BlueCross BlueShield of Alabama

Pharmacy News

JANUARY 2018

Drug List and Clinical Program Updates

The 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 Lists and made clinical program changes to select medications. All information is online at our website, **AlabamaBlue.com/pharmacy**. This committee – consisting of doctors, pharmacists and other healthcare professionals – 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. Negative changes will not be communicated in the case where no impacted members (NIM) are identified and noted in the comments below:

Prescription Drug Guide Updates – Effective January 1, 2018 (unless otherwise noted)

Brand Name (generic name if available)	Therapeutic Class	Description of Change	Additional Comments
Axiron	Hormone Replacement	Move from Tier 2 to Tier 3	Generic equivalent now available
Cosentyx	Plaque Psoriasis and Psoriatic Arthritis	Addition to Tier 2	
Haegarda	Hereditary Angioedema	Addition to Tier 2	Effective 10/1/2017
Lialda	Inflammatory Bowel Medications	Move from Tier 2 to Tier 3	Generic equivalent now available
Lynparza tablets	Anticancer Medications	Addition to Tier 2	
Mavyret	Hepatitis C	Addition to Tier 2	Effective 11/15/2017
Neulasta	Hematopoetic Agents	Addition to Tier 2	
Neupogen	Hematopoetic Agents	Addition to Tier 2	
Nityr	Hereditary Tyrosinemia	Addition to Tier 2	
Pataday	Eye Medications	Move from Tier 2 to Tier 3	Generic equivalent now available
Relpax	Migraine Products	Move from Tier 2 to Tier 3	Generic equivalent now available
Renvela Packet	Phosphate Binders	Move from Tier 2 to Tier 3	Generic equivalent now available
Transderm-Scop	Antiemetics	Move from Tier 2 to Tier 3	Generic equivalent now available
Vigamox	Eye Medications	Move from Tier 2 to Tier 3	Generic equivalent now available
Vosevi	Hepatitis C	Addition to Tier 2	Effective 11/15/2017
Zarxio	Hematopoetic Agents	Addition to Tier 2	
Ziagen Solution	Antiretrovirals	Move from Tier 2 to Tier 3	Generic equivalent now available

The Drug List is updated quarterly and reflects changes in the Standard Prescription Drug List. Please visit **AlabamaBlue.com/pharmacy** for the most up-to-date information.

Generic Plus Drug Guide Updates – Effective January 1, 2018 (unless otherwise noted)

Brand Name (generic name if available)	Therapeutic Class	Description of Change	Additional Comments
Cosentyx	Plaque Psoriasis and Psoriatic Arthritis	Addition to Tier 2	
Haegarda	Hereditary Angioedema	Addition to Tier 2	Effective 10/1/2017
Lynparza tablets	Anticancer Medications	Addition to Tier 2	
Mavyret	Hepatitis C	Addition to Tier 2	Effective 11/15/2017
Nityr	Hereditary Tyrosinemia	Addition to Tier 2	
Relpax	Migraine Products	Move from Tier 2 to Tier 3	Generic equivalent now available
Vosevi	Hepatitis C	Addition to Tier 2	Effective 11/15/2017
Zarxio	Hematopoetic Agents	Addition to Tier 2	
Ziagen solution	Antiretrovirals	Move from Tier 2 to Tier 3	Generic equivalent now available

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

***Note**: Prescription and generic drug 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 January 1, 2018 (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 Self-Administered (Pharmacy) Drug PA or ST Programs

Policy Name	Type of Policy	Coverage Criteria and Changes
Biologic Immunomodulators	PAQL	**NEW –** The program helps ensure that the prescribed therapy for patients with autoimmune conditions is properly selected according to Food and Drug Administration-approved product labeling and clinical guidelines. The program will encourage use of preferred brands or generics and allow for continuation of current therapy for patients without annual review. If approved, the products are subject to quantity limits.
Carbaglu	PA	**NEW –** The program encourages appropriate use of Carbaglu.
Doxycycline/Minocycline	ST	**REVISED –** Addition of Ximino as a target drug.
Opioid Induced Constipation	PA	**REVISED –** Addition of Symproic 0.2 mg tablet.
Otezla	PAQL	**NEW –** The program helps ensure that patients prescribed therapy are properly selected according to FDA-approved product labeling and clinical guidelines. If approved, Otezla is subject to quantity limits.
Phenylketonuria	PA	**NEW –** The program encourages appropriate use of Kuvan.
Self-Administered Oncology	PAQL	**REVISED –** Addition of Lynparza tablets as a target drug. If approved, the quantity limit is 120 tablets per 30 days.
Self-Administered Oncology	PAQL	**REVISED –** Addition of Verzenio as a target drug. If approved, the quantity limit is 60 tablets per 30 days.
Substrate Reduction Therapy	PAQL	**NEW –** The program encourages appropriate use of Cerdelga and Zavesca. If approved, the products are subject to quantity limits.
URAT1 Inhibitor	PAQL	**REVISED –** Addition of Duzallo as a target drug. If approved, the quantity limit is 30 tablets per 30 days.

