru* | Haegarda | Neulasta | Sustol* |
| Actemra IV | Cyramza* | Herceptin* | Neupogen* | Synagis |
| Adcetris* | Darzalex* | Hizentra* | Nivestym* | Synvisc |
| Akynzeo* | Dysport | HyQvia* | Nplate | Synvisc-One |
| Aldurazyme | Elaprase | Ilumya | Nucala | Takhzyro |
| Alimta* | Elelyso | Imfinzi* | Ocrevus | Tecentriq* |
| Aloxi* | Emend IV* | Inflectra | Octagam* | Testopel |
| Arzerra* | Emliciti* | Kadcyla* | Onpattro | Treanda* |
| Avastin* | Entyvio | Kalbitor | Opdivo* | Trogarzo |
| Bavencio* | Erbitux* | Kanuma | Orencia IV | Tysabri |
| Bendeka* | Euflexxa | Keytruda* | Palonosetron* | Udenyca* |
| Benlysta IV | Eylea | Krystexxa | Panzyga* | Ultomiris |
| Berinert | Fabrazyme | Kymriah* | Perjeta* | Varubi IV* |
| Besponsa* | Fasenra p | Kyprolis* | Privigen* | Vectibix* |
| Bivigam* | Firazyr | Lartruvo* | Provenge* | Velcade* |
| Blinicyto* | Flebogamma* | Lemtrada | Radicava | Vimizim |
| Bortezomib* | Fulphila* | Leukine* | Remicade | Visudyne |
| Botox | Gamifant | Lucentis | Renflexis | Vivitrol |
| Brineura | Gammagard Liquid* | Lumizyme | Rituxan* | Vpriv |
| Carimune NF* | Gammagard S/D* | Luxturna | Rituxan Hycela* | Xeomin |
| Cerezyme | Gammaked* | Macugen | Ruconest | Xiaflex |
| Cimzia | Gammaplex Liquid* | Makena | Simponi Aria | Xolair |
| Cinqair | Gamunex-C | Mepsevii | Soliris | Yervoy* |
| Cinryze | Gazyva* | Mylotarg* | Spinraza | Yescarta* |
| Cinvanti* | Granix* | Myobloc | Stelara | Zaltrap* |
| Crysvita | H.P. Acthar | Naglazyme | Sublocade | Zarxio* |

*Included in Oncology Select Program

| Non-Covered Provider-Administered Drugs | | | | |
|---|-------------|-----------|------------|---------|
| Durolane | Gelsyn-3 | Hymovis | Probuphine | Visco-3 |
| Exondys-51 | GenVisc 850 | Monovisc | Supartz | |
| Gel-One | Hyalgan | Orthovisc | TriVisc | |

Hemophilia Drug Management through Magellan Rx – Prior Authorizations Required

Effective July 1, 2019, Prior Authorization for the following hemophilia products will be required for groups with carved-in pharmacy benefits that participate in Utilization Management. Magellan Rx will perform the drug reviews for Prior Authorization (PA) based on new policy criteria. The PA reviews will ensure that optimal dosing and products are being prescribed.

Additionally, Magellan Rx will provide oversight of specialty pharmacy dispensing as part of this program. Specialty pharmacies dispensing the hemophilia drugs will also be required to obtain hemophilia dose authorizations from Magellan Rx prior to each dispense of the drug.

For more information on hemophilia management, please visit the website on the back of the member's ID card and navigate to Hemophilia Drug Management under Policies & Guidelines. Draft Hemophilia Product policies are also posted for review and comment.

| Hemophilia Drugs Requiring Prior Authorization | | | | |
|--|-------------|-------------|---------------|----------|
| Advate | Coagadex | Idelvion | Novoeight | Tretten |
| Adynovate | Corifact | Ixinity | Novoseven RT | Vonvendi |
| Afstyla | Eloctate | Jivi | Nuwig | Wilate |
| Alphanate | Feiba NF/VF | Koate DVI | Obizur | Xyntha |
| Alphanate SD | Helixate FS | Kogenate FS | Profilnine SD | |
| Alprolix | Hemlibra | Kovaltry | Rebinyn | |
| Bebulin | Hemofil M | Monoclate-P | Recombinate | |
| BeneFIX | Humate-P | Mononine | Rixubis | |

Drug Guide and Clinical Program Updates

Prime Therapeutics® Pharmacy and Therapeutics (P & T) Committee in association with Blue Cross and Blue Shield of Alabama's Formulary Business Committee recently approved updates to the Drug Guides and made clinical program changes to select medications. All information is online at AlabamaBlue.com/pharmacy. The Prime Therapeutics P & T Committee — consisting of doctors, pharmacists, and other healthcare professionals — advises and makes recommendations based on clinical appropriateness. The Blue Cross and Blue Shield of Alabama Formulary Business Committee makes final approval of these clinical recommendations before implementation.

