The following changes will be effective on February 1, 2024, unless otherwise specified and apply to the following plan:

Yamhill Community Care (Medicaid)

Formulary Changes

Drug Name	Formulary Status	Policy Name
Latanoprost/pf (lyuzeh) Droperette	New dosage form (droperette). • Medicaid: Non-Formulary, Step Therapy, Quantity Limit of one (1) droperette per day	Anti-Glaucoma Agents Step Therapy Policy
Lacosamide (Motpoly Xr) Cap ER 24h	New dosage form (Cap ER 24H). • Medicaid: Non-Formulary (Covered by the state directly)	N/A
Dronabinol Capsule / Solution	Add quantity limit for Medicaid: • Capsules: Two (2) capsules per day • Solution: 4 milliliters (mL) per day	N/A
Rifamycin sodium (Aemcolo) Tablet DR	Update quantity limit for Medicaid to one (1) claim per year	N/A

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Acute Hereditary Angioedema Therapy	☒ Medicaid	Added exclusion for use of multiple agents for acute treatment and clarified icatibant prerequisite therapy will only be required for adult patients.
Antifungal Agents	☒ Medicaid	Updated criteria based on new guidelines: Aspergillus/Candida prophylaxis for HIV/AIDS for secondary prophylaxis for patients with frequent or severe recurrences only, not for primary prophylaxis
Cablivi	☒ Medicaid	Specified treatment extension criteria to define persistent severe genetic deficiency as ADAMTS13 activity less than 10% or 10 IU/dL
Constipation Agents - Medicaid	☒ Medicaid	Removed Zelnorn (obsolete), updated coverage duration for patient under 21 years of age to one year or until member reaches age 21, whichever is shortest.
Empaveli	☒ Medicaid	Redefined severe disease as symptomatic hemolytic PNH with LDH greater than 1.5 time the upper limit of normal (ULN) plus one additional finding.
Enjaymo	☒ Medicaid	1) Removed requirement that the person must have had a blood transfusion within the past six months as updated indication now includes those with cold agglutinin diseases that are not transfusion dependent. 2) Added exclusion criteria that use must not be for treatment of cold-induced symptoms of cold agglutinin disease as these are caused by red blood cell (RBC) agglutination not complement-mediated (Enjaymo mechanism of action). 3) Updated documentation of successful response to therapy to also include improvement in markers of hemolysis or symptoms.
Erythropoiesis Stimulating Agents (ESAs)	☒ Medicaid	Preoperative use in patients scheduled for cardiac surgery added as medically accepted indication as per guidance from guidelines. Criteria updated for hemoglobin levels to be drawn up to 45 days prior to initiation of therapy.
Hemgenix	☒ Medicaid	Updated criteria required for confirmation of diagnosis for Hemgenix, allowing historical diagnosis of severe hemophilia or provider attestation.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Hemlibra	☒ Medicaid	Coverage duration updated to until no longer eligible with the plan upon initial authorization.
• **Hepatitis C - Direct Acting Antivirals** • **Hepatitis C - Direct Acting Antivirals - Medicaid**	☒ Medicaid	Removed Viekira Pak (obsolete) and made minor edits to criteria and coverage duration.
Injectable Anti-Cancer Medications	☒ Medicaid	Updated preferred biosimilar products for trastuzumab. Kanjinti® will no longer be preferred and Trazimera® will be preferred.
Livtencity	☒ Medicaid	Added exclusion of coadministration with ganciclovir or valganciclovir.
Lotronex	☒ Medicaid	Removed loperamide requirement due to conflicting guideline recommendations.
Medications For Rare Indications	☒ Medicaid	Age restriction updated to align with FDA-approved indication(s). Clarified criteria regarding confirmation of diagnosis and prerequisite therapy.
Prophylactic Hereditary Angioedema Therapy	☒ Medicaid	Clarified quantity limitation for Takhzyro.
Pyrukynd	☒ Medicaid	Changed criteria to allow low hemoglobin levels OR transfusion dependence.
Reblozyl	☒ Medicaid	Eyl1) Updated myelodysplastic syndrome (MDS) criteria to allow for newly approved indication, 2) Simplified diagnosis criteria for beta thalassemia, 3) Updated prescriber restrictions to hematologist / oncologist, 4) Removed exclusion criteria as not FDA labeled contraindication, 5) changed wording to allow for continuation of therapy for patients new to the health plan.
Syfovre	☒ Medicaid	History of choroidal neovascularization (CNV) removed from exclusion criteria but added medical necessity criteria for patients with active CNV. Exclusion criteria updated to state exclusion criteria is pertinent to requested eye being treated.
Tavneos	☒ Medicaid	Updated reauthorization coverage duration from 6 months to 12 months.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Ultomiris	☒ Medicaid	Criteria regarding symptomatic hemolytic PNH simplified to align with the market.
Viberzi	☒ Medicaid	Remove trial and failure of loperamide, add all contraindications to exclusion criteria.
Xermelo	☒ Medicaid	Removed prescriber restriction.
Xifaxan	☒ Medicaid	Added requirement for combination with lactulose for hepatic encephalopathy and added requirement for azithromycin or fluoroquinolone to Traveler's Diarrhea criteria.

Retired Medical Policies

- **Aemcolo -** Due to low risk of inappropriate utilization
- **Antimalarial Agents –** Due to low utilization
- **Dronabinol –** Due to low risk of overutilization and availability of low-cost generic capsules
- **Ivermectin –** Due to low utilization
- **Mepron -** Due to low risk of inappropriate utilization

New Drugs:

Drug Name	Recommendations	Policy Name
Nadofaragene firadenovec-vncg (Adstiladrin) Vial	Medical Benefit, Prior Authorization	Injectable Anti-cancer Medications
Talquetamab-tgvs (Talvey) Vial	Medical Benefit, Prior Authorization	T Cell Therapy
Elranatamab-bcmm (Elrexfio) Vial	Medical Benefit, Prior Authorization	T Cell Therapy
Niraparib tosylate abiraterone acetate (Akeega) Tablet	Formulary, Tier 6, Prior Authorization	Oral Anti-Cancer Medications
Momelotinib dihydrochloride (Ojjaara) Tablet	Formulary, Tier 6, Prior Authorization	Oral Anti-Cancer Medications
Avacincaptad pegol sodium pf (Izervay) Vial	Medical Benefit, Prior Authorization, Quantity Limit (4 mg per 30 days)	Izervay
Pozelimab-bbfg (Veopoz) Vial	Medical Benefit, Prior Authorization	Medications for Rare Indications
Rezafungin acetate (Rezzayo) Vial	Medical Benefit	N/A
Perfluorohexyloctane pf (Miebo) Drops Indication	Non-Formulary, Quantity Limit (6 mL per 30 days)	N/A