PREVEA360 health plan℠

ProviderNews

Pharmacy and Therapeutics Update

Spring 2018

Below are highlights of recent drug policy revisions, as well as any new drug policies approved by Prevea360 Health Plan's Medical Policy Committee. **NOTE: All changes to the policies may not be reflected in the written highlights below. We encourage all prescribers to review the current policies.**

ALL DRUGS that have written Prevea360 Health Plan policies MUST BE PRIOR AUTHORIZED by sending requests to Navitus unless otherwise noted in the policy. Please note that most drugs listed below with policies require specialists to prescribe and request authorization.

Policies regarding medications may be found on the Medical Management page at prevea360.com. Under helpful links, click Drug Policy Search. Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar. Medical injectable drugs may also be searched using the appropriate J-code (e.g., J931 for Gazyva).

New Drug Policies

MAVYRET (glecaprevir/pibrentasvir) PA9958

MAVYRET is used to treat Hepatitis C, and must be prescribed by a gastroenterology, hepatology, infectious disease or transplant specialist. Specialty pharmacy is required

and the drug would be limited to a 28-day supply. This new policy is effective on January 1, 2018.

VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) PA9957
VOSEVI is used to treat Hepatitis C, and must be prescribed by a gastroenterology, hepatology, infectious disease or transplant specialist. Specialty pharmacy is required and the drug would be limited to a 28-day supply. This new policy is effective on January 1, 2018.

SPINRAZA (nusinersen) MB9949
SPINRAZA is used to treat spinal muscular atrophy (SMA) and must be prescribed by a neurology specialist with expertise in SMA treatment. This new policy is effective on January 1, 2018.

RADICAVA (edaravone) MB9948
RADICAVA is used to treat ALS and must be prescribed by a neurology specialist. This new policy is effective on January 1, 2018.

DUPIXENT (dupilumab) PA9955
DUPIXENT is used to treat severe atopic dermatitis and must be prescribed by or in consultation with an allergist, immunologist or dermatologist. This new policy is effective on January 1, 2018.

ZEJULA (niraparib) PA9959
ZEJULA is used recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer and must be prescribed by or in consultation with an oncologist. This new policy is effective on January 1, 2018.

ALUNBRIG (brigatinib) PA9950
ALUNBRIG is used to treat advanced or metastatic non-small cell lung cancer and must be prescribed by or in consultation with an oncologist. This new policy is effective on January 1, 2018.

ZYKADIA (ceritinib) PA9960
ZYKADIA is used to treat metastatic non-small cell lung cancer and must be prescribed by or in consultation with an oncologist. This new policy is effective on January 1, 2018.

RYDAPT (midostaurin) PA9953
RYDAPT is used to treat newly diagnosed acute myeloid leukemia (AML) that is FLT3 mutation positive and must be prescribed by or in consultation with an oncologist or hematologist. This new policy is effective on January 1, 2018.

ODOMZO (sonidegib) PA9952
ODOMZO is used to treat locally advanced basal cell carcinoma; or metastatic basal cell carcinoma and must be prescribed by or in consultation with an oncologist, hematologist or dermatologist. This new policy is effective on January 1, 2018.

LARTRUVO (olaratumab) MB9956
LARTRUVO is used to treat soft-tissue sarcoma and must be prescribed by an oncologist. This new policy is effective on January 1, 2018.

ERIVEDGE (vismodegib) PA9951
ERIVEDGE is used to treat locally advanced basal cell carcinoma; or metastatic basal cell carcinoma and must be prescribed by or in consultation with an oncologist, hematologist or dermatologist. This new policy is effective on January 1, 2018.

XALKORI (crizotinib) PA9954
XALKORI is used to treat advanced or metastatic non-small cell lung cancer and must be prescribed by or in consultation with an oncologist. This new policy is effective on January 1, 2018.

NEULASTA (pegfilgrastim) MB188
NEULASTA is used to prevent chemotherapy-induced neutropenia and to treat acute hematopoitic radiation injury syndrome. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

SANDOSTATIN (octreotide acetate) MB1809
SANDOSTATIN is used to treat acromegaly, carcinoid tumors, vasoactive intestinal peptide tumors and nueroendocrint tumors as recommended by NCCN guidelines. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

ABRAXANE (paclitaxel albumin-bound) MB181
ABRAXANE is used to treat metastic breast cancer, locally advanced or metastatic non-small cell lung cancer (NSCLC) and metastatic pancreatic adenocarcinoma. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

Antihemophilia Factors and Clotting Factors MB1802
This new policy lists specific antihemophilia and clotting factors with covered indications and the specific criteria. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

VECTIBIX (panitumumab) MB1810
VECTIBIX is used to treat metastice colorectal cancer. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

HERCEPTIN (trastuzumab) MB1805
HERCEPTIN is used to treat HER-2 overexpressing breast cancer or HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

CINQAIR (reslizumab) MB1811
CINQAIR is used to treat severe eosinophilic asthma. This new policy includes the specific criteria, documentation requirements, dosing and coding information. The policy will become effective April 1, 2018.

Changes to Drug Policy

STELARA (ustekinumab) PA9891
Effective March 1, 2018, failure or intolerance of COSENTYX (secukinumab) will now be required before the use of STELARA in the treatment of psoriatic arthritis. The patient must also fail ENBREL (etanercept), and HUMIRA (adalimumab). This policy includes the specific criteria, documentation requirements, dosing and coding information. Effective July 1, 2018, this drug will be placed in a not covered status for both IV and subcutaneous dosage forms and must be requested through the 'Exception to Coverage' form to Navitus.

