

NOVEMBER 14, 2017



Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

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PHARMACY AND THERAPEUTICS (P&T) COMMITTEE MEETING

NORTH CAROLINA STATE HEALTH PLAN
3200 ATLANTIC AVENUE, RALEIGH, NC 27604

Pharmacy and Therapeutics (P&T) Committee Meeting Tuesday, November 14th 2017, 6:00 p.m. to 8:00 p.m.

Agenda

Topic:

Presenter:

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| <ol style="list-style-type: none"> 1. Welcome <ul style="list-style-type: none"> • Call to Order 2. Conflict of Interest Statement 3. Minutes from Aug 22, 2017 Meeting* 4. Old Business <ul style="list-style-type: none"> • P&T Charter • Formulary Development and Management at CVS Caremark • Recap of CVS Health's 2018 Formulary Strategy 5. Formulary Updates* <ul style="list-style-type: none"> • 2018 Advanced Control Specialty Formulary Updates <ul style="list-style-type: none"> ○ Autoimmune ○ Hepatitis C ○ Hyperinflation • Tier Changes <ul style="list-style-type: none"> ○ Negative ○ Positive • New Drug Reviews <ul style="list-style-type: none"> ○ Besponsa[®] ○ Kisqali[®] ○ Kevzara[®] ○ Haegarda[®] ○ Vosevi[®] ○ Baxdela[®] ○ Endari[®] ○ Austedo[®] | <p>Carl Antolick III, Chair</p> <p>Carl Antolick III, Chair</p> <p>Carl Antolick III, Chair</p> <p>Carl Antolick III, Chair</p> <p>Carl Antolick III, Chair</p> <p>Heather Renee Jarnigan, CVS</p> <p>Carl Antolick III, Chair</p> <p>Michael Spiritos, MD</p> <p>Michael Spiritos, MD</p> <p>Joseph Shanahan, MD</p> <p>Joseph Shanahan, MD</p> <p>John Engemann, MD</p> <p>John Engemann, MD</p> <p>David Konanc, MD</p> <p>David Konanc, MD</p> |
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6. Utilization Management Policy Review*

- Enhanced Opioid Management
 - Opioids ER Step Therapy & Limits
 - Opioids IR Acute Pain Duration & Quantity Limit
 - Opioid IR Combo Acute Pain Duration Limit
 - Opioid IR Combo Quantity Limit
 - Xartemis® XR Limit Policy
- Specialty Drug Management Strategies
- Long Acting Insulin & GLP-1 Agonist Combo Policy
- Vytorin® 10-80 Zocor® 80 ST Policy
- Lyrica®, Gralise®, Horizant® ST Policy
- Existing Policies
 - Tysabri® SGM
 - Feiba® SGM
 - Rituxan Hycela® SGM
 - Lynparza® SGM
 - Epogen®, Procrit® SGM
 - Ibrance® SGM
 - Alecensa® SGM
 - Uptravi® SGM
 - Prolia® SGM
 - Makena® SGM
 - Simponi® SGM
 - Remicade®, Inflectra®, Renflexis® SGM
 - Otezla® SGM
 - Orencia® SGM
 - Praluent® SGM
 - Cimzia® SGM
 - Cosentyx® SGM

7. Executive Closed Session (if necessary)

8. Adjourn

- Next Meeting: TBD

Carl Antolick III, Chair
Heather Renee Jarnigan, CVS
Michael Spiritos, MD
Joseph Shanahan, MD
Jennifer Burch, PharmD, CDE
Jennifer Burch, PharmD, CDE
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Carl Antolick III, Chair
Jennifer Burch, PharmD, CDE
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David Konanc, MD

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Michael Spiritos, MD
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John Anderson, MD
John Anderson, MD
John Anderson, MD
Joseph Shanahan, MD
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Jennifer Burch, PharmD, CDE
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Carl Antolick III, Chair
Carl Antolick III, Chair

*Requires a recommendation from the P&T Committee



STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

ETHICS AWARENESS & CONFLICT OF INTEREST REMINDER

(to be read by the Chair of the P&T Committee or his or her designee at the beginning of each meeting)

In accordance with the NC State Health Plan for Teachers and State Employees' ethics policy, it is the duty of every member of the Pharmacy and Therapeutics ^{Committee}, whether serving in a vote casting or advisory capacity, to avoid both conflicts of interest and appearances of conflict.

Does any Committee member have any known conflict of interest or the appearance of any conflict with respect to any manufacturers of any medication to be discussed at today's meeting?

Or, if during the course of the evaluation process if you identify a conflict of interest or the appearance of a conflict.

If so, please identify the conflict or appearance of conflict and refrain from any undue participation¹ in the particular matter involved.

¹ "A public servant shall take appropriate steps, under the particular circumstances and considering the type of proceeding involved, to remove himself or herself to the extent necessary, to protect the public interest and comply with this Chapter, from any proceeding in which the public servant's impartiality might reasonably be questioned due to the public servant's familial, personal, or financial relationship with a participant in the proceeding." *See N.C.G.S. §138A-36 (c). If necessary, the Chairman or individual member involved should consult with his ethics liaison, legal counsel, or the State Ethics Commission to help determine the appropriate response in a given situation. Rev. 1-16-07*

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

August 22, 2017

The meeting of the Pharmacy and Therapeutics (P&T) Committee of the North Carolina State Health Plan for Teachers and State Employees was called to order at 6:05 P.M. (EST) on Tuesday, August 22, 2017, at the Department of State Treasurer (DST), Dogwood Conference Room, 3200 Atlantic Avenue, Raleigh, NC 27604.

MEMBERS PRESENT:

John Anderson, MD, MPH, Chief Medical Officer, Duke Primary Care
Matthew K. Flynn, MD, Founder, Family Dermatology
David Konanc, MD, Neurologist, Raleigh Neurology Associates
Joseph Shanahan, MD, Owner, Shanahan Rheumatology & Immunotherapy
Michael D. Spiritos, MD, Chief Medical Officer, Duke Raleigh Hospital
John J. Engemann, MD, Infectious Disease Specialist, Raleigh Infectious Disease Associates, PA
Carl Antolick III, PharmD, Clinical Pharmacist, NCSHP (Chair)
Heather Renee Jarnigan, RPh, Clinical Advisor, CVS Health (non-voting member)

MEMBERS ABSENT:

Connie Rominger, Medical Team Lead, BCBSNC Member Rights & Appeals (non-voting member)
Jennifer Burch, PharmD, Owner, Central Compounding Center
W. Randolph Grigg, MD, Psychiatrist, Psychiatric Associates of North Carolina, PA

GUESTS:

Natasha Davis, Pharmacy Benefits Program Manager, NCSHP
Neha Zadoo, Pharmacy Business Analyst, NCSHP
Dee Jones, Executive Administrator, NCSHP
Caroline Smart, Director, Plan Integration, NCSHP
Lucy Barreto, DDS, MHA, Healthcare Product Manager, NCSHP
Brian Hermreck, Director, Strategic Accounts, CVS Health
Scott Ramsey, MBA, Regional Account Executive, Boehringer Ingelheim
Christine Lynch, PharmD, MPH, Sr. Associate Director, Account Medical Advisor, Boehringer Ingelheim
Timothy Poole, Director, Boehringer Ingelheim
Mike Laraway, Account Executive, Novo Nordisk
Jason Richardson, Regional Account Manager, Allergan
John Sutter, MBA, Senior Account Executive, Merck
Ken Krause, Senior Account Executive, Eli Lilly
Kimberly Turk, Specialty Account Director, GlaxoSmithKline
Steve Patterson, Regional Managed Markets Director of NC/VA, Alkermes Inc.
Darrell Smith, National Account Director, Johnson & Johnson Health Care Systems, Inc
Mark Roshelli, MBA, Account Executive, US Market Access, Sanofi
Don Medlin, Health Outcomes and Pharmacoeconomic Scientific Specialist, UCB
John Laurel, Sales Marketing, Lilly USA, LLC

EXECUTIVE SESSION:

Welcome

The Chairperson welcomed the Committee members and guests to the meeting and introduced Dee Jones as the NCSHP's new executive administrator.

Conflict of Interest

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act the Chairperson read the NCSHP's Ethics Awareness & Conflict of Interest Reminder to the P&T Committee members and requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. No conflicts of interest were noted.

For Committee Recommendation

The Chairperson then outlined the meeting agenda, which had previously been distributed to the members together with other materials. The agenda for the meeting included the following subjects which required a vote from the members of the P&T Committee: (1) May 2017 P&T Committee Meeting Minutes; (2) updates and changes to the NCSHP's customized drug formulary; and (3) utilization management criteria. The agenda was approved unanimously by the members.

The Chairperson then asked the P&T Committee members to review the May 2017 P&T meeting minutes, which were distributed prior to the meeting. There were no additions or corrections to the minutes so they were approved as is.

Heather Renee Jarnigan, clinical pharmacist CVS Health, introduced the 2018 Standard Control Formulary Removals and Updates. This included the removal of the following branded products: Doryx/Doryx MPC, Monodox, Follistim, Elelyso, Tanzeum, Sumavel Dosepro, Benicar/Benicar HCT, Effexor XR, Nuvigil, Seroquel XR, Zetia, Horizant, Jardiance, Synjardy/Synjardy XR, Dulera, Hyalgan & Synvisc/Synvisc One and included the addition of the following products back to the formulary: Xtandi, Incruse Ellipta, Avonex, Plegridy, Lastacraft, Lumigan, FML, Pred Mild, Zubsolv, Opsumit, Invokana, Invokamet/Invokamet XR, Symbicort, Androgel, Abstral, & Gelnique.

Dr. Anderson voiced concern that Jardiance was being removed from the NCSHP formulary for 2018. He noted that he was in touch with Dr. Buse, whom he considers one of the top endocrinologists in the country, and that Dr. Buse had raised the same concerns. Dr. Anderson detailed that bone fracture and amputations were not as great with Jardiance as they were for Invokana. The data for collected for Invokana prompted the FDA to place a black box warning for amputation on Invokana as 1 of 12 studies showed there was an increased risk of amputation. Dr. Konanc voiced concern over the removal of Horizant as it is not comparable to generic gabapentin due to saturation issues. He felt that it did not warrant being removed from the formulary as it still plays a secondary role for the treatment of restless leg syndrome. The P&T Committee unanimously voted to adopt all drug removals except Horizant, Jardiance, Synjardy, & Synjardy XR, in which they agreed to leave at status quo. Caroline Smart also noted that additional considerations will need to be evaluated before a final decision is made regarding any formulary changes.

It was motioned to adopt all formulary add backs except Invokana & Invokamet/Invokamet XR, as this would keep the SGLT-2 inhibitor class as status quo. Dr. Anderson voiced concern regarding the continued exclusion of Invokana & Invokamet/Invokamet XR as it would cause member disruption that was not warranted. It was explained by the Chairperson that the thousand or so members that gained coverage of Invokana & Invokamet/Invokamet XR in 2017 would continue to have coverage of those drugs until their exceptions approval expired which for most would be sometime in 2018. Upon explanation it was unanimously voted to adopt all formulary add backs except Invokana & Invokamet/Invokamet XR.

The meeting topic shifted to the quarter four 2017 Formulary updates. The first to be presented by the Chairperson was all hyperinflation exclusions and tier changes CVS is proposing to be effective 10/1/2017. The following listed medications were for the branded products only and not for any equivalent generics. Indocin suspension 25mg/5mL and Indocin suppositories 50mg were poised to be removed from the formulary due to hyperinflation of their prices. Naprosyn suspension 125mg/5mL, Qudexy XR, Gabitril, Klonopin, Lamictal, and Opana ER were all moving to a non-preferred tier, while Soliqua and Vemlidy were moving to a preferred tier. There were no comments from the Committee and they unanimously agreed to the changes.

The next section to be addressed were drug additions to the NCSHP Formulary. The following drugs were being removed from CVS Health's new-to-market block list and could be added to the formulary: Rydapt, Pertzeye, Tepadina, Herceptin, Afstyla, vancomycin/NACL injection 750/250, Rubraca, Trulance, Xatmep, Vraylar, Soliqua, Aczone, Rhofade, Qbrelix, Lazanda, Tymlos & Xtampza were all scheduled to be added as non-preferred products while Selzentry, Orenitram, Isentress HD & Zytiga 500mg were scheduled to be added as preferred products respectively. The Chairperson explained that only products that were new molecular entities would undergo a full new drug review, each of which had been assigned to the committee members prior to the meeting. The other products listed were either new formulations, new strengths, or new combinations of products already on the NCSHP Formulary.

Dr. Spiritos commented that because there was not any alternative treatment options for patients using Rydapt & possibly even Rubraca, they should be placed at a preferred tier. Dr. Shanahan asked the Plan to research the actual cost of Tymlos to determine if it too should be preferred because it is less costly than Forteo. He also mentioned that the prior authorization approval time of 24 months might be too long as treatment with Tymlos was only studied at 18 months. The Committee unanimously voted to add all the new to market released products at CVS Health's proposed tiering, except for Rydapt & Rubraca which will be assigned a preferred product status (tier 5).

The Committee was then responsible for reviewing new utilization management criteria as well as some existing criteria. The new criteria was reviewed by Drs. Engemann, Flynn, Shanahan, & Burch and are as follows: Albenza, Biltricide, Emverm Limit Policy, Ciclopirox Topical Solution 8% Policy, Elidel Policy, Protopic Policy, Soriatane Policy, Prudoxin, Zonalon Policy, Sitavig Policy, Cuprimine, Syprine Policy, Voltaren Gel Policy, & Lidoderm Policy. Dr. Flynn had some additional indications that might be applicable for the Soriatane Policy and will present them to the Chair at a later date. Dr. Burch had some concerns that the Lidoderm policy would limit member access, but Drs. Shanahan & Konanc disagreed as their use in practice is still very limited. All policies were unanimously approved by the Committee.

The Committee members were then responsible for reviewing existing criteria. Drs. Engemann, Shanahan, Flynn, Anderson, and Burch reviewed the following policies: Daraprim, Difucid, Influenza Treatment, Grastek, Oralair, Ragwitek, Solodyn, Ximino, Restasis, Testosterone Oral, Testosterone, and Solaraze. Dr. Flynn commented that the 30 day step therapy of a generic antibacterial drug for the Solodyn/Ximino Policy might not be adequate as it usually takes at least 90 days of treatment to have the full effect. The Plan will consider customization to the policy. The Committee unanimously approved the existing policies and their continued use.

Information Only

The Chairperson made note that the CVS Caremark “White Papers” had been updated February 20, 2017 and that the only significant change was the reduction of their physician membership by one. The Chairperson explained that the P&T Committee Charter that was to be reviewed was tabled as it required additional revisions from our legal counsel. The Chairperson announced that the Plan was considering holding future P&T meetings via teleconference only. The members were in agreement with this suggestion and it will be evaluated by the Plan for future adoption.

Adjourn

The meeting was adjourned at approximately 7:20 P.M. (EST).



Carl Antolick III, Chair

NORTH CAROLINA STATE HEALTH PLAN PHARMACY AND THERAPEUTICS (P&T) COMMITTEE CHARTER

I. AUTHORITY

Pursuant to N.C.G.S. §§ 135-48.51(2) and 58-3-221(a)(1) the North Carolina State Health Plan (Plan), by maintaining a closed formulary, must develop the formulary and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating physicians who are licensed to practice medicine in North Carolina.

II. MISSION AND PURPOSE

The mission of the Plan is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

The Plan's Pharmacy and Therapeutics Committee (P&T Committee) will support this mission by serving in an advisory capacity to the Plan to ensure the Plan's Comprehensive Formulary Document is appropriately revised to adapt to the release of new drugs, changes in product availability, and changes in evidence-based clinical or safety guidelines.

III. FUNCTIONS

The P&T Committee will be responsible for the following core functions:

- Review and vote on proposed updates to the Comprehensive Formulary Document quarterly.
- Recommend pharmacy-related utilization management criteria that will promote the safety, effectiveness, and affordability of medication used in clinical settings.
- Review new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information.
- Serve in an advisory capacity to the Plan on other matters when needed.

IV. MEMBERSHIP

In addition to members from the Plan, the P&T Committee's membership shall include broad primary care and specialty representation, all of whom must be practicing physicians and pharmacists in North Carolina.

V. MEETINGS

The P&T Committee will meet at least quarterly. The Committee's Chair may call additional meetings as needed.

VI. DURATION

This Charter shall become effective when signed by all initial P&T Committee members and shall last perpetually until dissolved.

VII. EXECUTION

It being the desire of the P&T Committee to meet its responsibilities to the State of North Carolina, and in the most efficient and conscientious manner possible to discharge its duties under the law, the Committee does hereby adopt this Charter to be effective immediately this ____ day of _____ 2017.

[NAME], P&T Committee Chair

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member

[NAME], P&T Committee Member



Formulary Development and Management at CVS Caremark®

Development and management of drug formularies is an integral component in the pharmacy benefit management (PBM) services CVS Caremark provides to health plans and plan sponsors. Formularies have two primary functions: 1) to help the PBM provide pharmacy care that is clinically sound and affordable for plans and their plan members; and 2) to help manage drug spend through the appropriate selection and use of drug therapy.

Underlying principles of the CVS Caremark Formulary Development and Management Process include the following:

- CVS Caremark is committed to providing a clinically appropriate formulary.
- Decisions on formulary are made by a committee of independent, unaffiliated clinical pharmacists and physicians.
- The physician always makes the ultimate prescribing determination as to the most appropriate course of therapy.

The CVS Caremark formulary development process is based on nearly two decades of experience as well as extensive clinical pharmaceutical management resources. The formulary is developed and managed through the activities of the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee and Formulary Review Committee.

CVS Caremark National Pharmacy and Therapeutics Committee

The CVS Caremark National P&T Committee is foundational in the process. The P&T Committee is an external advisory body of experts from across the United States, composed of 21 independent health care professionals including 17 physicians and four pharmacists, all of whom have broad clinical backgrounds and/or academic expertise regarding prescription drugs. A majority of the CVS Caremark National P&T Committee members are actively practicing pharmacists and physicians. Two physicians and two pharmacists are experts in the care of the elderly or disabled. One of the physicians is a medical ethicist. The role of the medical ethicist is to assist in the decision-making process by facilitating the discussion, as needed, and to provide unbiased feedback with respect to the logic and appropriateness of the conclusions drawn and the decisions reached. The composition of the CVS Caremark National P&T Committee exceeds the Centers for Medicare and Medicaid Services (CMS) P&T committee requirements for Medicare Part D sponsors and also exceeds URAC standards.