The following drugs may have coverage changes that affect what a member will be required to pay at the time of purchase. Members will receive a letter if they are negatively affected by a formulary change that is not a result of a new generic being available.

| Brand Name (generic name if available) | Therapeutic Class | Description of Change | Additional Comments |
|---|-------------------------|--|---------------------|
| AIMOVIG (ereenumab-aooe) | Migraine Products | Addition to Tier 2 | 3/17/19 |
| ALBENZA (albendazole) | Anti-Infective Agents | Move from Tier 2 to Tier 3, generics available | |
| ASACOL HD (mesalamine) | Gastrointestinal Agents | Move from Tier 2 to Tier 3, generics available | |
| CIALIS (tadalafil) | Cardiovascular Agents | Move from Tier 2 to Tier 3, generics available | |

| Brand Name (generic name if available) | Therapeutic Class | Description of Change | Additional Comments |
|---|-------------------------------|--|---------------------|
| CODEINE SULFATE (codeine sulfate) | Analgesics And Anesthetics | Addition to Tier 2 | |
| COLCRYS (colchicine) | Analgesics And Anesthetics | Excluded | |
| MITIGARE (colchicine) | Analgesics And Anesthetics | Addition to Tier 2 | |
| NIVESTYM (filgrastim-aafi) | Hematopoetic Product | Addition to Tier 2 | 4/1/19 |
| PRIMAQUINE PHOSPHATE (primaquine phosphate) | Anti-Infective Agents | Move from Tier 2 to Tier 3, generics available | |
| REVCIVI (elapegademasevlr) | Miscellaneous Products | Addition to Tier 2 | |
| TRESIBA (insulin degludec) | Endocrine And Metabolic Drugs | Addition to Tier 2 | 2/3/19 |
| UDENYCA (pegfilgrastimcbqv) | Hematological Agents | Addition to Tier 2 | |
| VENCLEXTA (venetoclax) | Antineoplastic Agents | Addition to Tier 2 | |
| VENCLEXTA Starting Pack (venetoclax) | Antineoplastic Agents | Addition to Tier 2 | |
| VIRAMUNE (nevirapine) | Anti-Infective Agents | Move from Tier 2 to Tier 3, generics available | |
| WELCHOL (colesevelam hcl) | Cardiovascular Agents | Move from Tier 2 to Tier 3, generics available | |

The Prescription Drug Guide is updated quarterly. Please visit AlabamaBlue.com/pharmacy for the most up-to-date information.

Note: Coverage is subject to each member's specific benefits. Group-specific policies will supersede these policies when applicable. Please refer to the member's benefit plan.

Generic Plus Drug Guide Updates – Effective July 1, 2019 (unless otherwise noted)

| Brand Name (generic name if available) | Therapeutic Class | Description of Change | Additional Comments |
|---|----------------------------|--|---------------------|
| AIMOVIG (ereumab-aooe) | Migraine Products | Addition to Tier 2 | 3/17/19 |
| ALBENZA (albendazole) | Anti-Infective Agents | Move from Tier 2 to Tier 3, generics available | |
| AMOXICILLIN/CLAVULANATE | | | 4/3/19 |
| POTASSIUM ER (amoxicillin & k clavulanate) | Anti-Infective Agents | Move from Tier 1 to Tier 2 | |
| ASACOL HD (mesalamine) | Gastrointestinal Agents | Move from Tier 2 to Tier 3, generics available | |
| CIALIS (tadalafil) | Cardiovascular Agents | Move from Tier 2 to Tier 3, generics available | |
| CODEINE SULFATE (codeine sulfate) | Analgesics And Anesthetics | Addition to Tier 2 | |
| COLCRYS (colchicine) | Analgesics And Anesthetics | Excluded | 3/7/19 |
| DOXEPIN HCL (doxepin hcl) | Topical Products | Move from Tier 1 to Tier 2 | 3/7/19 |
| ISOSORBIDE DINITRATE (isosorbide dinitrate) | Cardiovascular Agents | Move from Tier 1 to Tier 2 | 3/10/19 |
| MEXILETINE HCL (mexiletine hcl) | Cardiovascular Agents | Move from Tier 1 to Tier 2 | 3/7/19 |
| MITIGARE (colchicine) | Analgesics And Anesthetics | Addition to Tier 2 | |
| MUPIROCIN (mupirocin calcium) | Topical Products | Move from Tier 1 to Tier 2 | 2/25/19 |

