Provider Update

Trillium Community Health Plan

February 1, 2024

Pharmacy Information and Preferred Drug List Changes – 1st Quarter 2024

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

UPDATES TO COVID-19 VACCINE COVERAGE

The Oregon Health Authority (OHA) has partially reversed the requirement to return to use of Vaccines for Children (VFC) providers as the established pathway for children's vaccines for Oregon Health Plan members. In addition to VFC providers, Trillium members under age 19 are now covered to receive COVID-19 vaccines from any Oregon Medicaid contracted pharmacy, regardless of VFC enrollment, through September 30, 2024. For additional information visit OHA's COVID-19 Oregon Health Plan provider guidance site.

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 first quarter of 2024. For the most current preferred drug list, visit the Pharmacy section of our website.

Medication	Effective Date
Additions	
Adalimumab-adbm (unbranded Cyltezo) 40MG/0.8ML auto-injector; 10MG/0.2ML, 20MG/0.4ML & 40MG/0.8ML prefilled syringes Added to PDL with PA required	04.01.2024
Kombiglyze XR (saxagliptin-metformin) 2.5-1000 MG, 5-500 MG, 5-1000 MG Tab Added to PDL with QL	04.01.2024
Onglyza (saxagliptin) 2.5 MG, 5 MG Tabs Added to PDL with QL	04.01.2024
Paxlovid (nirmatrelvir-ritonavir) 150-100 MG Tabs Added to PDL	01.01.2024
Tiotropium bromide monohydrate (generic Spiriva Handihaler) 18 MCG Inhalation Cap Added to PDL	04.01.2024
Changes	
Celecoxib 50 MG, 100 MG, 200 MG, 400 MG Caps Removed PA requirement	03.01.2024
Removals	
Ademelog (insulin lispro) 100 U/ML vial and pen-injector Removed from PDL	04.01.2024
Basaglar (insulin glargine) 100 U/ML pen-injector	04.01.2024

Removed from PDL	
Kevzara (arilumab) 150MG/1.14ML & 200MG/1.14ML auto-injector; 150MG/1.14ML & 200MG/1.14ML prefilled syringe Removed from PDL	04.01.2024
Olumiant (baricitinib) 1 MG, 2 MG Tabs Removed from PDL	04.01.2024
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
Abilify Asimtufii (aripiprazole)	J0402	Injection, aripiprazole (Abilify Asimtufii), 1 mg
Abrilada (adalimumab-afzb)	Q5132	Injection, adalimumab-afzb (Abrilada), biosimilar, 10 mg
Balfaxar (prothrombin complex human-lans)	C9159	Injection, prothrombin complex concentrate (human), Balfaxar, per IU of Factor IX activity
Barhemsys (amisulpride)	J0184	Injection, amisulpride, 1 mg
Brixadi (buprenorphine)	J0576	Injection, buprenorphine extended-release (Brixadi), 1 mg
carmustine	J9052	Injection, carmustine (Accord), not therapeutically equivalent to J9050, 100 mg*
Columvi (glofitamab-gxbm)	J9286	Injection, glofitamab-gxbm, 2.5 mg*
cyclophosphamide	J9072	Injection, cyclophosphamide, (Dr. Reddy's), 5 mg*
Daxxify (daxibotulinumtoxinA-lanm)	C9160	Injection, daxibotulinumtoxina-lanm, 1 unit
docetaxel	J9172	Injection, docetaxel (Ingenus), not therapeutically equivalent to J9171, 1 mg*
Elevidys (delandistrogene moxeparvovec-rokl)	J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose
Elfabrio (pegunigalsidase alfa-iwxj)	J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg
Elrexfio (elranatamab-bcmm)	C9165	Injection, elranatamab-bcmm, 1 mg*
Eylea HD (aflibercept)	C9161	Injection, aflibercept HD, 1 mg
Igalmi (dexmedetomidine)	J1105	Dexmedetomidine, oral, 1 mcg
Izervay (avacincaptad pegol)	C9162	Injection, avacincaptad pegol, 0.1 mg
Lamzede (velmanase alfa-tycv)	J0217	Injection, velmanase alfa-tycv, 1 mg
Leqembi (lecanemab-irmb)	J0174	Injection, lecanemab-irmb, 1 MG
Nexobrid (anacaulase-bcdb)	J7353	Anacaulase-bcdb 8.8% gel 1 GM
paclitaxel protein-bound particles	J9258	Injection, paclitaxel protein-bound particles (Teva), not therapeutically equivalent to J9264, 1 mg*
pemetrexed	J9324	Injection, pemetrexed (Pemrydi RTU), 10 mg*
Qalsody (tofersen)	J1304	Injection, tofersen, 1 mg
Roctavian (valoctocogene roxaparvovec-rvox)	J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^{13} vector genomes
Rystiggo (rozanolixizumab-noli)	J9333	Injection, rozanolixizumab-noli, 1 mg
Talvey (talquetamab-tgv)	C9163	Injection, talquetamab-tgvs, 0.25 mg*
Uzedy (risperidone)	J2799	Injection, risperidone (Uzedy), 1 mg
Vyjuvek (beremagene geperpavec-svdt)	J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^{9} PFU/ml vector genomes, per 0.1 ml
Vyvgart Hytrulo (efgartigimod alfa-hyaluronidas-qvfc)	J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc

* 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 first quarter of 2024. All coverage guidelines will go into effect April 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.01 Omalizumab (Xolair)	CP.PHAR.410 Bortezomib (Velcade)
CP.PHAR.100 Axitinib (Inlyta)	CP.PHAR.411 Amifampridine (Firdapse)
CP.PHAR.106 Enzalutamide (Xtandi)	CP.PHAR.414 Larotrectinib (Vitrakvi)
CP.PHAR.111 Cabozantinib (Cabometyx, Cometriq)	CP.PHAR.426 Risankizumab-rzaa (Skyrizi)
CP.PHAR.114 Teduglutide (Gattex)	CP.PHAR.428 Romosozumab-aqqg (Evenity)
CP.PHAR.115 Pegloticase (Krystexxa)	CP.PHAR.443 Upadacitinib (Rinvoq)
CP.PHAR.119 Ramucirumab (Cyramza)	CP.PHAR.453 Golodirsen (Vyondys 53)
CP.PHAR.121 Nivolumab (Opdivo)	CP.PHAR.461 Nadofaragene firadenovec-vncg (Adstiladrin)
CP.PHAR.123 Evolocumab (Repatha)	CP.PHAR.462 Ozanimod (Zeposia)
CP.PHAR.124 Alirocumab (Praluent)	CP.PHAR.464 Selumetinib (Koselugo)
CP.PHAR.135 Baricitinib (Olumiant)	CP.PHAR.465 Teprotumumab (Tepezza)
CP.PHAR.137 Ivosidenib (Tibsovo)	CP.PHAR.466 Valoctocogene Roxaparvovec (Roctavian)
CP.PHAR.168 Corticotropin (H.P. Acthar, Purified Cortrophin Gel)	CP.PHAR.467 Zanubrutinib (Brukinsa)
CP.PHAR.179 Romiplostim (Nplate)	CP.PHAR.470 Casimersen (Amondys 45)
CP.PHAR.180 Eltrombopag (Promacta)	CP.PHAR.472 Brexucabtagene autoleucel (Tecartus)
CP.PHAR.188 Teriparatide (Forteo, Bonsity)	CP.PHAR.473 Lumasiran (Oxlumo)
CP.PHAR.189 Ibandronate injection (Boniva)	CP.PHAR.484 Viltolarsen (Viltepso)
CP.PHAR.196 Selexipag (Uptravi)	CP.PHAR.492 Teplizumab-mzwv (Tzield)
CP.PHAR.204 Trabectedin (Yondelis)	CP.PHAR.511 Evinacumab-dgnb (Evkeeza)
CP.PHAR.224 Enoxaparin (Lovenox)	CP.PHAR.515 Avacopan (Tavneos)
CP.PHAR.225 Dalteparin (Fragmin)	CP.PHAR.562 Allogeneic cultured keratinocytes and dermal fibroblasts (StrataGraft)
CP.PHAR.226 Fondaparinux (Arixtra)	CP.PHAR.567 Cipaglucosidase alfa-atga--miglustat (Pombiliti-Opfolda)
CP.PHAR.235 Atezolizumab (Tecentriq)	CP.PHAR.568 Inclisiran (Leqvio)
CP.PHAR.24 Fostamatinib (Tavalisse)	CP.PHAR.59 Zoledronic Acid (Reclast, Zometa)
CP.PHAR.241 Abatacept (Orencia)	CP.PHAR.590 Omaveloxolone (Skyclarys)
CP.PHAR.242 Adalimumab (Humira) Humira Biosimilars	CP.PHAR.597 Leniolisib (Joenja)
CP.PHAR.244 Anakinra (Kineret)	CP.PHAR.605 Adagrasib (Krazati)
CP.PHAR.247 Certolizumab (Cimzia)	CP.PHAR.607 Deucravacitinib (Sotyktu)
CP.PHAR.250 Etanercept (Enbrel)	CP.PHAR.612 Tremelimumab-actl (Imjudo)
CP.PHAR.253 Golimumab (Simponi, Simponi Aria)	CP.PHAR.616 Zilucoplan (Zilbrysq)
CP.PHAR.254 Infliximab (Avsola, Inflectra, Remicade, Renflexis, Zymfentra)	CP.PHAR.63 Everolimus (Afinitor, Afinitor Disperz, Zortress)
CP.PHAR.261 Secukinumab (Cosentyx)	CP.PHAR.655 Motixafortide (Aphexda)
CP.PHAR.264 Ustekinumab (Stelara)	CP.PHAR.84 Abiraterone (Zytiga, Yonsa)