CVS Caremark National Pharmacy and Therapeutics Committee Membership		
4 pharmacists, including	17 physicians, representing	
1 academic pharmacist	Allergy	Internal medicine
1 hospital pharmacist	Cardiology	Infectious disease
2 geriatric pharmacists	Clinical pharmacology	Pediatrics
	Endocrinology	Neurology
	Family practice	Medical ethics
	Gastroenterology	Pharmacoeconomics
	Gerontology	Pharmacology
	Hematology/oncology	Psychiatry-adult/ pediatric/adolescent
		Rheumatology

The regular voting members on the CVS Caremark National P&T Committee are not employees of CVS Caremark. The CVS Caremark National P&T Committee is charged with reviewing all drugs, including generics that are represented on the CVS Caremark approved drug lists. The approvals made are non-biased, quality driven and evidence based. The clinical merit of the drug, not the cost, is the primary consideration of the CVS Caremark National P&T Committee.

New members are included on the current CVS Caremark National P&T Committee on the basis of: active involvement in clinical practice (patient care), whether in the academic, hospital, or community setting; national recognition in their specialty; contributions to medical and/or pharmacy literature; and previous experience with pharmacy and therapeutics committees. The CVS Caremark National P&T Committee members are compensated for their participation with an appropriate honorarium and any travel/hotel expenses incurred in the process of serving on the P&T Committee.

The CVS Caremark National P&T Committee meets face-to-face on a quarterly basis and, as needed, on an ad hoc basis. CVS Caremark has a stringent conflict of interest policy for CVS Caremark P&T Committee members. CVS Caremark requires each P&T Committee member to complete a Conflict of Interest Disclosure Statement annually. Completed Conflict of Interest Statements are carefully scrutinized by the CVS Caremark Chief Health Officer and Vice President of Clinical Affairs responsible for formulary development and maintenance. An objective party in the CVS Caremark Compliance Department verifies that conflict of interest requirements have been met. Through this careful review, CVS Caremark helps ensure that the P&T Committee meets or exceeds all federal and state regulatory requirements for conflict of interest, including CMS, and all industry accreditation standards, including URAC and the National Committee for Quality Assurance (NCQA).

Clinical Formulary Department

The CVS Caremark National P&T Committee functions are supported by the CVS Caremark Clinical Formulary Department. Clinical pharmacists in the Formulary Department prepare individual Drug Monographs and Therapeutic Class Reviews following a comprehensive review of available clinical literature. Numerous references and information resources are used to assist in the evaluation and review of the medications under consideration for formulary addition. These peer-reviewed resources are selected based on being accurate, reliable, current, comprehensive and well respected.

Formulary Development and Maintenance Process

The CVS Caremark National P&T Committee bases decisions on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information. The CVS Caremark P&T Committee reviews medications from a purely clinical perspective; it does not have access to nor does it consider any information on rebates, negotiated discounts or net costs. In alignment with this clinical perspective, the CVS Caremark National P&T Committee also reviews new drug evaluations, new FDA-approved indications, new clinical line extensions and publications on new clinical practice trends.

In evaluating new drugs for formulary inclusion, the CVS Caremark P&T Committee reviews the individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews prepared by the Clinical Formulary Department. CVS Caremark National P&T Committee members share insights based on their clinical practice and the quality of published literature. FDA-approved drugs products¹ are reviewed and considered for inclusion on the CVS Caremark National Formulary and standard formularies/drug lists by the CVS Caremark National P&T Committee. The CVS Caremark National P&T Committee also reviews and approves all utilization management (UM) criteria (i.e., prior authorization, step therapy and quantity limits outside of FDA-approved labeling).

The CVS Caremark National P&T Committee reviews all standard formularies annually. The review is conducted by drug class to assure that the formulary recommendations previously established are maintained and to recommend additional changes for clinical appropriateness if advisable based on newly available pharmaceutical information. In addition, the CVS Caremark National P&T Committee reviews all UM criteria annually.

Review of new drugs or new indications for drugs in six classes is expedited. These classes include the immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals and antineoplastics. For drugs in these classes, the CVS Caremark National P&T Committee makes a National Formulary and Medicare Part D Drug List status decision within 90 days of launch/ market availability. For drugs outside of these classes, the CVS Caremark National P&T Committee makes a National Formulary decision within 90 days of launch/market availability and a Medicare Part D Drug List status decision within 180 days of launch/market availability. In addition, the CVS Caremark National P&T Committee will make a formulary status decision for the Managed Medicaid Drug List within 90 days of launch/market availability of newly FDA-approved drugs, or will provide a clinical justification if this timeframe is not met.

Formulary Review Committee

The Formulary Review Committee (FRC) is an internal CVS Caremark committee that evaluates additional factors that may affect the formulary. For example, when two or more drugs produce similar clinical results, the FRC may evaluate factors such as:

- Utilization trends
- Impact of generic drugs or drugs designated to become available over-the-counter
- Brand and generic pipeline
- Line of business
- Plan sponsor cost
- Applicable manufacturer agreement
- Potential impact on members

The FRC makes business recommendations based on such factors to the CVS Caremark P&T Committee. It is important to note that any drug product must first be deemed safe and effective by the P&T Committee before it is considered eligible for inclusion on a CVS Caremark Formulary or Drug List, and that any recommendations made by the FRC must be approved by the CVS Caremark National P&T Committee before implementation.

Formulary Management

The formulary is a dynamic tool that may be responsive to changes in the marketplace. It is intended to offer savings to clients while ensuring clinically appropriate products are available for members to use. Clients may choose to utilize CVS Caremark formularies for their plans or use them as the foundation for custom formularies.

Most drug classes have multiple generic and low-cost brand-name options that cover the same indications as more costly brand-name options in the same class. The generic and low-cost brand-name options offer similar efficacy and safety. Since many brand-name drugs do not provide clear clinical and/or financial advantages when compared to available drug options within the therapeutic class, several strategies are available to promote cost-effective use of medications ranging from tiered copayments, excluding products from coverage or having a closed plan design.

- Tiered copayments encourage members to use preferred formulary drugs. A three-tier formulary—typically with generics in the first, lowest cost tier; preferred brand-name drugs at second tier; and non-preferred brand-name drugs at the highest-cost third tier—is the option chosen by the vast majority of plan sponsors working with CVS Caremark.
- Many of our standard formularies also exclude certain products from coverage. The excluded products have alternatives available that will deliver cost savings to plan sponsors.
- Closed formularies will cover a set number of products and the others are not covered unless the claim goes through an override process.

Within these plan designs, clients may opt to implement a formulary exception process where members, after meeting certain criteria, could have an excluded product covered, or could receive a third-tier product at a second-tier copay.

All formularies include generic drugs, and generics are typically in the lowest tier of pricing for members. Brand-name products may be considered preferred or non-preferred in the common three-tier plan design. Preferred brand-name drugs are encouraged with a lower copay than non-preferred brand-name products.

Formulary Compliance

Plan design, as noted above, is primary in achieving formulary compliance. CVS Caremark also provides plan sponsors with a range of solutions that encourage the use of generics and preferred brand-name drugs. Many CVS Caremark clients choose a plan that requires that a cost-effective generic be used before a single-source brand in the same therapeutic class.

Promotion of generics. When an A-rated generic becomes available, it is considered preferred and proactively encouraged. At that point, significant efforts are made to transition utilization to the lower-cost generic product. Client plan design will direct the effort and can be very aggressive and only cover the generic, or be more moderate and require the member to pay the difference between the brand-name drug and the generic if the brand-name product is chosen. Some clients may no longer cover the brand-name drug if a generic is available.

Member-directed formulary education. Members are notified when a new brand-name or generic product replaces a product they are using on the formulary. They are also notified if a product they are using is removed from the drug list, which could occur due to withdrawal from the market for safety reasons. If a non-preferred product has been dispensed at a retail pharmacy due to a prescription marked "Dispense As Written," the member may also be alerted via mail about alternative formulary product(s) that could be available at a lower copayment.

Members can also learn about the formulary through mailings such as the Prescriptions Savings Guide® report, which provides a personalized analysis of their prescription utilization and any opportunity they may have to save money. Such opportunities could include the use of a generic

or preferred brand-name product in place of a non-preferred product, or accessing prescriptions through the CVS Caremark Mail Service Pharmacy. The website Caremark.com, in addition to providing a simple way to order prescription refills, allows the member to access information about their specific drug list, pricing information and generic availability, as well as general drug and health information.

Improving Member Experience and Outcomes

CVS Caremark is focused on helping members achieve their health and wellness goals through proper understanding and utilization of their medications. There are a number of strategies used to support members in their desire for positive outcomes including:

- Helping them become knowledgeable about their plan, benefit structure and drug therapy management options
- Helping them understand and comply with their prescribed therapies by providing:
 - Adherence counseling with all new prescriptions (face-to-face at CVS Pharmacy® locations, by letter through mail service and retail network)
 - Refill reminders (letters, Interactive Voice Response (IVR), Internet) and non-adherent prompts (letters and phone calls)
 - Availability of automatic prescription renewals and refills
 - Information about ways to save on prescriptions by using lower-cost alternatives or lower-cost channels
- Coordinating with plan sponsors to promote enrollment in wellness and health management programs and offering appropriate and timely immunizations
- Making formularies readily available on Caremark.com.

1. All drugs that are legally marketed under the Federal Food Drug and Cosmetic Act (e.g., "grandfathered" drugs).

At CVS Health, we remain committed to helping our clients provide a comprehensive, high quality prescription benefit at a sustainable cost.

The pharmaceutical landscape today is characterized by escalating costs for existing brand drugs and new drugs coming to market at ever-higher prices. We have long recognized that formulary management is the cornerstone of cost containment and have brought innovative, effective strategies to market for many years.

That continues today. Our focus remains on developing forward-looking, industry-leading solutions to ensure our clients get the most value for the investment they are making in their prescription drug benefit.

Formulary management is the cornerstone of cost containment

Your plan is aligned with our Standard Control Formulary.

First-quarter per-member-per-month (PMPM) cost for 2017 was \$85.90 compared to \$121.12 for those aligned with a Standard Opt-Out Formulary which does not include formulary removals. Generic Dispensing Rate for Standard Control Formulary clients was 86.5 percent compared to 83.8 percent for those with Standard Opt-Out Formulary.*

Since 2012, when we introduced our industry-leading and rigorous approach to formulary management, through 2018, our formulary strategy is expected to deliver \$13.4 billion in cumulative savings to PBM clients, through inclusion of lower cost brands and transition to generics.

Q1 2017 Post-Rebate PMPM Cost

Standard Control Formulary	\$85.90
Standard Opt-Out Formulary	\$121.12



CVS Health continues to be the market leader in formulary innovation

In 2012, we were the first to remove drugs from our formulary. In 2015, we were the first to introduce new-to-market drug evaluations. Value-based management initiatives build upon that success, helping to deliver additional value for the most cost effective treatment options, while advancing health outcomes.

Transform Value: Beyond Formulary

In addition to our formulary management strategies, we are pleased to announce our new Transform Value program, which is designed to offer incremental benefit based on specific outcomes and cost cap-based management in key trend categories. Outcomes-based management aligns reimbursement for a drug to it achieving a pre-defined outcome. Cost cap-based programs establish a cost threshold based on expected utilization of a drug, for instance as a per-member-per-month cap. The program will launch with:

- **Transform Oncology Value:** This program encompasses several cancer types including breast cancer and non-small cell lung cancer. For members on a certain breast cancer drug, if a plan's average cost is above a pre-determined threshold, the manufacturer would be responsible to add value. If members on a certain non-small cell lung cancer drug progress to secondary therapy and key lab data has been obtained, the manufacturer would contribute additional pre-determined value.
- **Transform Obesity Value:** The manufacturer would be required to provide additional value if members do not achieve a minimum level of weight reduction within the initial assessment period.
- **Transform Respiratory Value:** For members on a certain chronic obstructive pulmonary disorder controller, if a greater percent of these members escalate to triple therapy compared to those on other controllers, the manufacturer would need to provide enhanced value.

Additional detail about the Transform Value program will be shared in mid-September.

Value-based management strategies can help ensure reimbursement is based on the value a drug delivers, not its sales volume or a pre-set price tag

2018 Formulary Removals

CVS Health offers a range of formulary management options that help reduce pharmacy costs for clients and members, while ensuring clinical integrity and access. In addition to expanding our value-based initiatives, effective January 1, 2018 we expect to remove 17 products from our Standard Control Formulary in 10 drug classes.

We remove drugs only when clinically-appropriate, lower-cost (often generic) alternatives are available. Our targeted approach ensures minimum member disruption. For 2018, we estimate that 99.76 percent of members will be able to stay on their current therapy.

Our proactive member and prescriber communication strategy helps members transition to clinically-appropriate medications, minimizing disruption. Every member's journey is unique and that's why we take a personalized approach to member outreach. Our communications are informed by our data analysis and predictive modeling, which enable us to concentrate our efforts where they are most needed. Our engagement strategies are grounded in research, and we know that better engagement helps improve outcomes as well as member satisfaction.

Future Updates

The autoimmune category is the leading trend driver for commercial clients, due primarily to utilization and price. Many drugs are also obtaining a growing number of supplemental indications, making careful management of this therapeutic class critical to helping payors manage the financial impact.

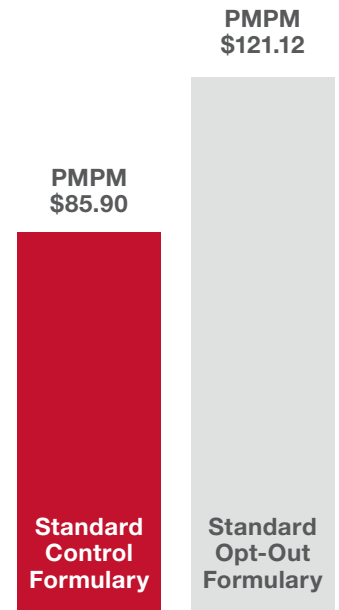
In addition, consistent with our policy, as a new specialty product launches all existing products in the class will be re-evaluated to determine appropriate formulary placement and potentially removed or added to formulary. New entrants are expected in the hepatitis C class.

We are in the process of finalizing changes for autoimmune and hepatitis C categories, which will be communicated mid-September.

Read about our [formulary strategy](#) and other pharmacy benefit news and trends, in [Insights](#).

Contact your CVS Health Account Representative to discuss our new 2018 formulary strategy and learn more about our range of formulary innovations.

*CVS Health Enterprise Analytics, 2017. Trend data based on a CVS Health commercial PBM client - employer and health plan - cohort. Data not age-adjusted. Savings and trend will vary based on a variety of factors, including demographics, plan design and programs adopted by the client. Client-specific modeling available upon request.



Well managed formularies can lower PMPM costs

2018 Standard Control Formulary Removals and Updates

These are the therapy classes with drug removals and updates for 2018. We are in the process of finalizing changes for autoimmune and hepatitis C, which will be communicated mid-September. For 2018, we estimate that 99.76 percent of members will be able to stay on their current therapy.

Class	Products
Antiandrogens	Xtandi ^P
Anticholinergics	Incruse Ellipta ^P
Dermatology Tetracycline	Doryx/Doryx MPC, Monodox
Erectile Dysfunction	Levitra ^{NP}
Fertility	Follistim
Gaucher's	Elelyso
Incretin Mimetics	Tanzeum
Migraine Injectable	Sumavel Dosepro
Multi-Source Brands	Benicar/Benicar HCT, Effexor XR, Nuvigil, Seroquel XR, Zetia
Multiple Sclerosis Agents	Avonex ^{NP} , Plegridy ^{NP}
Ophthalmic Allergies	Lastacaft ^P
Ophthalmic Prostaglandins	Lumigan ^P
Ophthalmic Steroids	FML* ^P , Pred Mild ^P
Opioid Dependence	Zubsolv ^P
PAH Endothelin Receptor Antagonists	Opsumit ^P
Post-Herpetic Neuralgia	Horizant
Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors and Combination Products	Jardiance, Synjardy/Synjardy XR, Invokana ^P , Invokamet/Invokamet XR ^P
Steroid Beta Agonists Combos	Dulera, Symbicort ^P
Transmucosal IR Fentanyl	Abstral ^{NP}
Testosterone Replacements	Androgel 1.62% ^P
Urinary Antispasmodics	Gelnique ^{NP}
Viscosupplements	Hyalgan, Synvisc/Synvisc One

* FML Forte and FML S.O.P. will be preferred. FML Ophthalmic Suspension will be non-preferred.

NP = Non Preferred drug being added back P = Preferred drug being added back

In today's dynamic marketplace, effective formulary management continues to be the cornerstone of cost containment.

On August 1, we announced our 2018 Standard Control Formulary, which included several key, targeted changes to help payors better manage costs, while ensuring plan member access to clinically appropriate therapy. To further manage costs for specialty medications, your plan has also adopted the Advanced Control Specialty Formulary™.

Today we are providing details about additional changes to several high impact therapy classes including autoimmune conditions and hepatitis C. In addition, we are providing new additions to our hyperinflation list, which will be effective January 1, 2018.

The changes to autoimmune and hepatitis C agents expand member access to preferred drugs and provide greater choice for prescribers.

Autoimmune

Autoimmune agents are used to treat conditions such as rheumatoid arthritis, ulcerative colitis, psoriasis, and Crohn's disease.

This is a dynamic therapy class with multiple new drugs coming to market. Autoimmune agents were the highest specialty trend driver inclusive of rebates in the first quarter of 2017.*

Given the high launch price, year-over-year inflation and significant trend impact of these drugs, careful management that balances patient access with cost control is critical. Our formulary placement and removal decisions for autoimmune agents are based on extensive member and prescriber experience with comparable moves across other formularies.

In addition, existing drugs are increasingly obtaining multiple supplemental indications, and the cost is the same regardless of the drugs' efficacy in treating different conditions.