New or Revised Dispensing Limits

Brand Name (generic if available)	Strength	Dispensing Limit per month	New or Revised
Bevyxxa	40 mg, 80 mg	43 capsules/42 days	**New**
Naloxone injection	1 mg/mL	4 mg/365 days	**New**
Trelegy Ellipta	100-62.5-25 mcg/inhaler	1 inhaler/month	**New**
Xhance	93 mcg	32 mL/30 days	**New**

Clinical Program Updates – Effective January 1, 2018 (unless otherwise noted)

New or revised physician-administered (medical) drug programs

Policy Name	Type of Policy	Coverage Criteria and Changes
Abraxane	Oncology PA	**Revised – Effective 12/16/17**, updated criteria for metastatic breast cancer
Blincyto	Oncology PA	**NEW – Effective 12/1/17**, oncology policy with criteria for acute lymphocytic leukemia
Colony Stimulating Factors	Medical PA	**Revised – Effective 1/1/18**, significant modifications to approval criteria have been made to align with FDA label and NCCN 1 and 2a level of evidence standards, including but not limited to, the following: • Agents are no longer recommended in low risk for febrile neutropenia (FN) in any circumstance • The following indications are removed from coverage criteria: aplastic anemia, HIV infection, drug-induced neutropenia (ganciclovir/zidovudine), malignant melanoma, Crohn's disease • Leukemia is added as an approvable diagnosis • Requirement added that the CSF agent will not be used when chemotherapy and radiation are used concomitantly • Changed approval length to 6 months from 12 months for reassessment of need
Erbitux	Oncology PA	**Revised – Effective 12/24/17**, we added criteria for non-small cell lung cancer and updated criteria for colorectal cancer to include NRAS wild-type.
Hereditary Angioedema	Medical PA	**Revised – Effective 10/15/17**, Haegarda, a new drug for routine prophylaxis to prevent HAE attacks in adolescent and adult patients, was added to the medical policy.
IV Multiple Sclerosis	Oncology PA	**Revised – Effective 1/1/18**, the coverage criteria for Tysabri has been updated to require the use of one disease modifying agent prior to treatment with Tysabri.
Ocular Angiogenesis Inhibitors	Medical PA	**Revised – Effective 1/1/18**, Lucentis criteria has been updated to include coverage of new indication, Myopic Choroidal Neovascularization.
Tecentriq	Oncology PA	**Revised – Effective 12/1/17**, criteria was added for first line treatment of locally advanced or metastatic urothelial carcinoma.
Vectibix	Oncology PA	**Revised – Effective 11/10/17**, we updated criteria for colorectal cancer to include NRAS wild-type.

Select Prescription Drugs That Are Not Covered

Blue Cross and Blue Shield of Alabama and Prime Therapeutics evaluate drugs to be included on the formulary based on the drug's clinical safety, efficacy and uniqueness. Blue Cross' 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.
  - Clinical merit is always first and foremost in our evaluations. As medication prices continue to increase, cost will be considered when alternative drugs exist or there is not sufficient data to support efficacy.

Beginning January 1, 2018, the following drugs will no longer be covered on the Standard Prescription Drug List. Impacted members will receive notification of this change.

- Diclegis
- Zipsor
- Cambia
- Sprix
- Zyclara
- Retin-A Micro Pump
- Zelapar*
- Xatmep*

*New drugs with no utilization; exclusion effective immediately

Autoimmune Strategy

Beginning January 1, 2018, a prior authorization (PA) will be required for members who are prescribed biologic medications for autoimmune disorders. This means that before medications included in the program will be covered, a member's doctor will need to get approval from Blue Cross and Blue Shield of Alabama.

Blue Cross is taking extra steps to ensure that the PA process goes smoothly for our members in the following ways:

- Members who have a current prescription for an autoimmune-related drug will be automatically grandfathered into the PA program. This means they will be able to continue taking their current medication without going through the steps of acquiring a PA. These members can also change to a preferred drug for their condition without requiring a new PA, and their PA will be automatically renewed on an annual basis.
- Members who are diagnosed with an appropriate autoimmune disease and have claims for prerequisite drugs will automatically receive a PA for preferred drugs, and their PA will be automatically renewed on an annual basis.

Members who want a non-preferred product must go through the initial PA process. However, once a PA is received, it will be automatically renewed on an annual basis.

Opioid Strategies

Beginning February 1, 2018, Blue Cross and Blue Shield of Alabama will launch three new strategies surrounding the opioid epidemic. The strategies are described below:

1. Members will be limited to a seven-day initial supply for short-acting opioid medication on their first fill. After the initial seven-day supply is filled, members may obtain additional scripts without a prior authorization. Members who wish to have more than a seven-day supply on their first fill will need to have their provider submit a prior authorization.
2. Members will be required to have their provider submit a prior authorization for all initial fills of long-acting opioid medications.
3. Formulations of naloxone, the antidote for an opioid overdose, will be available to a majority of members at a generic copay tier. Formulations that will move to a generic copay tier include prefilled syringes and nasal spray. Additionally, the branded auto-injector Evzio will be removed from the formulary when these changes take place.