PREVEA360 health plan℠

ProviderNews

Fall 2016 Pharmacy and Therapeutics Update

TRESIBA (insulub degudec) (Effective 7/1/16)
Add to the formulary at the preferred brand tier to all formularies.
Indication: To improve glycemic control in adults with diabetes mellitus

ZEPATIER (elbasvir / grazoprevir) (Effective 7/1/16)
Add to the formulary at the preferred brand tier and to specialty tier where applicable.
PA criteria (initial approval duration of 2 months):
Prescribed by gastroenterology, hepatology, infectious disease, or transplant specialist
Member aged 18 years or older
Evidence of liver fibrosis (Metavir Score ≥ F2)
Patient not involved in illicit drug use or alcohol abuse
For patients infected with genotype 1a, testing for the presence of virus with NS5A resistance- associated polymorphisms is REQUIRED to help determine appropriate length of therapy
QL of 1 tablet per day (per label)
Required filling at a specialty network participating specialty pharmacy
Indication: Treatment of chronic hepatitis C virus genotypes 1 or 4 in adults, with or without ribavirin

STRENSIQ (asfotase alfa) (Effective 7/1/16)
Add to formulary at the preferred brand tier and to specialty tier where applicable
PA criteria (initial approval for 6 months) include:
Prescribed by pediatric endocrinology specialists
Members diagnosed < 18 years of age
QL and dosing to FDA label
Required filling at a specialty network participating specialty pharmacy
Indication: Treatment of perinatal/infantile- and juvenile-onset hypophosphatasia

NUCALA (mepolizumab) (Effective 7/1/16)
Add as an approved medical benefit agent with PA
PA criteria (initial approval 12 months) include:
Prescribed by pulmonology, allergy, or immunology specialist
Blood eosinophil counts at therapy initiation and during the past 12 months that indicate eosinophilia involvement
Age ≥ 12 years
Previously treated and evidence of minimal adherence to standard asthma therapies
Symptoms not well controlled or ≥ 2 exacerbations in previous 12 months
Renewal (for additional 12 months) requires documentation of response to this treatment
Indication: Add-on agent in the maintenance treatment of severe asthma with an eosinophilic phenotype in patients 12 years and older.

ILUVIEN (fluocinolone acetonide intravitreal implant) (Effective 7/1/16)
Add as an approved medical benefit agent with PA
PA to FDA indications, prescribed only by eye specialists
QL one implant per eye per 36 months
Indication: Treatment of diabetic macular edema in patients previously treated with course of corticosteroids and did not have a clinically significant rise in intraocular pressure

TAGRISSO (osimertinib) (Effective 7/1/16)
Add to formulary at the preferred brand tier and to specialty tier where applicable
PA criteria (initial approval for 3 months) include:

Prescribed by oncology specialists
Prescribed to NCCN category 1, 2a, or 2b
Mutation status verified
Due to potential toxicity, assessment of LVEF by echocardiogram or MUGA before initiation, then every 3 months
Renewals (additional 3 months) criteria include no progression of disease or unacceptable toxicity
QL and dosing to FDA label or NCCN algorithms
Required filling at a specialty network participating specialty pharmacy through the split fill program
Indication: Treatment of metastatic EGFR T790M mutation-positive NSCLC, as detected by an FDA-approved test, in patients who have progressed on or after EGFR TKI therapy

COTELLIC (cobimetinib) (Effective 7/1/16)
Add to formulary at the preferred brand tier and to specialty tier where applicable
PA criteria (initial approval for 3 months) include:
Prescribed by oncology specialists
Prescribed to NCCN category 1, 2a, or 2b
Mutation status verified
Due to potential toxicity, assessment of LVEF by echocardiogram or MUGA before initiation, then every 3 months
Renewals (additional 3 months) criteria include no progression of disease or unacceptable toxicity
QL and dosing to FDA label or NCCN algorithms
Required filling at a specialty network participating specialty pharmacy through the split fill program
Indication: Treatment of unresectable or metastatic melanoma with BRAF V600E or V600K mutation, in combination with vemurafenib

VARUBI (rolapitant) (Effective 7/1/16)
Add to formulary at the preferred brand tier
PA criteria include:

Prescribed by oncology specialists
Member receiving MEC or HEC and used in combination with 5-HT3 receptor antagonist and a corticosteroid
QL and dosing to FDA label or NCCN algorithms
Indication: Prevention of delayed chemotherapy-induced nausea and vomiting

MITIGARE (colchicine) –same effective date as above except for 1/1/17 for Medicare D
Add to formulary at the preferred brand tier
NDC block COLCRYS and its authorized generic tab
Members using COLCRYS or its authorized generic will be allowed around 3 months to switch
MITIGARE is an FDA approved AB-rated branded generic containing the same active ingredient (colchicine) in the same dosage (0.6 mg) but in a different dosage form compared to the branded product, COLCRYS, and its authorized generics (capsule versus tablet, respectively). It is indicated for gout flares as well as familial Mediterranean fever.

NIASPAN (Vitamin B6 (niacin)-New start (Effective 7/1/16)
Move all extended- and sustained-release niacin products (including OTC versions) and Niaspan-containing combination products (e.g. ADVICOR and SIMCOR) to NC status
Current users (and their prescribers) of these now NC products will be sent mailed notification on this formulary change and allowed 90 days to continue with coverage, afterwards claims will deny
Immediate-release niacin will remain at preferred generic formulary status
New ACC guidelines do not recommend extended- or sustained-release niacin therapy. Although they have shown significant improvements in HDL cholesterol and triglyceride levels, there is no evidence of efficacy in incremental benefit in atherosclerotic cardiovascular disease and LDL cholesterol levels less than 70 mg/dL.

VIVITROL (naltrexone extended release injection) MP9439
Failure of the oral naltrexone is no longer required before requesting the injectable naltrexone. The patient must demonstrate compliance. The initial approval will be for 6 months.

OPSUMIT (macitentan) PA9921
OPSUMIT is a treatment for pulmonary arterial hypertension. Prior authorization is required and it must be prescribed by a Cardiologist or Pulmonologist.

NC = Not covered
PA = Prior authorization required
SP = Available through specialty pharmacy program
OTC= Over the counter
QL = Quantity limit