In 2017, Autoimmune Agents:

- Are the **#1 driver** of specialty drug trend*
- Account for **five of the top 20** brand drug drivers of trend*
- Are expected to be **the fastest growing drug class** over the next five years¹

Effective January 1, 2018, our 2018 Advanced Control Specialty Formulary expands the indication-based approach, launched last year for psoriasis, to offer a more precise management strategy across this rapidly growing therapy class. An indication-based approach manages utilization for specific drugs used to treat particular diagnoses or conditions – and the value it delivers to an individual patient – rather than managing formulary placement at a therapy class level. Members will continue to have access to numerous preferred drug options and our clinical approach also provides continued access, when appropriate, for members currently on a given therapy.

2018 Advanced Control Specialty Formulary Changes: Autoimmune Agents

Indication	2017 Formulary Preferred Agents	2018 Formulary Preferred Agents	2018 Formulary Removals [†]
Ankylosing Spondylitis	Enbrel, Humira	Cosentyx, Enbrel, Humira	Cimzia, Simponi
Crohn's Disease	Humira	Cimzia [‡] , Humira	Entyvio, Stelara
Psoriasis	Humira, Stelara, Taltz	Humira, Stelara [‡] , Taltz [‡]	Cosentyx, Enbrel, Otezla
Psoriatic Arthritis	Enbrel, Humira	Cosentyx, Enbrel, Humira, Otezla	Cimzia, Orencia SC & IV/Orencia ClickJect, Simponi, Stelara
Rheumatoid Arthritis	Enbrel, Humira	Enbrel, Humira, Kevzara, Orencia/Orencia ClickJect (SubQ)	Actemra, Cimzia, Kineret, Orencia IV, Simponi, Xeljanz/XR
Ulcerative Colitis	Humira	Humira, Simponi [‡]	Entyvio
All Other	Enbrel, Humira	Enbrel, Humira	Actemra, Kineret, Orencia SC & IV/Orencia ClickJect

[†] Other drugs in the auto-immune class that are not FDA-approved for the given indication would also not be covered.

[‡] After failure of Humira.

Hepatitis C

Our 2018 formulary strategy for hepatitis C is consistent with our current approach and maintains member access to several preferred therapies. Members will have expanded access to preferred hepatitis C drugs with the addition of Vosevi, which has recently been approved for previous treatment failures. Vosevi will be available as a preferred option October 1, 2017.

Hyperinflation

Although price inflation has moderated slightly, brand inflation continues to be the biggest driver of trend. Brand inflation contributed a 7.5 percentage point increase to trend for our commercial book of business in the first half of 2017.² In addition to the cost increases seen in most drugs, some branded medications see extreme – even triple-digit – price surges. In 2017, we implemented a hyperinflation management component to our Standard Control Formulary to help address such significant price inflation and help control costs for clients and their members. To date, this strategy resulted in 29 drugs being removed from our Standard Control Formulary.

We monitor and review hyperinflationary drugs and implement formulary changes on a quarterly basis to minimize the cost impact of these drugs.

Effective January 1, 2018, the following drugs will be removed from our formulary under our hyperinflation criteria**:

- Primlev (241.1% inflation)
- Sprix (796.5% inflation)
- Stendra (156.6% inflation)

Formulary management is a critical component of cost management in the rapidly evolving pharmaceutical marketplace, and we remain committed to continually innovating our strategy to help reduce pharmacy costs for clients and members, while ensuring clinical integrity and access. We remove drugs only when clinically appropriate, lower-cost (often generic) alternatives are available.

Your CVS Health Account Team will be contacting you to discuss our 2018 formulary strategy and provide more information about our range of formulary innovations.

*Based on CVS Caremark commercial book-of-business data

**Hyperinflation percentages reflect three year inflation rates

Sources:

1. <https://www.fool.com/investing/2016/12/10/the-3-fastest-growing-drug-classes-over-the-next-5.aspx>
2. CVS Health Enterprise Analytics, 2017.

2018 Advanced Control Specialty Formulary Removals and Updates

Class	Products
Antiandrogens	XTANDI ^P
Antilipemics, PCSK9 Inhibitors	PRALUENT ^P
Antivirals, Hepatitis C	MAVYRET ^R
Autoimmune Agents	REMICADE ^P
Calcium Regulators, Miscellaneous	PROLIA ^P
Crohn's Disease & Ulcerative Colitis	ENTYVIO ^R
Fertility Regulators, Follicle-Stimulating Hormone	FOLLISTIM AQ ^R , GONAL-F ^P
Gaucher Disease	ELELYSO ^R
Hematopoietic Growth Factors	PROCRIT ^P
Multiple Sclerosis	AVONEX ^{NP} , PLEGRIDY ^{NP}
Osteoarthritis, Viscosupplements	HYALGAN ^R
Pulmonary Arterial Hypertension, Endothelin Receptor Antagonists	OPSUMIT ^P

NP = Non Preferred drug being added back P = Preferred drug being added back R = Removal

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Drug Guide and Clinical Program Updates

The CVS Caremark National Pharmacy and Therapeutics Committee in association with the CVS Caremark Formulary Review Committee (FRC) have proposed the following updates to the North Carolina State Health Plan's Comprehensive Formulary and clinical program changes to select medications to be effective January 1, 2018 (unless otherwise noted).

The following drugs may have coverage changes that affect what a member will be required to pay at the time of purchase. Members will receive a letter if they are negatively affected by a formulary change 30 days prior to the effective date of the change.

Advanced Control Specialty Formulary Exclusions – Effective January 1, 2018

Therapeutic Category	Drug Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Endocrine and Metabolic/ Gaucher Disease	ELELYSO VIAL 200 UNIT (taliglucerase alfa) for injection	Tier 3--> Not Covered/ ACSF	Availability of additional options for the treatment of Gaucher disease. Preferred options include Cerdelga (eliglustat), Cerezyme (imiglucerase).	Not Covered	0
Immunologic Agents/ Autoimmune Agents	ENTYVIO VIAL 300 MG (vedolizumab) for injection	Tier 3--> Not Covered/ ACSF	Availability of additional options for the treatment of ulcerative colitis (UC) and Crohn's disease (CD). Preferred options include: • Cimzia (certolizumab) – Crohn's disease (CD), after failure of Humira (adalimumab) • Humira • Simponi (golimumab) – ulcerative colitis (UC), after failure of Humira (adalimumab)	Not Covered	10
Anti-Infectives/ Hepatitis Agents/ Hepatitis C	MAVYRET TAB 100-40MG (glecaprevir/pibrentasvir)	NTM block--> Not Covered/ ACSF	Availability of additional options for the treatment of hepatitis C virus (HCV) infection. Preferred options include Harvoni and Eplclusa.	Not Covered	1
Immunologic Agents/ Autoimmune Agents	XELJANZ XR TAB 11MG	NTM block--> Not Covered/ ACSF	Availability of additional options for the treatment of rheumatoid arthritis (RA). Preferred options include Enbrel (etanercept), Humira (adalimumab), Kevzara (sarilumab), Orencia SC (abatacept), and Orencia ClickJect (abatacept).	Not Covered	97

NOTE: A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug.

Hyperinflation Exclusions – Effective January 1, 2018

Therapeutic Category	Drug Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Analgesics/ Opioid Analgesics	PRIMLEV (oxycodone/acetaminophen) available in 5/300, 7.5/300 & 10/300 mg	Tier 3 --> Not Covered	241.1% price inflation over 3 years. Availability of additional options for the relief of moderate to moderately severe pain. Preferred options include hydrocodone-acetaminophen, hydromorphone, morphine, oxycodone-acetaminophen, and Nucynta (tapentadol).	Not Covered	0
Analgesics/ Nonsteroidal Anti-inflammatory Agents (NSAIDs)	SPRIX SPRAY 15.75 MG (ketorolac tromethamine)	Tier 3 --> Not Covered	796.5% price inflation over 3 years. Availability of a generic option (oral) for the relief of moderate to moderately severe pain. Preferred options include includes diclofenac sodium, meloxicam, and naproxen.	Not Covered	123

NOTE: A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug.

On August 1, 2017 CVS announced their 2018 Standard Control Formulary Exclusions, which only included non-specialty medications and was reviewed during the August P&T Meeting. On September 29, 2017 CVS announced the remainder of their formulary exclusions which included specialty and hyperinflation removals.

Key Points:

- Low utilization due to current non-preferred tier or non-formulary tier status
- Several preferred alternative treatment options for each excluded product
- Exception process available for members failing alternative treatment options
- STENDRA (avanafil) tablets were not included in the analysis as the Plan does not offer a benefit for the treatment of erectile dysfunction.

On October 1, 2017 CVS announced the remainder of their updates to the 2018 Standard Control and Advanced Control Specialty Formularies. Changes to the formularies include tier changes and the addition of drug products, either from the removal of a New-to-Market block or change in their 2017 excluded status.

Key Points:

- Members will receive a letter if they are negatively affected by a formulary change 30 days prior to the effective date of the change
- Members cannot appeal a drug's tier placement
- Many of the tier changes are the result of the generic availability of the branded product, and all but one drug (TRELSTAR) have a comparable generic therapy alternative
- The Plan does not have a Dispense as Written (DAW) Penalty enacted at this time

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Uptiers (Negative Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Topical/ Ophthalmic/ Anti-Inflammatories/ Steroidal	ALREX SUSPENSION 0.2% (loteprednol etabonate)	2--> 3	Availability of additional options for relief of signs and symptoms of seasonal allergic conjunctivitis. Preferred options include azelastine, cromolyn sodium, olopatadine, Lastacaft (alcaftadine), and Pazeo (olopatadine).	3	391
Endocrine and Metabolic/ Calcium Regulators/ Bisphosphonates	ATELVIA 4PK TAB 35MG DR (risedronate sodium)	2--> 3	Availability of a generic option for the treatment of Paget disease and osteoporosis. Preferred options include generic alendronate, ibandronate, risedronate.	3	4
Endocrine and Metabolic/ Androgens	AXIRON SOL 30 MG/ACT (testosterone)	2--> 3	Availability of a generic option for the treatment of hypogonadism. Preferred options include generic testosterone 2% gel, testosterone soln, or preferred brands Androderm (testosterone), AndroGel 1.62% (testosterone).	3	597
Cardiovascular/ Angiotensin II Receptor Antagonist/ Calcium Channel Blocker Combinations	AZOR TAB (amlodipine/olmesartan) <i>available in 5/20, 10/20, 5/40, & 10/40 mg</i>	2--> 3	Availability of a generic option for the treatment of hypertension. Preferred options include generic amlodipine-olmesartan, amlodipine-telmisartan, amlodipine-valsartan.	3	231
Genitourinary/ Benign Prostatic Hyperplasia	CARDURA XL TAB (doxazosin mesylate) <i>available in 4 & 8 mg</i>	2--> 3	Availability of additional options for treatment of BPH. Preferred options include alfuzosin ext-rel, doxazosin, tamsulosin, terazosin, and Rapaflo (silodosin).	3	7
Topical/ Dermatology/ Corticosteroids/ Medium Potency	CLODERM CREAM 0.1% (clocortolone pivalate)	2--> 3	Availability of a generic option for the treatment of anal and genital itching, dermatoses, hemorrhoids, ulcerative colitis. Preferred options include generic hydrocortisone butyrate, mometasone, triamcinolone.	3	21

Uptiers (Negative Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Topical/ Ophthalmic/ Carbonic Anhydrase Inhibitor/Beta-Blocker Combinations	COSOPT P-F SOLUTION (dorzolamide/timolol)	2--> 3	Availability of a generic option for the treatment of elevated intraocular pressure. Preferred options include generic dorzolamide-timolol.	3	74
Hematologic/ Platelet Aggregation Inhibitors	EFFIENT (prasugrel) <i>available in 5 & 10 mg</i>	2--> 3	Availability of a generic option for the prevention of thrombotic cardiovascular events in patients with ACS. Preferred options include generic prasugrel, clopidogrel or preferred brand Brilinta (ticagrelor).	3	510
Topical/ Dermatology/ Corticosteroids/ Medium Potency	LOCOID (hydrocortisone) (all strengths & dosage forms)	2--> 3	Availability of a generic option for the treatment of anal and genital itching, dermatoses, hemorrhoids, ulcerative colitis. Preferred options include clocortolone, hydrocortisone butyrate, mometasone, and triamcinolone.	3	32
Topical/ Ophthalmic/ Anti-Inflammatories/ Steroidal	LOTEMAX SUSP 0.5% (loteprednol etabonate)	2--> 3	Availability of additional anti-inflammatory options for relief of signs and symptoms of seasonal allergic conjunctivitis and treatment of postoperative ocular inflammation and pain. Preferred options include dexamethasone, prednisolone acetate 1%, Durezol (difluprednate), Flarex (fluorometholone), FML Forte (fluorometholone), FML S.O.P (fluorometholone), Maxidex (dexamethasone), and Pred Mild (prednisolone acetate).	3	1853
Endocrine and Metabolic/ Progestins/ Oral	MEGACE ES SUSP 625/5ML (megestrol acetate)	2--> 3	Availability of a generic option for the treatment of anorexia, cachexia, or unexplained significant weight loss in patients with AIDS. Preferred options include generic megestrol.	3	0

Uptiers (Negative Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Cardiovascular/ Nitrates	NITROLINGUAL PUMP 0.4/DOSE (nitroglycerin)	2--> 3	Availability of a generic option for the treatment or prevention of angina. Preferred options include generic nitroglycerin lingual spray, nitroglycerin sublingual.	3	5
Topical/ Ophthalmic/ Antiallergics	PATADAY SOLUTION 0.2% (olopatadine)	2--> 3	Availability of generic options for the treatment of ocular itching associated with allergic conjunctivitis. Preferred options include generic azelastine, cromolyn sodium, olopatadine, or preferred brands Lastacast (alcaftadine), Pazeo (olopatadine).	3	1081
Central Nervous System/ Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)	PRISIQ TAB (desvenlafaxine) <i>available in 25, 50 & 100 mg</i>	2--> 3	Availability of generic options for the treatment of depression. Preferred options include desvenlafaxine ext-rel, duloxetine, venlafaxine, and venlafaxine ext-rel capsule.	3	1119
Topical/ Ophthalmic/ Anti-Inflammatories/ Nonsteroidal	PROLENSA SOL 0.07% (bromfenac)	2--> 3	Availability of additional anti-inflammatory options for treatment of postoperative ocular inflammation and pain. Preferred options include generic bromfenac, diclofenac, ketorolac, or preferred brands Acuvail (ketorolac), Ilevro (nepafenac), Nevanac (nepafenac).	3	629
Central Nervous System/ Migraine/ Selective Serotonin Agonists	RELPAK (eletriptan HBr) <i>available in 20 & 40 mg</i>	2--> 3	Availability of additional options for the acute treatment of migraines. Preferred options include eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan, Onzetra Xsail (sumatriptan), Zembrace Symtouch (sumatriptan), and Zomig nasal spray (zolmitriptan).	3	1279

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Uptiers (Negative Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Central Nervous System/ Attention Deficit Hyperactivity Disorder	STRATTERA (atomoxetine) <i>available in 10, 18, 25, 40, 60, 80 & 100 mg</i>	2--> 3	Availability of other options for the treatment of ADHD. Preferred options include amphetamine-dextroamphetamine mixed salts ext-rel, atomoxetine, guanfacine ext-rel, methylphenidate ext-rel, Aptensio XR (methylphenidate), Quillivant XR (methylphenidate), and Vyvanse (lisdexamfetamine).	3	731
Antineoplastic Agents/ Hormonal Antineoplastic Agents/ Luteinizing Hormone-Releasing Hormone (LHRH) Agonists	TRELSTAR (triptorelin pamoate) <i>available in 3.75, 11.25, & 22.5 mg</i>	Tier 2-> Tier 3/ ACSF	Availability of additional options for palliative treatment of advanced prostate cancer. Preferred options include Eligard, Lupron Depot, and Zoladex.	6	1
Angiotensin II Receptor Antagonist/Calcium Channel Blocker/ Diuretic Combinations	TRIBENZOR (olmesartan/amlopidine/hydrochlorothiazide) <i>available in 20/5/12.5, 40/5/12.5, 40/5/25, 40/10/12.5 & 40/10/25 mg</i>	2--> 3	Availability of a generic option for the treatment of hypertension. A preferred option is generic olmesartan-amlopidine-hydrochlorothiazide.	3	344
Endocrine and Metabolic/ Contraceptives/ Estrogens/ Vaginal	VAGIFEM TAB 10 MCG (estradiol)	2--> 3	Availability of additional options for treatment of vulvar and vaginal atrophy associated with menopause. Preferred options include estradiol, Estrace (estradiol) cream, Premarin (conjugated estrogens) cream.	3	234
Topical/ Ophthalmic/ Anti-Infectives	VIGAMOX SOL 0.5% (moxifloxacin)	2--> 3	Availability of other options for the treatment of bacterial conjunctivitis. Preferred options include generic ciprofloxacin, erythromycin, gentamycin, levofloxacin, moxifloxacin, ofloxacin, sulfacetamide, tobramycin, or preferred brands Besivance (besifloxacin), Ciloxan (ciprofloxacin) oint, Moxeza (moxifloxacin).	3	1456

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Uptiers (Negative Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Alternatives	Proposed NC Status/Tier	# Utilizers (YT)
Cardiovascular/ Antilipemics/ HMG-CoA Reductase Inhibitors/ Combinations	VYTORIN (ezetimibe/simvastatin) available in 10/10, 10/20, 10/40 & 10/80 mg	2--> 3	Availability of a generic option for the treatment of hyperlipidemia and homozygous familial hypercholesterolemia. Preferred options include generic atorvastatin, ezetimibe-simvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin.	3	747
Topical/ Ophthalmic/ Prostaglandins	ZIOPTAN SOL 0.0015% (tafluprost)	2--> 3	Availability of additional options for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension. Preferred options include generic latanoprost or preferred brands Lumigan (bimatoprost), and Travatan Z (travoprost).	3	131

