Provider Update

Trillium Community Health Plan

August 1, 2024

Pharmacy Information and Preferred Drug List Changes – 3rd Quarter 2024

This update applies to Trillium Community Health Plan's Oregon Health Plan

APPROPRIATE USE OF GLP-1 AGONISTS

GLP-1 agonists have become part of the standard of care in the treatment of Type II Diabetes. The American Diabetes Association (ADA) guidelines now recommends other medications (including GLP-1 agonists) with or without metformin based on glycemic needs, as appropriate initial therapy for individuals with type II diabetes with or at high risk for atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease. Inappropriate prescribing of drugs like Ozempic and Mounjaro for treatment of obesity alone has contributed to shortages of these products for patients with Type II diabetes.

We have noted, in recent months, many coverage requests for GLP-1 agonists (particularly Ozempic and Mounjaro) appear to be intended for use outside of the FDA-approved indications for the particular product. Trillium Community Health Plan in conjunction with Centene Pharmacy Solutions will be actively monitoring and reviewing PA requests to ensure these medications are used only per their FDA-approved indications. **Requests for documentation to substantiate attestations made in the prior authorization (PA) request process may be required.** It is also important to note that coverage of products with weight loss indications are not covered by Trillium Community Health Plan as pharmacologic treatment of obesity is an excluded benefit of the Oregon Health Plan.

TRILLIUM COMMUNITY HEALTH PLAN PREFERRED DRUG LIST CHANGES

Trillium's Preferred Drug List (PDL) is updated monthly and is available online.

- See the table below for a summary of the PDL changes made in the third quarter of 2024. For the most current preferred drug list, visit the Pharmacy section of our website.

Medication	Effective Date
Additions	
Amikacin Sulfate 500 MG/2ML, 1 GM/4ML Inj Added to PDL	06.03.2024
Amphotericin B 50 MG Soln for IV ; 5 MG/ML lipid susp for IV; 50 MG liposome for IV susp Added to PDL	06.03.2024
Ampicillin Sodium 125 MG, 250 MG, 500 MG, 1 GM, 2 GM for Inj; 1 GM, 2 GM, 10 GM for IV Soln Added to PDL	06.03.2024
Ampicillin & Sulbactam Sodium 1-0.5 GM, 2-1 GM for Inj; 1-0.5 GM, 2-1 GM, 10-5 GM for IV Soln Added to PDL	06.03.2024

Amoxicillin & K Clavulanate ER 12HR 1000-62.5 MG Tab Added to PDL	06.03.2024
Avsola (infliximab-axxq) 100 MG IV Inj Added to PDL; PA required	10.01.2024
Azithromycin 500 MG For IV Soln Added to PDL	06.03.2024
Dabigatran Etexilate Mesylate 75 MG, 150 MG Caps Added to PDL; QL 2/day	10.01.2024
Dabigatran Etexilate Mesylate 110 MG Cap Added to PDL; PA required	10.01.2024
Calamine Phenolated Lotion Added to PDL	07.01.2024
Calamine-Zinc Oxide Lotion Added to PDL	07.01.2024
Cefazolin Sodium 500 MG, 1 GM, 2 GM, 3 GM, 10 GM, 100 GM, 300 GM for Inj; 1 GM, 2 GM, 3 GM for IV Soln; 1 GM/10ML, 2 GM/20ML, 3 GM/30ML Pref Syringe; 2 GM/100ML, 3 GM/100ML in Sodium Chloride 0.9% IV Soln; 1 GM, 2 GM/100ML in Dextrose 4% IV Solution; 2 GM in Dextrose 3% IV Solution Added to PDL	06.03.2024
Cefepime HCl 1 GM for Inj; 2 GM, 100 GM for IV Soln; 1 GM/50ML, 2 GM/100ML IV Soln; 1 GM/50ML, 2 GM/50M in dextrose for IV Soln Added to PDL	06.03.2024
Ceftaroline Fosamil 400 MG, 600 MG for IV Soln Added to PDL	06.03.2024
Ceftriaxone Sodium100 GM for Inj; 20 MG/ML, 40 MG/ML Inj in Dextrose; 1 GM in 3.74% Dextrose for IV Soln; 2 GM in 2.22% Dextrose for IV Soln Added to PDL	06.03.2024
Ciprofloxacin 200 MG/100ML, 400 MG/200ML in D5W Added to PDL	06.03.2024
Clindamycin Phosphate Inj 300 MG/2ML, 600 MG/4ML, 900 MG/6ML, 9 GM/60ML Inj; 300 MG/2ML, 600 MG/4ML, 900 MG/6ML IV Soln; 300 MG/50ML, 600 MG/50ML, 900 MG/50ML IV Soln in D5W; 300 MG/50ML, 600 MG/50ML, 900 MG/50ML IV Soln in 0.9% NaCl Added to PDL	06.03.2024
Colloidal Oatmeal 1%, 2% Cream Added to PDL	07.01.2024
Daptomycin 350 MG, 500 MG for IV Soln; 350 MG/50ML, 500 MG/50ML, 700 MG/100ML, 1000 MG/100ML IV Solution in 0.9% NaCl Added to PDL	06.03.2024
Dimethicone 1%, 1.3%, 1.5%, 2%, 4.5%, 5%, 8% Cream Added to PDL	07.01.2024
Emollient Cream Added to PDL	07.01.2024
Emollient Lotion Added to PDL	07.01.2024
Emollient Ointment Added to PDL	07.01.2024
Ertapenem Sodium 1 GM for Inj Added to PDL	06.03.2024
Fluconazole 100 MG/50ML, 200 MG/100ML, 400 MG/200ML Inj Added to PDL	06.03.2024
Foscarnet Sodium 6000 MG/250ML Inj Added to PDL	06.03.2024
Imipenem-Cilastatin 250 MG, 500 MG for IV Soln Added to PDL	06.03.2024
Lactic Acid (Ammonium Lactate) 12% Cream; 5%, 10%,12% Lotion Added to PDL	07.01.2024
Lanolin Cream	07.01.2024

