# 30 Day Change Notice
## Effective Date: January 1st, 2021

| NEW PREFERRED DRUGS | |
|---|---|
| **THERAPEUTIC CLASS** | **NO PA REQUIRED PREFERRED** |
| Central Nervous System (CNS) Agents: Anticonvulsants | Clobazam (Generic of Onfi) |
| Central Nervous System (CNS) Agents: Multiple | Aubagio |
| Endocrine Agents: Osteoporosis-Bone Ossification Enhancers | Forteo |
| Gastrointestinal Agents: Anti-Emetics | Bonjesta |
| Genitourinary Agents: Benign Prostatic Hyperplasia | Alfuzosin (Generic of Uroxatral)<br>Dutasteride (Generic of Avodart) |
| Genitourinary Agents: Electrolyte Depleter Agents | Sevelamer (Generic of Renagel and Renvela) |
| Infectious Disease Agents: Antibiotics-Macrolides | Eryped |
| Infectious Disease Agents: Antivirals-HIV | Atazanavir Sulfate Oral Powder (Generic of Reyataz)<br>Tivicay PD |
| Infectious Disease Agents: Antibiotics-Tetracyclines | Vibramycin Suspension (no PA Required for age 12 or under) |
| Ophthalmic Agents: Antibiotics and Antibiotic -Steroid Combination Drops and Ointments | Neomycin/Polymyxin/Bacitracin/Hydrocortisone Ointment |
| Ophthalmic Agents: Glaucoma Agents | Dorzolamide/Timolol (Generic of Cosopt PF) |

| NEW CLINICAL PA REQUIRED "PREFERRED" DRUGS | |
|---|---|
| **THERAPEUTIC CLASS** | **CLINICAL PA REQUIRED PREFERRED** |
| Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors | Corifact |
| Immunomodulator Agents for Systemic Inflammatory Disease | Taltz |
| Immunomodulator Agents for Systemic Inflammatory Disease | Xeljanz 5mg |

| NEW STEP THERAPY REQUIRED "PREFERRED" | |
|---|---|
| **THERAPEUTIC CLASS** | **STEP THERAPY REQUIRED "PREFERRED"** |
| Central nervous System (CNS) Agents: Anti-Migraine, Prophylaxis Treatment | Aimovig<br>Ajovy |
| Endocrine Agents: Diabetes - Non-Insulin | Farxiga<br>Invokana<br>Invokamet<br>Miglitol (Generic of Glyset) |

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| NEW NON-PREFERRED DRUGS | |
|---|---|
| **THERAPEUTIC CLASS** | **PA REQUIRED NON-PREFERRED** |
| Central Nervous System (CNS) Agents: Multiple Sclerosis | Zeposia |
| Central Nervous System (CNS) Agents: Parkinson's Agents | Kynmobi |
| Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate | Dayvigo |
| Endocrine Agents: Diabetes-Insulin | Lyumjev |
| Gastrointestinal Agents: Anti-Emetics | Doxylamine and Pyridoxine (generic of Diclegis) |
| Immunomodulator Agents for Systemic Inflammatory Disease | Cosentyx |
| Infectious Disease Agents: Antibiotics-Tetracyclines | Vibramycin Suspension (PA Required for age over 12)<br>Doxycycline (generic of Doryx) |
| Ophthalmic Agents: Antihistamines and Mast Cell Stabilizers | Pazeo Drops |

