Yamhill Community Care Organization

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

Yamhill Community Care Organization (Medicaid)

Formulary Changes

Drug/Policy Name	Recommendation
Aciphex® (rabeprazole) sprinkle	Medicaid: Remove quantity limit for all strengths of medication
Colchicine capsule	Add to formulary and remove quantity limits Medicaid: Formulary
Colchicine tablets	Medicaid: Remove quantity limit for all strengths of medication
Daklinza® (daclatasvir) tablets	Medicaid: Remove from formulary
dronabinol (Marinol®) capsules	Medicaid: Remove quantity limit for all strengths of medication
Epclusa® (sofosbuvir/velpatasvir) tablets	Medicaid: Remove quantity limit for all strengths of medication
Epinephrine auto-injector (EpiPen®) 0.15 and 0.3 mg	EpiPen® brand and generic products will be on formulary (No changes to quantity limits)
Auvi-Q® (epinephrine) 0.15 and 0.3 mg auto-injector	Medicaid: Non-formulary
Auvi-Q® (epinephrine) 0.1 mg autoinjector	Medicaid: Formulary, Brand, Quantity limit: • Age 0-17: 6 doses per year • Age 18+: 4 doses per year

Esomeprazole (Nexium®)	Medicaid: Remove quantity limit for all strengths of medication
Gardasil® vaccine	Medicaid: Remove age restrictions
Harvoni® (ledipasvir/sofosbuvir)	Medicaid: Remove from formulary
Lonsurf® (trifluride/tipiracil)	Medicaid: Remove quantity limit for all strengths of medication
Lyrica CR® (pregabalin) tablets	Medicaid: Remove from formulary and add to New Formulations and Medications without established benefit policy
Olysio® (simeprevir) capsule	Medicaid: Remove from formulary
palonosetron 0.25 mg vial	New Dosage Form Medicaid: Medical benefit
Ryclora® (dexchlorpheniramine) 2 mg/5mL syrup	Return of Drug to Market Medicaid: Non-formulary
Siklos® (hydroxyurea) 1000 mg tablet	New Strength Medicaid: Non-formulary
Sovaldi® (sofosbuvir)	Medicaid: Remove from formulary
Technivie®	Medicaid: Remove from formulary
(ombitasvir/paritaprevir/ritonavir) tablets	Medicaid: Remove quantity limit for all strengths of medication
Viekira®/Viekira XR® (ombitasvir/paritaprevir/ritonavir/dasabuvir)	Medicaid: Remove from formulary
Vosevi® (sofosbuvir/grazoprevir) tablets	Medicaid: Remove quantity limit for all strengths of medication

Zepatier® (elbasvir/velpatasvir/ voxilaprevir) tablets	Medicaid: Remove quantity limit for all strengths of medication

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plan Affected	Summary of Change
Enstilar, Taclonex, Taclonex Scalp	☒ Medicaid	Removed quantity limit due to low risk of overutilization. Updated coverage duration to lifetime approval
Eucrisa	☒ Medicaid	Removed quantity limit due to low risk of overutilization
Extavia	☒ Medicaid	Removed quantity limit due to low risk of overutilization
Insomnia Agents	☒ Medicaid	Due to large operational/administrative burden in reviewing prior authorization requests, the criteria related to comorbid diagnoses and failure of non-pharmacologic measures were removed.
Kapvay	☒ Medicaid	Removed quantity limit due to low risk of overutilization
Lidocaine Patch	☒ Medicaid	Removed quantity limit due to low risk of overutilization