Added to PDL	
Levocarnitine 1 GM/10ML (10%) Oral Soln Additional generic products added to PDL	07.01.2024
Linezolid 200 MG/100ML, 600 MG/300ML IV Soln Added to PDL	06.03.2024
Menthol-Zinc Oxide 0.44-20%, 0.44-20.6%, 0.44-20.625%, 0.45-20% Oint Added to PDL	07.01.2024
Meropenem 500 MG, 1 GM, 2 GM for IV Soln; 500 MG/50ML, 1 GM/50ML IV Soln in 0.9% NaCl Added to PDL	06.03.2024
Meropenem-Vaborbactam 1-1 GM for IV Soln Added to PDL	06.03.2024
Metronidazole 375 MG Cap; 500 MG/5ML Susp; 500 MG/100ML IV Soln; 50 MG/ML kit for Susp Added to PDL	06.03.2024
Micafungin Sodium 50 MG, 100 MG for IV Soln; 50 MG/50ML, 100 MG/100ML in 0.9% NaCl for IV Soln Added to PDL	06.03.2024
Mineral Oil-Hydrophilic Petrolatum Ointment Added to PDL	07.01.2024
Moxifloxacin HCl 400 MG/250ML IV Solution; 400 MG/250ML in 0.8% NaCl for Inj; 0.5% Ophth Soln; 1.5 MG/0.3ML Ophth Soln Pref Syr; 1 MG/ML, 5 MG/ML Intraocular Soln; 0.3 MG/0.3ML, 1.6 MG/ML Intraocular Soln Pref Syr; 1 MG/ML Intravitreal Soln in BSS Added to PDL	06.03.2024
Nafcillin Sodium 1 GM, 2 GM for Inj; 1 GM, 2 GM, 10 GM for IV Soln; 1 GM/50ML, 2 GM/100ML Inj in Dextrose Added to PDL	06.03.2024
Opill (norgestrel) 0.075 MG Tab Added to PDL	06.21.2024
Penicillin G Potassium 5000000 Unit, 20000000 Unit for Inj; 20000 Unit/ML, 40000 Unit/ML, 60000 Unit/ML Inj in Dextrose Added to PDL	06.03.2024
Penicillin G Sodium 5000000 Unit for Inj Added to PDL	06.03.2024
Piperacillin Sodium-Tazobactam Sodium 2-0.25 GM, 3-0.375 GM, 4-0.5 GM, 12-1.5 GM, 36-4.5 GM for Inj; 2-0.25GM/50ML, 4-0.5GM/100ML, 3-0.375GM/50ML in dextrose for IV Soln Added to PDL	06.03.2024
Simlandi (adalimumab-ryvk) 40 MG/0.4ML 1-Pen & 2-Pen Auto-injector Kits Added to PDL; PA required	10.01.2024
Tobramycin-Vancomycin HCl 1.5-5% Ophth Soln Added to PDL	06.03.2024
Vancomycin HCl IV Soln 500 MG/100ML, 750 MG/7.5ML, 1000 MG/10ML, 1000 MG/200ML, 1250 MG/12.5ML, 1500 MG/15ML, 1500 MG/300ML, 1750 MG/17.5ML, 2000 MG/400ML, 2000 MG/20ML IV Soln; 1.25 GM, 1.5 GM, 10 GM for IV Soln; 25 MG/ML for Oral Soln; 1.5 GM/300ML-5% IV soln in Dextrose Added to PDL	06.03.2024
Vitamin E Cream Added to PDL	07.01.2024
Vitamin E w/ A & D Cream Added to PDL	07.01.2024
Xolair (omalizumab) 75 MG/0.5ML, 150 MG/ML, 300 MG/2ML SC Soln Auto-Injector Added to PDL; PA required	04.01.2024
Zinc Oxide 10%, 11.3%, 12%, 13%, 22% Cream; 9.38%, 10%, 12.8%, 16%, 20%, 25%, 30%, 40% Oint Added to PDL	07.01.2024
Key: PA = prior authorization; PDL = preferred drug list; QL = quantity limit	