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Add Backs to Formulary – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Additional Information	Proposed NC Status/Tier	# Utilizers (YT)
Endocrine & Metabolic/ Ovulation Stimulants, Gonadotropins	GONAL-F (follitropin alfa)	Excluded- > Tier 2/ ACSF		5	6
Cardiovascular/ Antilipemics/ PCSK9 Inhibitors	PRALUENT (alirocumab) available in 75 & 150 mg/mL	Excluded- > Tier 2/ ACSF		5	42
Hematologic/ Hematopoietic Growth Factors	PROCRIT (epoetin alfa) available in 2000, 3000, 4000, 10000, 20000 & 40000 U/mL	Excluded- > Tier 2/ ACSF		5	8
Endocrine & Metabolic/ Calcium Regulators/ Miscellaneous	PROLIA 60 MG/ML (denosumab)	Excluded- > Tier 2/ ACSF		5	52
Immunologic Agents/ Autoimmune Agents	REMICADE 100 MG (vedolizumab)	Excluded- > Tier 2/ ACSF		5	12
Immunologic Agents/ Autoimmune Agents	CIMZIA (certolizumab) available in 200 & 400 mg	Excluded- > Tier 2/ ACSF		5	104
Immunologic Agents/ Autoimmune Agents	COSENTYX (secukinumab)	Excluded- > Tier 2/ ACSF		5	151
Immunologic Agents/ Autoimmune Agents	ORENCIA (abatacept)	Excluded- > Tier 2/ ACSF		5	95
Immunologic Agents/ Autoimmune Agents	OTEZLA (apremilast)	Excluded- > Tier 2/ ACSF		5	245
Immunologic Agents/ Autoimmune Agents	SIMPONI (golimumab)	Excluded- > Tier 2/ ACSF		5	67

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New-to-Market Block Removals – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Additional Information	Proposed NC Status/Tier	# Utilizers (YT)
Immunologic Agents/ Autoimmune Agents	ORENCIA CLCK 125 MG/ML (abatacept)	NTM block-> Tier 2/ ACSF	Self-injectable device	5	0
Anti-Infectives/ Hepatitis Agents/ Hepatitis C	VOSEVI TAB (sofosbuvir/velpatasvir/voxilaprevir)	NTM block-> Tier 2/ ACSF	First single tab salvage	5	1
Analgesics/ Viscosupplements	GELSYN-3 SYR 16.8 MG/2ML (hyaluronic acid)	NTM block-> Tier 2/ ACSF	Biofermentative HA	5	0
Immunologic Agents/ Autoimmune Agents	KEVZARA (sarilumab) available in 150 & 200 mg	NTM block-> Tier 2/ ACSF		5	4
Antineoplastic Agents/ Kinase Inhibitors	KISQALI (ribociclib)	NTM block-> Tier 2/ ACSF		5	3
Respiratory/ Anticholinergic/Beta Agonist Combinations/ Long Acting	STIOLTO RESP INH 2.5-2.5 (tiotropium bromide/olodaterol)	NTM block--> 2	Anoro/Bevespi competitor	2	48
Endocrine and Metabolic/ Antidiabetics/ Insulin-Incretin Mimetic Combinations	XULTOPHY PEN 100/3.6 (insulin degludec/liraglutide)	NTM block--> 3	Soliqua competitor	3	
Antineoplastic Agents/ Antineoplastic Combinations	RITUXAN HYCELA INJ (rituximab/hyaluronidase human) available in 1400/23400 & 1600/26800 mg/units	NTM block-> Tier 3/ ACSF	Subcutaneous form	6	
Hematologic Agents/ Complement Inhibitors	HAEGARDA VIAL (C1 esterase inhibitor human) available in 2000 & 3000 units	NTM block-> Tier 3/ ACSF	First subq tx for HAE	6	
Antineoplastic Agents/ Antineoplastic - Antibodies	BESPONSA INJ 0.9MG (inotuzumab ozogamicin)	NTM block-> Tier 3/ ACSF		6	

Formulary Update

November 2017

New-to-Market Block Removals – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Additional Information	Proposed NC Status/Tier	# Utilizers (YT)
Antineoplastic Agents/ Antineoplastic Enzyme Inhibitors	LYNPARZA TAB (olaparib) available in 100 & 150 mg	NTM block-> Tier 3/ ACSF	New tablet formulation	6	
Ophthalmics - Misc.	JETREA INJ 1.25/ML (ocriplasmin)	NTM block-> Tier 3/ ACSF		6	
Endocrine and Metabolic/ Progestins	MAKENA PF VIA 250MG/ML (hydroxyprogesterone caproate)	NTM block-> Tier 3/ ACSF		6	
Antineoplastic Agents/ Kinase Inhibitors	KISQALI FEMARA COPAK (ribociclib/letrozole) available as 200/2.5 mg	NTM block-> Tier 3/ ACSF		6	
Vitamins/ Prenatal Vitamins	CITRANATAL TAB BLOOM (iron, folic acid, cyanocobalamin, ascorbic acid, docusate sodium)	NTM block--> 2		2	
Hematopoietic Agents/ Sickle Cell Anemia Agents	ENDARI POW 5 GM (L-glutamine)	NTM block-> Tier 3/ ACSF		6	
Endocrine and Metabolic/ Miscellaneous	NITYR TAB (nitisinone) available as 2, 5 & 10 mg	NTM block-> Tier 3/ ACSF		6	
Hematologic Agents/ Antihemophilic Products	FEIBA INJ (anti-inhibitor coagulant complex)	NTM block-> Tier 3/ ACSF		6	
Antineoplastic Agents/ Kinase Inhibitors	ALECENSA CAP 150MG (alecensa)	NTM block-> Tier 3/ ACSF		6	
Central Nervous System/ Huntington's Disease	AUSTEDO TAB (deutetrabenazine) available as 6, 9 & 12 mg	NTM block-> Tier 3/ ACSF		6	
Immunologic Agents/ Autoimmune Agents	ENBREL MINI INJ 50MG/ML (etanercept)	NTM block-> Tier 2/ ACSF	Single-dose prefilled cartridge	5	

Formulary Update
November 2017



Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

New-to-Market Block Removals – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Additional Information	Proposed NC Status/Tier	# Utilizers (YT)
Anti-Infectives/ Antibacterials/ Fluoroquinolones	BAXDELA (delafloxacin) available in 450 mg tabs & 300 mg injection	NTM block-> Tier 3		3	
Anti-Infectives/ Antibacterials/ Carbapenems	VABOMERE INJ 2 GM (meropenem & vaborbactam)	NTM block-> Tier 3		3	

Formulary Update

November 2017

Downtiers (Positive Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Additional Information	Proposed NC Status/Tier	# Utilizers (YT)
Topical/ Ophthalmic/ Anti-inflammatory/ Nonsteroidal	ACUVAIL(30) SOL 0.45% (ketorolac tromethamine)	3--> 2		2	2
Analgesics/ Opioid Analgesics	BELBUCA FILM (buprenorphine) available in 75, 150, 300, 450, 600, 750 & 900 mcg	3--> 2		2	34
Endocrine & Metabolic/ Gaucher Disease	CERDELGA CAP 84MG (eliglustat)	NTM block-> Tier 2/ ACSF		5	1
Endocrine & Metabolic/ Gaucher Disease	CEREZYME VIA 400U (imiglucerase)	Tier 3-> Tier 2/ ACSF		5	0
Topical/ Ophthalmic/ Anti- Infectives	CILOXAN OINT 0.3% (ciprofloxacin)	3--> 2		2	16
Antineoplastic Agents/ Hormonal Antineoplastic Agents/ Luteinizing Hormone- Releasing Hormone (LHRH) Agonists	ELIGARD (leuprolide) available in 7.5, 22.5, 30 & 45 mg)	Tier 3-> Tier 2/ ACSF		5	0
Topical/ Ophthalmic/ Anti- inflammatories/ Steroidal	FLAREX SUS 0.1% (fluorometholone)	3--> 2		2	4
Antineoplastic Agents/ Kinase Inhibitors	IBRANCE (palbociclib) available in 75, 125 & 125 mg	Tier 3-> Tier 2/ ACSF		5	77
Topical/ Ophthalmic/ Anti- inflammatories/ Nonsteroidal	ILEVRO DRO 0.3% (nepafenac)	3--> 2		2	541
Antineoplastic Agents/ Kinase Inhibitors	IRESSA TAB 250MG (gefitinib)	Tier 3-> Tier 2/ ACSF		5	1

Formulary Update

November 2017



Downtiers (Positive Tier Changes) – Effective January 1, 2018

Therapeutic Category	Brand Name	CVS Status Change	Additional Information	Proposed NC Status/Tier	# Utilizers (YT)
Topical/ Ophthalmic/ Anti-inflammatory/ Steroidal	MAXIDEX SUS 0.1% (dexamethasone)	3--> 2		2	5
Topical/ Ophthalmic/ Anti-inflammatory/ Nonsteroidal	NEVANAC SUS 0.1% (nepafenac)	3--> 2		2	8
Antineoplastic Agents/ Kinase Inhibitors	RYDAPT CAP 25MG (midostaurin)	Tier 3-> Tier 2/ ACSF	In effect Oct 1, 2017	5	1
Immunologic Agents/ Autoimmune Agents	SIMPONI ARIA SOL 50MG/4ML (golimumab)	Tier 3-> Tier 2/ ACSF		5	67
Endocrine & Metabolic/ Parathyroid Hormones	TYMLOS 3120 PEN 1.56ML (teriparatide)	Tier 3-> Tier 2/ ACSF		5	3
Central Nervous System/ Multiple Sclerosis Agents	TYSABRI VIA 300/15ML (natalizumab)	Tier 3-> Tier 2/ ACSF		5	11
Cardiovascular/ Pulmonary Arterial Hypertension/ Prostacyclin Receptor Agonists	UPTRAVI (selexipag)	Tier 3-> Tier 2/ ACSF		5	5
Analgesics/ Viscosupplements	VISCO-3 INJ 25/2.5ML (sodium hyaluronate)	Tier 2/ ACSF		5	0
Central Nervous System/ Antipsychotics/ Atypicals	VRAYLAR (cariprazine) available in 1.5, 3, 4.5 & 6 mg)	3--> 2		2	80

BESPONSA™

(inotuzumab ozogamicin) injection for IV infusion

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2018 Formulary
Proposed Tier Placement	Tier 6 – non-preferred specialty
Formulary Alternatives	BLINCYTO (blinatumomab)
FDA Approval	August 17, 2017 – Breakthrough Therapy & Priority Review
Therapeutic Class	Antineoplastic agent; monoclonal antibody; CD22-directed antibody-drug conjugate (ADC)
Indications and Usage	Treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)
Dosing	<p><u>Forms & Strengths:</u> 0.9 mg lyophilized powder in a single-dose vial for reconstitution and further dilution.</p> <p><u>Administration:</u> pre-med with corticosteroid, antipyretic, and antihistamine prior to all infusions. Minimum of 6 days in between doses, dose based on body surface area.</p> <p><u>Adjustments:</u> based on absolute neutrophil count, platelet count, liver function, infusion reaction or other non-hematologic toxicity greater or equal to Grade 2.</p>
Safety	<p><u>Contraindications:</u> None</p> <p><u>Warnings:</u> Myelosuppression; Infusion related reactions; QT interval prolongation (ECGs at baseline); Embryo-fetal toxicity</p> <p><u>Adverse Reactions:</u> (\geq thrombocytopenia, neutropenia, infection, anemia, leukopenia fatigue, hemorrhage, pyrexia, nausea, headache, febrile neutropenia, transaminases increased, abdominal pain, gamma-glutamyltransferase increased, and hyperbilirubinemia.</p>
Key Points	The first and only antibody drug conjugate (ADC) available for this type of leukemia. This indication includes treatment of adults with Philadelphia chromosome positive (Ph+) as well as Philadelphia chromosome negative (Ph-) relapsed or refractory B-cell precursor ALL. Adults with Ph+ relapsed or refractory CD22-positive B-cell precursor ALL should have failed treatment with at least one tyrosine kinase inhibitor (TKI).
Treatment Guidelines	<i>Induction phase:</i> vincristine, dexamethasone or prednisone, & doxorubicin, daunorubicin, or similar anthracycline drug. <i>Consolidation phase:</i> same drugs, possibly imatinib if Ph+, or stem cell transplant if high risk of relapse. <i>Maintenance phase:</i> methotrexate & 6-mercaptopurine +/- vincristine & prednisone, imatinib if Ph+.
Place in Therapy	Adds an additional treatment option for patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use **BESPONSA™** safely and effectively. See full prescribing information for **BESPONSA**.

BESPONSA (inotuzumab ozogamicin) for injection, for intravenous use
Initial U.S. Approval: 2017

<p>WARNING: HEPATOTOXICITY, INCLUDING HEPATIC VENO-OCCLUSIVE DISEASE (VOD) (ALSO KNOWN AS SINUSOIDAL OBSTRUCTION SYNDROME and INCREASED RISK OF POST-HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) NON-RELAPSE MORTALITY</p> <p><i>See full prescribing information for complete boxed warning.</i></p> <ul style="list-style-type: none"> • Hepatotoxicity, including fatal and life-threatening VOD occurred in patients who received BESPONSA. (5.1) • A higher post-HSCT non-relapse mortality rate occurred in patients receiving BESPONSA (5.2)
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----- **INDICATIONS AND USAGE** -----
BESPONSA is a CD22-directed antibody-drug conjugate (ADC) indicated for the treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL). (1)

----- **DOSAGE AND ADMINISTRATION** -----
• Pre-medicate with a corticosteroid, antipyretic, and antihistamine prior to all infusions. (2.2)
• Dosing regimens for Cycle 1 and subsequent cycles, depending on the response to treatment, are shown below. See full prescribing information for dosing details. (2)

	Day 1	Day 8	Day 15
Dosing regimen for Cycle 1			
All patients:			
Dose	0.8 mg/m ²	0.5 mg/m ²	0.5 mg/m ²
Cycle length	21 days ^a		
Dosing regimen for subsequent cycles depending on response to treatment			
Patients who have achieved a CR or CRi:			
Dose	0.5 mg/m ²	0.5 mg/m ²	0.5 mg/m ²
Cycle length	28 days		
Patients who have not achieved a CR or CRi:			
Dose	0.8 mg/m ²	0.5 mg/m ²	0.5 mg/m ²
Cycle length	28 days		

^a For patients who achieve a CR or a CRi, and/or to allow for recovery from toxicity, the cycle length may be extended up to 28 days (i.e., 7-day treatment-free interval starting on Day 21).

- See full prescribing information for instructions on reconstitution of lyophilized powder, and preparation and administration of reconstituted drug. (2.4)

----- **DOSAGE FORMS AND STRENGTHS** -----
For injection: 0.9 mg lyophilized powder in a single-dose vial for reconstitution and further dilution. (3)

----- **CONTRAINDICATIONS** -----
None (4)

- **WARNINGS AND PRECAUTIONS** -----
- Myelosuppression: Monitor complete blood counts; for signs and symptoms of infection; bleeding/hemorrhage; or other effects of myelosuppression during treatment; manage appropriately. (5.3)
 - Infusion related reactions: Monitor for infusion related reactions during and for at least 1 hour after infusion ends. (5.4)
 - QT interval prolongation: Obtain electrocardiograms (ECGs) and electrolytes at baseline and monitor during treatment. Monitor more frequently when using concomitant medications known to prolong QT interval. (5.5)
 - Embryo-fetal toxicity: Can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception. (5.6)

----- **ADVERSE REACTIONS** -----
The most common (≥ 20%) adverse reactions are thrombocytopenia, neutropenia, infection, anemia, leukopenia, fatigue, hemorrhage, pyrexia, nausea, headache, febrile neutropenia, transaminases increased, abdominal pain, gamma-glutamyltransferase increased, and hyperbilirubinemia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Pfizer Inc at 1-800-438-1985 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----- **USE IN SPECIFIC POPULATIONS** -----
Lactation: Advise not to breastfeed. (8.2)

See 17 for **PATIENT COUNSELING INFORMATION**.

Revised: 08/2017

SPECIALTY GUIDELINE MANAGEMENT

BESPONSA (inotuzumab ozogamicin)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Besponsa is indicated for the treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Acute lymphoblastic leukemia (ALL)

Authorization of 12 months may be granted for treatment of relapsed or refractory ALL when both of the following criteria are met:

- A. Member has B-cell precursor ALL, AND
- B. The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Besponsa [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals, Inc.; August 2017.
2. Kantarjian Hagop M, DeAngelo Daniel J., Stelljes Matthias, et al. Inotuzumab Ozogamicin versus Standard Therapy for Acute Lymphoblastic Leukemia. *N Engl J Med.* 2016; 375: 740-53.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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KISQALI®

(ribociclib) tablets, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	IBRANCE (palbociclib)
FDA Approval	March 13, 2017, Priority Review and Breakthrough therapy designation
Therapeutic Class	Antineoplastic Agent, Cyclin-Dependent Kinase Inhibitor (CDK4/6)
Indications and Usage	In combination with an aromatase inhibitor as initial endocrine-based therapy for treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer
Dosing	<p>Forms & Strengths: 200 mg tablets</p> <p>Administration: 600 mg orally (three 200 mg tablets) taken once daily with or without food for 21 consecutive days followed by 7 days off treatment</p> <p>Adjustments: Dose interruption, reduction, and/or discontinuation may be required based on individual safety and tolerability; Reduce dose to 400 mg once daily if given with a strong CYP3A inhibitor</p>
Safety	<p>Contraindications: None</p> <p>Warnings: QT Prolongation; Hepatobiliary toxicity; Neutropenia; Embryo-Fetal Toxicity</p> <p>Adverse Reactions: (≥ 20%) are neutropenia, nausea, fatigue, diarrhea, leukopenia, alopecia, vomiting, constipation, headache and back pain</p>
Key Points	Is available as a combination dose pack with FEMARA (letrozole). MONALEESA-2 trial showed a 44% reduction in risk of progression or death vs placebo + letrozole & a 12 month improvement of mPFS. (25.3 vs 16.0)
Treatment Guidelines	Postmenopausal women with metastatic, HR+ positive ABC should be offered an aromatase inhibitor +/- CDK4/6 inhibitor as first-line endocrine therapy. Combination hormone therapy with fulvestrant may be offered without prior exposure to adjuvant endocrine therapy. Exemestane and everolimus may be offered after progressing on prior treatment with non-steroidal AIs, either before or after treatment with fulvestrant.
Place in Therapy	Provides an additional treatment option for postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use KISQALI safely and effectively. See full prescribing information for KISQALI.

