Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights

Highlights of recent drug policy revisions, as well as any new drug policies approved by WellFirst Health's Medical Policy Committee, are shown below. *Drug policies are applicable to all WellFirst Health products, unless directly specified within the policy.* NOTE: All changes to the policies may not be reflected in the written highlights below. **We encourage all prescribers to review the current policies**.

All drugs with documented WellFirst Health policies must be prior authorized, unless otherwise noted in the policy. Please note that most drugs noted below and with policies require specialists to prescribe and request authorization.

To view WellFirst Health pharmacy medical benefit policies, visit wellfirstbenefits.com ➤ select the **Providers link** at the top of the web page ➤ **Pharmacy Services**. From the Pharmacy services for health care providers page, click the **See library link** located under the Current policies section.

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

Click here for the Spring 2022 Newsletter.

Newsletters are published on the WellFirst Health Provider news page at https://wellfirstbenefits.com/Providers/Provider-news. Please call the Customer Care Center at **866-514-4194** if you have questions about accessing the updates.

Pharmacy Drug Formulary Maintenance

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

- Latuda (lurasidone) 20, 40, 60, 80 & 120 mg tablets for schizophrenia and depressive episodes associated with bipolar I disorder. Removing the step therapy through quetiapine Latuda for all lines of business where it is covered.
- Saphris (asenapine) 2.5, 5 & 10 mg sublingual tablets for schizophrenia and acute mania or mixed episodes associated with bipolar I disorder. The prior authorization will be removed from the brand product.
- Xifaxan (rifaximin) 550 mg tablet for hepatic encephalopathy & moderate to severe irritable bowel syndrome without constipation. The prior authorization and quantity limit will be removed.

Pharmacy Drug New Indications

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

- Xeljanz (tofacitinib) 5 mg tablet & 11 mg ER tablet for active ankylosing spondylitis (AS) who have had an inadequate response or intolerance to one or more TNF blockers. The AS indication will be added to prior authorization forms.
- Rinvoq (upadacitinib) 15 mg tablet for active psoriatic arthritis (PsA) in adults who have had an inadequate response or intolerance to one or more TNF blockers. Previously upadacitinib was approved for the treatment of rheumatoid arthritis (RA). The PsA indication will be added to the prior authorization form.
- Benlysta (belimumab) - given intravenously (IV) or subcutaneously, for active systemic lupus erythematosus (SLE or lupus) or active lupus nephritis on other lupus medicines. Addition of anti-Smith antibodies as option to confirm SLE diagnosis will be added to prior authorization form.

New Medical Drug Policies

ABECMA (idecabtagene vicleucel) MB2129

Effective January 1, 2022, ABECMA, which is a chimeric antigen receptor T-cell (CAR-T) immunotherapy, for the treatment of adult patients with relapsed or refractory multiple myeloma (RRMM) after 4 or more prior therapies, including an immunomodulatory drug (IMiD), a proteasome inhibitor (PI), and an anti-CD38 antibody. Prior authorization is required and must be prescribed by, or in consultation with, an Oncologist or Hematologist prescriber.

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ADUHELM (aducanumab) MB2128

Effective January 1, 2022, ADUHELM, is a Human IgG1 monoclonal antibody directed against aggregated soluble and insoluble forms of amyloid beta used for treatment of Alzheimer's disease. This is a non-covered benefit and prior authorization is not required.

CABENUVA (cabotegravir-rilpivirine) MB2131

Effective January 1, 2022, CABENUVA, which is a 2-drug co-packaged product of cabotegravir, a human immunodeficiency virus type-1 (HIV-1) integrase strand transfer inhibitor (INSTI), and rilpivirine, an HIV-1 non-nucleoside reverse transcriptase inhibitor (NNRTI), is indicated as a complete regimen for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine. Prior authorization is required.

MAPD CGM Policy MB1842

Effective January 1, 2022, CGM (Continuous Glucose Monitoring) policy is effective for Medicare Advantage. CGM is a way to measure glucose levels in real-time throughout the day and night. A tiny electrode called a glucose sensor is inserted under the skin to measure glucose levels in tissue fluid. It is connected to a transmitter that sends the information via wireless radio frequency to a monitoring and display device. Policy was created for NCD/LCD to operationalize with Pharmacy adjudication. Prior authorization is required and must be prescribed by specialist.

