Provider Update

Trillium Community Health Plan

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Pharmacy Information and Formulary Changes – Third Quarter 2018

THIS UPDATE APPLIES TO:

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

STATE:

- ● Oregon

LINES OF BUSINESS:

- ● Oregon Health Plan
- ○ Medicare

PROVIDER SERVICES

trilliumohp.com
877-600-5472

OREGON HEALTH PLAN

This update contains changes to the pharmacy services of Trillium Community Health Plan (Trillium) Oregon Health Plan (OHP) 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 3rd quarter of 2018. PDL revisions are as indicated beginning on page 4. Updated criteria can be accessed by going to the Provider Resources on our website: TrilliumOHP.com. Changes will go into effect October 1, 2018.

The Trillium 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 ANOUNCEMENTS

NON-PREFERRED MEDICATION COVERAGE GUIDELINES

As of January 1, 2018, the Trillium P&T Committee has started to review and approve coverage guidelines for medications that are not on the PDL. The use of these guidelines for the review of non-preferred medication requests helps to facilitate more constant determinations between reviewers based on rigorously reviewed practice guidelines and clinical evidence. Approval of non-preferred medications remain subject to the Oregon Health Plan's Prioritized List and Guideline Notes as well as a trial and failure of preferred options and cost analysis of alternative treatment options.

NEW COVERAGE GUIDELINES FOR BUPRENORPHINE PRODUCTS

Trillium has revised the coverage guidelines for buprenorphine products, which have gone into effect as of 7/1/2018. There are now three separate coverage guidelines: 1. TCHP.PMN.82 Buprenorphine (Subutex); 2. TCHP.PMN.81 Buprenorphine-Naloxone (Bunavail, Suboxone, Zubsolv); 3. CP.PHAR.289 Buprenorphine Implant/Injection (Probuphine, Sublocade). The new guidelines for oral buprenorphine increase access to buprenorphine for treatment of opioid dependence and opens up the use of Subutex for members for induction and continuation of therapy if the use of a naloxone combination product is contraindicated. Additionally, new coverage guidelines for Probuphine and Sublocade give members who are unable to continue oral therapy alternative options. These coverage guidelines do not have criteria for the use of buprenorphine for the treatment of pain as this is not an FDA approved indication. Requests for buprenorphine for the treatment of pain will be reviewed for medical necessity by a pharmacist.

NEW COVERAGE GUIDELINES FOR OPIOIDS

Oregon Trillium Health Plan has revised the coverage guidelines for opioid products, which have gone into effect as of 7/1/2018. The new guidelines are more in-line with the Center for Disease Control (CDC) guidelines on the prescribing of opioids and aim to promote safe and appropriate prescribing practices as part of the fight against the opioid epidemic.

NEW AGE RESTRICTIONS ON CODEINE, HYDROCODONE AND TRAMADOL

The Food and Drug Administration (FDA) has released several new recommendations regarding the use of prescription codeine, hydrocodone and tramadol for pain and cough in pediatrics. In April 2017 the FDA recommended that codeine should not be used to treat cough in children younger than 12 years, that tramadol should not be used to treat pain in children younger than 12 years, and that tramadol should not be used in children younger than 18 years to treat pain after surgery to remove the tonsils and/or adenoids. More recently in January 2018, the FDA released the recommendations to limit the use of drugs containing hydrocodone and codeine for cough and cold in children younger than 18 years of age. Trillium OHP has adopted these safety recommendations and as of October 1, 2018 will no longer cover codeine used for pain for those younger than 12 years of age, tramadol for pain for those younger than 18 years of age, and codeine or hydrocodone containing products for use of cough and/or cold for those younger than 18 years of age. Trillium's preferred agent for treating pain in pediatrics is oxycodone and oxycodone 5mg/5ml solution up to 150ml per year will no longer require prior authorization for coverage to allow short term opioid treatment of acute pain in pediatrics who are unable to take tablets.

HYOSCYAMINE REMOVED FROM PREFERRED DRUG LIST

The Drug Efficacy Study Implementation (DESI) was a program started by the Food and Drug Administration (FDA) in the 1960s after the Kefauver-Harris Drug Control Act was passed in 1962 introducing the requirement for all drugs to be efficacious as well as safe before FDA approval. The DESI program was intended to classify all pre-1962 drugs on the market to determine if they were either effective, ineffective, or needed further study. Per a Federal Court ruling in 1981 all drugs designated as less than effective or drug identical, related to, or similar to a DESI drug are not reimbursable under Medicaid or Medicare Part B program. The FDA is responsible for determining the DESI status of a drug. Hyoscyamine is designated as DESI 5 which means is has been classified as a less than effective drug for all indications and is thus not covered by federal funds. Trillium has removed all hyoscyamine products from their preferred drug list effective October 1, 2018.

PREFERRED DRUG LISTS NO LONGER ON EPOCRATES

As of June 30, 2018 Trillium Community Health Plan Preferred Drug Lists (PDL) are no longer available through Epocrates. To access the plan's PDLs please visit Provider Resources on our website, available at: TrilliumOHP.com/providers/helpful-links.

