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## Pharmacy Information and Formulary Changes – Fourth Quarter 2018

### OREGON HEALTH PLAN

This update contains changes to the pharmacy services of Trillium Community Health Plan (Trillium) Oregon Health Plan members. Based on the recommendations of the Trillium Pharmacy and Therapeutics (P&T) Committee, the Trillium Oregon Health Plan medication coverage guidelines (criteria) and Preferred Drug List (PDL) has been revised for the fourth quarter of 2018. PDL revisions are as indicated beginning on page 5. Updated criteria can be accessed by going to the Provider Resources on our website: [www.trilliumohp.com](http://www.trilliumohp.com). Changes will go into effect January 1, 2019.

The Trillium Oregon Health Plan P&T Committee determines updates to criteria and the PDL based on quarterly, comprehensive reviews. Criteria and the PDL serves as a reference for providers to use when prescribing pharmaceutical products for Trillium members with pharmacy coverage. Medications newly approved by the FDA require prior-authorization until reviewed by P&T. Prior authorization (PA) does not guarantee payment. PA determination is based on multiple factors in conjunction to the criteria posted in drug coverage guidelines. These factors include but are not limited to: treatment of a funded vs non-funded condition as defined by the Oregon Prioritized List and applicable guidelines; prior trial and failure of agents on the PDL; comparative costs of available treatment options.

### OREGON HEALTH PLAN PHARMACY SERVICES ANNOUNCEMENTS

#### TRILLIUM WEBPAGE UPDATES

As of early October, the location of Trillium Health Plan's clinical & pharmacy policies has moved. Trillium policies, including medication coverage guidelines, can now be viewed directly by visiting [www.trilliumohp.com/providers/helpful-links/clinical-payment-policies.html](http://www.trilliumohp.com/providers/helpful-links/clinical-payment-policies.html) or by navigating to Trillium's website at [www.trilliumohp.com](http://www.trilliumohp.com) then For Providers -> Provider Resources -> Clinical & Pharmacy Policies link located on the left side of the webpage. Coverage guidelines are listed alphabetically by brand name or drug class.

#### AVAILABLE SEATS ON THE PHARMACY AND THERAPEUTICS COMMITTEE

Seats are open on the combined Trillium Community Health Plan and Health Net of Oregon Pharmacy and Therapeutics (P&T) Committee. We are looking for community based practitioners representing various clinical specialties who adequately represent the membership of our health plans. If you are interested in learning more or attending a quarterly meeting please contact Susan Van Horn via email at: [Susan.E.VanHorn@TrilliumCHP.com](mailto:Susan.E.VanHorn@TrilliumCHP.com). Meetings are held once a quarter and are comprised of a remote review of clinical drug information and coverage guidelines, electronic vote and committee meetings. Individuals who are selected to join by the committee are eligible to receive an honorarium to compensate them for the time spent reviewing materials and attending meetings.

#### NATURAL PRODUCTS ADDED TO PREFERRED DRUG LIST

The Trillium Oregon Health Plan P&T Committee has started to review natural products every quarter to determine if there is enough supporting evidence to recommend their addition to the Preferred Drug List (PDL). This quarter the Committee approved the addition of two products: Glucosamine Sulfate/Chondroitin and Coenzyme Q-10. Given the diversity of products available, only cost effective USP tested products will be added to the PDL. See the following sections for additional information on these two natural products.

#### THIS UPDATE APPLIES TO:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

#### STATE:

- Oregon

#### LINES OF BUSINESS:

- Oregon Health Plan
- Medicare

#### PROVIDER SERVICES

[trilliumohp.com](http://trilliumohp.com)  
877-600-5472

## GLUCOSAMINE SULFATE WITH CHONDROITIN ADDED TO PREFERRED DRUG LIST

Glucosamine Sulfate/Chondroitin will be added to the Trillium Oregon Health Plan PDL effective January 1, 2019. Studies show that the use of glucosamine is comparable to NSAIDs in pain reduction in those with osteoarthritis and has been shown in studies to reduce pain and improve functionality. The combination product was selected as stronger evidence is seen with the sulfate form of glucosamine and most studies include chondroitin. Use of glucosamine products is generally considered safe and when use replaces or reduces the amount of NSAID used, it can lead to a reduction of the number of adverse effects associated with NSAIDs, such as stomach ulcers. Caution is recommended however as glucosamine does have several known drug-drug interactions other medications which are listed in standard drug compendiums. One of the known major interactions is with warfarin as it may cause an increase in warfarin's anticoagulant effect.