KISQALI® (ribociclib) tablets, for oral use

Initial U.S. Approval: 2017

INDICATIONS AND USAGE

KISQALI is a kinase inhibitor indicated in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer. (1)

DOSAGE AND ADMINISTRATION

KISQALI tablets are taken orally with or without food in combination with letrozole. (2)

- Recommended starting dose: 600 mg orally (three 200 mg tablets) taken once daily with or without food for 21 consecutive days followed by 7 days off treatment. (2.1)
- Dose interruption, reduction, and/or discontinuation may be required based on individual safety and tolerability. (2.2)

DOSAGE FORMS AND STRENGTHS

- Tablets: 200 mg (3)

CONTRAINDICATIONS

None. (4)

WARNINGS AND PRECAUTIONS

- QT interval prolongation: Monitor electrocardiograms (ECGs) and electrolytes prior to initiation of treatment with KISQALI. Repeat ECGs at approximately Day 14 of the first cycle and at the beginning of the second cycle, and as clinically indicated. Monitor electrolytes at the beginning of each cycle for 6 cycles, and as clinically indicated. (2.2, 5.1)
- Hepatobiliary toxicity: Increases in serum transaminase levels have been observed. Perform Liver Function Tests (LFTs) before initiating treatment with KISQALI. Monitor LFTs every 2 weeks for the first 2 cycles, at the beginning of each subsequent 4 cycles, and as clinically indicated. (2.2, 5.2)

- Neutropenia: Perform Complete Blood Count (CBC) before initiating therapy with KISQALI. Monitor CBC every 2 weeks for the first 2 cycles, at the beginning of each subsequent 4 cycles, and as clinically indicated. (2.2, 5.3)
- Embryo-Fetal Toxicity: Can cause fetal harm. Advise patients of potential risk to a fetus and to use effective contraception during therapy. (5.4, 8.1, 8.3)

ADVERSE REACTIONS

Most common adverse reactions (incidence $\geq 20\%$) are neutropenia, nausea, fatigue, diarrhea, leukopenia, alopecia, vomiting, constipation, headache and back pain. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Novartis Pharmaceuticals Corporation at 1-888-669-6682 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- CYP3A4 Inhibitors: Avoid concomitant use of KISQALI with strong CYP3A inhibitors. If strong inhibitors cannot be avoided, reduce KISQALI dose. (2.2, 7.1)
- CYP3A4 Inducers: Avoid concomitant use of KISQALI with strong CYP3A inducers. (7.2)
- CYP3A substrates: The dose of sensitive CYP3A substrates with narrow therapeutic indices may need to be reduced when given concurrently with KISQALI. (7.3)
- Drugs known to prolong QT interval: Avoid concomitant use of drugs known to prolong QT interval such as anti-arrhythmic medicines. (7.4)

USE IN SPECIFIC POPULATIONS

Lactation: Advise not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 3/2017

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SPECIALTY GUIDELINE MANAGEMENT

KISQALI (ribociclib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication

Kisqali is indicated in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted to postmenopausal members for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer when Kisqali is used in combination with an aromatase inhibitor.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Kisqali [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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SPECIALTY GUIDELINE MANAGEMENT

KISQALI FEMARA CO-PACK (ribociclib tablets; letrozole tablets)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication

The Kisqali Femara Co-Pack is indicated as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted to postmenopausal members for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Kisqali Femara Co-Pack [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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KEVZARA[®]

(sarilumab) injection, for subcutaneous use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 5 – Preferred Specialty
Formulary Alternatives	HUMIRA (adalimumab); ENBREL (etanercept); SIMPONI ARIA (golimumab);
FDA Approval	May 22, 2017
Therapeutic Class	Disease Modifying Antirheumatic; Interleukin-6 Receptor Antagonist; Monoclonal Antibody
Indications and Usage	Treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs).
Dosing	<p><u>Forms & Strengths:</u> 150 mg/1.14 mL or 200 mg/1.14 mL solution in a single-dose pre-filled syringe</p> <p><u>Administration:</u> 200 mg once every two weeks, administered as a subcutaneous injection</p> <p><u>Adjustments:</u> Modify dosage to manage neutropenia, thrombocytopenia, and/or elevated liver transaminases</p>
Safety	<p><u>Contraindications:</u> Known hypersensitivity to sarilumab or any of the inactive ingredients</p> <p><u>Warnings:</u> Serious Infections; Neutropenia, Thrombocytopenia, Elevated Liver Enzymes, Lipid Abnormalities; GI Perforation with NSAIDs or corticosteroids; Hypersensitivity Reactions; Avoid Live Vaccines</p> <p><u>Adverse Reactions:</u> ($\geq 3\%$) neutropenia, increased ALT, injection site erythema, upper respiratory infections and urinary tract infections.</p>
Key Points	Similar to ACTEMRA (tocilizumab) however can be given subcutaneously once every 2 weeks instead of once weekly. In a study of 369 adults sarilumab showed superiority over adalimumab, by reducing DAS28-ESR—a disease-activity metric that evaluates joint swelling and inflammation—down from baseline by 3.28 points, compared with a 2.20 decrease from the other medication. The DAS28 scale ranges from 0 to 9.4.
Treatment Guidelines	For patients DMARD-native or low disease activity: start drug therapy with DMARD monotherapy. If patient is still experiencing moderate or high disease activity after DMARD monotherapy consider: combination traditional DMARDs or TNF inhibitor +/- MTX or non-TNF Biologic +/- MTX. Treatment failure involves the use of different biologics or a combination of therapies.
Place in Therapy	Provides an additional alternative treatment pathway for rheumatoid arthritis patients who may not be responding appropriately to TNF inhibitors.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use KEVZARA® safely and effectively. See full prescribing information for KEVZARA.

KEVZARA® (sarilumab) injection, for subcutaneous use

Initial U.S. Approval: 2017

WARNING: RISK OF SERIOUS INFECTIONS

See full prescribing information for complete boxed warning.

- Serious infections leading to hospitalization or death including bacterial, viral, invasive fungal, and other opportunistic infections have occurred in patients receiving KEVZARA. (5.1)
- If a serious infection develops, interrupt KEVZARA until the infection is controlled. (5.1)
- Cases of tuberculosis (TB) have been reported. Prior to starting KEVZARA, test for latent TB; if positive, start treatment for TB. (5.1)
- Closely monitor patients for signs and symptoms of infection during treatment with KEVZARA. (5.1)

INDICATIONS AND USAGE

KEVZARA® is an interleukin-6 (IL-6) receptor antagonist indicated for treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs). (1)

DOSAGE AND ADMINISTRATION

- KEVZARA may be used as monotherapy or in combination with methotrexate (MTX) or other conventional DMARDs. (2.1)
- The recommended dosage of KEVZARA is 200 mg once every two weeks, administered as a subcutaneous injection. (2.1)

General Considerations for Administration

- KEVZARA initiation is not recommended in patients with ANC less than 2000/mm³, platelets less than 150,000/mm³ or liver transaminases above 1.5 times ULN. (2.2)

Dosage Modifications

- Modify dosage to manage neutropenia, thrombocytopenia, and/or elevated liver transaminases. (2.1, 2.4)

DOSAGE FORMS AND STRENGTHS

Injection: 150 mg/1.14 mL or 200 mg/1.14 mL solution in a single-dose pre-filled syringe (3)

CONTRAINDICATIONS

KEVZARA is contraindicated in patients with known hypersensitivity to sarilumab or any of the inactive ingredients. (4)

WARNINGS AND PRECAUTIONS

- Serious Infections: Avoid KEVZARA use during an active infection. (5.1)
- Neutropenia, Thrombocytopenia, Elevated Liver Enzymes, Lipid Abnormalities: Monitor laboratory parameters. (5.2)
- Gastrointestinal (GI) Perforation: Risk may be increased with concurrent diverticulitis or concomitant use of NSAIDs or corticosteroids. Promptly evaluate acute abdominal signs or symptoms. (5.3)
- Hypersensitivity reactions. (5.5)
- Live vaccines: Avoid use with KEVZARA due to the risk of infection. Follow vaccination guidelines. (5.7, 7.3)

ADVERSE REACTIONS

Most common adverse reactions (incidence at least 3%) are neutropenia, increased ALT, injection site erythema, upper respiratory infections and urinary tract infections. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact sanofi-aventis at 1-800-633-1610 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

USE IN SPECIFIC POPULATIONS

- Lactation: Discontinue drug or nursing taking into consideration importance of drug to mother. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 05/2017

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SPECIALTY GUIDELINE MANAGEMENT

KEVZARA (sarilumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Kevzara is indicated for treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Moderately to severely active rheumatoid arthritis (RA)

- A. Authorization of 24 months may be granted for members who have received any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request.
- B. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
 1. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
 2. Member has an intolerance or contraindication to methotrexate (see Appendix).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Kevzara as evidenced by low disease activity or improvement in signs and symptoms of RA.

IV. OTHER

Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

V. APPENDIX: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

VI. REFERENCES

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3. Strand V, Reaney M, Chen C, et al. Sarilumab improves patient-reported outcomes in rheumatoid arthritis patients with inadequate response/intolerance to tumour necrosis factor inhibitors. *RMD Open.* 2017; 3:e000416. doi: 10.1136/rmdopen-2016-000416.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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HAEGARDA®

(C1 esterase inhibitor subcutaneous [human]) for subcutaneous injection

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – non-preferred specialty
Formulary Alternatives	CINRYZE (C1 esterase inhibitor [human])
FDA Approval	June 23, 2017
Therapeutic Class	Plasma-derived concentrate of C1 esterase inhibitor (human) (C1-INH)
Indications and Usage	For routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients
Dosing	<i>Forms & Strengths:</i> 2000 or 3000 IU white lyophilized powder supplied in single-use vials <i>Administration:</i> inject 60 IU per kg body weight sub-q twice weekly (every 3 or 4 days) within 8 hours after reconstitution <i>Adjustments:</i> none
Safety	<i>Contraindications:</i> hypersensitivity, including anaphylaxis to C1-INH or excipients <i>Warnings:</i> Hypersensitivity reactions; Thrombosis; Theoretical risk of transmitting infectious agents <i>Adverse Reactions:</i> (≥ 4%) injection site reaction, hypersensitivity, nasopharyngitis and dizziness
Key Points	First and only subcutaneous preventive treatment for hereditary angioedema (HAE). Reduced HAE attacks by 95 percent; use of rescue medication reduced by greater than 99 percent per the COMPACT trial
Treatment Guidelines	C1-INH, ecallantide, icatibant → if not available, solvent detergent-treated plasma (SDP) → if not available, fresh frozen plasma
Place in Therapy	Provides a subcutaneous option for the routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use HAEGARDA safely and effectively. See full prescribing information for HAEGARDA.

HAEGARDA[®] (C1 Esterase Inhibitor Subcutaneous [Human])
For Subcutaneous Injection, Freeze-Dried Powder for Reconstitution
Initial U.S. Approval: 2017

INDICATIONS AND USAGE

HAEGARDA is a plasma-derived concentrate of C1 Esterase Inhibitor (Human) (C1-INH) indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients. (1)

DOSAGE AND ADMINISTRATION

For subcutaneous use after reconstitution only.

- Administer 60 International Units per kg body weight twice weekly (every 3 or 4 days). (2)
- Reconstitute HAEGARDA prior to use using Sterile Water for Injection, USP. (2.1)
- Use a silicone-free syringe for reconstitution and administration. (2.1)
- Administer at room temperature within 8 hours after reconstitution. (2.1)

DOSAGE FORMS AND STRENGTHS

HAEGARDA is available as a white lyophilized powder supplied in single-use vials containing 2000 or 3000 International Units (IU) of C1-INH. (3)

CONTRAINDICATIONS

Do not use in patients with a history of life-threatening immediate hypersensitivity reactions, including anaphylaxis to C1-INH preparations or its excipients. (4)

WARNINGS AND PRECAUTIONS

- Severe hypersensitivity reactions may occur. In case of severe hypersensitivity, discontinue HAEGARDA administration and institute appropriate treatment. Epinephrine should be immediately available for treatment of severe hypersensitivity reaction. (5.1)
- At the recommended subcutaneous (S.C.) dose, a causal relationship between thromboembolic events (TEEs) and the use of HAEGARDA has not been established. However, thrombosis has occurred in treatment attempts with high doses of C1-INH intravenous (I.V.) for prevention or therapy of capillary leak syndrome before, during or after cardiac surgery (unapproved indication and dose). (5.2)
- Because HAEGARDA is made from human blood, it may carry a risk of transmitting infectious agents, e.g., viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent and, theoretically, the Creutzfeldt-Jakob disease (CJD) agent. (5.3)

ADVERSE REACTIONS

- Adverse reactions occurring in more than 4% of subjects treated with HAEGARDA were injection site reaction, hypersensitivity, nasopharyngitis and dizziness. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact the CSL Behring Pharmacovigilance Department at 1-866-915-6958 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: July 2017

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SPECIALTY GUIDELINE MANAGEMENT

HAEGARDA (C1 Esterase Inhibitor Subcutaneous [Human])

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Indefinite authorization may be granted for prevention of hereditary angioedema attacks when either of the following criteria is met:

1. Member has C1 inhibitor deficiency as confirmed by laboratory testing.
2. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
 - a. Member has an F12 gene mutation as confirmed by genetic testing, or
 - b. Member has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (e.g., cetirizine) for at least one month.

III. REFERENCES

1. Haegarda [package insert]. Kankakee, IL: CSL Behring LLC; June 2017.
2. Craig T, Pursun EA, Bork K, et al. WAO guideline for the management of hereditary angioedema. *WAO Journal*. 2012; 5:182-199.
3. Cicardi M, Bork K, Caballero T, et al. Hereditary Angioedema International Working Group. Evidence-based recommendations for the therapeutic management of angioedema owing to hereditary C1 inhibitor deficiency: consensus report of an International Working Group. *Allergy*. 2012;67:147-157.
4. Bowen T, Cicardi M, Farkas H, et al. 2010 International consensus algorithm for the diagnosis, therapy, and management of hereditary angioedema. *Allergy Asthma Clin Immunol*. 2010;6(1):24.
5. Zuraw BL, Banerji A, Bernstein JA, et al. US Hereditary Angioedema Association Medical Advisory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. *J Allergy Clin Immunol: In Practice*. 2013; 1(5): 458-467.
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10. Bernstein J. Update on angioedema: Evaluation, diagnosis, and treatment. *Allergy and Asthma Proceedings*. 2011;32(6):408-412.
11. Longhurst H, Cicardi M. Hereditary angio-edema. *Lancet*. 2012;379:474-481.
12. Farkas H, Martinez-Saguer I, Bork K, et al. International consensus on the diagnosis and management of pediatric patients with hereditary angioedema with C1 inhibitor deficiency. *Allergy*. 2017;72(2):300-313.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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VOSEVI®

(sofosbuvir, velpatasvir, and voxilaprevir) tablets, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 5 (Preferred Specialty)
Formulary Alternatives	None
FDA Approval	July 18, 2017, Priority Review and Breakthrough Therapy designations
Therapeutic Class	Antihepaciviral, Polymerase Inhibitor (Anti-HCV); NS5A Inhibitor; NS3/4A Inhibitor; NS5B RNA polymerase Inhibitor
Indications and Usage	Treatment of adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have: genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor, OR genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor. (Additional benefit of VOSEVI over sofosbuvir/velpatasvir was not shown in adults with genotype 1b, 2, 4, 5, or 6 infection previously treated with sofosbuvir without an NS5A inhibitor.)
Dosing	<p><u>Forms & Strengths:</u> Fixed-dose tablet: 400 mg sofosbuvir, 100 mg velpatasvir, and 100 mg voxilaprevir</p> <p><u>Administration:</u> One tablet taken orally once daily with food for 12 weeks</p> <p><u>Adjustments:</u> Not recommended for moderate to severe hepatic impairment; no adjustments can be made for severe renal impairment or end-stage renal disease.</p>
Safety	<p><u>Contraindications:</u> Coadministration with rifampin</p> <p><u>Warnings:</u> Risk of Hepatitis B virus reactivation; Bradycardia with amiodarone coadministration;</p> <p><u>Adverse Reactions:</u> ($\geq 10\%$) headache, fatigue, diarrhea, and nausea</p>
Key Points	First once-daily single-tablet HCV regimen approved as salvage therapy for certain patients.
Treatment Guidelines	Direct-acting antiviral (DAA) regimens, liver transplantation, vaccination for Hep A & B, lifestyle modifications.
Place in Therapy	Provides a second line/salvage treatment option for patients who have failed certain HCV DDA treatments.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use VOSEVI safely and effectively. See full prescribing information for VOSEVI.

VOSEVI™ (sofosbuvir, velpatasvir, and voxilaprevir) tablets, for oral use
Initial U.S. Approval: 2017

WARNING: RISK OF HEPATITIS B VIRUS REACTIVATION IN PATIENTS COINFECTED WITH HCV AND HBV
See full prescribing information for complete boxed warning.

Hepatitis B virus (HBV) reactivation has been reported, in some cases resulting in fulminant hepatitis, hepatic failure, and death. (5.1)

INDICATIONS AND USAGE

VOSEVI is a fixed-dose combination of sofosbuvir, a hepatitis C virus (HCV) nucleotide analog NS5B polymerase inhibitor, velpatasvir, an HCV NS5A inhibitor, and voxilaprevir, an HCV NS3/4A protease inhibitor, and is indicated for the treatment of adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have (1, 2.2, 14):

- genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor.
- genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.
 - Additional benefit of VOSEVI over sofosbuvir/velpatasvir was not shown in adults with genotype 1b, 2, 4, 5, or 6 infection previously treated with sofosbuvir without an NS5A inhibitor.

DOSAGE AND ADMINISTRATION

- Testing prior to the initiation of therapy: Test all patients for HBV infection by measuring HBsAg and anti-HBc. (2.1)
- Recommended dosage: One tablet (400 mg of sofosbuvir, 100 mg of velpatasvir, and 100 mg of voxilaprevir) taken orally once daily with food. (2.2)
- See recommended treatment regimen and duration in table below (2.2):

Genotype	Patients Previously Treated with an HCV Regimen Containing:	VOSEVI Duration
1, 2, 3, 4, 5, or 6	An NS5A inhibitor ^a	12 weeks
1a or 3	Sofosbuvir without an NS5A inhibitor ^b	12 weeks

a. In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir.

b. In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir).