QUARTERLY UPDATE ON COVERAGE GUIDELINE

See the table below for all the updated or new coverage guidelines that were approved by P&T at our third quarter meeting July 13, 2018. All coverage guidelines will go into effect on October 1, 2018 and will become available to view in their entirety at TrilliumOHP.com by the end of August.

UPDATED COVERAGE GUIDELINES	
CP.PHAR.114 Teduglutide (Gattex)	CP.PHAR.63 Everolimus (Afinitor, Afinitor Disperz)
CP.PHAR.121 Nivolumab (Opdivo)	CP.PHAR.84 Abiraterone (Zytiga)
CP.PHAR.239 Dabrafenib (Tafinlar)	CP.PHAR.89 Peginterferon Alfa-2b (PegIntron, Sylatron)
CP.PHAR.240 Trametinib (Mekinist)	CP.PMN.151 Diabetic Test Strip Quantity Limit - Not Receiving Insulin
CP.PHAR.283 Lomitapide (Juxtapid)	CP.PMN.159 Dronabinol (Marinol, Syndros)
CP.PHAR.284 Mipomersen (Kynamro)	CP.PMN.70 Ivabradine (Corlanor)
CP.PHAR.338 Cerliponase alfa (Brineura)	TCHP.PHAR.1801 Hepatitis C Direct-Acting Antivirals
CP.PHAR.350 Rucaparib (Rubraca)	TCHP.PHAR.1802 Acitretin (Soratane)
CP.PHAR.355 Abemaciclib (Verzenio)	TCHP.PHAR.1807 Pregabalin (Lyrica)
CP.PHAR.361 Tisagenlecleucel (Kymriah)	TCHP.PHAR.187 Biologics for Autoimmune Diseases
CP.PHAR.61 Cinacalcet (Sensipar)	

NEW COVERAGE GUIDELINES	
CP. PHAR.378 Ibalizumab-uiyk (Trogarzo)	CP.PHAR.383 Trifluridine/Tipiracil (Lonsurf)
CP.PHAR.103 Immune Globulins	CP.PHAR.384 Lutetium Lu 177 dotatate (Lutathera)
CP.PHAR.106 Enzalutamide (Xtandi)	CP.PHAR.385 Corticosteroid Intravitreal Implants (Iluvien, Ozurdex, Retisert)
CP.PHAR.11 Burosumab-twza (Crysvita)	
CP.PHAR.123 Evolocumab (Repatha)	CP.PHAR.41 Enfuvirtide (Fuzeon)
CP.PHAR.124 Alirocumab (Praluent)	CP.PHAR.81 Pazopanib (Votrient)
CP.PHAR.126 Ibrutinib (Imbruvica)	CP.PHAR.82 Collagenase Clostridium Histolyticum (Xiaflex)
CP.PHAR.145 Deferasirox (Exjade, Jadenu)	CP.PHAR.83 Vorinostat (Zolinza)
CP.PHAR.146 Deferoxamine (Desferal)	CP.PHAR.88 Belimumab (Benlysta)
CP.PHAR.147 Deferiprone (Ferriprox)	CP.PHAR.95 Thyrotropin Alfa (Thyrogen)
CP.PHAR.150 Mecasermin (Increlex)	CP.PMN.09 Lindane Shampoo
CP.PHAR.169 Vigabatrin (Sabril)	CP.PMN.139 naloxone (Evzio)
CP.PHAR.24 Fostamatinib (Tavalisse)	CP.PMN.141 Dolasetron (Anzemet)
CP.PHAR.27 Tolvaptan (Jynarque)	CP.PMN.144 Epinephrine (EpiPen and EpiPen Jr) Quanity Limit Override
CP.PHAR.270 Paricalcitol Injection (Zemplar)	CP.PMN.146 fluticasone-umeclidinium-vilanterol (Trelegy Ellipta)
CP.PHAR.277 Cytomegalovirus Immune Globulin (CytoGam)	CP.PMN.147 indacaterol-glycopyrrolate (Utibron Neohaler)
	CP.PMN.148 tiotropium-olodaterol (Stiolto Respimat)
CP.PHAR.282 Parathyroid hormone (Natpara)	CP.PMN.149 umeclidinium-vilanterol (Anoro Ellipta)
CP.PHAR.287 Obeticholic acid (Ocaliva)	CP.PMN.150 Lesinurad (Zurampic), lesinurad-allopurinol (Duzallo)
CP.PHAR.294 Osimertinib (Tagrisso)	CP.PMN.155 Lacosamide (Vimpat)
CP.PHAR.295 Sargramostim (Leukine)	CP.PMN.156 Perampanel (Fycompa)
CP.PHAR.296 Pegfilgrastim (Neulasta)	CP.PMN.157 rufinamide (Banzel)
CP.PHAR.297 Filgrastim (Neupogen), Filgrastim-sndz (Zarxio), Tbo-filgrastim (Granix)	CP.PMN.158 netupitant;palonosetron (Akynzeo)
	CP.PMN.160 nabilone (Cesamet)
CP.PHAR.302 Ixazomib (Ninlaro)	CP.PMN.19 Aprepitant (Emend)
CP.PHAR.303 Brentuximab Vedotin (Adcetris)	CP.PMN.31 Fluticasone/Salmeterol (Advair Diskus, Advair HFA)
CP.PHAR.310 Daratumumab (Darzalex)	CP.PMN.44 Pyrimethamine (Daraprim)
CP.PHAR.312 Blinatumomab (Blincyto)	CP.PMN.45 Ondansetron (Zuplenz)
CP.PHAR.319 Ipilimumab (Yervoy)	CP.PMN.46 Roflumilast (Daliresp)
CP.PHAR.323 Plerixafor (Mozobil)	CP.PMN.47 Rifaximin (Xifaxan)
CP.PHAR.327 Nusinersen (Spinraza)	CP.PMN.74 Granisetron (Kytril, Sancuso)
CP.PHAR.351 Daptomycin (Cubicin Cubicin RF)	CP.PMN.76 Calcifediol (Rayaldee)
CP.PHAR.377 Tezacaftlor-Ivacaflor (Symdeko)	CP.PST.17 Atomoxetine (Strattera)
CP.PHAR.379 Etelcalcetide (Parsabiv)	TCHP.PHAR.18.06 Idiopathic Pulmonary Fibrosis (IPF) Agents
CP.PHAR.380 Cobimetinib (Cotellic)	TCHP.PHAR.1804 Direct Oral Anticoagulants (DOACs)
CP.PHAR.381 Mechlorethamine (Valchlor)	TCHP.PHAR.1805 Lidocaine Transdermal (Lidoderm)
CP.PHAR.382 Panobinostat (Farydak)	TCHP.PHAR.1808 Lidocaine-Prilocaine (EMLA)