## COENZYME Q-10 ADDED TO PREFERRED DRUG LIST

Coenzyme Q-10 (CoQ-10) will be added to the Trillium Oregon Health Plan PDL effective January 1, 2019. Use will be restricted to those with congestive heart failure (CHF) and migraine and will require prior authorization for coverage. Studies have shown that the use of CoQ-10 can lead to a reduction in cardiovascular mortality in CHF patients and is also likely to be effective for prevention of migraine. CoQ-10 is generally considered safe as it has few adverse effects or drug interactions.

## PRIOR AUTHORIZATION NOW REQUIRED FOR DPP-4 INHIBITORS AND GLP-1 MEDS

Dipeptidyl peptidase-4 (DPP-4) inhibitors and glucagon-like peptide-1 (GLP-1) receptor agonists are common medications used to treat diabetes. As of November 1, 2018 prior authorization will be required for new utilizers of DPP-4 inhibitors and GLP-1 receptor agonists. Members that have been on these medication at or below the FDA max dose prior to this change will continue to be able to receive as a benefit without requiring prior authorization. New members and new starts will need prior authorization for use. Members currently utilizing doses over the maximum FDA dosing will need prior authorization for use at above max doses starting December 1, 2018.

## ALOGLIPTIN NOW TRILLIUM OHP'S PREFERRED DPP-4 INHIBITOR

Alogliptin, the generic of Nesina, is the first dipeptidyl peptidase-4 (DPP-4) inhibitor to become available on the market as a generic. Alogliptin is now on Trillium Oregon Health Plan's (OHP) Preferred Drug List (PDL) and as of November 1, 2018 Januvia will be removed from the PDL. Current utilizers of Januvia and Januvia combination products will continue to receive these medications as a benefit without requiring prior authorization.

## QUARTERLY UPDATE ON PHARMACY COVERAGE GUIDELINES

See the table below for all the updated or new coverage guidelines that were approved by P&T at our fourth quarter meeting October 12, 2018. All coverage guidelines will go into effect on January 1, 2019 and will become available to view in their entirety at [www.Trilliumohp.com](http://www.Trilliumohp.com) by the end of November.

UPDATED COVERAGE GUIDELINES	
CP.PHAR.24 fostamatinib (Tavalisse)	CP.PHAR.266 rilonacept (Arcalyst)
CP.PHAR.27 tolvaptan (Jynarque, Samsca)	CP.PHAR.294 Osimertinib (Tagrisso)
CP.PHAR.63 everolimus (Afinitor, Afinitor Disperz, Zortress)	CP.PHAR.322 pembrolizumab (Keytruda)
CP.PHAR.93 bevacizumab (Avastin, Mvasi)	CP.PHAR.357 copanlisib (Aliqopa)
CP.PHAR.168 corticotropin (H.P. Acthar)	CP.PHAR.359 inotuzumab ozogamicin (Besponsa)
CP.PHAR.179 romiplostim (Nplate)	CP.PHAR.361 Tisagenlecleucel (Kymriah)
CP.PHAR.180 eltrombopag (Promacta)	CP.PHAR.362 axicabtagene ciloleucel (Yescarta)
CP.PHAR.214 desmopressin (DDAVP, Stimat, Noctiva)	CP.PMN.47 rifaximin (Xifaxan)
CP.PHAR.259 natalizumab (Tysabri)	TCHP.PHAR.187 Biologics for Autoimmune Diseases
CP.PHAR.358 gemtuzumab ozogamicin (Mylotarg)	TCHP.PHAR.18000 Compounded Medications
CP.PMN.53 Off Label Use	TCHP.PHAR.18001 Supplement, Herbal and Vitamin Products
CP.PMN.74 Granisetron (Kytril, Sancuso, Sustol)	TCHP.PHAR.18002 Smoking Cessation Products
CP.PHAR.68 gefitinib (Iressa)	TCHP.PHAR.18005 Rosuvastatin (Crestor)
CP.PHAR.125 palbociclib (Ibrance)	
NEW COVERAGE GUIDELINES	
CP.PHAR.128 ertenumab-aa0e (Aimovig)	CP.PMN.179 megestrol Acetate Oral Suspension (Megace ES)
CP.PHAR.129 venetoclax (Venclexta)	
CP.PHAR.149 intra baclofen (Gablofen)	CP.PMN.178 Tafenoquine (Krintafel)
CP.PHAR.151 levoleucovorin (Fusilev)	CP.PMN.180 halobetasol Propionate Lotion (Ultravate)
CP.PHAR.201 belatacept (Nulojix)	CP.PMN.182 betamethasone dipropionate (Sernivo)
CP.PMN.16 Request for Medically Necessary Drug not on the PDL	CP.PHAR.79 lapatinib (Tykerb)
	CP.PHAR.170 degarelix Acetate (Firmagon)