CP.PHAR.265 Vedolizumab (Entyvio)	CP.PHAR.94 Alpha1-Proteinase Inhibitors
CP.PHAR.267 Tofacitinib (Xeljanz Xeljanz XR)	CP.PHAR.98 Ruxolitinib (Jakafi, Opzelura)
CP.PHAR.270 Paricalcitol Injection (Zemplar)	CP.PMN.03 DPP-4 inhibitors
CP.PHAR.283 Lomitapide (Juxtapid)	CP.PMN.100 Risedronate (Actonel, Atelvia)
CP.PHAR.288 Eteplirsen (Exondys 51)	CP.PMN.123 Colchicine (Colcrys, Lodoco)
CP.PHAR.289 Buprenorphine Injection (Sublocade, Brixadi)	CP.PMN.183 GLP-1 receptor agonists
CP.PHAR.300 Bezlotoxumab (Zinplava)	CP.PMN.186 Cenegermin-bkbj (Oxervate)
CP.PHAR.301 Erwinia Asparaginase (Rylaze)	CP.PMN.218 Lasmiditan (Reyvow)
CP.PHAR.323 Plerixafor (Mozobil)	CP.PMN.22 Brand Name Override
CP.PHAR.329 Siltuximab (Sylvant)	CP.PMN.257 Clascoterone (Winlevi)
CP.PHAR.336 Dupilumab (Dupixent)	CP.PMN.259 Inhaled asthma and COPD agents
CP.PHAR.346 Sarilumab (Kevzara)	CP.PMN.271 Maribavir (Livtencity)
CP.PHAR.350 Rucaparib (Rubraca)	CP.PMN.272 Mavacamten (Camzyos)
CP.PHAR.360 Olaparib (Lynparza)	CP.PMN.277 Ulcer Therapy Products (Omeclamox Pak, Pylera, Talicia, Voquezna)
CP.PHAR.361 Tisagenlecleucel (Kymriah)	CP.PMN.57 Febuxostat (Uloric)
CP.PHAR.362 Axicabtagene ciloleucel (Yescarta)	CP.PMN.58 Propranolol (Hemangeol)
CP.PHAR.364 Guselkumab (Tremfya)	CP.PMN.90 Benznidazole
CP.PHAR.367 Letermovir (Prevymis)	CP.PMN.92 CNS Stimulants
CP.PHAR.368 Pemetrexed (Alimta, Pemfexy)	CP.PMN.93 Dextromethorphan-Quinidine (Nuedexta)
CP.PHAR.386 Tildrakizumab-asmn (Ilumya)	CP.PMN.96 Ibandronate Oral (Boniva)
CP.PHAR.40 Octreotide Acetate (Sandostatin, Sandostatin LAR, Bynfezia, Mycapssa)	OR.CP.PHAR.517 Human Growth Hormones (Somapacitan, Somatrogon, Somatropin)
CP.PHAR.402 Emapalumab-lzsg (Gamifant)	OR.CP.PMN.1003 Sedatives
CP.PHAR.407 Lusutrombopag (Mulpleta)	OR.CP.PMN.1011 Antifungals
CP.PHAR.409 Talazoparib (Talzenna)	OR.CP.PMN.81 Buprenorphine-Naloxone (Suboxone, Zubsolv)
New Coverage Guidelines	
CP.PHAR.659 Vamorolone (Agamree)	CP.PHAR.666 Fruquintinib (Fruzaqla)
CP.PHAR.660 Bimekizumab-bkzx (Bimzelx)	CP.PHAR.667 Repotrectinib (Augtyro)
CP.PHAR.661 Etrasimod (Velsipity)	CP.PHAR.668 Toripalimab (Loqtorzi)
CP.PHAR.662 Mirikizumab-mrkz (Omvoh)	OR.CP.PMN.1014 Topical Moisturizers
CP.PHAR.663 Capivasertib (Truqap)	

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.