NULIBRY (fosdenopterin) MB2133

Effective January 1, 2022, NULIBRY, which is a cyclic pyranopterin monophosphate (cPMP) replacement indicated for reducing the risk of mortality in patients with molybdenum cofactor deficiency (MoCD) Type A. Prior authorization is required and must be prescribed by, or in consultation with, a neurologist, medical geneticist, or a provider who specializes in management of inborn errors of metabolism.

UPTRAVI IV (selexipag) MB2130

Effective January 1, 2022, UPTRAVI IV, which is a prostacyclin receptor agonist indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH. Created new medical benefit policy for when member is to "take nothing by mouth" (NOP) and unable to take anything orally. Prior authorization is required and must be prescribed by, or in consultation with, a cardiologist or pulmonologist prescriber.

INFUGEM (gemcitabine) MB2132

Effective April 1, 2022, INFUGEM, which is a nucleoside metabolic inhibitor indicated: (1) in combination with carboplatin, for the treatment of advanced ovarian cancer that has relapsed at least 6 months after completion of platinum based therapy; (2) in combination with paclitaxel, for first-line treatment of metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless anthracyclines were clinically contraindicated; (3) in combination with cisplatin, for the treatment of non-small cell lung cancer; and (4) as a single agent for the treatment of pancreatic cancer. Infugem (premixed gemcitabine in sodium chloride solution); J9198 will require prior authorization. Gemcitabine hydrochloride (J9201) will not require prior authorization. The prior authorization must be prescribed by, or in consultation with, an oncologist prescriber.

Parenteral Iron Products MB2134

Effective April 1, 2022, Parenteral Iron Products, which are used for patients intolerant or unresponsive to oral iron therapy, for receiving recombinant erythropoietin therapy, or for use in treating functional iron deficiency. Prior authorization is not required for preferred 1st line products (Venofer, INFeD, Ferrlicit and Feraheme). Prior authorization is required for non-preferred products (Injectafer and Monoferric).

Changes To Medical Drug Policies

ERWINAZE (asparaginase erwinia chrysanthemi) MB1919

Effective January 1, 2022, ERWINAZE, which is an asparagine specific enzyme indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL) who have developed hypersensitivity to E. coli-derived asparaginase. Addition of the drug RYLAZE (asparaginase Erwinia chrysanthemi recombinant) to the policy. Prior authorization is required and must be prescribed by an oncology/hematologist prescriber.

LEMTRADA (alemtuzumab) MB9468

Effective January 1, 2022, LEMTRADA, is a CD52-directed cytolytic monoclonal antibody indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include relapsing-remitting disease and active secondary progressive disease, in adults. Policy updated to have fewer restrictions under prior authorization criteria. Prior authorization is required and must be prescribed by a neurology prescriber.

LUMIZYME, Myozyme (alglucosidase alfa), Nexviazyme (avalglucosidase alfa) MB2107

Effective January 1, 2022, LUMIZYME, Myozyme, Nexviazyme, are used for treatment of Pompe Disease (Acid Alpha glucosidase (GAA) deficiency). Addition of new drug Nexviazyme (avalglucosidase alfa) which is for treating of Pompe Disease. Prior authorization is required and must be prescribed by, or in consultation with, medical geneticist or other prescriber specialized in the treatment of Pompe disease.

Effective February 1, 2022, LUMIZYME, Myozyme-alglucosidase alfa, Nexviazyme-avalglucosidase alfa, used for treatment of Pompe Disease (Acid Alpha glucosidase (GAA) deficiency). J Code update for Nexviazyme (avalglucosidase alfa) for hospital outpatient from drug code C9399 to drug code C9085. Prior authorization is required and must be prescribed by, or in consultation with, medical geneticist or other prescriber specialized in the treatment of Pompe disease.

LUPRON-ELIGARD (leuprolide) MB1842

Effective January 1, 2022, LUPRON-ELIGARD, used for the management of endometriosis, including pain relief and reduction of endometriotic lesions. Added recommended criteria (no prior authorization required) additional potential approved indications, and changed NCCN criteria language to follow template language. Prior authorization is not required but must be prescribed by, or in consultation with, oncology, urology, OBGYN, internal medicine, family medicine, or pediatrics. FENSOLVI is a non-covered medical benefit product.

Medically Administered Oncology Products MB2112

Effective January 1, 2022, Medically Administered Oncology Products, is the overarching oncology policy replacing most of the individual policies. Removal of the drug LARTRUVO (olaratumab) as FDA revoked the approval to manufacture and market in February 2020 and all PA forms for drug were termed as of September 1, 2021. Prior authorization is required and is restricted to oncology prescribers.