PRIOR AUTHORIZATION CHANGES TO SPECIALIZED MEDICATIONS GIVEN IN OFFICE

See the table below for list of new HCPC codes. These codes now require prior authorization for coverage for Trillium Oregon Health Plan members.

Brand (Generic Name)	HCPC Code	Description
Adzynma (ADAMTS13, recombinant-krhn)	J7171	Injection, ADAMTS13, recombinant-krhn, 10 IU
Cosentyx (secukinumab)	J3247	Injection, secukinumab, IV, 1 mg
iDose TR (travoprost)	J7355	Injection, travoprost, intracameral implant, 1 mcg
Jylamvo (methotrexate)	J8611	Methotrexate (Jylamvo), oral, 2.5 mg*
Loqtorzi (toripalimab-tpzi)	J3263	Injection, toripalimab-tpzi, 1 mg*
Lyfgenia (lovotibeglogene autotemcel)	J3394	Injection, lovotibeglogene autotemcel, per treatment
Omvoh (mirikizumab-mrkz)	J2267	Injection, mirikizumab-mrkz, 1 mg
Palonosetron	J2468	Injection, palonosetron HCl (Avyxa), not therapeutically equivalent to J2469, 25 mcg*
Ryzneuta (efbemalenograstim alfa-vuxw)	J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg
Wezlana (ustekinumab-auub)	Q5137	Injection, ustekinumab-auub (Wezlana), biosimilar, SC, 1 mg
Wezlana (ustekinumab-auub)	Q5138	Injection, ustekinumab-auub (Wezlana), biosimilar, IV, 1 mg
Xatmep (methotrexate)	J8612	Methotrexate (Xatmep), oral, 2.5 mg*
Zymfentra (infliximab-dyyb)	J1748	Injection, infliximab-dyyb (Zymfentra), 10 mg
Zynteglo (betibeglogene autotemcel)	J3393	Injection, betibeglogene autotemcel, per treatment

* Oncology/supportive drug-prior authorization requests are to be submitted to and reviewed by Evolvent (previously known as New Century Health)

QUARTERLY UPDATE ON PHARMACY COVERAGE GUIDELINES

The P&T Committee determines updates to coverage guidelines (criteria) based on quarterly, comprehensive reviews. Criteria serves as a reference for providers to use when prescribing pharmaceutical products for Trillium members with pharmacy coverage. 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.

- See the table below for all the updated or new Trillium Community Health Plan coverage guidelines that were approved by P&T in the third quarter of 2024. All coverage guidelines will go into effect October 1, 2024 and will become available to view in their entirety at our website approximately 2 weeks prior to their implementation date.

Clinically Significant Change(s)	
CP.PHAR.11 Burosumab-twza (Crysvita)	CP.PHAR.497 Tucatinib (Tukysa)
CP.PHAR.61 Cinacalcet (Sensipar)	CP.PHAR.500 Lurbinectedin (Zepzelca)
CP.PHAR.81 Pazopanib (Votrient)	CP.PHAR.524 Pegcetacoplan (Empaveli, Syfovre)
CP.PHAR.89 Peginterferon Alfa-2a (Pegasys)	CP.PHAR.539 Loncastuximab Tesirine-lpyl (Zynlonta)
CP.PHAR.97 Eculizumab (Soliris)	CP.PHAR.540 Dostarlimab-gxly (Jemperli)
CP.PHAR.109 Tesamorelin (Egrifta SV)	CP.PHAR.542 Talimogene laherepvec (Imlygic)
CP.PHAR.145 Deferasirox (Exjade, Jadenu)	CP.PHAR.543 Maralixibat (Livmarli)
CP.PHAR.146 Deferoxamine (Desferal)	CP.PHAR.544 Amivantamab-vmjw (Rybrevant)
CP.PHAR.147 Deferiprone (Ferriprox)	CP.PHAR.545 Betibeglogene Autotemcel (Zynteglo)
CP.PHAR.150 Mecasermin (Increlex)	CP.PHAR.547 Infigratinib (Truseltiq)
CP.PHAR.209 Aztreonam (Cayston)	CP.PHAR.549 Sotorasib (Lumakras)
CP.PHAR.210 Ivacaftor (Kalydeco)	CP.PHAR.572 Budesonide (Tarpeyo)
CP.PHAR.213 Lumacaftor/Ivacaftor (Orkambi)	CP.PHAR.588 Nivolumab and Relatlimab-rmbw (Opdualag)
CP.PHAR.295 Sargramostim (Leukine)	CP.PHAR.592 Beremagene geperpavec-svdt (Vyjuvek)