Drug/Policy Name(s)	Plan Affected	Summary of Change
Lyrica, Lyrica CR	☒ Medicaid	Lyrica CR will be moved from this policy to the New Medications and Formulations without Established Benefits. Prior Authorization for Lyrica will remain for Medicaid due to several uses for below the line indications.
Therapeutic Immunomodulators Policies: • Medically Infused Therapeutic Immunomodulators • TIMs - Medicaid	☒ Medicaid	Coverage duration was updated to lifetime coverage after initial response to therapy is documented.
New Medications and Formulations Without Established Benefit	☒ Medicaid	Lexette® (halobetasol propionate) 0.05% foam , Abilify Mycite®, and Lyrica CR® are being added to the policy
Noctiva	☒ Medicaid	Nocdurna® added to this policy and name will be updated. Both drugs will have the same criteria except that Nocdurna® is approved for adults 18 older whereas Noctiva® is only approved for adults 50 and older.
Drug/Policy Name(s)	**Plan Affected**	**Summary of Change**
Promacta	☒ Medicaid	Removed criterion requiring immunosuppressive therapy for the severe aplastic anemia indication.

Provenge	☒ Medicaid	The Medicaid criteria was updated to reflect current National Comprehensive Cancer Network guidelines.
Rituxan	☒ Medicaid	Criteria was added for oncologic indications, Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA), and autoimmune hemolytic anemia.
Xifaxan	☒ Medicaid	The diagnostic criteria was removed for the irritable bowel syndrome with diarrhea (IBS-D) indication, as this was deemed unnecessary due to restricting prescribing to gastroenterologists. Total number of treatment courses approved was increased to three for IBS-D consistent with package labeling.

The following represents a positive change and was implemented on 3/1/19 as an off-cycle implementation from February ORPTC:

Table Key: F = formulary, NF = non-formulary; PA = prior authorization; ST = step therapy; QL = quantity limit, N/A = not applicable (no changes)

Medication	Medicaid Formulary Status	Covered Uses	Step Therapy Criteria
Banzel® (rufinamide tablet)	F, ST	Seizure Disorder	1. The patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy)
clobazam oral tablet (Onfi®)	F, ST, QL (2/1)		

Medication	Medicaid Formulary Status	Covered Uses	Step Therapy Criteria
Onfi® (clobazam suspension)	F, ST, QL (16ML/1)	Seizure Disorder	OR 2. Documentation of trial and failure of at least one formulary antiepileptic medication
Aptiom® (eslicarbazepine tablet)	F, ST		
Vimpat® (locosamide tablet, oral solution)	F, ST		
Fycompa® (perampanel tablets and suspension)	F, ST Remove QL and age restriction		
Oxtellar XR® (oxcarbazepine etended-release)	F, ST Remove age restriction	Seizure Disorder	1. The patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy) OR 2. Documentation of trial and failure of immediate-release oxcarbazepine

Lamotrigine extended-release (Lamictal XR®)	F, ST	Seizure Disorder	1. The patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy) OR 2. Documentation of trial and failure of immediate-release lamotrigine
Medication	**Medicaid Formulary Status**	**Covered Uses**	**Step Therapy Criteria**
Briviact® (brivaracetam oral tablet, oral solution)	F, ST, QL (2/1 for tablets; 20mL/1 for oral solution) Remove age restriction	Seizure Disorder	1. The patient is currently established on therapy with the requested medication (Note: starting on samples will not be considered established on therapy) OR 2. Documentation of trial and failure of levetiracetam