OCREVUS (ocrelizumab) MB9941

Effective January 1, 2022, OCREVUS, is a CD20-directed cytolytic antibody indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults and primary progressive MS, in adults. Policy updated to have fewer restrictions under prior authorization criteria. Prior authorization is required and is restricted to neurology prescribers.

TECARTUS (brexucabtagene autoleucel) MB2013

Effective January 1, 2022, TECARTUS, CAR T-cell therapy for adults with acute lymphoblastic leukemia (ALL). New indication added. Prior authorization is required and may only be prescribed by, or in consultation with, an oncologist prescriber.

TECENTRIQ (atezolizumab) MB1817

Effective January 1, 2022, TECENTRIQ, is a prescription medicine used to treat adults with: a type of lung cancer called small cell lung cancer (SCLC). TECENTRIQ may be used with the chemotherapy medicines carboplatin and etoposide as first treatment when lung cancer: is a type called “extensive-stage small cell lung cancer,” which means that it has spread or grown. Added as an adjuvant treatment following resection and platinum-based chemotherapy Stage II to IIIA NSCLC; updated percentages for high PD-L1 expression metastatic NSCLC; included all other indications. Prior authorization is required and must be prescribed by, or in consultation with, an oncologist prescriber.

TEPEZZA (teprotumumab-trbw) MB2005

Effective January 1, 2022, TEPEZZA, is an insulin-like growth factor-1 receptor inhibitor indicated for the treatment of Thyroid Eye Disease. Corrected statement that either/or specialist is needed, not both. Prior authorization is required and must be prescribed by, and or in consultation with, an ophthalmologist or endocrinologist prescribers.

TYSABRI (natalizumab) MB9854

Effective January 1, 2022, TYSABRI, is a prescription medicine used to treat relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Policy updated to have fewer restrictions under PA criteria. Prior authorization is required and must be prescribed by a neurology specialist or a gastroenterology prescriber.

UPTRAVI (selexipag) MB9926

Effective January 1, 2022, UPTRAVI, is a prostacyclin receptor agonist indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH. Policy was reinstated and is now under Pharmacy benefit and was created for new oral use to limit use of other PAH products. Drug will be covered as long as the prior authorization criteria is met. Prior authorization is required and must be prescribed by, or in consultation with, a cardiologist or pulmonologist prescriber.

VYZULTA (latanoprostene bunod)-RHOPRESSA (netarsudil) MB1847

Effective January 1, 2022, VYZULTA, is a prostaglandin analog indicated for the reduction of intraocular pressure in patients with open-angle glaucoma or ocular hypertension. RHOPRESSA, is a Rho kinase inhibitor indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. Continuation criteria updated to include language that VYZULTA and RHOPRESSA must be within FDA recommended dosage restrictions. Prior authorization is required.

FLOLAN-epoprpstenol-REMODULIN-treprostinil MB1934

Effective February 1, 2022, FLOLAN, is a prostaglandin (a hormone-like substance that occurs naturally in the body) used to treat pulmonary hypertension. REMODULIN, which is a prostacyclin mimetic indicated for: Treatment of pulmonary arterial hypertension (PAH; WHO Group 1) to diminish symptoms associated with exercise and patients who require transition from epoprostenol, to reduce the rate of clinical deterioration. Prior authorization is required for generic and be prescribed by, or in consultation, with a cardiologist or pulmonologist.

Infliximab Infusions MB9231

Effective February 1, 2022, Infliximab infusions, which is a tumor necrosis factor (TNF) blocker indicated for Crohn's Disease, Pediatric Crohn's Disease, Ulcerative Colitis, Pediatric Ulcerative Colitis, Rheumatoid Arthritis in combination with methotrexate, Ankylosing Spondylitis, Psoriatic Arthritis, and Plaque Psoriasis. Criteria removed for preferred infliximab product Renflexis. Renflexis prior authorization will only require an accepted indication. Prior authorization is required and must be prescribed by a dermatology, rheumatology, or gastroenterology prescriber. Prior authorization continues to be required for all other non-preferred infliximab products.

JEMPERLI-dostarlimab MB2126

Effective February 1, 2022, JEMPERLI, is used for the treatment of adult patients with mismatch repair deficient (dMMR) recurrent or advanced: endometrial cancer (EC), as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen, or solid tumors, as determined by an FDA-approved test, that have progressed on or following prior treatment and who have no satisfactory alternative treatment options. J Code update from C9082, J9999 to J9272. Prior authorization is required and must be prescribed by, or in consultation with, an oncologist or OB/GYN prescriber.

