Provider Update

Trillium Community Health Plan

November 1, 2022

Pharmacy Information and Preferred Drug List Changes – 4th Quarter 2022

This update applies to Trillium Community Health Plan

90-DAY MAINTENANCE MEDICATION PRESCRIPTION COVERAGE

If your Trillium patients are on a maintenance medication, you may be able to prescribe a 90-day supply of their drugs. Patients can only get more than 31 days of a drug if it is a maintenance drug and any network retail or mail order pharmacy can fill the extended day supply. The Trillium Preferred Drug List says "MP" next to drugs that are maintenance products. You can also call Trillium Member Services at 1-877-600-5472 (TTY: 711) and ask for a paper copy.

COVERAGE OF PRESCRIPTION REFILLS

Did you know that the day supply and type of medication prescribed impacts how early Trillium patients can refill their medication? The table below lists refill coverage thresholds and how early members can get their medications for commonly prescribed amounts.

Be sure to inform your Trillium patients that they don't need to wait until they are out of medications to request refills from their Pharmacy, especially if the prescription label says they're out of refills.

Drug Type	Early Refill Coverage		
	Percent Used	30-Day Supply	90-Day Supply
Controlled Substances (CII, CIII, CIV, CV)	90%	3 days left	9 days left*
Ophthalmic Agents	50%	15 days left	45 days left
All Other Medications▪	80%	6 days left	18 days left

▪Maintenance medications filled through mail order pharmacy can be refilled when at least 65% has been used.

*CII medications are not eligible for 90-day supplies.

EXPANSION OF CONTRACEPTIVE COVERAGE

Effective January 1, 2023 Trillium members will be able to fill up to a 12-month supply of oral hormonal contraceptives. Talk with your Trillium patients to determine the prescription duration that will work best for them and be sure that the prescription indicates when an extended duration fill is preferred.

ADDITIONAL PREFERRED OPTIONS FOR GENDER-AFFIRMING HORMONAL THERAPY

This year Trillium has worked hard to listen to providers and members to ensure that we are providing appropriate and accessible gender-affirming hormonal therapy options for our members. Earlier this year Trillium removed the prior authorization requirement on generic testosterone gel and generic estradiol patches for members 17 years of age and older and as of September 1, 2022 estradiol valerate intramuscular oil has been added to the list of preferred agents. See the table below for a comprehensive list of the current preferred gender-affirming hormonal therapy options.

PREFERRED GENDER-AFFIRMING HORMONAL THERAPIES		
Drug Name and Formulation	**Strength**	**Applicable Quantity Limits**
Estradiol Tablets	0.5mg; 1mg; 2mg	None
Estradiol TD Biweekly Patch	0.025mg/24HR; 0.05mg/24HR; 0.0375mg/24HR; 0.075mg/24HR; 0.1mg/24HR	8 patches/28 days
Estradiol TD Weekly Patch	0.025mg/24HR; 0.0375mg/24HR; 0.05mg/24HR; 0.06mg/24HR; 0.075mg/24HR, 0.1mg/24HR	4 patches/28 days
Estradiol Valerate Intramuscular Oil	20mg/ml; 40mg/ml	None
Testosterone Cypionate Intramuscular Oil	100mg/ml; 200mg/ml	None
Testosterone Enanthate Intramuscular Oil	200mg/ml	None
Testosterone TD Gel	1%; 1.62%; 2%	1%: 300gm/30 days: 1.62%: 150gm/30 days; 2%: 120gm/30 days
All gender-affirming hormonal therapy options have an age limit of at least 17 years old. Coverage for members less than 17 years old or for amounts exceeding applicable quantity limits require prior authorization.		

JANUARY 1, 2023 CHANGES TO DIRECT-ACTING ANTIVIRAL TREATMENT OF HEPATITIS C

Effective January 1, 2023 initial treatment of hepatitis C virus (HCV) with preferred direct-acting antiviral (DAA) agents will no longer require PA. Retreatment and extended duration treatments (Mavyret treatment greater than 8 weeks and sofosbuvir-velpatasvir treatment greater than 12 weeks) will still require PA. Case management services will continue to be offered to members filling DAAs to address treatment barriers and help them achieve sustained virologic response (SVR), but will no longer be a requirement for coverage.

