The following changes will be effective on **April 1, 2021**, unless otherwise specified and apply to the following plan:

**Yamhill Community Care (Medicaid)**

**Formulary Changes**

| **Drug Name** | **Recommendation** | **Policy Name** |
| --- | --- | --- |
| **Alkindi Sprinkle® (hydrocortisone) Capsules** | New Dosage Form and Strength:* Non-Formulary
 | N/A |
| **Atorvastatin 10, 20, and 40 mg Tablets** | Remove Quantity Limit for Medicaid* Medicaid: Formulary
 | N/A |
| **Cosentyx® (secukinumab)** | Add to Medicaid Formulary: Formulary, Specialty, Prior Authorization, Quantity Limit (2 injections per 28 days) | Therapeutic Immunomodulators - Medicaid |
| **Dificid® (fidaxomicin) 40 mg/mL suspension** | New Dosage Form* Medicaid: Formulary, Step Therapy
 | Dificid |
| **Impeklo® (clobetasol) 0.05% lotion pump** | New Dosage Form* Non-Formulary, Prior Authorization
 | New Medications and Formulations without Established Benefit |
| **Moxifloxacin (Vigamox®) Eye Drops** | Down-tier the generic and add to Medicaid formulary:* Medicaid: Formulary
 | N/A |
| **Otezla® (apremilast)** | * Remove from Medicaid Formulary: Non-Formulary, Specialty, Prior Authorization, Quantity Limit (2 tablets per day) Effective 5/1/2021
 | Therapeutic Immunomodulators - Medicaid |
| **Pregabalin (Lyrica®) Capsules** | Remove Quantity Limits for Medicaid* Medicaid: Formulary
 | N/A |
| **Qdolo® (tramadol) 5 mg/mL Oral Solution** | New Dosage Form: * Non-Formulary, Prior Authorization, Quantity Limit 80 mL/day
 | Pediatric Analgesics |
| **Simvastatin 40 and 80 mg Tablets** | Remove Quantity Limits for Medicaid* Medicaid: Formulary
 | N/A |
| **Sutab® (sodium sulfate/potassium chloride/magnesium sulfate) Tablet** | New Combination: * Medicaid: Formulary
 | N/A |
| **Trelstar® (triptorelin pamoate) Vial** | Add Prior Authorization for Medicaid: * Medicaid: Medical Benefit, Prior Authorization

Effective 5/1/2021 | Gonadotropin Releasing Hormone Agonists |

**Medical Policy Changes**

**Coverage Criteria Changes**

| **Drug/Policy Name(s)** | **Plans Affected** | **Summary of Change** |
| --- | --- | --- |
| **Acute Hereditary Angioedema Therapy** | [x]  Medicaid | Generic icatibant was added as required prerequisite therapy for new starts; updated reauthorization criteria to better align with disease state |
| **CAR-T** | [x]  Medicaid | Updated exclusion and indication-specific criteria to align with clinical trial inclusion/exclusion criteria, FDA label and National Comprehensive Cancer Network (NCCN) recommendations. |
| **Hepatitis C - Direct Acting Antivirals - Medicaid** | [x]  Medicaid | Add Epclusa® 200-50 MG Tablet to Medicaid Formulary, Specialty, Prior Authorization to align with OHA |
| **Injectable Anti-Cancer Medications** | [x]  Medicaid | Updated authorization duration to until no longer eligible with the plan. Removed requirement for use of intravenous trastuzumab and pertuzumab prior to approval of Phesgo® and/or Herceptin Hylecta®. Minimal cost differences and possible future availability of home administration for these products. |
| **Insomnia Agents - Medicaid** | [x]  Medicaid | Updated policy criteria to require a trial and failure of preferred agents for all requests, added a trial of cognitive behavior therapy for new starts as recommended per the American Academy of Sleep Medicine guidelines, updated criteria to restrict use of sedatives to Medicaid funded conditions. |
| **Lidocaine Patch** | [x]  Medicaid | Based on drug utilization review, criteria were updated to allow coverage if the patient has a diagnosis of post-herpetic neuralgia, diabetic peripheral neuropathy, or neuropathic Pain |
| **Non-Preferred Fumarate Products** | [x]  Medicaid | Added Medicaid to policy, requiring Vumerity® and Bafiertam® to step through generic dimethyl fumarate (Tecfidera®). |
| **Oral Anti-Cancer Medications** | [x]  Medicaid | Removed Zejula® indication-specific criteria to align with cost-positioning contracts. In addition, removed prior authorization for Medicare Part B temozolomide and Alkeran® given low risk for over utilization. |
| **Provenge** | [x]  Medicaid | Removed comment about “no complaints of bone pain as an example of minimally symptomatic metastatic disease” to better reflect population in clinical trials. Updated definition of castrate resistant prostate cancer to include clinical or biochemical progression (as well as radiographic) to align with NCCN Prostate Cancer guideline definition. Added other visceral metastases in addition to hepatic to align with NCCN guidelines. Clarified exclusion statement regarding immunosuppressive agents. |
| **Rituximab** | [x]  Medicaid | * Changed criteria for Rheumatoid Arthritis to trial/failure of one tumor necrosis factor (TNF) antagonist to align with FDA labeling. Criteria change for Relapsing and Remitting Multiple Sclerosis to trial/failure of two disease modifying agents (removed requirement for specific agents) OR patient has severe disease (without trial/failure of two agents) to align with current practice patterns. For warm autoimmune hemolytic anemia, removed requirement for splenectomy as it is moving to third line therapy after corticosteroids and rituximab. Increased reauthorization duration from 6 months to one year for all indications.
 |
| **Therapeutic Immunomodulators - Medicaid** | [x]  Medicaid | Based on a drug utilization review of psoriasis treatments in this population, Cosentyx® was added as a preferred agent for the indication. Otezla® and Enbrel® were removed as preferred agents due to their poor efficacy in this disease state. |

**Retired Medical Policies**:

* None

**New Medical Policies**:

* None

**New Drugs**:

|  |  |  |
| --- | --- | --- |
| **Drug Name** | **Recommendation** | **Policy Name** |
| **Orladeyo® (berotralstat)** | * Medicaid: Formulary, Specialty, Prior Authorization
 | HAE Prophylactic Therapy |
| **Naxitamab-gqgk (Danyelza®) Vial** | Medicaid: Medical Benefit, Prior Authorization | Injectable Anti-Cancer Medications |
| **Nifurtimox (Lampit®) Tablet** | Non-Formulary | N/A |
| **Opicapone (Ongentys®) Capsule** | * Medicaid: Formulary, Step Therapy
 | Ongentys |
| **Levamlodipine maleate (Conjupri®) Tablet** | Medicaid: Non-Formulary, Prior Authorization | New medications and formulations without established benefit |
| **Remdesivir (Veklury®) Vial** | Medicaid: Medical Benefit |  |
| **Lumasiran sodium (Oxlumo®) Vial** | Medicaid: Medical Benefit, Prior Authorization | Oxlumo |
| **Oxybates salts (calcium, magnesium, potassium, and sodium) oral solution (Xywav)** | * Medicaid: Formulary, Prior Authorization
 | Xyrem and Xywav |