KEYTRUDA-pembrolizumab MB1812

Effective February 1, 2022, KEYTRUDA, is used for treatment of melanoma, non-small cell lung cancer (NSCLC), head and neck squamous cell cancer (HNSCC), classical Hodgkin lymphoma (cHL), primary mediastinal B-cell lymphoma (PMBCL), urothelial carcinoma, microsatellite instability-high (MSI-H) or a mismatch repair deficient (dMMR) solid tumor, colon or rectal cancer, gastric or gastroesophageal junction (GEJ) adenocarcinoma that tests positive for "PD-L1, cervical cancer that tests positive for "PD-L1", hepatocellular carcinoma, Merkel cell carcinoma (MCC), renal cell carcinoma (RCC), cutaneous squamous cell carcinoma (cSCC), and triple-negative breast cancer (TNBC). Indication update for melanoma and label expansion for Renal Cell Carcinoma (RCC). Prior authorization is required and must be prescribed by an oncologist or hematologist prescriber.

Rituximab Products MB9847

Effective February 1, 2022, Rituximab Products, which is used alone or in combination with other medicines to treat a type of cancer called non-Hodgkin's lymphoma (NHL). Additional clarification for nephrology specialists only may prescribe for indications of steroid-dependent nephrotic syndrome and membranous nephropathy. Prior authorization is required and must be prescribed by rheumatology, transplant, hematology, neurology, dermatology, ENT, nephrology, or oncology prescribers.

XOLAIR-omalizumab MB9309

Effective February 1, 2022, XOLAIR, which is an anti-IgE antibody indicated for moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids, nasal polyps in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment, and Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. Additional criteria added for nasal polyps using Navitus exception to coverage (ETC) criteria. Prior authorization is required and must be prescribed by Allergy, Pulmonary, Immunology, Otolaryngologist, or Dermatology prescriber.

GAZYVA-obinutuzumab MB9451

Effective May 1, 2022, GAZYVA, which is a CD20-directed cytolytic antibody indicated: in combination with chlorambucil, for the treatment of patients with previously untreated chronic lymphocytic leukemia; in combination with bendamustine followed by GAZYVA monotherapy, for the treatment of patients with follicular lymphoma who relapsed after, or are refractory to, a rituximab-containing regimen; and in combination with chemotherapy followed by GAZYVA monotherapy in patients achieving at least a partial remission, for the treatment of adult patients with previously untreated stage II bulky, III or IV follicular lymphoma. Criteria information updated to include a more robust combination products and Initial and Renewal criteria. Prior authorization is required and must be prescribed by, or in consultation with an oncologist prescriber.

SPINRAZA-nusinersen MB9949

Effective May 1, 2022, SPINRAZA, which is a survival motor neuron-2 (SMN2)-directed antisense oligonucleotide indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients. Additional language definition and criteria added around Risdiplam and Zolgensma products. Prior authorization is required and must be prescribed by, or in consultation with a neurology specialist with expertise in SMA treatment.

Retired Medical Drug Policies

Effective January 1, 2022, the drug policies listed below will be retired, but not the drugs themselves. The policy is being retired due to NCD/LCD is now effective.

MAPD 9405 ACTEMRA IV (tocilizumab)

MAPD 9231 Infliximab Infusions

MAPD 9457 ORENCIA (abatacept IV)

Effective January 1, 2022, the drug policies listed below will be retired, but not the drugs themselves. The policy is being retired and the drugs are now under the Medically Administered Oncology Policy MB2112.

LUMOXITI (moxetumomab) - MB1920

ONCASPAR (pegasparagase) - MB1903

POLIVY (polatuzumab vedotin-piiq) - MB1938

Effective February 1, 2022, the drug policy listed below will be retired, but not the drug itself. The policy is being retired due to removing prior authorization requirement to be consistent with other long-acting injectable antipsychotics.

ABILIFY MAINTENA - aripiprazole MB9456

Effective February 1, 2022, the drug policy listed below will be retired, but not the drug itself. The policy is being retired due to going under the pharmacy benefit per Navitus adoption.

ACTHAR GEL - repository corticotropin injection MB2103

Effective February 1, 2022, the drug policy listed below will be retired, but not the drug itself. The policy is being retired due to NCD/LCD is now effective and the drug is now included under the medical benefit policy MB1934 FLOLAN/REMODULIN.

REMODULIN (Treprostinil) – MB9888

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