| Brand Name (generic name if available) | Therapeutic Class | Description of Change | Additional Comments |
|--|---------------------------------|---|---------------------|
| NADOLOL/BENDROFLUMETHIAZIDE | | | 3/11/19 |
| (nadolol & bendroflumethiazide) | Cardiovascular Agents | Move from Tier 1 to Tier 2 | 4/1/19 |
| NIVESTYM (filgrastim-aafi) | Hematopoetic Product | Addition to Tier 2 | 4/1/19 |
| PRIMAQUINE PHOSPHATE (primaquine phosphate) | Anti-Infective Agents | Move from Tier 2 to Tier 3, generics available | |
| RELEXXII (methylphenidate hcl) | Central Nervous System Drugs | Move from Tier 1 to Tier 2 | 3/10/19 |
| REVCovi (elapegedemase-lvlr) | Miscellaneous Products | Addition to Tier 2 | |
| UDENYCA (pegfilgrastim-cbqv) | Hematological Agents | Addition to Tier 2 | |
| VENCLEXTA (venetoclax) | Antineoplastic Agents | Addition to Tier 2 | |
| VENCLEXTA Starting Pack (venetoclax) | Antineoplastic Agents | Addition to Tier 2 | |
| VIRAMUNE (nevirapine) | Anti-Infective Agents | Move from Tier 2 to Tier 3, generics available | |

For a complete listing of generic and preferred brand alternatives, please refer to the Generics Plus Drug Guide located in the Pharmacy section of the Blue Cross website, AlabamaBlue.com/pharmacy.

Note: Coverage is subject to each member's specific benefits. Group-specific policies will supersede these policies when applicable. Please refer to the member's benefit plan.

Clinical Program Updates – Effective July 1, 2019 (unless otherwise noted)

The following medication dispensing limits, referred to here as prior authorization (PA), quantity limits (QL) predetermination (PD) and/or step therapy (ST) programs have been added or revised:

New or Revised Pharmacy PA or ST Programs

| Policy Name | Type of Policy | Coverage Criteria and Changes |
|------------------------------|----------------|---|
| Arikayce | PADL | NEW – Arikayce (amikacin liposome inhalation suspension) oral inhalation. Indicated in adults who have limited or no alternative treatment options, for the treatment of Mycobacterium avium complex (MAC) lung disease as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy. If approved, a dispensing limit of 28 vials (235.2 mL)/ 28 days will apply. |
| Biologic Immunomodulators | PADL | REVISED – Addition of Skyrizi (risankizumab-rzaa) solution prefilled syringe kit, 75 mg/0.83 ml (2). Indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. If approved, a dispensing limit of 2 injections (1 box) per 12 weeks. |
| CGRP | PADL | REVISED – Addition of Aimovig (erenumab-aooe) 140 mg/mL autoinjector. Indicated for the preventive treatment of migraines in adults. If approved, a dispensing limit of 1 injection per month. |
| Firdapse | PADL | NEW – Firdapse (amifampridine) oral tablet indicated for the treatment of Lambert-Eaton myasthenic syndrome (LEMS). If approved, a dispensing limit of 8 tablets per day will apply. |
| hATTR Amyloidosis Neuropathy | PADL | NEW – Onpattro (patisiran) intravenous infusion and Tegsedi (inotersen) subcutaneous injection for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults. If approved, a dispensing limit of 30 mg/ 3 weeks for Onpattro and 6 mL (4 syringes)/ 28 days for Tegsedi will apply. |
| Jynarque | PADL | REVISED – Addition of Jynarque 15 mg and 30 mg tablets as a target in the program. |
| Neurotrophic Keratitis | PADL | NEW – Oxervate (cenegermin-bkbj) 0.002% Ophthalmic solution indicated for the treatment of neurotrophic keratitis. If approved, a dispensing limit of 56 vials/ 8 weeks will apply. |