UPDATE ON SPECIALTY PHARMACY RESTRICTED MEDICATIONS

In most cases, Trillium Oregon Health Plan members must fill specialty drugs through Acaria Health Pharmacy. This restriction has been removed from several drugs effective December 1, 2022.

- Specialty drugs that will no longer be locked into Acaria Health and can be filled by any network pharmacy when coverage restrictions are met include:

Drug Classification	Brand (Generic Name)	Formulary Restrictions
Vasopressins	Desmopressin acetate 1.5 mg/ml nasal soln.	Non-formulary
	Desmopressin 4 mcg/ml inj	Non-formulary

PEER TO PEERS AVAILABLE WITH A PHARMACIST

Trillium Community Health Plan pharmacists are available to discuss prior authorization denials and help you navigate treatment options for your patients. If you would like to speak to a pharmacist, please call our Provider Services team at 1-877-600-5472.

PRIOR AUTHORIZATION CHANGES TO SPECIALIZED MEDICATIONS GIVEN IN OFFICE

See the table below for all HCPC codes affected by changes in the third quarter of 2022. These codes require prior authorization for coverage for Trillium Community Health Plan members.

Brand (Generic Name)	Description	HCPC Code
Alymsys (bevacizumab-maly)	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg	C9142
Carvykti (ciltacabtagene)	Ciltacabtagene autoleucel, up to 100 million autologous B-cell maturation antigen (BCMA) directed CAR-positive T cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Q2056
Enjaymo (sutimlimab-jome)	Injection, sutimlimab-jome, 10 mg	J1302
Kimmtrak (tebentafusp-tebn)	Injection, tebentafusp-tebn, 1 mcg	J9274
Lanreotide	Injection, lanreotide, (Cipla), 1 mg	J1932
Opdaulag (nivolumab/relatlimab-rmbw)	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	J9298
Releuko (filgrastim-ayow)	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg	Q5125
Vabysmo (faricimab-svoa)	Injection, faricimab-svoa, 0.1 mg	J2777

OREGON HEALTH PLAN PHARMACY SERVICES ANNOUNCEMENTS

This update contains changes to the pharmacy services of Trillium Community Health Plan (Trillium) Oregon Health Plan. Based on the recommendations of the Trillium Pharmacy and Therapeutics (P&T) Committee, the Trillium Community Health Plan medication coverage guidelines (criteria) and Preferred Drug List (PDL) have been revised for the fourth quarter of 2022. PDL revisions are as indicated on page 7. Updated criteria and PDL can be accessed by going to the Provider Resources section of our website. Changes will go into effect January 1, 2023.

The Trillium Community 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.