- A dosage recommendation cannot be made for patients with severe renal impairment or end stage renal disease (2.3)
- VOSEVI is not recommended in patients with moderate or severe hepatic impairment (Child-Pugh B or C) (2.4)

DOSAGE FORMS AND STRENGTHS

Tablets: 400 mg sofosbuvir, 100 mg velpatasvir, and 100 mg voxilaprevir (3)

CONTRAINDICATIONS

Coadministration with rifampin. (4)

WARNINGS AND PRECAUTIONS

- Risk of Hepatitis B virus reactivation: Test all patients for evidence of current or prior HBV infection before initiation of HCV treatment. Monitor HCV/HBV coinfecting patients for HBV reactivation and hepatitis flare during HCV treatment and post-treatment follow-up. Initiate appropriate patient management for HBV infection as clinically indicated. (5.1)
- Bradycardia with amiodarone coadministration: Serious symptomatic bradycardia may occur in patients taking amiodarone with VOSEVI, a sofosbuvir-containing regimen, particularly in patients also receiving beta blockers, or those with underlying cardiac comorbidities and/or advanced liver disease. Coadministration of amiodarone with VOSEVI is not recommended. In patients without alternative viable treatment options, cardiac monitoring is recommended. (5.2, 7.3)

ADVERSE REACTIONS

- The most common adverse reactions (incidence greater than or equal to 10%, all grades) observed with treatment with VOSEVI for 12 weeks were headache, fatigue, diarrhea, and nausea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Gilead Sciences, Inc. at 1-800-GILEAD-5 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- P-gp inducers and/or moderate to potent CYP inducers (e.g., St. John's wort, carbamazepine): May decrease concentrations of sofosbuvir, velpatasvir, and/or voxilaprevir. Use of VOSEVI with P-gp inducers and/or moderate to potent CYP inducers is not recommended (5.3, 7)
- Consult the full prescribing information prior to use for potential drug interactions (4, 5.2, 5.3, 7)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 07/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNING: RISK OF HEPATITIS B VIRUS REACTIVATION IN PATIENTS COINFECTED WITH HCV AND HBV

1 INDICATIONS AND USAGE

2 DOSAGE AND ADMINISTRATION

- 2.1 Testing Prior to Initiation of Therapy
- 2.2 Recommended Dosage
- 2.3 No Dosage Recommendations in Severe Renal Impairment and End Stage Renal Disease
- 2.4 Moderate or Severe Hepatic Impairment

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

5 WARNINGS AND PRECAUTIONS

- 5.1 Risk of Hepatitis B Virus Reactivation in Patients Coinfected with HCV and HBV
- 5.2 Serious Symptomatic Bradycardia When Coadministered with Amiodarone
- 5.3 Risk of Reduced Therapeutic Effect Due to Concomitant Use of VOSEVI with Inducers of P-gp and/or Moderate to Potent Inducers of CYP

6 ADVERSE REACTIONS

- 6.1 Clinical Trials Experience
- 6.2 Postmarketing Experience

7 DRUG INTERACTIONS

- 7.1 Potential for Other Drugs to Affect VOSEVI
- 7.2 Potential for VOSEVI to Affect Other Drugs
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8 USE IN SPECIFIC POPULATIONS

- 8.1 Pregnancy
- 8.2 Lactation
- 8.4 Pediatric Use
- 8.5 Geriatric Use
- 8.6 Renal Impairment
- 8.7 Hepatic Impairment

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics

SPECIALTY GUIDELINE MANAGEMENT

VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Vosevi is indicated for the treatment of adult patients with chronic hepatitis C virus (HCV) infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have:

- A. Genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor
- B. Genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor

Additional benefit of Vosevi over sofosbuvir/velpatasvir was not shown in adults with genotype 1b, 2, 4, 5, or 6 infection previously treated with sofosbuvir without an NS5A inhibitor.

All other indications are considered experimental/investigational and are not a covered benefit.

II. EXCLUSIONS

Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh Class B or C)

Note: When the requested drug is being used in a combination therapy regimen, exclusions to the other antiviral drugs also apply.

III. CRITERIA FOR INITIAL APPROVAL

A. Chronic hepatitis C virus infection

Authorization of up to 12 weeks total may be granted for members when either of the following criteria is met:

1. Member has genotype 1, 2, 3, 4, 5, or 6 infection and failed prior treatment with an HCV NS5A inhibitor-containing regimen
2. Member has genotype 1a or 3 infection and failed prior treatment with a sofosbuvir-containing regimen without an NS5A inhibitor

B. HCV and HIV Coinfection

Authorization may be granted for members with HCV and HIV coinfection when the criteria for approval of the requested regimen in Section A above are met.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCE

1. Vosevi [package insert]. Foster City, CA: Gilead Sciences, Inc.; July 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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BAXDELA[®]

(delafloxacin) tablets, for oral use & injection, for IV use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 3 – Non-preferred Brand
Formulary Alternatives	Vancomycin; linezolid
FDA Approval	June 19, 2017
Therapeutic Class	Fluoroquinolone antibacterial
Indications and Usage	Treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by designated susceptible bacteria in adults.
Dosing	<p><u>Forms & Strengths:</u> For Injection: 300 mg of delafloxacin (equivalent to 433 mg delafloxacin meglumine) as a lyophilized powder in a single dose vial for reconstitution and further dilution before intravenous infusion. Oral Tablets: 450 mg delafloxacin (equivalent to 649 mg delafloxacin meglumine).</p> <p><u>Administration:</u> Administer BAXDELA for injection 300 mg by intravenous infusion over 60 minutes, every 12 hours, or a 450-mg BAXDELA tablet orally every 12 hours for 5 to 14 days total duration.</p> <p><u>Adjustments:</u> Dosage for patients with renal impairment is based on the estimated glomerular filtration rate (eGFR).</p>
Safety	<p><u>Contraindications:</u> Known hypersensitivity to BAXDELA or other fluoroquinolones</p> <p><u>Warnings:</u> Hypersensitivity Reactions; Clostridium difficile-associated diarrhea</p> <p><u>Adverse Reactions:</u> (≥ 2%) are nausea, diarrhea, headache, transaminase elevations and vomiting.</p>
Key Points	Offers a new option for treatment of adult patients with acute bacterial skin and skin structure infections (ABSSSI) including hospital-treated skin infections in oral and IV formulations as monotherapy
Treatment Guidelines	During hospitalization the most frequently used IV medications for ABSSSI include vancomycin, clindamycin, daptomycin, linezolid, & tigecycline. Oral antibiotics include linezolid, clindamycin, cephalexin, TMP-SMZ, amoxicillin/clavulanate, ciprofloxacin, doxycycline, levofloxacin, and metronidazole.
Place in Therapy	Baxdela provides a treatment option for adult patients with ABSSSI based on its coverage spectrum, IV and oral dosing flexibility, efficacy and safety profile

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use BAXDELA™ safely and effectively. See full prescribing information for BAXDELA.

BAXDELA (delafloxacin) tablets, for oral use

BAXDELA (delafloxacin) for injection, for intravenous use
Initial U.S. Approval: 2017

WARNING: SERIOUS ADVERSE REACTIONS INCLUDING TENDINITIS, TENDON RUPTURE, PERIPHERAL NEUROPATHY, CENTRAL NERVOUS SYSTEM EFFECTS, and EXACERBATION OF MYASTHENIA GRAVIS

See full prescribing information for complete boxed warning.

Fluoroquinolones have been associated with disabling and potentially irreversible serious adverse reactions that have occurred together (5.1), including:

- Tendinitis and tendon rupture (5.2)
- Peripheral neuropathy (5.3)
- Central nervous system effects (5.4)

Discontinue BAXDELA immediately and avoid the use of fluoroquinolones, including BAXDELA, in patients who experience any of these serious adverse reactions. (5.1)

- Fluoroquinolones may exacerbate muscle weakness in patients with myasthenia gravis. Avoid BAXDELA in patients with known history of myasthenia gravis. (5.5)

INDICATIONS AND USAGE

BAXDELA is a fluoroquinolone antibacterial indicated in adults for the treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by designated susceptible bacteria. (1.1)

To reduce the development of drug-resistant bacteria and maintain the effectiveness of BAXDELA and other antibacterial drugs, BAXDELA should be used only to treat infections that are proven or strongly suspected to be caused by bacteria. (1.2)

DOSAGE AND ADMINISTRATION

- Administer BAXDELA for injection 300 mg by intravenous infusion over 60 minutes, every 12 hours, or a 450-mg BAXDELA tablet orally every 12 hours for 5 to 14 days total duration. (2.1)
- Dosage for patients with renal impairment is based on the estimated glomerular filtration rate (eGFR) (2.3)

Estimated Glomerular Filtration Rate (eGFR)(mL/min/1.73m ²) ^a	Recommended Dosage Regimen for BAXDELA ^c	
	Oral	Intravenous ^b
30-89	No dosage adjustment	No dosage adjustment
15-29	No dosage adjustment	200 mg every 12 hours
End Stage Renal Disease (ESRD) (<15 including hemodialysis)	Not Recommended ^d	
a. Estimate of GFR based on a Modification of Diet in Renal Disease (MDRD) equation. b. All intravenous doses of BAXDELA are administered over 60 minutes. c. For a total treatment duration of 5 to 14 days. d. Not recommended due to insufficient information to provide dosing recommendations.		

DOSAGE FORMS AND STRENGTHS

- For Injection: 300 mg of delafloxacin (equivalent to 433 mg delafloxacin meglumine) as a lyophilized powder in a single dose vial for reconstitution and further dilution before intravenous infusion. (3)
- Oral Tablets: 450 mg delafloxacin (equivalent to 649 mg delafloxacin meglumine). (3)

CONTRAINDICATIONS

Known hypersensitivity to BAXDELA or other fluoroquinolones (4, 5.6)

WARNINGS AND PRECAUTIONS

- Hypersensitivity Reactions: May occur after first or subsequent doses of BAXDELA. Discontinue BAXDELA at the first sign of a skin rash or any other sign of hypersensitivity. (5.7)
- *Clostridium difficile*-associated diarrhea: Evaluate if diarrhea occurs. (5.8)

ADVERSE REACTIONS

Most common adverse reactions (incidence ≥ 2%) are nausea, diarrhea, headache, transaminase elevations and vomiting. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Melinta Therapeutics at (844) 635-4682 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

USE IN SPECIFIC POPULATIONS

Renal Impairment: Closely monitor serum creatinine levels in patients with severe renal impairment (eGFR 15-29 mL/min/1.73 m²) receiving intravenous delafloxacin. If serum creatinine level increases occur, consider changing to oral delafloxacin. Discontinue BAXDELA if eGFR decreases to <15 mL/min/1.73 m² (8.6).

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 6/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNING: SERIOUS ADVERSE REACTIONS INCLUDING TENDINITIS, TENDON RUPTURE, PERIPHERAL NEUROPATHY, CENTRAL

NERVOUS SYSTEM EFFECTS and EXACERBATION OF MYASTHENIA GRAVIS
1 INDICATIONS AND USAGE

ENDARI[®]

(L-glutamine) powder for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	None
FDA Approval	July 7, 2017 – Orphan Drug designation
Therapeutic Class	Amino Acid, Gastrointestinal Agent
Indications and Usage	Reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older
Dosing	<p><u>Forms & Strengths:</u> Oral Powder: 5 grams of L-glutamine powder per paper-foil-plastic laminate packet.</p> <p><u>Administration:</u> 5 grams to 15 grams orally, twice daily based on body weight; Each dose of Endari should be mixed in 8 oz. (240 mL) of cold or room temperature beverage or 4 oz. to 6 oz. of food before ingestion</p> <p><u>Adjustments:</u> None</p>
Safety	<p><u>Contraindications:</u> None</p> <p><u>Warnings:</u> None</p> <p><u>Adverse Reactions:</u> ($\geq 10\%$) constipation, nausea, headache, abdominal pain, cough, pain in extremity, back pain, and chest pain.</p>
Key Points	The first and only FDA-approved treatment of sickle cell disease in pediatric patients and first new sickle cell treatment in nearly 20 years for adults.
Treatment Guidelines	Hydroxyurea and long-term, periodic blood transfusions, deferasirox/deferoxamine, erythrocytapheresis, morphine, penicillin prophylaxis, pneumococcal vaccine.
Place in Therapy	First-line treatment option for adults and pediatric patients suffering from sickle cell disease.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use ENDARI™ safely and effectively. See full prescribing information for ENDARI.

ENDARI (L-glutamine oral powder)
Initial U.S. Approval: 2017

-----INDICATIONS AND USAGE-----

ENDARI is an amino acid indicated to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older. (1)

-----DOSAGE AND ADMINISTRATION-----

- 5 grams to 15 grams orally, twice daily based on body weight. (2)
- Each dose of Endari should be mixed in 8 oz. (240 mL) of cold or room temperature beverage or 4 oz. to 6 oz. of food before ingestion. (2)

-----DOSAGE FORMS AND STRENGTHS-----

Oral Powder: 5 grams of L-glutamine powder per paper-foil-plastic laminate packet. (3)

-----CONTRAINDICATIONS-----

None (4)

-----ADVERSE REACTIONS-----

Most common adverse reactions (incidence > 10%) are constipation, nausea, headache, abdominal pain, cough, pain in extremity, back pain, and chest pain. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Emmaus Medical, Inc. at 1-877-420-6493 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 7/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

1 INDICATIONS AND USAGE

2 DOSAGE AND ADMINISTRATION

2.1 Dosage

2.2 Preparation of Product

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

8.2 Lactation

8.4 Pediatric Use

8.5 Geriatric Use

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

12.2 Pharmacodynamics

12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

14 CLINICAL STUDIES

14.1 Clinical Studies

16 HOW SUPPLIED/STORAGE AND HANDLING

17 PATIENT COUNSELING INFORMATION

* Sections or subsections omitted from the full prescribing information are not listed.

SPECIALTY GUIDELINE MANAGEMENT

ENDARI (L-glutamine oral powder)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Endari is indicated to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Sickle cell disease

Authorization of 12 months may be granted for use in reducing the acute complications of sickle cell disease in members 5 years of age or older.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Endari [package insert]. Torrance, CA: Emmaus Medical, Inc; July 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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AUSTEDO®

(deutetrabenazine) tablets, for oral use

P&T Consideration	Drug is being removed from New to Market Block and can be added to the NCSHP 2017 Formulary
Proposed Tier Placement	Tier 6 – Non-preferred Specialty
Formulary Alternatives	XENAZINE (tetrabenazine)
FDA Approval	April 3, 2017
Therapeutic Class	Vesicular Monoamine Transporter 2 (VMAT2) Inhibitor
Indications and Usage	Treatment of chorea associated with Huntington’s disease & tardive dyskinesia in adults
Dosing	<p>Forms & Strengths: Tablets: 6 mg, 9 mg, and 12 mg</p> <p>Administration: Chorea associated with Huntington’s disease: Initial dose of 6 mg/day up to a maximum dose of 48 mg/day; Tardive dyskinesia: Initial dose of 12 mg/day up to a maximum dose of 48 mg/day</p> <p>Adjustments: For patients at risk for QT prolongation, assess the QT interval before and after increasing the total dosage above 24 mg per day. Maximum recommended dosage of AUSTEDO in poor CYP2D6 metabolizers is 36 mg per day (i.e., 18 mg twice daily)</p>
Safety	<p>Contraindications: Suicidal, or untreated/inadequately treated depression in patients with Huntington’s disease; Hepatic impairment; Taking reserpine, MAOIs, tetrabenazine (XENAZINE®), or valbenazine</p> <p>Warnings: QT Prolongation; Neuroleptic Malignant Syndrome (NMS); Akathisia, agitation, restlessness, and parkinsonism; Sedation/somnolence</p> <p>Adverse Reactions: (>8%) somnolence, diarrhea, dry mouth, and fatigue; (4%) nasopharyngitis and insomnia</p>
Key Points	First deuterated product approved by the FDA and only the second product approved in the treatment of Huntington’s disease (HD). The first and only medication approved to treat both tardive dyskinesia in adults and chorea associated with Huntington’s disease. Deutetrabenazine breaks down slower than tetrabenazine hence maintains efficacy at a lower dose.
Treatment Guidelines	Chorea associated with Huntington’s disease is typically treated with tetrabenazine, antipsychotic drugs, such as haloperidol & chlorpromazine or risperidone & quetiapine, and other medications such as levetiracetam and clonazepam.
Place in Therapy	Provides an additional treatment option for chorea associated with Huntington’s disease & tardive dyskinesia in adults.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use AUSTEDO safely and effectively. See full prescribing information for AUSTEDO.

AUSTEDO® (deutetrabenazine) tablets, for oral use

Initial U.S. Approval: 2017

WARNING: DEPRESSION AND SUICIDALITY IN PATIENTS WITH HUNTINGTON'S DISEASE

See full prescribing information for complete boxed warning.