SIMPONI and SIMPONI ARIA (golimumab) PA9874
Effective July 1, 2018, this drug will be placed in a not covered status for both IV and subcutaneous dosage forms and must be requested and authorized through the 'Exception to Coverage' form to Navitus.

XELJANZ (tofacitinib) PA9897
Effective July 1, 2018, this drug will be placed in a not covered status and must be requested and authorized through the 'Exception to Coverage' form to Navitus.

RITUXIMAB Products PA9847
Effective January 1, 2018, criteria for the FDA approved uses for RITUXAN HYCELA have been added. Prior authorization through Navitus by an oncology specialist is required. RITUXAN HYCELA is covered for follicular lymphoma, previously untreated

diffuse large B-cell lymphoma and chronic lymphocytic leukemia. This policy includes the specific criteria, documentation requirements, dosing and coding information.

VIVITROL (naltrexone extended release injection) MB9439
Effective January 1, 2018, VIVITROL no longer requires an addictionologist or a physician associated with a substance abuse program to prescribe. Any licensed prescriber may prescribe.

EPCLUSA (sofosbuvir/velpatasvir) PA9932
Effective January 1, 2018, treatment of HCV no longer requires documentation of previous treatment and response, that the patient is not involved in high-risk behaviors and documentation of cirrhosis.

HARVONI (ledipasvir/sofosbuvir) PA9904
Effective January 1, 2018, the prior authorization criteria for HARVONI have been updated. The new criteria state the patient must not have cirrhosis or be HIV infected.

INFLIXIMAB Infusions MB9231
The policy includes information regarding the use of RENFLEXIS. Infliximab products must be prescribed by dermatology, rheumatology and gasterenterology specialists with prior authorization. This policy includes the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective April 1, 2018.

XOLAIR (omalizumab) MBP9309
XOLAIR is used to treat chronic idiopatic urticaria and moderate to severe persistent allergic asthma. This policy includes the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective April 1, 2018.

NUCALA (mepolizumab) MB9914
NUCALA is used to treat eosinophilic asthma. This policy includes the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective April 1, 2018.

Immune Globulin MB9423
Immune globulin is considered medically appropriate for the treatment of the indications listed in the policy when the criteria have been met. This policy includes the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective April 1, 2018.

PROLIA, XGEVA (denosumab) MB9409
PROLIA, XGEVA is used to treat patients with high risk of fracture. This be prescribed by (or prescribed in consultation with) Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialists. This policy includes the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective April 1, 2018.

AVASTIN (bevacizumab) MB9431
AVASTIN for ophthalmology use can be found in Compounded Bevacizumab for ocular uses. This policy includes the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective April 1, 2018.

VENCLEXTA (venetoclax) PA9931
VENCLEXTA must be prescribed by, or in consultation with, an oncologist or hematologist with prior authorization through Navitus. An approved prior authorization is now allowed for a lifetime duration (subject to formulary changes). The policy changes will become effective February 1, 2018.

ABILIFY MAINTENA (aripiprazole) MB9456
ABILIFY MAINTENA is now covered for adults with bipolar I disorder. This policy includes the specific criteria, documentation requirements, dosing and coding information. This change will be effective February 1, 2018. Prior authorization through Navitus is required.

SUTENT (sunitinib) PA9848
SUTENT cannot be used as adjuvant treatment. This change will be effective February 1, 2018. Prior authorization through Navitus is required.

SPRYCEL (dasatinib) PA9855
SPRYCEL is now covered for pediatric patients with Ph+ CML in chronic phase. This change will be effective 2/1/2018. Prior authorization through Navitus is required.

BOSULIF (bosutinib) PA9896
BOSULIF is now covered for newly diagnosed adult patient with Ph+CML in chronic phase. This change will be effective February 1, 2018. Prior authorization through Navitus is required.

ACTEMRA IV (tocilizimab) MB9405
Changes in this policy include the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective March 1, 2018.

GAZYVA (obinutuzumab) MB9451
Changes in this policy include the specific criteria, documentation requirements, dosing and coding information. Added one-year prior authorization duration limit. The policy changes will become effective March 1, 2018.

ORENCIA IV (abatacept) MB9457
Changes in this policy include the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective March 1, 2018.

CIMZIA (certolizumab pegol) MB9875
Changes in this policy include the specific criteria, documentation requirements, dosing and coding information. The policy changes will become effective March 1, /2018.

COTELLIC (cobimetinib)/ZELBORAF (vemurafenib) PA9916
Added diagnosis of Chester-Erdheim disease with BRAF V600 mutation with prior authorization criteria for Zelboraf only. Other clarifications made on combined therapy requirements. Effective February 1, 2018.

YERVOY (ipilimumab) PA9945
Added clarification for the use in adults and pediatric patients (12 years and older). Other clarifications made on combined therapy requirements. Changes in this policy include the specific criteria, documentation requirements, dosing and coding information. Effective February 1, 2018.

The following policies have been or will be retired:
Effective January 1, 2018

ZEPATIER (elbasvir/grazoprevir) PA9919
DAKLINZA (daclatasvir) PA9912
SOVALDI (sofosbuvir) PA9894

Effective July 1, 2018:
Simponi and Simponi Aria PA9874
Stelara PA9891
Xeljanz/Xeljanz XR PA9897