CP.PHAR.297 Filgrastim (Neupogen), Filgrastim-sndz (Zarxio), Tbo-filgrastim (Granix), Filgrastim-aafi (Nivestym), Filgrastim-ayow (Releuko)	CP.PHAR.593 Delandistrogene Moxeparvovec-rokl (Elevidys)
CP.PHAR.302 Ixazomib (Ninlaro)	CP.PHAR.594 Donanemab-azbt (Kisunla)
CP.PHAR.303 Brentuximab Vedotin (Adcetris)	CP.PHAR.602 Atidarsagene autotemcel (Lenmeldy)
CP.PHAR.310 Daratumumab (Darzalex), Daratumumab/Hyaluronidase-fihj (Darzalex Faspro)	CP.PHAR.633 Eplontersen (Wainua)
CP.PHAR.312 Blinatumomab (Blincyto)	CP.PHAR.634 Epcoritamab-bysp (Epkinly)
CP.PHAR.322 Pembrolizumab (Keytruda)	CP.PHAR.636 Glofitamab-gxbm (Columvi)
CP.PHAR.323 Plerixafor (Mozobil)	CP.PHAR.643 Fidanacogene Elaparvovec-dzkt (Beqvez)
CP.PHAR.346 Sarilumab (Kevzara)	CP.PHAR.644 Givinostat (Duvyzat)
CP.PHAR.377 Tezacaftor/Ivacaftor; Ivacaftor (Symdeko)	CP.PMN.08 Lidocaine Transdermal (Lidoderm, ZTlido)
CP.PHAR.384 Lutetium Lu 177 Dotatate (Lutathera)	CP.PMN.27 Linezolid (Zyvox)
CP.PHAR.423 Erdafitinib (Balversa)	CP.PMN.125 Milnacipran (Savella)
CP.PHAR.424 Fulvestrant (Faslodex Injection)	CP.PMN.155 Lacosamide (Motpoly XR, Vimpat)
CP.PHAR.426 Risankizumab-rzaa (Skyrizi)	CP.PMN.199 Esketamine (Spravato)
CP.PHAR.431 Selinexor (Xpovio)	CP.PMN.205 Patiromer (Veltassa)
CP.PHAR.432 Tafamidis (Vyndaqel, Vyndamax)	CP.PMN.236 Amisulpride (Barhemsys)
CP.PHAR.433 Polatuzumab Vedotin-piiq (Polivy)	CP.PMN.240 Gabapentin ER (Gralise, Horizant)
CP.PHAR.440 Elexacaftor/Ivacaftor/Tezacaftor; Ivacaftor (Trikafta)	CP.PMN.243 Progesterone (Crinone, Endometrin, Milprosa)
CP.PHAR.488 Apomorphine (Apokyn, Kynmobi)	CP.PMN.269 Ivermectin (Stromectol, Sklice)
CP.PHAR.494 Capmatinib (Tabrecta)	OR.CP.PHAR.517 Human Growth Hormone (Somapacitan, Somatrogon, Somatropin)
New Coverage Guidelines	
CP.PHAR.684 Nogapendekin alfa inbakicept-pmln (Anktiva)	CP.PHAR.687 Tovorafenib (Ojemda)
CP.PHAR.685 Tarlatamab-dlle (Imdelltra)	CP.PHAR.688 Elafibranor (Iqirvo)
CP.PHAR.686 Tislelizumab-jsgr (Tevimbra)	CP.PHAR.690 Imetelstat (Rytelo)

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.

For additional information on medication coverage guidelines visit the Provider Resources section of Trillium's website.

If you have questions regarding the information contained in this update, contact Trillium Provider Services through the Trillium website or by telephone at 1-877-600-5472.