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February 23, 2022

RE: Provider Notification of Medical and Pharmacy Benefit Drug Policies

Dear WellFirst Health™ Provider:

WellFirst Health's Medical Policy Committee has approved the drug policies highlighted in this notification. These changes, and other changes not included in this notification, will also be communicated in the quarterly provider newsletters and available online. Please share this information with others within your organization who may be affected by these changes.

Information in this notification is applicable to all WellFirst Health products, unless directly specified.

WellFirst Health requires providers to obtain prior authorization on all drugs with written policies, unless otherwise noted in the policy. Please note that most drugs require specialists to prescribe and request authorization.

Prior Authorization Form Updates

Effective for dates of service on and after March 1, 2022:

- Zydelig (idelalisib) — a kinase inhibitor indicated for the treatment of patients with: (1) Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities; (2) Relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies; and (3) Relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies. Two indications were voluntarily withdrawn by the manufacturer and will be removed from the prior authorization form.

Effective for dates of service on and after April 1, 2022:

- Cimzia (certolizumab pegol) — a tumor necrosis factor (TNF) blocker indicated for: (1) Reducing signs and symptoms of Crohn's disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy; (2) Treatment of adults with moderately to severely active rheumatoid arthritis; (3) Treatment of adult patients with active psoriatic arthritis; (4) Treatment of adults with active ankylosing spondylitis; (5) Treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation; and (6) Treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Adding another step therapy option of Skyrizi that can be counted as one of the trialed drugs (need to try 2).
- Orencia (abatacept) — a selective T cell costimulation modulator indicated for: (1) the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA); (2) the treatment of patients 2 years of age and older with moderately to severely active

polyarticular juvenile idiopathic arthritis (pJIA); (3) the treatment of adult patients with active psoriatic arthritis (PsA); and (4) the prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adults and pediatric patients 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor. Adding another step therapy option of Skyrizi that can be counted as one of the trialed drugs (need to try 2).

- Fetzima (levomilnacipran) — a serotonin and norepinephrine reuptake inhibitor (SNRI) indicated for the treatment of Major Depressive Disorder (MDD) in adults. Removed psychiatrist requirement as a prescriber.

New Indications

Effective for dates of service on and after April 1, 2022:

- Oxbryta (voxelotor) — 300 mg tablet for oral suspension for sickle cell disease in patients aged 4 years and older. Recently voxelotor received an age expansion from 12 years old to 4 years old. The new age expansion will be added to prior authorization forms.
- Skyrizi (risankizumab) — 150 mg/mL subcutaneous injection for active psoriatic arthritis in adults. Received a new indication for the treatment of adults with active psoriatic arthritis (PsA). The PsA indication will be added to the prior authorization form as a preferred agent for the treatment of PsA. Forms will also be updated for the non-preferred PsA agents to add risankizumab to the list of preferred alternatives that could be tried (certolizumab and abatacept; also, secukinumab for the Extended formularies).
- Cosentyx (secukinumab) — 75, 150, & 300 mg subcutaneous injection for active enthesitisrelated arthritis in patients 4 years and older & psoriatic arthritis in patients 2 years and older. Secukinumab recently received a new indication for active enthesitis-related arthritis (ERA) in patients four years of age and older. Secukinumab also received an age expansion for psoriatic arthritis (PsA) in patients two years of age and older, previously indicated in only adults. The new indications will be added to the prior authorization form.
- Solosec (secnidazole) — 2-gram packet for bacterial vaginosis and trichomoniasis in patients aged 12 years and older. Secnidazole recently received an age expansion down to 12 years of age for the treatment of bacterial vaginosis in female patients and for the treatment of trichomoniasis, previously only approved in adults. Currently, there is no age listed as part of the prior authorization criteria and therefore, this is informational only.

Changes to Drug Policies

Effective for dates of service on and after March 1, 2022:

- Epoetin Alfa Products MB9715 — used to treat severe anemia in patients on kidney dialysis or for those not on dialysis. Also, it may be used to prevent or treat anemia that is caused by surgery or medicines (e.g., zidovudine) that are used for other conditions, such as HIV or cancer. Effective March 1, 2022, removed preferred product designation for Retacrit during planned shortages in 2022. This requirement will be reinstated once the planned shortage has resolved.