| Policy Name | Type of Policy | Coverage Criteria and Changes |
|-------------------------------|----------------|--|
| Oral PAH | PADL | REVISED – Addition of ambrisentan, generic of Letairis, will be a target in program. If approved, a dispensing limit of 1 tablet/ day will apply. |
| Oral Tetracycline Derivatives | ST | REVISED – Addition of doxycycline hyclate ER 80 mg tablets. Indicated for Rickettsial infections, sexually transmitted infections, respiratory tract infections, specific bacterial infections, ophthalmic infections, Anthrax (including inhalation, post exposure), adjunctive therapy in acute intestinal emebiasis and severe acne, and prophylaxis of malaria. If approved, a dispensing limit of 2 tablets per day. |
| SA Oncology | PADL | REVISED – Addition of Balversa (erdafitinib) tablets, 3 mg, 4 mg, 5 mg. Indicated for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma that has: susceptible FGFR3 or FGFR2 genetic alterations, and progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy. If approved, a dispensing limit of 3 tablets/day for 3 mg, 2 tablets/ day 4 mg and 1 tablet/day 5 mg will apply. |
| Weight Loss Agents | PADL | NEW – This new Weight Loss Agents PA ensures appropriate use of all weight loss target medications when this optional coverage category is included in member benefits. If approved, the following dispensing limit will apply. Adipex-P (phentermine) 37.5 mg, 1 capsule/ day, 37.5 mg, 1 tablet/ day Belviq (lorcaserin) 10 mg, 2 tablets/day Belviq XR (lorcaserin) 20 mg, 1 tablet/ day Bontril PDM (phendimetrazine) 35 mg, 6 tablets/ day Bontril Slow Release (phendimetrazine) 105 mg extendedrelease, 1 capsule/ day Contrave (naltrexone/bupropion) 8 - 90 mg, 4 tablets/ day Didrex (benzphetamine) 50 mg, 3 tablets/ day Diethylpropiona 25 mg, 3 tablets/ day, 75 mg extendedrelease, 1 tablet/ day Lomaira (phentermine) 8 mg, 3 tablets/ day Phenterminea 15 mg and 30 mg, 1 capsule/ day Qsymia (phentermine/topiramate) 3.75mg-23mg, 7.5mg-46mg, 11.25mg-69mg and 15mg-92mg, 1 capsule/ day Regimex (benzphetamine) 25 mg, 3 tablets/ day |

New or Revised Dispensing Limits

| Brand Name (generic name if available) | Strength | Dispensing Limit | New or Revised |
|--|---|--|----------------|
| Dovato | 50-300 mg | 1 tablet/ day | New |
| Mavenclad | 10 mg (4 tabs) 10 mg (5 tabs) 10 mg (6 tabs) 10 mg (7 tabs) 10 mg (8 tabs) 10 mg (9 tabs) 10 mg (10 tabs) | 8 tablets per 301 days 10 tablets per 301 days 12 tablets per 301 days 14 tablets per 301 days 8 tablets per 301 days 9 tablets per 301 days 20 tablets per 301 days | New |
| Mayzent | 0.25 mg 2 mg Starter Pack | 4 tablets per day 1 tablet per day 12 tablets per 180 days | New |

Clinical Program Updates – Effective July 1, 2019

Non-Coverage of Select Prescription Drugs

Blue Cross and Blue Shield of Alabama and Prime Therapeutics evaluate drugs to be included on our formulary based on the drug's clinical safety, efficacy and uniqueness. Blue Cross's formulary is designed to provide sufficient options to treat patients who require pharmacologic treatment. As a result, Blue Cross may determine that select medications are not covered on the formulary when those decisions are supported by clinical rationale.

Drugs may not be covered on the formulary for the following reasons:

- The medication has safety or efficacy concerns.
- The medication has been shown to have excessive adverse effects and/or safer alternatives.
- The medication has an over-the-counter (OTC) alternative and/or ingredients.
- The medication is considered a cost outlier with lower cost alternatives available.

Beginning July 1, 2019, the following drugs will no longer be covered on the formulary. Impacted members will receive notification of this change, and will be grandfathered until September 1, 2019.

- | | | |
|-------------|-------------------|-------------------------------------|
| • Seysara* | • Nocdurna* | • Bryhali* |
| • Firdapse* | • Aemcolo* | • Kapsprago Sprinkle |
| • Xepi* | • Abilify Mycite* | • Osmolex* |
| • Minolira* | • Sympazan* | • Prednisolone ODT |
| • Tolsura* | • Xelpros* | • Migranal nasal spray brand and AG |
| • Xyosted* | • Lexette* | • Mupirocin cream |

*New drugs with no utilization; exclusion effective immediately.

Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

Magellan Rx ManagementSM is an independent company providing medical review services on behalf of Blue Cross and Blue Shield of Alabama.

AIM Specialty Health® (AIM), an independent company, provides evidence-based cancer treatment information to physicians on behalf of Blue Cross and Blue Shield of Alabama.