Drug Guide 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 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 October 1, 2017 (unless otherwise noted)**

<table>
<thead>
<tr>
<th>Brand Name (generic name if available)</th>
<th>Therapeutic Class</th>
<th>Description of Change</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALKERAN</td>
<td>Anticancer Medications</td>
<td>Move from Tier 2 to Tier 3</td>
<td>Generic equivalent now available</td>
</tr>
<tr>
<td>ALUNBRIG</td>
<td>Anticancer Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>FLUTICASONE PROPIONATE/ SALMETEROL</td>
<td>Asthma Medications</td>
<td>Addition to Tier 2</td>
<td>Effective 7/1/17</td>
</tr>
<tr>
<td>HUMULIN R U-500</td>
<td>Insulin</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>ISENTRESS HD</td>
<td>Antiretrovirals</td>
<td>Addition to Tier 2</td>
<td>Effective 6/11/17</td>
</tr>
<tr>
<td>KISQALI – FEMARA Co-Pack</td>
<td>Anticancer Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>RYDAPT</td>
<td>Anticancer Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>SULFADIAZINE</td>
<td>Antibiotics</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>SYNJARDY XR</td>
<td>Antidiabetic Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>TAZORAC</td>
<td>Skin Products</td>
<td>Move from Tier 2 to Tier 3</td>
<td>Generic equivalent now available</td>
</tr>
<tr>
<td>TYMLOS</td>
<td>Osteoporosis Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>VIBERZI</td>
<td>Gastrointestinal Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>ZETIA</td>
<td>Cholesterol Lowering Medications</td>
<td>Move from Tier 2 to Tier 3</td>
<td>Effective 6/25/17, Generic equivalent now available</td>
</tr>
</tbody>
</table>

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 October 1, 2017 (unless otherwise noted)

<table>
<thead>
<tr>
<th>Brand Name (generic name if available)</th>
<th>Therapeutic Class</th>
<th>Description of Change</th>
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</tr>
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<tbody>
<tr>
<td>ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE</td>
<td>Pain Relievers</td>
<td>Move from Tier 1 to Tier 3</td>
<td>Effective 6/20/17</td>
</tr>
<tr>
<td>ALKERAN</td>
<td>Anticancer Medications</td>
<td>Move from Tier 2 to Tier 3</td>
<td>Generic equivalent now available</td>
</tr>
<tr>
<td>ALUNBRIG</td>
<td>Anticancer Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>AUGMENTED BETAMETHASONE 0.05% Gel</td>
<td>Skin Products</td>
<td>Move from Tier 1 to Tier 3</td>
<td>Effective 6/1/17</td>
</tr>
<tr>
<td>CLOMIPHENE CITRATE</td>
<td>Miscellaneous Products</td>
<td>Move from Tier 1 to Tier 2</td>
<td>Effective 5/14/17</td>
</tr>
<tr>
<td>FLUNISOLIDE</td>
<td>Nasal Steroid Medications</td>
<td>Move from Tier 1 to Tier 2</td>
<td>Effective 7/27/17</td>
</tr>
<tr>
<td>FLUOROURACIL Solution</td>
<td>Skin Products</td>
<td>Move from Tier 1 to Tier 3</td>
<td>Effective 7/23/17</td>
</tr>
<tr>
<td>FLUTICASONE PROPIONATE/ SALMETEROL</td>
<td>Asthma Medications</td>
<td>Addition to Tier 2</td>
<td>Effective 7/1/17</td>
</tr>
<tr>
<td>HUMULIN R U-500</td>
<td>Insulin</td>
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<tr>
<td>ISENTRESS HD</td>
<td>Antiretrovirals</td>
<td>Addition to Tier 2</td>
<td>Effective 6/11/17</td>
</tr>
<tr>
<td>KISQALI – FEMARA Co-Pack</td>
<td>Anticancer Medications</td>
<td>Addition to Tier 2</td>
<td></td>
</tr>
<tr>
<td>LEVONORGESTREL AND ETHINYL ESTRADIOL (continuous) 90-20 mcg</td>
<td>Birth Control Medications</td>
<td>Move from Tier 1 to Tier 2</td>
<td>Effective 5/14/17</td>
</tr>
<tr>
<td>METOPROLOL/HYDROCHLOROTHIAZIDE</td>
<td>High Blood Pressure Medications</td>
<td>Move from Tier 1 to Tier 3</td>
<td>Effective 6/1/17</td>
</tr>
<tr>
<td>RYDAPT</td>
<td>Anticancer Medications</td>
<td>Addition to Tier 2</td>
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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:** 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 October 1, 2017 (unless otherwise noted)