Effective for dates of service on and after April 1, 2022:

- Botulinum Toxin MB9020 — used to treat certain eye disorders such as crossed eyes (strabismus) and uncontrolled blinking (blepharospasm), to treat muscle stiffness/spasms or movement disorders (such as cervical dystonia, torticollis), and to

reduce cosmetic appearance. Prior authorization is no longer required. Post service claim edits per medical policy criteria remain.

Effective for dates of service on and after June 1, 2022:

- ALDURAZYME-laronidase MB9940 — a hydrolytic lysosomal glycosaminoglycan (GAG)-specific enzyme indicated for adult and pediatric patients with Hurler and Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I) and for patients with the Scheie form who have moderate to severe symptoms. Alignment with Medica policy criteria including addition of criteria for baseline values and continuation criteria of documented reduction of urinary glycosaminoglycan (uGAG) levels and one other beneficial response from baseline values. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis I.
- ARANESP-darbepoetin alpha MB9799 — an erythropoiesis-stimulating agent (ESA) indicated for the treatment of anemia due to Chronic Kidney Disease (CKD) in patients on dialysis and patients not on Dialysis. The effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy. Reduction in approval timeframe to 45 days, refined approvable diagnosis code and covered ranges for hemoglobin (Hb) and hematocrit (Hct). Additional edits in comment section. Prior authorization is required and must be prescribed by, or in consultation with, an oncology, infectious disease, hematology, or nephrology prescriber.
- ELAPRASE-idursulfase MB2105 — used for treatment of Mucopolysaccharidosis II (Hunter syndrome). Policy criteria including new requirements for lab values and baseline measurements for initial approval and additional continuation criteria (e.g., cognitive impairment requirement) and lab values. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis II.
- ELELYSO-taliglucerase alfa MB2106 — used for treatment of Gaucher disease type 1. Policy criteria including clarifying use as single agent, requirement of complications apply to adults only, addition of national drug code (NDC) and references. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of Gaucher DX.
- Epoetin Alfa Products MB9715 — used to treat severe anemia in patients on kidney dialysis or for those not on dialysis. Also, it may be used to prevent or treat anemia that is caused by surgery or medicines (e.g., zidovudine) that are used for other conditions, such as HIV or cancer. Policy criteria including reduction in approval timeframe to 45 days, refined approvable diagnosis and covered ranges for Hb and Hct. Also, additional edits added in the comment section. Prior authorization is required and is restricted to oncology, infectious disease, hematology or nephrology prescribers.
- NAGLAZYME-galsulfase MB2108 — used for treatment of Mucopolysaccharidosis VI (MPS VI). Policy criteria including addition of baseline values and continuation criteria of documented reduction of uGAG levels and one other beneficial response from baseline values. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis VI.
- VIMIZIM-elosulfase MB2109 — used for treatment of Mucopolysaccharidosis IV type A (Morquio syndrome). Policy criteria including additional requirement for initial therapy (6 minute walk test) and clarification on what is needed to confirm diagnosis. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis IVA.

Medical Benefit Drug Policies

Prescribers are encouraged to track changes and review policies in their entirety. Medical benefit drug policies are accessible online via the WellFirst Health Document Library at *wellfirstbenefits.com/document-library* or by visiting wellfirstbenefits.com and following the step-by-step instructions below:

- Select **Providers,** and then **Document Library**.
- From the Document Library page, for best results, select **Provider** in the **Audience dropdown** and select **Drug Policies** in the **Category** dropdown.
- In the **Search for** field, enter the drug name or numerical digits of the assigned policy number (e.g., entering 1234 of the medical benefit policy number MB1234) and click **Go** to access drug policies.

Pharmacy Benefit Drug Policies

Criteria for pharmacy benefit medications may be found on the associated prior authorization form located in the Provider Portal.

Please email any questions to DHPPharmacyServices@deancare.com.

Sincerely,

WellFirst Health Pharmacy Services