New Medical Policies: None

Retired Medical Policies: None

New Drugs to Market

- **Aripiprazole (Abilify Mycite®) Tab Senspt** ○ Medicaid: Non-formulary
- **Cannabidiol (CBD) Extract (Epidiolex®) Solution** ○ Medicaid: Formulary, Brand, Prior Authorization
- **Cemiplimab-RWLC (Libtayo®) Vial** ○ Medicaid: Medical Benefit, Prior Authorization (Added to Injectable ANTI-Cancer Medications policy)
- **Dacomitinib (Vizimpro®) Tablet** ○ Medicaid: Formulary, Specialty, Prior Authorization (Added to Oral Anti-Cancer Medications Policy)
- **Duvelisib (Copiktra®) Capsule** ○ Medicaid: Formulary, Specialty, Prior Authorization (Added to Oral Anti-Cancer Medications Policy)
- **Gilteritinib Fumarate (Xospata®) Tablet** ○ Medicaid: Formulary, Specialty, Prior Authorization (Added to Oral Anti-Cancer Medications Policy)
- **Glasdegib Maleate (Daurismo®) Tablet** ○ Medicaid: Formulary, Specialty, Prior Authorization (Added to Oral Anti-Cancer Medications Policy)
- **Lorlatinib (Lorbrena®) Tablet** ○ Medicaid: Formulary, Specialty, Prior Authorization (Added to Oral Anti-Cancer Medications Policy)
- **Moxetumomab pasudotox-tdfk (Lumoxiti®) Vial** ○ Medicaid: Medical Benefit, Prior Authorization (Added to Injectable ANTI-Cancer Medications policy)
- **Talazoparib Tosylate (Talzenna®) Capsule** ○ Medicaid: Formulary, Specialty, Prior Authorization (Added to Oral Anti-Cancer Medications Policy)
- **Inotersen sodium (Tegsedi®) Syringe** ○ Medicaid: Formulary, Specialty, Prior Authorization, Quantity Limit (4 pens per 28 days)
- **Patisiran Sodium, Lipid Complex (Onpattro®) Vial** ○ Medicaid: Medical Benefit, Prior Authorization, Quantity Limit
- **Ozenoxacin (Xepi®) Cream** ○ Medicaid: Non-Formulary
- **Tafenoquine succinate (Arakoda®) Tablet** ○ Medicaid: Non-Formulary
- **Tildrakizumab-ASMN (Ilumya®) Syringe** ○ Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1mL per 84 days)
- **Amikacin sulfate liposomal with nebulizer accessories (Arikayce®) Vial-Neb** ○ Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (8.4ml per day)

Drug/Policy Name	Recommendation
Altreno® (tretinoin) 0.5% lotion	New Dosage Form • Medicaid: Non-formulary
Symjepi® (epinephrine) 0.3 mg syringe	New Dosage Form. Add to formulary • Medicaid: Formulary, Brand, Quantity limit: o Age 0-17: 6 doses per year o Age 18+: 4 doses per year
Minolira ER® (minocycline extendedrelease) 105 mg and 135 mg tablets	New Dosage Form • Medicaid: Non-Formulary, Prior Authorization (add to New Formulations and Medications without established benefit policy)
Nocdurna® (desmopressin acetate) 27.7 and 55.3 mg rapid dissolving tablets	New Dosage Form and Strength • Medicaid: Non-formulary
Novolin 70/30 FlexPen® (insulin NPH/insulin regular)	New Dosage Form • Medicaid: Non-formulary, but Relion manufacturer to be added to formulary
palonosetron 0.25 mg vial	New Dosage Form • Medicaid: Medical benefit
Panzyga® (immune globulin-IFAS human/glycine) 10% vial	New entity. Line extend to other medically infused immune globulin products • Medicaid: Medical benefit, Prior Authorization (add to Immune Gamma Globulin policy)

Drug/Policy Name	Recommendation
Sympazan® (clobazam) 5, 10, and 20 mg film	New Dosage Form • Medicaid: Formulary, Specialty tier, Prior Authorization, Quantity Limit (2 films per day) Prior Authorization criteria for Medicaid: ○ Prescriber restrictions: Must be prescriber by or in consultation with a neurologist Other Criteria: Documentation of trial and failure, contraindication, or intolerance to generic clobazam and two (2) additional alternative generic formulary antiepileptic agents (e.g., valproic acid, lamotrigine, topiramate, felbamate)
Tiglutik® (riluzole) 50 mg/10mL oral suspension	New Dosage Form • Medicaid: Non-Formulary
Xelpros® (latanoprost) 0.005% emulsion drops	New Dosage Form • Medicaid: Non-Formulary
Xyosted® (testosterone enanthate) autoinjector	New Dosage Form and Strength • Medicaid: Non-formulary, prior authorization (Add to Testosterone Replacement Policy)