ADDITIONAL INFORMATION

For additional information regarding changes to the Trillium Preferred Drug List (PDL), contact Trillium by telephone at 877-600-5472. For the most current version of the PDL, visit the Trillium website at 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.

If you have questions regarding the information contained in this update, contact the Trillium Provider Services through the Trillium provider website at 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
FORMULARY ADDITIONS AND CHANGES			
-	Sumatriptan succinate injection	ANTIMIGRAINE AGENT: Used as an abortive therapy for acute migraines	Limit changed to 2.5mL per 30 days and restriction of age ≥12 years old added. Current utilizers will be grandfathered.
Ciprodex	Ciprofloxacin/Dexamethasone suspension	OTIC AGENT: Combination antibiotic steroid medication used to reduce inflammation	Added limit of 7.5ml (1 bottle) per 30 days
-	Hyoscyamine sulfate	BELLADONNA ALKALOID: Commonly used as a gastrointestinal antispasmodic	All formulations removed from PDL as drug is DESI 5. Current utilizers will be grandfathered.
Lupron Depot	Leuprolide acetate	GnRH ANALOG: Used in the treatment of prostate cancer, endometriosis and gender dysphoria in pediatrics.	All strengths removed from PDL to match Medical benefit. Current utilizers will be grandfathered.
Fuzeon	Enfuvirtide	HIV AGENT: Subcutaneous HIV therapy used in treatment-experienced individuals	Removed from PDL
Sensipar	Cinacalcet	CALCIUM REGULATOR: Used in the treatment of multiple hyperparathyroidism conditions	Removed from PDL. Current utilizers will be grandfathered.
Amicar	Aminocaproic acid	HEMOSTATIC AGENT: Used in the prevention and treatment of bleeding	Added limit of 60ml for 25% soln and #24 to 500mg tablets
Vimpat	Lacosamide	ANTICONVULSANT: Used to treat seizure disorders	Added PA requirement. Current utilizers will be grandfathered.
Serevent Diskus	Salmeterol xinafoate	LABA: Used in the treatment of asthma and COPD	Added limit of 60 per 30 days. Current utilizers will be grandfathered.
EpiPen	Epinephrine	ADRENERGIC AGENT: Used for the treatment of anaphylaxis	Added limit of 4 pens per 365 to all strengths
-	Codeine sulfate + promethazine or chlorpheniramine	OPIOID: Codeine products use for cough suppression	Added restriction of age ≥18 years
-	All other Codeine containing products	OPIOID: Codeine products used in the treatment of pain	Added restriction of age ≥12 years
-	Tramadol containing products	OPIOID: Used in the treatment of pain	Added restriction of age ≥18 years
-	Hydrocodone containing products	OPIOID: Used in the treatment of pain	Added restriction of age ≥18 years
-	Oxycodone	OPIOID: Used in the treatment of pain	Removed PA requirement for 5mg/5ml solution. Added limit of 150mL per 365 days. Current utilizers will be grandfathered.