QUARTERLY UPDATE ON PHARMACY COVERAGE GUIDELINES

See the table below for all the updated or new Trillium Community Health Plan coverage guidelines that were approved by P&T at our fourth quarter meeting October 6, 2022. All coverage guidelines will go into effect on January 1, 2023 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.79 Lapatinib (Tykerb)	CP.PHAR.434 Bremelanotide (Vyleesi)
CP.PHAR.93 Bevacizumab (Alymsys, Avastin, Mvasi, Zirabev)	CP.PHAR.435 Darolutamide (Nubeqa)
CP.PHAR.97 Eculizumab (Soliris)	CP.PHAR.436 Pexidartinib (Turalio)
CP.PHAR.98 Ruxolitinib (Jakafi Opzelura)	CP.PHAR.437 Thioguanine (Tabloid)
CP.PHAR.129 Venetoclax (Venclexta)	CP.PHAR.441 Entrectinib (Rozlytrek)
CP.PHAR.136 Elagolix (Orilissa), Elagolix/Estradiol/Norethinedrone (Oriahnn)	CP.PHAR.442 Fedratinib (Inrebic)
CP.PHAR.137 Ivosidenib (Tibsovo)	CP.PHAR.446 Flibanserin (Addyi)
CP.PHAR.138 Lenvatinib (Lenvima)	CP.PHAR.458 Inebilizumab-cdon (Uplizna)
CP.PHAR.141 Ribavirin (Rebetol, Ribasphere)	CP.PHAR.467 Zanubrutinib (Brukinsa)
CP.PHAR.173 Leuprolide Acetate (Lupron, Lupron Depot, Eligard, Lupaneta Pack, Fensolvi, Camcevi)	CP.PHAR.476 Ubrogepant (Ubrelvy)
CP.PHAR.232 OnabotulinumtoxinA (Botox)	CP.PHAR.483 Lisocabtagene maraleucel (Breyanzi)
CP.PHAR.304 Irinotecan Liposome (Onivyde)	CP.PHAR.489 Eptinezumab-jjmr (Vyepti)
CP.PHAR.305 Obinutuzumab (Gazyva)	CP.PHAR.490 Rimegepant (Nurtec ODT)
CP.PHAR.307 Bendamustine (Belrapzo, Bendeka, Treanda)	CP.PHAR.491 Setmelanotide (Imcivree)
CP.PHAR.309 Carfilzomib (Kyprolis)	CP.PHAR.508 Tafasitamab-cxix (Monjuvi)
CP.PHAR.311 Belinostat (Beleodaq)	CP.PHAR.524 Pegcetacoplan (Empaveli, APL-2)
CP.PHAR.314 Romidepsin (Istodax)	CP.PHAR.545 Betibeglogene autotemcel (Zynteglo)
CP.PHAR.315 Vincristine Sulfate Liposome Injection (Marqibo)	CP.PHAR.550 Vutrisiran (Amvuttra)
CP.PHAR.317 Cetuximab (Erbitux)	CP.PHAR.555 Efgartigimod alfa-fcab (Vyvgart)
CP.PHAR.318 Eribulin Mesylate (Halaven)	CP.PHAR.561 Tisotumab Vedotin-tftv (Tivdak)
CP.PHAR.321 Panitumumab (Vectibix)	CP.PHAR.566 Atogepant (Qulipta)

CP.PHAR.324 Temsirolimus (Torisel)	CP.PMN.153 Alosetron (Lotronex)
CP.PHAR.325 Ziv-aflibercept (Zaltrap)	CP.PMN.155 Lacosamide (Vimpat)
CP.PHAR.332 Pasireotide (Signifor, Signifor LAR)	CP.PMN.164 Cannabidiol (Epidiolex)
CP.PHAR.358 Gemtuzumab Ozogamicin (Mylotarg)	CP.PMN.17 Droxidopa (Northera)
CP.PHAR.359 Inotuzumab Ozogamicin (Besponsa)	CP.PMN.46 Roflumilast (Daliresp, Zoryve)
CP.PHAR.361 Tisagenlecleucel (Kymriah)	CP.PMN.47 Rifaximin (Xifaxan)
CP.PHAR.363 Enasidenib (Idhifa)	CP.PMN.53 Off-Label Use
CP.PHAR.366 Acalabrutinib (Calquence)	CP.PMN.176 Amlodipine/Atorvastatin (Caduet)
CP.PHAR.389 Pegvisomant (Somavert)	CP.PMN.210 Acyclovir Buccal Tablet (Sitavig)
CP.PHAR.391 Lanreotide (Somatuline Depot)	CP.PMN.226 Pancrelipase (Creon, Pancreaze, Pertzye, Viokace, Zenpep)
CP.PHAR.395 Patisiran (Onpattro)	CP.PMN.240 Gabapentin ER (Gralise, Horizant)
CP.PHAR.398 Moxetumomab pasudotox-tdfk (Lumoxiti)	CP.PMN.249 Ciprofloxacin/Fluocinolone (Otovel)
CP.PHAR.40 Octreotide Acetate (Sandostatin, Sandostatin LAR Depot, Bynfezia, Mycapssa)	CP.PMN.255 No Coverage Criteria, Recent Label Changes Pending Clinical Policy Update
CP.PHAR.400 Duvelisib (Copiktra)	CP.PMN.259 Inhaled asthma and COPD agents
CP.PHAR.403 Fremanezumab-vfrm (Ajovy)	CP.PMN.266 Finerenone (Kerendia)
CP.PHAR.404 Galcanezumab-gnlm (Emgality)	CP.PMN.272 Mavacamten (Camzyos)
CP.PHAR.405 Inotersen (Tegsedi)	OR.CP.PMN.214 Continuous Glucose Monitors
CP.PHAR.415 Ravulizumab-cwvz (Ultomiris)	OR.CP.PMN.354 Testosterone
CP.PHAR.430 Alpelisib (Piqray, Vijoice)	
New Coverage Guidelines	
CP.PHAR.585 Omburtamab (Omblastys)	CP.PMN.282 Ketorolac nasal spray (Sprix)
CP.PHAR.590 Omaveloxolone (RTA-408)	CP.PMN.283 Tapinarof (Vtama)
CP.PHAR.591 Tofersen (BIIB067)	
No Clinically Significant Change(s)	
CP.PHAR.125 Palbociclib (Ibrance)	CP.PHAR.556 Elivaldogene Autotemcel
CP.PHAR.130 Avatrombopag (Doptelet)	CP.PHAR.557 Udenafil
CP.PHAR.132 Nitisinone (Nityr, Orfadin)	CP.PHAR.558 Mitapivat (Pyrukynd)
CP.PHAR.133 Idelalisib (Zydelig)	CP.PHAR.559 Mobocertinib (Exkivity)
CP.PHAR.134 Methotrexate (Otrexup, Rasuvo, Xatmep, Reditrex)	CP.PHAR.560 Bardoxolone Methyl (RTA 402)
CP.PHAR.139 Mogamulizumab-kpkc (Poteligeo)	CP.PMN.54 Clobazam (Onfi, Sympazan)
CP.PHAR.140 Pegvaliase-pqpz (Palynziq)	CP.PMN.59 Quantity Limit Override and Dose Optimization
CP.PHAR.142 Adefovir (Hepsera)	CP.PMN.73 Lifitegrast (Xiidra)
CP.PHAR.143 Betaine (Cystadane)	CP.PMN.116 L-glutamine (Endari)
CP.PHAR.149 Baclofen (Fleqsuvy, Gablofen, Lioresal, Lyvispah, Ozobax)	CP.PMN.165 Fluorouracil Cream (Tolak)