CP.PMN.59 Quantity Limit Overrides	CP.PHAR.171 goserelin acetate (Zoladex)
CP.PHAR.304 irinotecan Liposome (Onivyde)	CP.PHAR.172 histrelin acetate (Vantas, Supprelin LA)
CP.PHAR.305 obinutuzumab (Gazyva)	CP.PHAR.173 leuprolide acetate (Eligard, Lupaneta Pack, Lupron Depot, Lupron Depot-Ped)
CP.PHAR.307 bendamustine (Bendeka, Treanda)	CP.PHAR.172 histrelin acetate (Vantas, Supprelin LA)
CP.PHAR.309 carfilzomib (Kyprolis)	CP.PHAR.174 nafarelin acetate (Synarel)
CP.PHAR.314 romidepsin (Istodax)	CP.PHAR.175 triptorelin pamoate (Trelstar, Triptodur)
CP.PHAR.316 cabazitaxel (Jevtana)	CP.PHAR.306 ofatumumab (Arzerra)
CP.PHAR.332 pasireotide (Signifor LAR)	CP.PHAR.308 elotuzumab (Empliciti)
CP.PHAR.353 pegaspargase (Oncaspar)	CP.PHAR.311 belinostat (Beleodaq)
CP.PHAR.363 enasidenib (Ibhifa)	CP.PHAR.313 pralatrexate (Folotyng)
CP.PHAR.365 neratinib (Nerlynx)	CP.PHAR.315 vincristine sulfate liposome injection (Marqibo)
CP.PMN.114 betrixaban (Bevyxxa)	CP.PHAR.313 pralatrexate (Folotyng)
CP.PMN.143 isotretinoin (Claravi, Absorica, Myorisan, Zenatane)	CP.PHAR.317 cetuximab (Erbix)
CP.PHAR.130 Avatrombopag (Doptelet)	CP.PHAR.318 eribulin Mesylate (Halaven)
CP.PHAR.132 nitisinone (Orfadin, Nityr)	CP.PHAR.320 necitumumab (Portrazza)
CP.PHAR.133 idelalisib (Zydelig)	CP.PHAR.321 panitumumab (Vectibix)
CP.PHAR.134 Methotrexate (Otrexup, Rasuvo, Xatmep)	CP.PHAR.324 temsirolimus (Torisel)
CP.PHAR.136 Elagolix (Orilissa)	CP.PHAR.325 ziv-aflibercept (Zaltrap)
CP.PHAR.137 Ivosidenib (Tibsovo)	CP.PHAR.326 olaratumab (Lartruvo)
CP.PHAR.138 Lenvatinib (Lenvima)	CP.PHAR.328 asfotase alfa (Strensiq)
CP.PHAR.139 Mogamulizumab-kpkc (Poteligeo)	CP.PHAR.352 daunorubicin/cytarabine (Vyxeos)
CP.PHAR.140 Pegvaliase-pqpz (Palynziq)	CP.PMN.115 delafloxacin (Baxdela)
CP.PHAR.143 betaine (Cystadane)	CP.PMN.116 L-glutamine (Endari)
CP.PHAR.387 azacitidine (Vidaza)	CP.PMN.17 droxidopa (Northera)
CP.PHAR.388 Chloramphenicol	CP.PHAR.142 adefovir (Hepsera)
CP.PHAR.389 pegvisomant (Somavert)	CP.PHAR.141 Ribavirin (Copegus, Moderiba, Rebetol, Ribasphere)
CP.PHAR.390 cholic Acid (Cholbam)	CP.PHAR.142 adefovir (Hepsera)
CP.PHAR.391 Lanreotide (Somatuline Depot)	CP.PMN.163 Sodium zirconium cyclosilicate (Lokelma)
CP.PHAR.392 pegademase Bovine (Adagen)	CP.PHAR.372 voretigene neparvovec-rzyl (Luxturna)
CP.PHAR.393 Leucovorin Injection	TCHP.PHAR.18003 Sedatives
CP.PMN.161 Methadone (Dolophine)	TCHP.PHAR.18004 Atopic Dermatitis and Topical Antipsoriatics
CP.PMN.162 Moxidectin	TCHP.PHAR.1806 Coenzyme Q-10 (Ubiquinone, Ubiquinol)
CP.PMN.174 perindopril-amlodipine (Prestalia)	
CP.PMN.176 amlodipine-atorvastatin (Caduet)	
CP.PMN.178 Tafenoquine (Krintafel)	