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

## New or Revised Self-Administered (Pharmacy) Drug PA or ST Programs

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Type of Policy</th>
<th>Coverage Criteria and Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrezza</td>
<td>PAQL</td>
<td>REVISED – Addition of Afrezza 8 unit cartridges with a quantity limit of 1,260 cartridges/30 days, and 12 unit cartridges with a quantity limit of 900 cartridges per 30 days</td>
</tr>
<tr>
<td>Emflaza</td>
<td>PAQL</td>
<td>NEW – The program encourages the appropriate selection of patients for treatment according to product labeling and/or clinical studies and/or guidelines. If approved, Emflaza is subject to quantity limits.</td>
</tr>
<tr>
<td>Amitiza Linzess</td>
<td>PA</td>
<td>REVISED – Addition of Trulance 3 mg as a target</td>
</tr>
<tr>
<td>Androgen/Anabolic Steroids</td>
<td>PAQL</td>
<td>REVISED – Addition of testosterone solution as target 30 mg/act 180 mg for 30 days</td>
</tr>
<tr>
<td>Biologic Immunomodulators</td>
<td>STQL</td>
<td>REVISED – Addition of Siliq as a target – If approved, Siliq injection 210 mg/1.5 mL will have a quantity limit of 3 per 28 days. Addition of Tremfya as a target. If approved, Tremfya injection 100 mg/mL will have a quantity limit of 1 syringe per 56 days.</td>
</tr>
<tr>
<td>Buprenorphine and Buprenorphine-Naloxone for Opioid Dependence</td>
<td>PAQL</td>
<td>REVISED – Prior authorizations for buprenorphine/naloxone combination product prescriptions (buprenorphine/naloxone, Suboxone, Bunavail and Zubsolv) are no longer needed if they do not exceed specific quantity limits. A prior authorization is required for opioids for members on buprenorphine products. Additionally, prior authorizations will remain in place for single agent buprenorphine products.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>PA</td>
<td>REVISED – Addition of Mavyret and Vosevi as target drugs</td>
</tr>
<tr>
<td>Injectable Atopic Dermatitis</td>
<td>PAQL</td>
<td>NEW – The program encourages the use of a first-line conventional product prior to approval of Dupixent. If approved, Dupixent is subject to quantity limits.</td>
</tr>
<tr>
<td>Oral Pulmonary Arterial Hypertension</td>
<td>PAQL</td>
<td>REVISED – Addition of Orenitram 5 mg as a target</td>
</tr>
<tr>
<td>Self-Administered Oncology</td>
<td>PAQL</td>
<td>REVISED – Addition of Nerlynx and Idhifa as targets – If approved, Nerlynx will have a quantity limit of 180 tablets per 30 days, and Idhifa will have a quantity limit of 30 tablets per 30 days.</td>
</tr>
<tr>
<td>Topical Doxepin</td>
<td>PAQL</td>
<td>NEW – The program encourages appropriate use of topical doxepin according to the product labeling. If approved, the quantity limit is 45 grams per approval.</td>
</tr>
<tr>
<td>Triptan</td>
<td>STQL</td>
<td>REVISED – Addition of eletriptan tablet as target. If approved, eletriptan 20 mg and 40 mg tablets will have a quantity limit of 12 tablets per 30 days.</td>
</tr>
<tr>
<td>Xermelo</td>
<td>PAQL</td>
<td>NEW – The program encourages appropriate use of Xermelo. If approved, the quantity limit is 90 tablets per 90 days.</td>
</tr>
</tbody>
</table>
### New or Revised Dispensing Limits

<table>
<thead>
<tr>
<th>Brand Name (generic if available)</th>
<th>Strength</th>
<th>Dispensing Limit per Month</th>
<th>New or Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aristada</td>
<td>1064 mg/3.9 mL</td>
<td>1 syringe/56 days</td>
<td>New</td>
</tr>
<tr>
<td>Cotempla</td>
<td>8.6 mg, 17.3 mg, 25.9 mg</td>
<td>30 tablets 60 tablets</td>
<td>New</td>
</tr>
<tr>
<td>Isentress</td>
<td>600 mg</td>
<td>60 tablets</td>
<td>New</td>
</tr>
<tr>
<td>Mydayis</td>
<td>12.5 mg, 25 mg, 37.5 mg, 50 mg</td>
<td>30 capsules</td>
<td>New</td>
</tr>
<tr>
<td>Nucynta</td>
<td>50 mg, 75 mg, 100 mg</td>
<td>180 tablets</td>
<td>Revised</td>
</tr>
<tr>
<td>OxyContin (oxycodone ER)</td>
<td>10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</td>
<td>60 tablets 120 tablets</td>
<td>Revised</td>
</tr>
<tr>
<td>Selzentry</td>
<td>20 mg/mL</td>
<td>1840 mL</td>
<td>New</td>
</tr>
</tbody>
</table>