| CHANGES IN CRITERIA | |
|---|---|
| **THERAPEUTIC CLASS** | **SUMMARY OF CHANGE** |
| Central Nervous System (CNS) Agents: Anti-Migraine, Prophylaxis | **STEP THERAPY REQUIRED PREFERRED MEDICATION:**<br>For a drug requiring step therapy, there must have been inadequate clinical response to a trial of at least 30 days each to at least 3 controller migraine medications or has experienced contraindications or intolerance to them (i.e., beta-blockers, anticonvulsants, tricyclic antidepressants, and/or serotonin-norepinephrine reuptake inhibitors).<br>**NON-PREFERRED MEDICATION:**<br>For a non-preferred medication drug requiring step therapy, there must have been inadequate clinical response to a trial of at least 30 days each to at least 3 controller migraine medications or has experienced contraindications or intolerance to them (i.e., beta-blockers, anticonvulsants, tricyclic antidepressants, and/or serotonin-norepinephrine reuptake inhibitors) AND an inadequate clinical response to a trial of at least 30 days of one step therapy required preferred medication<br>**ADDITIONAL CRITERIA FOR MIGRAINE PROPHYLAXIS:**<br>1. Patient must have one of the following diagnoses:<br>a. **Episodic** migraine with the following frequencies of migraine: 4-15 headaches per 30 days measured over 90 consecutive days and headache duration of longer than 4 hours per day or longer during an attack on average.<br>b. **Chronic** migraine with the following frequencies of migraine: 15 or more headaches per 30 days measured over 90 consecutive days and headache duration of longer than 4 hours per day or longer during an attack on average |

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<table>
<tr><th colspan="2">CHANGES IN CRITERIA</th></tr>
<tr><th>THERAPEUTIC CLASS</th><th>SUMMARY OF CHANGE</th></tr>
<tr><td>Central Nervous System (CNS) Agents: Anticonvulsants</td><td><u>ADDITIONAL CRITERIA FOR CANNABINOID</u><br>Patient has a diagnosis of Lennox-Gastaut syndrome, Dravet syndrome or tuberous sclerosis complex<br>Maximum daily dose (QL) not to exceed 20 mg/kg/day (titration based on response/tolerability) for Lennox-Gastaut syndrome or Dravet syndrome and not to exceed 25 mg/kg/day (titration based on response/tolerability) for tuberous sclerosis complex</td></tr>
<tr><td>Central Nervous System (CNS) Agents: Parkinson’s Agents</td><td><u>ADDITIONAL INFORMATION</u><br>Requests for Apokyn, Inbrija, Kynmobi and Nourianz must have documentation of a trial of at least one other medication for the treatment of “off episodes” (dopamine agonist, COMT inhibitor, or MAO-B inhibitor).</td></tr>
<tr><td>Cardiovascular Agents: Lipotropics</td><td><u>TRIAL PERIOD</u><br>30 days for HMG-CoA Reductase Inhibitors, Niacin derivatives, ezetimibe (Zetia), 90 days for Fibrates, 12 weeks for PCSK9 Inhibitors and 12 weeks for ATP Citrate Lyase (ACL) Inhibitors<br><u>ADDITIONAL CRITERIA FOR ATP Citrate Lyase (ACL) Inhibitor:</u><br>A trial and failure with one PCSK9 inhibitor</td></tr>
<tr><td>Endocrine Agents: Diabetes-Non-Insulin</td><td><u>STEP THERAPY</u><br>1. For a drug requiring step therapy, there must have been inadequate clinical response to metformin products (either single-ingredient or in a sulfonylurea/ metformin or TZD/metformin combination), including a trial of no less than 60 days of at least one preferred metformin product<br>2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including metformin and a trial of no less than 60 days of at least one preferred or step therapy product.<br>Note: Inadequate clinical response after at least 60 days of recommended therapeutic dose with documented adherence to the regimen<br>DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR<br><table><tr><th>STEP THERAPY REQUIRED “PREFERRED”</th></tr><tr><td>Farxiga (dapagliflozin)*<br>Invokana (canagliflozin)</td></tr></table>*Step Therapy Requirements are waived for members with a diagnosis of Heart Failure, Chronic Kidney Disease, Cardiovascular Disease or with multiple Cardiovascular Disease risk factors</td></tr>
<tr><td>Endocrine Agents: Osteoporosis-Bone Ossification Enhancers</td><td><u>ADDITIONAL INFORMATION</u><br>The requested medication may be approved if there has been a therapeutic failure to no less than a 90-day trial of at least one preferred medication within the same class of the requested medication</td></tr>
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| CHANGES IN CRITERIA | |
|---|---|
| **THERAPEUTIC CLASS** | **SUMMARY OF CHANGE** |
| Genitourinary Agents: Electrolyte Depleter Agents | **NON-PREFERRED AGENT**<br>For a non-preferred agent, there must have been an inadequate clinical response during a trial of no less than 7 days of at least two preferred medications |
| Genitourinary Agents: Urinary Antispasmodics | **ADDITIONAL INFORMATION**<br>The requested non-preferred medication may be approved if there has been a therapeutic failure to a trial of no less than 30 days of at least two preferred medications with different active ingredients not requiring a prior authorization |
| Topical Agents: Immunomodulators | Elidel and Protopic 0.03% are indicated in patients 2 years old or older. Protopic 0.1% is indicated in adults only |
| Immunomodulator Agents for Systemic Inflammatory Disease | **ADDITIONAL INFORMATION**<br>If there has been a therapeutic failure to no less than a 90-day trial of at least two preferred medications |
| Infectious Disease Agents: Antivirals-Hepatitis C | **ADDITIONAL CRITERIA FOR DAAs**<br>Please see the Hepatitis C Direct Acting Antiviral Prior Authorization Form for criteria and the most recent regimens recommended by the American Association for the Study of Liver Diseases (AASLD) |