## TRILLIUM COMMUNITY HEALTH PLAN PHARMACY SERVICES ANOUNCEMENTS

### OHP AND MEDICARE PRIOR AUTHORIZATION CHANGES TO SPECIALIZED MEDICATIONS GIVEN IN OFFICE

See the list below for all HCPCS codes affected by changes as of January 1, 2019. "New" indicates new requirements, "Existing" indicates current requirements, "Step Therapy" indicates step therapy requirements added to existing criteria.

Brand (Generic Name)	HCPC Code	LINE OF BUSINESS	
		OHP	Medicare
<b>CHANGES, EFFECTIVE JANUARY 1, 2019</b>			
Actemra (tocilizumab)	J3262	Existing	Step Therapy
Aranesp (darbepoetin)	J0881/J0882	New	Step Therapy
Botox (onabotulinumtoxin a)	J0585	New	Step Therapy
Cimzia (certolizumab pegol)	J0717	Existing	Step Therapy, Criteria applies to all providers
Epogen, Procrit (epoetin alfa)	J0885	New	Step Therapy
Exondys 51 (etepirlsen)	J1428	Existing	New
Eylea (aflibercept)	J0178	Existing	Step Therapy
Acthar HP (corticotropin inj gel)	J0800	Existing	Step Therapy
Kymriah (tisagenlecleucel)	Q2040	Existing	New
Lucentis (ranibizumab)	J2778	Existing	Step Therapy
Macugen (pegaptanib)	J2503	Existing	Step Therapy

Mircera (methoxy polyethylene glycol epoetin beta)	J0887	New	Step Therapy, Criteria applies to all providers
Ocrevus (ocrelizumab)	J2350	Existing	New
Remicade (infliximab)	J1745	Existing	Step Therapy
Rituxan Hycela (rituximab-hyaluronidase)	J9467/C9467	Existing	New
Rituxan (rituximab)	J9310	Existing	Step Therapy
Tysabri (natalizumab)	J2323	Existing	Step Therapy
Visudyne (verteporfin)	J3396	Existing	Step Therapy
Yescarta (axicabtagene ciloleucel)	Q2041	Existing	New
Neulasta (pegfilgrastim)	J2505	Existing	Step Therapy
Crysvita (burosumab-twza)	C9399/J3590	Existing	Step Therapy
<b>ADDITIONS, EFFECTIVE JANUARY 1, 2019</b>			
Fulphila (pegfilgrastim-jmdb, biosimilar)	Q5108	New	N/A
Elaprase (idursulfase)	J1743	New	N/A
Mepsevii (vestronidase alfa-vjvk)	J3590	New	N/A
Vimizim (elosulfase alfa)	J1322	New	N/A
Fasenra (benralizumab)	J3590	New	N/A
Trogarzo (lbalizumab-uiyk)	J3590	New	N/A

