The following changes will be effective on **August 1, 2019**, unless otherwise specified and apply to the following plan:

**Yamhill Community Care (Medicaid)**

### Formulary Changes

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Change Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine hcl 2 mg tablets and buprenorphine/naloxone 2mg-0.5 mg tablets</td>
<td>Change Quantity Limit from 3 tablets per day to 4 tablets per day</td>
</tr>
</tbody>
</table>
| Buprenorphine hcl/naloxone hcl (Suboxone®) Film and tablet                                                                             | Quantity Limit change  
  - 4 mg-1 mg, 2 mg-0.5: 4 films per day  
  - 2 mg-0.5 mg: 4 films per day                                                                                                             |
| Chlorpheniramine maleate/codeine phosphate (Tuxarin® ER) Tab ER 12H                                                                      | New combination.  
  - Medicaid: Non-Formulary, Prior Authorization  
    - Add to New Formulations and Medications without established benefit policy                                                                 |
| Chlorzoxazone Tablet                                                                                                                       | New generic.  
  - Medicaid: Non Formulary, Prior Authorization  
    - Added to New Medications and Formulations without established benefit policy                                                                 |
| Elapegademase-lvrl (Revcovi®)                                                                                                               | Add to formulary.  
  - Medicaid: Formulary, Specialty, Prior Authorization                                                                                      |
<p>| Fexofenadine hcl (Children's Allegra Allergy) Tab Rapdis                                                                               | Remove from Medicaid formulary, keep prior authorization                                                                                           |
| Fluticasone furoate (Flonase® Sensimist) Spray Sus                                                                                         | Remove from Medicaid formulary, keep prior authorization                                                                                           |
| Interferon Beta-1A (Avonex®) Syringe kit/kit                                                                                                | Add Quantity Limit (4 injections per 28 days) to align with other multiple sclerosis drugs for Medicaid                                                                                                       |
| Ipratropium bromide (Atrovent®) Spray                                                                                                      | Remove from Medicaid formulary, keep prior authorization                                                                                           |
| Ivermectin (Soolantra®) Cream                                                                                                              | Change Quantity Limit to 45 grams per 30 days for Medicaid                                                                                         |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>New Information</th>
</tr>
</thead>
</table>
| Loteprednol etabonate (Lotemax® SM) Drops Gel | New strength.  
  - Medicaid: Formulary |
| Meloxicam (Qmiiz ODT®) tab rapdis | New dosage form  
  - Medicaid: Non-Formulary, Prior Authorization  
    - Add to New Formulations and Medications without established benefit policy |
| Naloxone hcl (Narcan®) Spray | Change Quantity Limit from 2 doses per year to 2 doses per 30 days for Medicaid |
| Netarsudil mesylate/latanoprost (0.02-0.005) (Rocklatan®) drops | New Combination: Non-Formulary for Medicaid |
| prenatal vitamins no.147/ferrous gluconate/folic acid (Azesco®) Tablet | Non-Formulary for Medicaid |
| Sumatriptan succinate (Sumavel Dosepro®) NDL FR INJ | Add Quantity Limit of 4 ml per 30 days for Medicaid |
| Tacrolimus (Prograf®) Gran Pack | New Dosage Form and Strength ([0.2 mg/gran pack]; [1 mg/gran pack]).  
  - Medicaid: Non-Formulary, Prior Authorization  
  Criteria: 1. Documentation that medically necessary dose of tacrolimus cannot be achieved through use of generic tacrolimus capsules (which are available in 0.5, 1, and 5 mg strengths) OR 2. Documentation that the patient has difficulty swallowing generic tacrolimus capsules |
| Tildrakizumab-asmn (Ilumya®) Syringe | Move from Therapeutic Immunomodulators policy to Medically Infused Therapeutic Immunomodulators (Tims) policy  
  - Medicaid: Medical Benefit, Prior Authorization |
| Trastuzumab-hyaluronidase-oysk (Herceptin Hylec®) Vial | New combination.  
  - Medicaid: Medical Benefit, Prior Authorization  
  Added to Injectable ANTI-Cancer Medications policy |
## Medical Policy Changes