CP.PHAR.151 Levoleucovorin (Fusilev, Khapzory)	CP.PMN.167 Neomycin/Fluocinolone Cream (Neo-Synalar)
CP.PHAR.170 Degarelix Acetate (Firmagon)	CP.PMN.168 Ospemifene (Osphena)
CP.PHAR.172 Histrelin Acetate (Vantas, Supprelin LA)	CP.PMN.170 Eluxadoline (Viberzi)
CP.PHAR.174 Nafarelin Acetate (Synarel)	CP.PMN.174 Perindopril/Amlodipine (Prestalia)
CP.PHAR.201 Belatacept (Nulojix)	CP.PMN.179 Megestrol Acetate (Megace ES)
CP.PHAR.308 Elotuzumab (Empliciti)	CP.PMN.180 Halobetasol Propionate (Bryhali, Lexette, Ultravate)
CP.PHAR.313 Pralatrexate (Folotyn)	CP.PMN.181 Calcipotriene/Betamethasone Dipropionate Foam (Enstilar)
CP.PHAR.320 Necitumumab (Portrazza)	CP.PMN.182 Betamethasone Dipropionate Spray (Sernivo)
CP.PHAR.326 Olaratumab (Lartruvo)	CP.PMN.184 Stiripentol (Diacomit)
CP.PHAR.328 Asfotase Alfa (Strensiq)	CP.PMN.185 Baloxavir Marboxil (Xofluza)
CP.PHAR.334 Ribociclib (Kisqali), Ribociclib/Letrozole (Kisqali Femara)	CP.PMN.213 Ferric Maltol (Accrufer)
CP.PHAR.352 Daunorubicin/Cytarabine (Vyxeos)	CP.PMN.215 Non-Preferred Blood Glucose Monitors/Test Strips
CP.PHAR.353 Pegaspargase (Oncaspar), Calaspargase Pegol-mknl (Asparlas)	CP.PMN.216 Diazepam Nasal Spray (Valtoco)
CP.PHAR.355 Abemaciclib (Verzenio)	CP.PMN.226 Pancrelipase (Creon, Pancreaze, Pertzye, Viokace, Zenpep)
CP.PHAR.357 Copanlisib (Aliqopa)	CP.PMN.244 Tazarotene (Arazlo, Fabior, Tazorac)
CP.PHAR.365 Neratinib (Nerlynx)	CP.PMN.248 Ciprofloxacin/Dexamethasone (Ciprodex)
CP.PHAR.387 Azacitidine (Onureg, Vidaza)	CP.PMN.250 Colesevelam (Welchol)
CP.PHAR.390 Cholic Acid (Cholbam)	CP.PMN.251 Lactic Acid/Citric Acid/Potassium Bitartrate (Phexxi)
CP.PHAR.393 Leucovorin Injection	CP.PMN.252 Metoclopramide (Gimoti)
CP.PHAR.394 Migalastat (Galafold)	CP.PMN.253 Abametapir (Xeglyze)
CP.PHAR.397 Cemiplimab-rwlc (Libtayo)	CP.PMN.256 Nifurtimox (Lampit)
CP.PHAR.399 Dacomitinib (Vizimpro)	CP.PMN.267 Levodopa Inhalation Powder (Inbrija)
CP.PHAR.438 Trientine (Cuvrior, Syprine)	CP.PMN.268 Tenofovir Alafenamide Fumarate (Vemlidy)
CP.PHAR.439 Valrubicin (Valstar)	CP.PMN.270 Pilocarpine (Vuity)
CP.PHAR.506 Antithymocyte Globulin (Atgam, Thymoglobulin)	OR.CP.PHAR.171 Goserelin Acetate (Zoladex)
CP.PHAR.507 Lomustine (Gleostine)	OR.CP.PHAR.175 Triptorelin pamoate (Trelstar, Triptodur)