- Increases the risk of depression and suicidal thoughts and behavior (suicidality) in patients with Huntington's disease (5.1)
- Balance risks of depression and suicidality with the clinical need for treatment of chorea when considering the use of AUSTEDO (5.1)
- Monitor patients for the emergence or worsening of depression, suicidality, or unusual changes in behavior (5.1)
- Inform patients, caregivers, and families of the risk of depression and suicidality and instruct to report behaviors of concern promptly to the treating physician (5.1)
- Exercise caution when treating patients with a history of depression or prior suicide attempts or ideation (5.1)
- AUSTEDO is contraindicated in patients who are suicidal, and in patients with untreated or inadequately treated depression (4, 5.1)

RECENT MAJOR CHANGES

Boxed Warning	08/2017
Indications and Usage (1)	08/2017
Dosage and Administration (2.1)	08/2017
Contraindications (4)	08/2017
Warnings and Precautions (5.1, 5.2, 5.3, 5.5, 5.7)	08/2017

INDICATIONS AND USAGE

AUSTEDO is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of:

- Chorea associated with Huntington's disease (1)
- Tardive dyskinesia in adults (1)

DOSAGE AND ADMINISTRATION

	Initial Dose	Recommended Dose	Maximum Dose
Chorea associated with Huntington's disease	6 mg/day	6 mg– 48 mg/day	48 mg/day
Tardive dyskinesia	12 mg/day	12 mg– 48 mg/day	48 mg/day

- Titrate at weekly intervals by 6 mg per day based on reduction of chorea or tardive dyskinesia, and tolerability, up to a maximum recommended daily dosage of 48 mg (24 mg twice daily) (2.1)
- Administer total daily dosages of 12 mg or above in two divided doses (2.1)

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNING: DEPRESSION AND SUICIDALITY IN PATIENTS WITH HUNTINGTON'S DISEASE

1 INDICATIONS AND USAGE

2 DOSAGE AND ADMINISTRATION

- Dosing Information
- Switching Patients from Tetrabenazine (XENAZINE®) to AUSTEDO
- Dosage Adjustment with Strong CYP2D6 Inhibitors
- Dosage Adjustment in Poor CYP2D6 Metabolizers
- Discontinuation and Interruption of Treatment

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

5 WARNINGS AND PRECAUTIONS

- Depression and Suicidality in Patients with Huntington's Disease
- Clinical Worsening and Adverse Events in Patients with Huntington's Disease
- QTc Prolongation
- Neuroleptic Malignant Syndrome (NMS)
- Akathisia, Agitation, and Restlessness
- Parkinsonism in Patients with Huntington's Disease
- Sedation and Somnolence
- Hyperprolactinemia
- Binding to Melanin-Containing Tissues

6 ADVERSE REACTIONS

- Clinical Trials Experience

7 DRUG INTERACTIONS

- Strong CYP2D6 Inhibitors
- Drugs that Cause QTc Prolongation
- Reserpine

- For patients at risk for QT prolongation, assess the QT interval before and after increasing the total dosage above 24 mg per day (2.1)
- Administer with food (2.1)
- Swallow tablets whole; do not chew, crush, or break (2.1)
- If switching patients from tetrabenazine, discontinue tetrabenazine and initiate AUSTEDO the following day. See full prescribing information for recommended conversion table (2.2)
- Maximum recommended dosage of AUSTEDO in poor CYP2D6 metabolizers is 36 mg per day (i.e., 18 mg twice daily) (2.4, 8.7)

DOSAGE FORMS AND STRENGTHS

Tablets: 6 mg, 9 mg, and 12 mg (3)

CONTRAINDICATIONS

- Suicidal, or untreated/inadequately treated depression in patients with Huntington's disease (4, 5.1)
- Hepatic impairment (4, 8.6, 12.3)
- Taking reserpine, MAOIs, tetrabenazine (XENAZINE®), or valbenazine (4, 7.3, 7.4, 7.7)

WARNINGS AND PRECAUTIONS

- QT Prolongation: May cause an increase in QT interval. Avoid use in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval (5.3)
- Neuroleptic Malignant Syndrome (NMS): Discontinue if this occurs (5.4)
- Akathisia, agitation, restlessness, and parkinsonism: Reduce dose or discontinue if this occurs (5.5, 5.6)
- Sedation/somnolence: May impair the patient's ability to drive or operate complex machinery (5.7)

ADVERSE REACTIONS

Most common adverse reactions (>8% of AUSTEDO-treated patients with Huntington's disease and greater than placebo): somnolence, diarrhea, dry mouth, and fatigue (6.1)

Most common adverse reactions (that occurred in 4% of AUSTEDO-treated patients with tardive dyskinesia and greater than placebo): nasopharyngitis and insomnia (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Teva Pharmaceuticals at 1-888-483-8279 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Concomitant use of strong CYP2D6 inhibitors: Maximum recommended dose of AUSTEDO is 36 mg per day (18 mg twice daily) (2.3, 7.1)
- Alcohol or other sedating drugs: May have additive sedation and somnolence (7.6)

USE IN SPECIFIC POPULATIONS

Pregnancy: Based on animal data, may cause fetal harm (8.1)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 08/2017

- Monoamine Oxidase Inhibitors (MAOIs)
- Neuroleptic Drugs
- Alcohol or Other Sedating Drugs
- Concomitant Tetrabenazine or Valbenazine

8 USE IN SPECIFIC POPULATIONS

- Pregnancy
- Lactation
- Pediatric Use
- Geriatric Use
- Hepatic Impairment
- Poor CYP2D6 Metabolizers

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

- Mechanism of Action
- Pharmacodynamics
- Pharmacokinetics

13 NONCLINICAL TOXICOLOGY

- Carcinogenesis, Mutagenesis, Impairment of Fertility

14 CLINICAL STUDIES

- Chorea Associated with Huntington's Disease
- Tardive Dyskinesia

16 HOW SUPPLIED/STORAGE AND HANDLING

- How Supplied
- Storage

17 PATIENT COUNSELING INFORMATION

*Sections or subsections omitted from the full prescribing information are not listed.

SPECIALTY GUIDELINE MANAGEMENT

AUSTEDO (deutetrabenazine)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Treatment of chorea associated with Huntington's disease
2. Tardive dyskinesia in adults

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Chorea associated with Huntington disease

Authorization of 12 months may be granted for treatment of chorea associated with Huntington disease.

Tardive dyskinesia

Authorization of 12 months may be granted for treatment of tardive dyskinesia.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Austedo [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc. August 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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New Pharmacy Utilization Management Programs Effective 1/1/2018

Policy Name	Type of Policy	Coverage Criteria
Opioids ER – MME	ST, QL, PA	≥ 7-day supply of an IR opioid in past 90 days OR ER opioid for a cumulative ≥ 30 days within the past 90 days; coverage up to 90 MME then a PA up to 200 MME; claims paid if patient is being treated for cancer
Opioids IR – Acute Pain MME	ST, QL, PA	≥ 7-day supply of an opioid (IR- or ER) in prescription claim history in the past 90 days, the immediate-release opioid will adjudicate for up to the initial quantity limit; claims paid if patient is being treated for cancer
Opioids IR – Combo MME	ST, QL, PA	≥ 7-day supply of an opioid (IR- or ER) in prescription claim history in the past 90 days, the immediate-release opioid will adjudicate for up to the initial quantity limit; claims paid if patient is being treated for cancer
Opioids IR – Combo MME	ST, QL, PA	≤ 90 MME; quantity limits are set at ≤ 4 g APAP or ASA and ≤ 3200 mg ibuprofen OR the maximum recommended dose based on prescribing information
Xartemis XR - MME	ST, QL, PA	Quantity limit of 120 tablets/25 days
Specialty Quantity Limits	QL	Quantity limits based on label information
Long-acting Insulin, GLP-1	PA, QL	Inadequate treatment response to metformin OR sulfonylurea OR thiazolidinedione OR combo therapy is needed with an A1c of 7.5% or higher.
Vytorin 10-80, Zocor 80	ST	Claims will be paid if patient has filled a prescription for a 290 day supply of 10/80 or 80 mg. Patient was being prescribed 10/80 or 80 mg chronically for 12 months or more.
Lyrica, Gralise, Horizant	ST	Inadequate response to IR generic gabapentin OR Lyrica is being used for fibromyalgia OR Horizant is being used for RLS.

Opioid briefing

September 21, 2017

CVS Health is committed to partnering with clients, health care providers, government agencies and pharmaceutical companies to help address the opioid crisis.

As part of its broad commitment to fighting the national opioid abuse epidemic, CVS Health is enhancing its enterprise-wide initiatives supporting utilization management of pain medications, safe drug disposal, and funding for treatment and recovery programs.

This effort will leverage the capabilities of CVS Health's pharmacy benefit manager (PBM), CVS Caremark, which covers nearly 90 million plan members, and the CVS Pharmacy retail presence in nearly 10,000 communities across the country. This expansion of our industry-leading initiatives includes a strengthened utilization management (UM) program to encourage clinically-appropriate use, greater pharmacist counseling for patients filling an opioid prescription for the first time, and an expansion of the drug disposal collection program at CVS Pharmacy locations.

In addition, the CVS Health Foundation will also be expanding its community education and support programs. Our standard opioid management program will be aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC) in March 2016, and based on morphine milligram equivalents — or MMEs — a measure of the number of equivalent milligrams of morphine a drug contains.

The enhancement is designed to positively influence the prescribing and use of opioids to treat pain. It complements measures already in place for clients, including ongoing monitoring for patterns of inappropriate prescribing or use, and controls such as drug utilization review.

In 2015, according to the U.S. Department of Health and Human Services¹:

19M

Americans reported having misused prescription drugs

12.5M

reported having misused opioids

35.7%

obtained them through a prescription

The enhanced MME-based UM program is aligned with the CDC Guideline and will:



Limit Days' Supply

The length of the first fill will be limited to seven days (when appropriate) for new, acute prescriptions for members who do not have a history of prior opioid use, based on their prescription claims. A physician can submit a prior authorization (PA) request if it is important to exceed the seven-day limit.



Limit Quantity of Opioids

The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited to 90 MME per day. Prescribers who believe a patient should exceed CDC Guideline recommendations can submit a PA request for up to 200 MME per day. Quantities higher than that would require an appeal. Products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.



Require Step Therapy

Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a PA.



U.S. accounts for **80 percent of the world's consumption** of opioid painkillers and **99 percent of hydrocodone**.²

Enterprise-wide Measures

We continue to build on ongoing efforts to help reduce opioid abuse, such as prevention education and proper medication disposal, providing increased access to the opioid-overdose reversal medication naloxone in 43 states, and ongoing advocacy to improve tools like Prescription Drug Monitoring Programs, which help pharmacies and prescribers prevent abuse.

At CVS Pharmacy Locations:



CVS Health is expanding its Medication Disposal for Safer Communities Program to a total of 1,550 kiosks, including 750 additional disposal units in CVS Pharmacy locations across the country beginning with Florida, Massachusetts, North Carolina, Pennsylvania, South Carolina and the District of Columbia.



Through this program, created with the Partnership for Drug-Free Kids, CVS Health has, to date, donated more than 800 medication disposal units to local police departments in 43 states, collecting more than 100 metric tons of unwanted medication.

CVS Pharmacy will also strengthen counseling for patients filling an opioid prescription with a robust safe use education program highlighting opioid safety and the dangers of addiction. This clinical program will educate patients about the CDC Guideline. Pharmacists will counsel patients about the risk of dependence and addiction tied to duration of opioid use, the importance of keeping medications secure in the home and methods of proper disposal of unused medication.

Community Action:

The CVS Health Foundation is adding a \$2 million commitment to previous investments in mitigating prescription drug abuse with support for federally qualified community health centers providing access to medication-assisted treatment and other recovery and prevention services. CVS Health is also expanding its commitment to opioid abuse prevention education by bringing its Pharmacists Teach program to a parent audience. To date, Pharmacists Teach, which connects CVS pharmacists to schools in their communities to provide a unique perspective to students about the dangers of prescription drug abuse, has focused on teens and has educated more than 295,000 students about prescription drug abuse.

Without a doubt, addressing our nation's opioid crisis calls for a multipronged effort involving many health care stakeholders — from physicians to pharmaceutical companies, and pharmacies to government officials. With the implementation of the MME-based management program, and the launch of an enterprise-wide campaign to reduce unnecessary opioid prescribing and use, we are further strengthening our commitment to helping our clients and their members balance the need for these powerful medications with the risk of abuse and misuse.

Troy Brennan, M.D.

Executive Vice President, Chief Medical Officer, CVS Health

1. Prescription Drug Use and Misuse in the United States: Results from the 2015 National Survey on Drug Use and Health. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm>.

2. OverDosed: A Comprehensive Federal Strategy for Addressing America's Prescription Drug and Heroin Epidemic; Sen. Ed Markey's Office National Institute on Drug Abuse for Teens: Drug Facts. <http://www.namsdl.org/library/D48C90EB-0ABF-9E30-5A24A1625C7FE602/>.

Important Update — Opioid Medication Management Strategy

CVS Health is committed to partnering with clients, health care providers, government agencies and pharmaceutical companies to address the opioid crisis. As part of its broad commitment to fighting the national opioid abuse epidemic, CVS Health is enhancing its enterprise-wide initiatives supporting utilization management of pain medications, safe drug disposal, and funding for treatment and recovery programs. This effort will leverage the capabilities of CVS Health's pharmacy benefit manager (PBM), CVS Caremark, which covers nearly 90 million plan members, and the CVS Pharmacy retail presence in nearly 10,000 communities across the country.

This expansion of our industry-leading initiatives includes a strengthened utilization management (UM) program to encourage clinically-appropriate use, pharmacist counseling for patients filling an opioid prescription for the first time, and an expansion of the medication disposal collection program at CVS Pharmacy locations. In addition, the CVS Health Foundation will also be broadening its support of community education and support programs and the reach of its Pharmacists Teach program.

Our standard opioid management program will be aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC) in March 2016.¹ The enhancement is designed to positively influence the prescribing and use of opioids to treat pain. It complements measures already in place for clients, including ongoing monitoring for patterns of inappropriate prescribing or use, and controls such as drug utilization review. Beginning in 2018, all clients will be transitioned to an opioid management program based on morphine milligram equivalents — or MMEs — a measure of the number of equivalent milligrams of morphine a drug contains.

In February 2017, we launched two new options to encourage appropriate use of opioids by patients and prescribers:

- A program based on dosage/quantity indicated in U.S. Food and Drug Administration (FDA) labels
- A program based on MMEs, supported by the March 2016 CDC Guideline



42

people die in the U.S. each day from prescription opioid overdose²



1,100

adolescents, on average, start to misuse prescription pain relievers each day³



More than

1/3

of those misusing prescription opioids obtained them through a prescription or a health care provider⁴

Effective February 1, 2018, all commercial health plan, employer and Medicaid clients will be transitioned, to the enhanced MME-based program, unless your plan chooses to opt-out. Plans aligned to this strategy will automatically be included in program updates. If your plan chooses not to align with our standard opioid management program, the existing label-based approach will still be available. If your plan uses the Standard Exchange Formulary, the change will be effective January 1, 2018. If you choose not to implement the enhanced UM criteria, your plan will need to use a custom formulary.

This enhanced UM program will:



Limit Days' Supply: The length of the first fill (when appropriate) will be limited to seven days for immediate release, new, acute prescriptions for plan members who do not have a history of prior opioid use, based on their prescription claims. A physician can submit a prior authorization (PA) request if it is important to exceed the seven-day limit.



Limit Quantity of Opioids: The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited up to 90 MME per day (based on a 30-day supply). Prescribers who believe their patient should exceed CDC Guideline recommendations can submit a PA request for up to 200 MME per day unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME per day. Quantities higher than that would require an appeal. Opioid products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.



Require Step Therapy: Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a PA.

Our strengthened UM criteria is aligned to the CDC Guideline which focuses on:

- The decision to begin or continue the use of opioid analgesics to treat patients with chronic pain, who are not receiving cancer treatment, palliative care or end-of-life care
- The selection of an opioid analgesic – including dosage, duration of therapy, follow-up, and when to discontinue opioids
- Identifying and mitigating opioid analgesic misuse

Opioid painkillers provide needed relief to those with acute or chronic pain. But given their potential for harm, and the very real – and pervasive – problem of misuse and abuse, ensuring appropriate use is more critical now than ever before. The CDC, as well as other medical organizations such as the American College of Physicians⁵, encourage prescribers to consider other options for treating chronic pain not associated with cancer, palliative or end-of-life care, and then make a treatment decision based on the expected benefits of therapy weighed against the risks.

CVS Health is committed to supporting members and prescribers through this transition. Targeted communications will be sent to affected members – and their prescribers – 60 days before the effective date. In addition, our Customer Care teams will be prepared to answer any additional inquiries.

Enterprise-wide Measures

We continue to build on ongoing efforts to reduce opioid abuse, such as prevention education and proper medication disposal, providing increased access to the opioid-overdose reversal medication naloxone in 43 states, and ongoing advocacy to improve tools like Prescription Drug Monitoring Programs, which help pharmacies and prescribers prevent abuse.



At CVS Pharmacy Locations: CVS Health is expanding its Medication Disposal for Safer Communities Program to a total of 1,550 kiosks, including 750 additional disposal units in CVS Pharmacy locations across the country beginning with Florida, Massachusetts, North Carolina, Pennsylvania, South Carolina and the District of Columbia. CVS Pharmacy will also strengthen counseling for patients filling an opioid prescription with a robust safe use education program highlighting opioid safety and the dangers of addiction. This clinical program will educate patients about the CDC Guideline. Pharmacists will counsel patients about the risk of dependence and addiction tied to duration of opioid use, the importance of keeping medications secure in the home and methods of proper disposal of unused medication.

Your Account Team will be contacting you to discuss your interest in aligning to the enhanced UM criteria as well as to answer any strategic or financial questions you may have. Please let your Account Team know by October 18, 2017, if your plan will align to the program or opt-out.



Community Action: The CVS Health Foundation is adding a \$2 million commitment to previous investments in mitigating prescription drug abuse with support for federally qualified community health centers providing access to medication-assisted treatment and other recovery and prevention services. CVS Health is also expanding its commitment to opioid abuse prevention education by bringing its Pharmacists Teach program to a parent audience. To date, Pharmacists Teach, which connects CVS pharmacists to schools in their communities to provide a unique perspective to students about the dangers of prescription drug abuse, has focused on teens and has educated more than 295,000 students about prescription drug abuse.

Without a doubt, addressing our nation's opioid crisis calls for a multi-pronged effort involving many health care stakeholders – from physicians to pharmaceutical companies, and pharmacies to government officials. **With the implementation of the MME-based management program, and the launch of an enterprise-wide campaign to reduce unnecessary opioid prescribing and use, we are further strengthening our commitment to helping our clients and their members balance the need for these powerful medications with the risk of abuse and misuse.**

To learn more about our enterprise-wide commitment to reducing opioid misuse and abuse, go to <https://payorsolutions.cvshealth.com/insights/comprehensive-response-to-national-opioid-abuse-epidemic>.

1. <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

2. <https://www.cdc.gov/drugoverdose/data/analysis.html>.

3. SAMHSA. Prescription Drug Use and Misuse in the United States: Results from the National Survey on Drug Use and Health.

4. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm>.

5. <http://annals.org/aim/article/2603228/noninvasive-treatments-acute-subacute-chronic-low-back-pain-clinical-practice>.