### Coverage Criteria Changes

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Plan Affected</th>
<th>Change Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstral, Fentora, Lazanda, Subsys</td>
<td>☒ Medicaid</td>
<td>Added that documentation of breakthrough cancer pain must be supported by chart notes. Added prescriber restrictions (must be prescribed by or in consultation with an oncologist or pain specialist) and reauthorization criteria.</td>
</tr>
<tr>
<td>Aranesp, Epogen, Procrit, Retacrit</td>
<td>☒ Medicaid</td>
<td>The coverage duration was updated to one year for both initial and reauthorization. A review of claims data shows very little inappropriate utilization after initial approval (all submitted lab values were within range); therefore, these claims will no longer be pended for review.</td>
</tr>
<tr>
<td>CFTR Modulators</td>
<td>☒ Medicaid</td>
<td>Criteria preferring Symdeko over Kalydeco was removed as these are similar cost and choice of therapy should be left to the prescriber.</td>
</tr>
<tr>
<td>Daliresp</td>
<td>☒ Medicaid</td>
<td>The policy criteria was updated to match the current FDA-approved indication. In addition, specific confirmatory diagnostic criteria was removed to improve operational burden of this prior authorization.</td>
</tr>
<tr>
<td>Fentanyl Citrate</td>
<td>☒ Medicaid</td>
<td>Added that documentation of breakthrough cancer pain must be supported by chart notes. Added prescriber restrictions (must be prescribed by or in consultation with an oncologist or pain specialist) and reauthorization criteria.</td>
</tr>
<tr>
<td>Gonadotropin Releasing Hormone Agonists</td>
<td>☒ Medicaid</td>
<td>Vantas (histrelin implant) was added to this policy to align with other agents in this class. Effective: 09/01/2019</td>
</tr>
<tr>
<td>Krystexxa</td>
<td>☒ Medicaid</td>
<td>Removed criteria that required trial of lesinurad (Zurampic®), as this drug has been withdrawn from the market.</td>
</tr>
<tr>
<td>Long Acting Opioids</td>
<td>☒ Medicaid</td>
<td>Criteria was updated for some of the drugs on this policy as follows: created separate criteria for Butrans and Belbuca and added tramadol ER as another trial and failure option. Added requirement that approval of Belbuca will also require trial of Butrans. Removed separate criteria for Xtampza and added to the criteria for Avinza, Exalgo.</td>
</tr>
<tr>
<td>Maximum Allowable Opioid Dose</td>
<td>☒ Medicaid</td>
<td>Removed criteria for Medicaid on conditions of the back and spine as requirement is changing per Oregon Health Authority (OHA).</td>
</tr>
</tbody>
</table>
### Medicaid Intranasal Medications

**Medicaid**

The policy was updated to align with the OHA preferred drug list and prior authorization criteria. The acceptable comorbidities were narrowed to asthma (without inhaled steroid therapy), acute/chronic sinusitis, and sleep apnea. In addition, the requirement for oral antihistamine use was removed and the preferred intranasal therapy was limited to fluticasone propionate (Flonase®).

### Nucynta

**Medicaid**

Increase initial approval length to 1 year. Changed covered uses to "Relief of moderate to severe pain”

### Oxymorphone (Opana)

**Medicaid**

Removed criteria for Medicaid on conditions of the back and spine as requirement is changing per OHA.

### Revcovi

**Medicaid**

Revcovi® may be approved as a “bridge” therapy before undergoing HSCT or a HSC-Gene Therapy clinical trial if a donor/clinical trial has been identified (subject to policy coverage durations). A recent consensus approach statement for the management of ADA-SCID recommends enzyme replacement therapy at time of diagnosis followed by definitive treatment with HSCT or HCSC-Gene Therapy.

### Second and Third generation antihistamines – Medicaid

**Medicaid**

The policy was reviewed for alignment with the OHA preferred drug list and Prior Authorization criteria. "Routine use of oxygen therapy” was removed as an acceptable comorbidity, as this is not included in the OHA criteria.

### Therapeutic Immunomodulators – Medicaid

**Medicaid**

Updating clinical policy with Cimzia's new indication for use in adult patients with non-radiographix axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; no clinical criteria required as it is the only medication FDA approved for non-radiographic axial spondyloarthritis.

### Triptan QL

**Medicaid**

Removing neurologist provider restriction. Increasing quantity limits for sumatriptan injectable (Medicaid line of business) to four (4) doses per 30 days (including Sumatriptan Dosepro).

### Xolair

**Medicaid**

For asthma, modifying number of months’ patient needs to be adherent inhalers (from 6 months to 3 months) to be in-line with IL-5 and Dupixent® policies. Modifying reauthorization criteria for asthma to "Reauthorization documentation of response to therapy, such as attainment and maintenance of remission or decrease."
New Medical Policies: None

Retired Medical Policies:
- Duzallo, Zurampic
- Ocrevus

New Drugs to Market
- **Cladribine tablet (Mavenclad®)**
  - Medicaid: Formulary, Specialty, Prior Authorization
- **Siponimod tablet (Mayzent®)**
  - Medicaid: Formulary, Specialty
- **Esketamine HCL (Spravato®) Spray**
  - Medicaid: Medical Benefit: Prior Authorization
- **Onasemnogene abeparvovec-xioi (Zolgensma) Kit**
  - Medicaid: Medical Benefit: Prior Authorization
- **Tagraxofusp-erzs (Elzonris) Vial**
  - Medicaid: Medical Benefit: Prior Authorization
- **Dolutegravir sodium Lamivudine (Dovato®) Tablet**
  - Medicaid: Non-Formulary
- **Caplacizumab-yhdp (Cablivi®) Kit**
  - Medicaid: Formulary, Specialty, Prior Authorization, Quantity Limit (1 vial per day)
- **Prucalopride succinate (Motegrity®) Tablet**
  - Medicaid: Non-Formulary, Prior Authorization
- **Sarecycline HCL (Seysara®) Tablet**
  - Medicaid: Non-Formulary, Prior Authorization