| NEW THERAPEUTIC CATEGORIES |
|---|
| Central Nervous System (CNS) Agents: Movement Disorders |
| Endocrine Agents: Diabetes – Hypoglycemia Treatments |
| Endocrine Agents: Endometriosis |
| Endocrine Agents: Uterine Fibroids |
| Ophthalmic Agents: Ophthalmic Steroids |
| Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE (Self-Administered) |

# Central Nervous System (CNS) Agents: Movement Disorders

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ADDITIONAL CRITERIA FOR THE TREATMENT OF TARDIVE DYSKINESIA:**
Prescribed by a Neurologist or Psychiatrist
Ingrezza is ONLY indicated for the treatment of Tardive Dyskinesia

**ADDITIONAL CRITERIA FOR AUSTEDO FOR THE TREATMENT OF HUNTINGTON'S DISEASE:**
The member must have a failure to respond to maximally tolerated dose of tetrabenazine

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**MOVEMENT DISORDERS**

| CLINCAL PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| AUSTEDO (deutetrabenazine)†<br>INGREZZA (valbenazine)<br>TETRABENAZINE (generic of Xenazine) | |

† Quantity limit of 4 tablets per day

# Endocrine Agents: Diabetes – Hypoglycemia Treatments

**LENGTH OF AUTHORIZATIONS**: 365 DAYS

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

**PA REQUIRED NON-PREFERRED:**

A non-preferred medication will be approved after a trial with a preferred medication or the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion.

**ENDOCRINE AGENTS: DIABETES – HYPOGLYCEMIA TREATMENTS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| BAQSIMI nasal spray (glucagon)<br>GLUCAGEN vial (glucagon, human recombinant)<br>GLUCAGON EMERGENCY KIT (glucagon, human recombinant) | GVOKE HYPOPEN 1-PACK (glucagon)<br>GVOKE PFS (glucagon) |

Quantity limit of 2 per month

# Endocrine Agents: Endometriosis

**LENGTH OF AUTHORIZATIONS**: 365 Days

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

**STEP THERAPY:**

For a drug requiring step therapy, there must have been a therapeutic failure of at least a 30-day trial with both a NSAID and an oral contraceptive

**NON-PREFERRED:**

There must have been a therapeutic failure of at least a 30-day trial with both a NSAID and an oral contraceptive and a trial and a therapeutic failure of no less than 3-months on at least one step therapy required "preferred"

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**ENDOMETRIOSIS TREATMENT**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | DANAZOL<br>DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)<br>LUPANETA PACK (leuprolide acetate and norethindrone acetate)<br>LUPRON DEPOT 3.75 MG, 11.25 MG (leuprolide acetate)<br>ORILISSA (elagolix)<br>ZOLADEX (goserelin acetate) | SYNAREL (nafarelin acetate) |

# Endocrine Agents: Uterine Fibroids

**LENGTH OF AUTHORIZATIONS:** 180 Days

Members who have been treated with Oriahnn® for 24 months or more are not eligible for additional authorizations
Members who have been treated with Lupron Depot for 6 months or more are not eligible for additional authorizations