### ADDITIONAL INFORMATION

For additional information regarding changes to the Trillium Preferred Drug List (PDL), contact Trillium by telephone at 1(877) 600-5472. For the most current version of the PDL, visit the Trillium website at [formulary.trilliumohp.com](http://formulary.trilliumohp.com).

For additional information on the drug classes and medication coverage guidelines reviewed by the P&T committee visit the Provider Resources on Trillium's website at [trilliumohp.com](http://trilliumohp.com).

If you have questions regarding the information contained in this update, contact the Trillium Provider Services through the Trillium provider website at [trilliumohp.com](http://trilliumohp.com) or by telephone at 877-600-5472.

## TRILLIUM OREGON HEALTH PLAN PREFERRED DRUG LIST CHANGES

Brand Name	Generic Name	Therapeutic Category and Indication	Comments
<b>FORMULARY ADDITIONS AND CHANGES</b>			
Hepsera	Adefovir	ANTIVIRAL AGENT: Used in the treatment of hepatitis B infections	Removed from PDL. Current utilizers will be grandfathered
Copegus, Moderiba, Rebetol, Ribasphere	Ribavirin	ANTIVIRAL AGENT: Used in the treatment of hepatitis C infections	Removed from PDL. Current utilizers will be grandfathered
Simponi, Simponi Aria	Golimumab	IMMUNOLOGICAL AGENT: Biologic agent used in the treatment of advanced psoriatic and rheumatoid arthritis, ankylosing spondylitis, ulcerative colitis.	Removed from PDL. Enbrel (etanercept) and Humira (adalimumab) preferred agents. Current utilizers will be grandfathered
Stelara	Ustekinumab	IMMUNOLOGICAL AGENT: Biologic agent used in the treatment of advanced Crohn's disease, plaque psoriasis, psoriatic arthritis.	Removed from PDL. Enbrel (etanercept) and Humira (adalimumab) preferred agents. Current utilizers will be grandfathered
Protopic	Tacrolimus ointment	DERMATOLOGICAL AGENT: Topical calcineurin inhibitor that is used for the treatment of atopic dermatitis.	Added to PDL. PA will be required for coverage.
Elidel	Pimecrolimus	DERMATOLOGICAL AGENT: Topical calcineurin inhibitor that is used for the treatment of atopic dermatitis.	Added to PDL. PA will be required for coverage.
-	Glucosamine Sulfate/Chondroitin	NATURAL PRODUCT: Supplement found to be beneficial in those with osteoarthritis.	Added to PDL.
-	Coenzyme Q-10	NATURAL PRODUCT: Supplement found to be beneficial in those with CHF and migraines.	Added to PDL. PA will be required for coverage.
-	Viscous Lidocaine 2% Solution	LOCAL ANESTHETIC: Product used for the topical anesthesia of mucous membranes of the mouth and pharynx.	Quantity limit of 100ml per claim and max of 900ml per 30days added. Current utilizers will be grandfathered if exceeding these limits
-	Lidocaine 4% solution	LOCAL ANESTHETIC: Product used for the topical anesthesia of mucous membranes of the oral and nasal cavities.	Removed from PDL. Preferred agent viscous lidocaine. Current utilizers will be grandfathered until 2/1/2019.
-	Lidocaine 2% gel	LOCAL ANESTHETIC: Product used for the topical anesthesia in procedures of the urethra; e.g. catheter insertion.	Quantity limit of 120gm per 30 days added. Current utilizers will be grandfathered if exceeding these limits
Emla	Lidocaine/Prilocaine 2.5%/2.5%	LOCAL ANESTHETIC: Product used for the topical anesthesia of skin and genital mucous membranes.	Quantity limit of 30gm per 30 days added. PA still required for coverage.