### Clinical Program Updates – Effective October 1, 2017 (unless otherwise noted)

**New or Revised Physician-Administered (Medical) Drug Programs**

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Type of Policy</th>
<th>Coverage Criteria and Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bavencio</td>
<td>Oncology PA</td>
<td><strong>NEW – Effective 8/1/17</strong>: Oncology policy with criteria for metastatic Merkel cell carcinoma and metastatic urothelial carcinoma</td>
</tr>
<tr>
<td>Bendeka/Treanda</td>
<td>Oncology PA</td>
<td><strong>NEW – Effective 6/30/17</strong>: Oncology policy with criteria for chronic lymphocytic leukemia, relapsed or refractory classical Hodgkin lymphoma, Non-Hodgkin lymphoma, relapsed or refractory multiple myeloma, and Waldenström’s macroglobulinemia</td>
</tr>
<tr>
<td>Benlysta</td>
<td>Medical PA</td>
<td><strong>REVISED – Effective 10/1/17</strong>: A new subcutaneous dosage form expands this policy to the prescription benefit. The medical policy was updated to include the new formulation.</td>
</tr>
<tr>
<td>Brineura</td>
<td>Medical PA</td>
<td><strong>NEW – Effective 9/1/17</strong>: The medical policy will define coverage for ambulatory, symptomatic, pediatric patients with late infantile onset CLN2/TPP1 deficiency (orphan drug for rare enzyme deficiency).</td>
</tr>
<tr>
<td>Darzalex</td>
<td>Oncology PA</td>
<td><strong>NEW – Effective 6/30/17</strong>: Oncology policy with criteria for multiple myeloma</td>
</tr>
<tr>
<td>Empliciti</td>
<td>Oncology PA</td>
<td><strong>NEW – Effective 6/30/17</strong>: Oncology policy with criteria for multiple myeloma</td>
</tr>
<tr>
<td>Imfinzi</td>
<td>Oncology PA</td>
<td><strong>NEW – Effective 8/8/17</strong>: Oncology policy with criteria for metastatic urothelial carcinoma</td>
</tr>
<tr>
<td>Infliximab &amp; Infliximab Biosimilars</td>
<td>Medical PA</td>
<td><strong>REVISED – Effective 8/1/17</strong>: Remicade is designated as the preferred product over Inflectra. Effective 10/1/17, Renflexis will be added to the medical policy as a non-preferred product.</td>
</tr>
<tr>
<td>Infusible Biologics</td>
<td>Medical PA</td>
<td><strong>REVISED – Effective 10/1/17</strong>: Actemra has been updated to include coverage of new indication, Giant Cell Arteritis (GCA).</td>
</tr>
<tr>
<td>Radicava</td>
<td>Medical PA</td>
<td><strong>NEW – Effective 9/1/17</strong>: The medical policy will define coverage for patients with diagnosis of amyotrophic lateral sclerosis (ALS) for two years or less, who has normal respiratory function and is able to perform most activities of daily living.</td>
</tr>
<tr>
<td>Rituxan</td>
<td>Oncology PA</td>
<td><strong>Revised – Effective 9/25/17</strong>: Rituxan Hycela is added to policy with criteria for follicular lymphoma, diffuse large b-cell lymphoma, and chronic lymphocytic leukemia.</td>
</tr>
<tr>
<td>Soliris</td>
<td>Medical PA</td>
<td><strong>NEW – Effective 10/1/17</strong>: The medical policy will define coverage for patients with paroxysmal nocturnal hemoglobinuria (PNH) or atypical hemolytic uremic syndrome (aHUS).</td>
</tr>
</tbody>
</table>
Select Prescription Drugs That Are Not Covered

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’ 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 October 1, 2017, the following drugs will no longer be covered on the Standard Prescription Drug List. Impacted members will receive notification of this change.

- Amrix
- Clindagel 1%
- Levorphanol
- Lorzone
- Rayos
- Tivorbex
- Vivodex
- Xatmep*
- Yosprala
- Zelapar*
- Zorvolex

*New drugs with no utilization; exclusion effective immediately

New-to-Market Drug Program

Effective October 1, 2017, coverage of new-to-market Food and Drug Administration approved products will not be available immediately. Coverage of new products will be temporarily delayed until Prime Therapeutics’ P&T Committee and Blue Cross and Blue Shield of Alabama’s Formulary Business Committee have evaluated it based on safety, effectiveness and the availability of other products within that class of medication. A coverage exception process will be available for patients requiring access to new products prior to P&T review.

Pharmacy Select Network and Home Delivery Network

Prime Therapeutics and Walgreens have joined forces to create a central specialty pharmacy and mail service company called AllianceRx Walgreens Prime. This company is jointly owned by Prime and Walgreens.

Effective January 1, 2018:

- The Prime Therapeutics Specialty Pharmacy Network will be referred to as the Pharmacy Select Network. The Pharmacy Select Network will include AllianceRx Walgreens Prime.
- PrimeMail® will be referred to as the Home Delivery Network. The Home Delivery Network will include PrimeMail by Walgreens Mail Service.

These name changes will not be effective for groups until their 2018 renewal effective date.