CP.PHAR.509 Triheptanoin (Dojolvi)	OR.CP.PHAR.1002 Gender Dysphoria
CP.PHAR.510 Arimoclomol	OR.CP.PMN.33 Pregabalin (Lyrica, Lyrica CR)
CP.PHAR.512 Pegunigalsidase Alfa (PRX-102)	OR.CP.PMN.161 Methadone
CP.PHAR.513 Plasminogen, Human-tvmh (Ryplazim)	OR.CP.PMN.1006 Compounded Medications
CP.PHAR.551 Anifrolumab-fnia (Saphnelo)	OR.CP.PMN.1007 Supplement Herbal and Vitamin Products
CP.PHAR.552 Belumosudil (Rezurock)	OR.CP.PMN.1008 Smoking Cessation Products
CP.PHAR.553 Belzutifan (Welireg)	OR.CP.PMN.1010 Coenzyme Q-10 (Ubiquinone, Ubiquinol)
CP.PHAR.554 Chlorambucil (Leukeran)	

TRILLIUM COMMUNITY HEALTH PLAN PREFERRED DRUG LIST CHANGES

Medication	**Effective Date**
Additions	
Vosevi (sofosbuvir-velpatasvir-voxilaprvir) 400-100-100mg Tabs Added to PDL; PA required	1.1.2023
Urine Ketone Test Strips Added to PDL	9.1.2022
Estradiol Valerate 10mg/ml, 20mg/ml & 40mg/ml Oil Added to PDL; AL of ≥17 years old	9.1.2022
Caya & Omniflex Diaphragms Added to PDL	10.1.2022
Removals	
Flovent (fluticasone propionate) HFA Generic fluticasone HFA preferred. Current utilizers will not be grandfathered	1.1.2023
Flovent (fluticasone propionate) Diskus Generic fluticasone HFA preferred. Current utilizers will be grandfathered x1 year.	1.1.2023
Changes	
Oral Hormonal Contraceptives Coverage of all preferred oral hormonal contraceptives has been extended to allow up to a 12-month supply of medication per fill	1.1.2023
Mavyret (glecaprevir-pibretasvir) 100-40mg tab PA no longer required for initial treatment	1.1.2023
Sofosbuvir-Velpatasvir 400-100mg tab PA no longer required for initial treatment	1.1.2023
Doxycycline Monohydrate 50mg & 100mg cap; 50mg & 100mg tab QL changed to: max 14-day supply, 2 fills every 90 days	10.1.2022
Doxycycline Hyclate 50mg & 100mg cap; 20mg & 100mg tab QL changed to: max 14-day supply, 2 fills every 90 days	10.1.2022
Key: PA = prior authorization; PDL = preferred drug list; QL = quantity limit	

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 the drug classes and medication coverage guidelines reviewed by the P&T committee, 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.