The requested medication may be approved if the member has a diagnosis of uterine leiomyomas (fibroids) and has failed a 90 day or more trial with an oral contraceptive

| CLINICAL PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| LUPRON DEPOT 3.75 MG, 11.25 MG (leuprolide acetate)<br>ORIAHNN (elagolix and estradiol and norethindrone) | |

# Ophthalmic Agents: Ophthalmic Steroids

**LENGTH OF AUTHORIZATIONS**: 30 Days

For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than 14 days each of at least two preferred products

**OTHER APPROVAL CRITERIA:**

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

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**OPHTHALMIC AGENTS: OPHTHALMIC STEROIDS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| DEXAMETHASONE SODIUM PHOSPHATE | ALREX (loteprednol etabonate) |
| DUREZOL (difluprednate) | FLAREX (fluorometholone acetate) |
| FLUOROMETHOLONE | INVELTYS (loteprednol etabonate) |
| FML FORTE (fluorometholone) | LOTEMAX (loteprednol etabonate) |
| FML S.O.P. (fluorometholone) | LOTEMAX SM (loteprednol etabonate) |
| PRED MILD (prednisolone acetate) | LOTEPREDNOL |
| PREDNISOLONE ACETATE | MAXIDEX (dexamethasone sodium phosphate) |
| PREDNISOLONE SODIUM PHOSPHATE | |

# Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE (Self-Administered)

**LENGTH OF AUTHORIZATIONS:** 365 DAYS

**CLINICAL CRITERIA FOR ASTHMA**

 Indicated for moderate to severe asthma if:

- Prescribed by or in consultation with an allergist/immunologist or pulmonologist
- Preferred medications will be approved for patients with uncontrolled eosinophilic asthma symptoms and/or exacerbations despite at least one-month adherence to therapy with:
  - Medium dose preferred ICS/LABA inhaler (members 6-11 years old) – Nucala only
  - Medium dose preferred ICS/LABA inhaler with tiotropium or high dose preferred ICS/LABA inhaler (members 12 years and older) – Nucala or Fasenra
- Non-preferred medications will be approved for patients with uncontrolled eosinophilic asthma symptoms and/or exacerbations despite at least three months adherence to therapy with a preferred agent

**ADDITIONAL CRITERIA FOR DUPILUMAB (DUPIXENT)**

 Indicated for moderate to severe atopic dermatitis if:

- Patient has minimum body surface area (BSA) involvement of at least 10%
- Prescribed by or in consultation with a dermatologist or allergist/immunologist
- Patient is 6 years of age or older
- Patient has had inadequate response or contraindication to two of the following: topical corticosteroids, topical calcineurin inhibitors [e.g. Elidel], or topical PDE-4 inhibitors [e.g. Eucrisa] unless atopic dermatitis is severe and involves greater than 25% of BSA.
- Initial authorization is limited to 112 days with re-authorization of up to 365 days granted following demonstration of improvement in patient condition with therapy (e.g. reduced BSA affected).

 Indicated for chronic rhinosinusitis with nasal polyposis if:

- Patient is 18 years of age or older
- Patient had an inadequate response, intolerance or contraindication to one oral corticosteroid
- Patient had a 30-day trial and experienced an inadequate response, intolerance or contraindication to one nasal corticosteroid spray

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**MONOCLONAL ANTIBODIES-ANTI-IL/ANTI-IGE (SELF-ADMINISTERED)**

| CLINICAL PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| FASENRA (benralizumab)<br>NUCALA (mepolizumab) | DUPIXENT (dupilumab) |

| NEW PREFERRED SUPPLY | |
|---|---|
| **DIABETIC SUPPLY** | **NO PA REQUIRED PREFERRED** |
| METERS | ONE TOUCH ULTRA METERS<br>ONE TOUCH VERIO METERS |
| STRIPS | ONE TOUCH ULTRA STRIPS<br>ONE TOUCH VERIO STRIPS |

| NEW NON-PREFERRED SUPPLY | |
|---|---|
| **DIABETIC SUPPLY** | **PA REQUIRED NON-PREFERRED** |
| METERS | FREESTYLE METERS<br>PRECISION XTRA METERS |
| STRIPS | FREESTYLE STRIPS<br>PRECISION XTRA STRIPS |

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