STEP THERAPY WITH QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

DRUG CLASS EXTENDED RELEASE OPIOID ANALGESICS

BRAND NAME*
(generic)

ARYMO ER
(morphine sulfate extended-release tablets)

AVINZA
(morphine extended-release capsules)

BELBUCA
(buprenorphine buccal film)

BUTRANS
(buprenorphine transdermal system)

CONZIP
(tramadol hydrochloride extended-release)

DOLOPHINE 5 MG, 10 MG
(methadone hydrochloride tablets)

DURAGESIC
(fentanyl transdermal system)

EMBEDA
(morphine sulfate and naltrexone hydrochloride extended-release)

EXALGO
(hydromorphone hydrochloride extended-release)

HYSINGLA ER
(hydrocodone bitartrate extended-release tablets)

KADIAN
(morphine extended-release capsules)

METHADONE 5 MG/5 ML & 10 MG/5 ML ORAL SOLN, 200 MG/20 ML INJ
(methadone hydrochloride injection; oral solution)

METHADONE INTENSOL 10 MG/ML
(methadone oral concentrate)

METHADOSE 5 MG, 10 MG
(methadone hydrochloride tablets)

MORPHABOND
(morphine extended-release tablets)

MS CONTIN
(morphine extended-release tablets)

NUCYNTA ER
(tapentadol extended-release tablets)

OPANA ER
(oxymorphone hydrochloride extended-release tablets)

OXYCONTIN
(oxycodone hydrochloride extended-release tablets)

(oxymorphone hydrochloride extended-release tablets)

TARGINIQ ER
(oxycodone HCl/naloxone HCl extended-release tablets)

(tramadol hydrochloride extended-release)

TROXYCA ER
(oxycodone hydrochloride/naltrexone extended-release capsules)

ULTRAM ER
(tramadol hydrochloride extended-release tablets)

VANTRELA ER
(hydrocodone bitartrate extended-release tablets)

XTAMPZA ER
(oxycodone extended-release capsules)

ZOHYDRO ER
(hydrocodone bitartrate extended-release capsules)

Status: CVS Caremark Criteria

Type: Initial Step Therapy; Initial Limit; Post Limit PA

** Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated.*

POLICY

FDA-APPROVED INDICATIONS

Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda

Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda are not indicated as an as-needed (prn) analgesic.

Belbuca and Butrans

Belbuca and Butrans are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse and misuse with opioids, even at recommended doses, and because of the greater risk of overdose and death with extended-release opioid formulations, reserve Belbuca and Butrans for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Belbuca and Butrans are not indicated as an as-needed (prn) analgesic.

ConZip

ConZip is indicated for the management of moderate to moderately severe chronic pain in adults who require around-the-clock treatment of their pain for an extended period of time.

Dolophine Tablets

Dolophine is indicated for the:

- Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Dolophine for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Dolophine is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

Duragesic

Duragesic is indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Duragesic for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

Exalgo

Exalgo is indicated for the management of pain in opioid-tolerant patients severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Patients considered opioid tolerant are those who are receiving, for one week or longer, at least 60 mg oral morphine per day, 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day or an equianalgesic dose of another opioid.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Exalgo for use in patients for

whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

- Exalgo is not indicated as an as-needed (prn) analgesic.

Hysingla ER

Hysingla ER (hydrocodone bitartrate) is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Hysingla ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Hysingla ER is not indicated as an as-needed (prn) analgesic.

Methadone Injection

Methadone Injection is indicated:

- For the treatment of moderate to severe pain not responsive to non-narcotic analgesics.
- For use in temporary treatment of opioid dependence in patients unable to take oral medication.

Outpatient maintenance and outpatient detoxification treatment may be provided only by opioid treatment programs (OTPs) certified by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and registered by the Drug Enforcement Administration (DEA). This does not preclude the maintenance treatment of a patient with concurrent opioid addiction who is hospitalized for conditions other than opioid addiction and who requires temporary maintenance during the critical period of hospitalization, or of a patient whose enrollment has been verified in a program which has been certified for maintenance treatment with methadone.

NOTE: INJECTABLE METHADONE PRODUCTS ARE NOT APPROVED FOR THE OUTPATIENT TREATMENT OF OPIOID DEPENDENCE. IN THIS PATIENT POPULATION, PARENTERAL METHADONE IS TO BE USED ONLY FOR PATIENTS UNABLE TO TAKE ORAL MEDICATION, SUCH AS HOSPITALIZED PATIENTS.

Methadone Intensol

Methadone Hydrochloride Intensol (oral concentrate) is indicated for the:

- Management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

Limitations of Use

- Methadone Hydrochloride Intensol (oral concentrate) is not for use:
- As an as-needed (prn) analgesic.
- For pain that is mild or not expected to persist for an extended period of time.
- For acute pain.
- For postoperative pain.

Methadone Oral Solution

Methadone Hydrochloride Oral Solution USP is indicated for the:

- Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Methadone Hydrochloride Oral Solution USP for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Methadone Hydrochloride Oral Solution USP is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

Methadose Tablets

Methadose Oral Tablets (methadone hydrochloride tablets USP) are indicated for the:

- Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Methadose for use in patients for whom

alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

- Methadone is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

Conditions For Distribution And Use Of Methadone Products For The Treatment Of Opioid Addiction

Code of Federal Regulations, Title 42, Sec 8

Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs shall dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (42 CFR 8.12). See below for important regulatory exceptions to the general requirement for certification to provide opioid agonist treatment.

Failure to abide by the requirements in these regulations may result in criminal prosecution, seizure of the drug supply, revocation of the program approval, and injunction precluding operation of the program.

Regulatory Exceptions To The General Requirement For Certification To Provide Opioid Agonist Treatment:

During inpatient care, when the patient was admitted for any condition other than concurrent opioid addiction [pursuant to 21CFR 1306.07(c)], to facilitate the treatment of the primary admitting diagnosis).

During an emergency period of no longer than 3 days while definitive care for the addiction is being sought in an appropriately licensed facility [pursuant to 21CFR 1306.07(b)].

Nucynta ER

Nucynta ER is indicated for the management of:

- Pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
- Neuropathic pain associated with diabetic peripheral neuropathy (DPN) in adults severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Usage

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Nucynta ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Nucynta ER is not indicated as an as-needed (prn) analgesic.

Opana ER

Opana ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Opana ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Opana ER is not indicated as an as-needed (prn) analgesic.

OxyContin

Oxycontin is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate in:

- Adults; and
- Opioid-tolerant pediatric patients 11 years of age and older who are already receiving and tolerate a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent.

Limitations of Usage

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Oxycontin for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Oxycontin is not indicated as an as-needed (prn) analgesic.

Targiniq ER

Targiniq ER is indicated for the management of pain severe enough to require daily, around the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Targiniq ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Targiniq ER is not indicated as an as-needed (prn) analgesic.
- The maximum total daily dose of Targiniq ER should not exceed 80 mg/40 mg (40 mg/20 mg q12h) because higher doses may be associated with symptoms of opioid withdrawal or decreased analgesia.

Tramadol Hydrochloride Extended-Release

Tramadol hydrochloride extended-release is indicated for the management of moderate to moderately severe chronic pain in adults who require around-the-clock treatment of their pain for an extended period of time.

Troxyca ER

Troxyca ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Troxyca ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Troxyca ER is not indicated as an as-needed (prn) analgesic.

Ultram ER

Ultram ER is indicated for the management of moderate to moderately severe chronic pain in adults who require around-the-clock treatment of their pain for an extended period of time.

Vantrela ER

Vantrela ER is an opioid agonist indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitation of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Vantrela ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Vantrela ER is not indicated as an as-needed (prn) analgesic.

Xtampza ER

Xtampza ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Xtampza ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Xtampza ER is not indicated as an as-needed (prn) analgesic.

Zohydro ER

Zohydro ER (hydrocodone bitartrate) is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Zohydro ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Zohydro ER is not indicated as an as-needed (prn) analgesic.

PROGRAM DESCRIPTION*

Neither step therapy requirements nor quantity limits apply if the patient has a drug in claims history that indicates the patient is being treated for cancer in the past year.

Step Therapy

If a patient has filled a cumulative ≥ 7 -day supply of an immediate-release opioid agent within the past 90 days OR has been receiving an extended-release opioid agent for a cumulative ≥ 30 days within the past 90 days, the extended-release opioid will adjudicate for up to the initial quantity limit.

If the patient does not have at least a cumulative 7-day supply of an immediate-release opioid agent OR at least a cumulative 30-day supply of an extended-release opioid within history in the past 90 days (i.e., the patient has not used an IR opioid prior to the ER opioid OR the patient is not already stable on an ER opioid), then the claim will reject with a message indicating that a prior authorization (PA) is required.

Quantity Limit/Post Limit

Plans implementing morphine milligram equivalent (MME) based quantity limits on extended-release opioids are providing coverage for an initial amount of 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below.

Prior authorization review is required to determine coverage for additional quantities above the initial limit.

Post limit quantities are set not to exceed 200 MME per day (unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day). Post limit quantities will not be set up for patients with cancer, a terminal condition or pain being managed through hospice or palliative care.

**Step Therapy logic will apply first, followed by initial quantity limit logic.*

INITIAL STEP THERAPY

If the patient has filled a prescription for a ≥ 1 day supply of a drug indicating the patient is being treated for cancer within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

For patients with no prescription claims of a cancer drug in the past 365 days:

If the patient has filled a prescription for a cumulative ≥ 7 -day supply of an immediate-release opioid agent within history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below).

If the patient has filled a prescription for a cumulative ≥ 30 -day supply of an extended-release opioid within the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below).

If the patient does not have at least a cumulative 7-day supply of an immediate-release opioid agent OR at least a cumulative 30-day supply of an extended-release opioid within history in the past 90-days (i.e., the patient has not used an IR opioid prior to the ER opioid OR the patient is not already stable on an ER opioid), the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care

OR

- The requested drug is being prescribed for CHRONIC pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]

AND

- The patient can safely take the requested dose based on their history of opioid use

AND

- The patient has been evaluated and will be monitored regularly for the development of opioid use disorder

AND

- The patient’s pain will be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety
AND
- This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days **OR**
- The patient has severe continuous pain and has received an immediate-release opioid for at least one week
AND
- If the request is for a methadone product, then it is NOT being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction

[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

Quantity Limits may apply.

Opioid Analgesics ER Quantity Limits Chart					
Coverage is provided without prior authorization for 30-day or 90-day ER opioid prescriptions for an amount ≤ 90 MME/day (when Step Therapy criteria met). Coverage for quantities ≤ 200 MME/day (unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day) for a 30-day or 90-day supply is provided through prior authorization when coverage conditions are met.					
These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc.)					
		COLUMN A	COLUMN B	COLUMN C	COLUMN D
Drug/Strength	Labeled Dosing	Initial 1 Month Limit* ≤ 90 MME/day (per 25 days)	Initial 3 Month Limit* ≤ 90 MME/day (per 75 days)	Post 1 Month Limit* ≤ 200 MME/day** (per 25 days)	Post 3 Month Limit* ≤ 200 MME/day** (per 75 days)
Arymo ER 15 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
Arymo ER 30 mg	q8-12h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	120 tabs (120 MME/day)	360 tabs (120 MME/day)
Arymo ER 60 mg	q8-12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
Avinza 30 mg	q24h, MAX 1600 mg/day	30 caps (30 MME/day)	90 caps (30 MME/day)	60 caps (60 MME/day)	180 caps (60 MME/day)
Avinza 45 mg	q24h, MAX 1600 mg/day	30 caps (45 MME/day)	90 caps (45 MME/day)	60 caps (90 MME/day)	180 caps (90 MME/day)
Avinza 60 mg	q24h, MAX 1600 mg/day	30 caps (60 MME/day)	90 caps (60 MME/day)	60 caps (120 MME/day)	180 caps (120 MME/day)
Avinza 75 mg	q24h, MAX 1600 mg/day	30 caps (75 MME/day)	90 caps (75 MME/day)	60 caps (150 MME/day)	180 caps (150 MME/day)
Avinza 90 mg	q24h, MAX 1600 mg/day	30 caps (90 MME/day)	90 caps (90 MME/day)	60 caps (180 MME/day)	180 caps (180 MME/day)
Avinza 120 mg	q24h, MAX 1600 mg/day	0***	0***	30 caps (120 MME/day)	90 caps (120 MME/day)
Belbuca 75 mcg	1 film q12h, MAX 900 mcg/12 hrs	60 films (4.5 MME/day)	180 films (4.5 MME/day)	90 films (6.75 MME/day)	270 films (6.75 MME/day)
Belbuca 150 mcg	1 film q12h, MAX 900 mcg/12 hrs	60 films (9 MME/day)	180 films (9 MME/day)	90 films (13.5 MME/day)	270 films (13.5 MME/day)
Belbuca 300 mcg	1 film q12h, MAX 900 mcg/12 hrs	60 films (18 MME/day)	180 films (18 MME/day)	90 films (27 MME/day)	270 films (27 MME/day)
Belbuca 450 mcg	1 film q12h, MAX 900 mcg/12 hrs	60 films (27 MME/day)	180 films (27 MME/day)	90 films (40.5 MME/day)	270 films (40.5 MME/day)
Belbuca 600 mcg	1 film q12h, MAX 900 mcg/12 hrs	0***	0***	60 films (36 MME/day)	180 films (36 MME/day)
Belbuca 750 mcg	1 film q12h, MAX 900 mcg/12 hrs	0***	0***	60 films (45 MME/day)	180 films (45 MME/day)

Belbuca 900 mcg	1 film q12h, MAX 900 mcg/12 hrs	0***	0***	60 films (54 MME/day)	180 films (54 MME/day)
Butrans 5 mcg/hr	1 patch q7d, MAX 20 mcg/hr	4 patches (9 MME/day)	12 patches (9 MME/day)	8 patches (18 MME/day)	24 patches (18 MME/day)
Butrans 7.5 mcg/hr	1 patch q7d, MAX 20 mcg/hr	4 patches (13.5 MME/day)	12 patches (13.5 MME/day)	8 patches (27 MME/day)	24 patches (27 MME/day)
Butrans 10 mcg/hr	1 patch q7d, MAX 20 mcg/hr	4 patches (18 MME/day)	12 patches (18 MME/day)	8 patches (36 MME/day)	24 patches (36 MME/day)
Butrans 15 mcg/hr	1 patch q7d, MAX 20 mcg/hr	0***	0***	4 patches (27 MME/day)	12 patches (27 MME/day)
Butrans 20 mcg/hr	1 patch q7d, MAX 20 mcg/hr	0***	0***	4 patches (36 MME/day)	12 patches (36 MME/day)
Conzip 100 mg	1 tab qd, MAX 300 mg/day	30 caps (10 MME/day)	90 caps (10 MME/day)	60 caps (20 MME/day)	180 caps (20 MME/day)
Conzip 200 mg	1 tab qd, MAX 300 mg/day	0***	0***	30 caps (20 MME/day)	90 caps (20 MME/day)
Conzip 300 mg	1 tab qd, MAX 300 mg/day	0***	0***	30 caps (30 MME/day)	90 caps (30 MME/day)
Dolophine 5 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
Dolophine 10 mg	q8-12h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	120 tabs (120 MME/day)	360 tabs (120 MME/day)
Duragesic 12 mcg	1 patch q72h	10 patches (28.8 MME/day)	30 patches (28.8 MME/day)	20 patches (57.6 MME/day)	60 patches (57.6 MME/day)
Duragesic 25 mcg	1 patch q72h	10 patches (60 MME/day)	30 patches (60 MME/day)	20 patches (120 MME/day)	60 patches (120 MME/day)
Duragesic 37.5 mcg	1 patch q72h	10 patches (90 MME/day)	30 patches (90 MME/day)	20 patches (180 MME/day)	60 patches (180 MME/day)
Duragesic 50 mcg	1 patch q72h	0***	0***	10 patches (120 MME/day)	30 patches (120 MME/day)
Duragesic 62.5 mcg	1 patch q72h	0***	0***	10 patches (150 MME/day)	30 patches (150 MME/day)
Duragesic 75 mcg	1 patch q72h	0***	0***	10 patches (180 MME/day)	30 patches (180 MME/day)
Duragesic 87.5 mcg	1 patch q72h	0***	0***	10 patches (210 MME/day)	30 patches (210 MME/day)
Duragesic 100 mcg	1 patch q72h	0***	0***	10 patches (240 MME/day)	30 patches (240 MME/day)
Embeda 20/0.8 mg	q12-24h	60 caps (40 MME/day)	180 caps (40 MME/day)	90 caps (60 MME/day)	270 caps (60 MME/day)
Embeda 30/1.2 mg	q12-24h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Embeda 50/2 mg	q12-24h	30 caps (50 MME/day)	90 caps (50 MME/day)	60 caps (100 MME/day)	180 caps (100 MME/day)
Embeda 60/2.4 mg	q12-24h	30 caps (60 MME/day)	90 caps (60 MME/day)	60 caps (120 MME/day)	180 caps (120 MME/day)
Embeda 80/3.2 mg	q12-24h	30 caps (80 MME/day)	90 caps (80 MME/day)	60 caps (160 MME/day)	180 caps (160 MME/day)
Embeda 100/4 mg	q12-24h	0***	0***	60 caps (200 MME/day)	180 caps (200 MME/day)
Exalgo 8 mg	1 tab qd	30 tabs (32 MME/day)	90 tabs (32 MME/day)	60 tabs (64 MME/day)	180 tabs (64 MME/day)
Exalgo 12 mg	1 tab qd	30 tabs (48 MME/day)	90 tabs (48 MME/day)	60 tabs (96 MME/day)	180 tabs (96 MME/day)
Exalgo 16 mg	1 tab qd	30 tabs (64 MME/day)	90 tabs (64 MME/day)	60 tabs (128 MME/day)	180 tabs (128 MME/day)
Exalgo 32 mg	1 tab qd	0***	0***	30 tabs (128 MME/day)	90 tabs (128 MME/day)
Hysingla ER 20 mg	q24h	30 tabs (20 MME/day)	90 tabs (20 MME/day)	60 tabs (40 MME/day)	180 tabs (40 MME/day)
Hysingla ER 30 mg	q24h	30 tabs (30 MME/day)	90 tabs (30 MME/day)	60 tabs (60 MME/day)	180 tabs (60 MME/day)
Hysingla ER 40 mg	q24h	30 tabs (40 MME/day)	90 tabs (40 MME/day)	60 tabs (80 MME/day)	180 tabs (80 MME/day)
Hysingla ER 60 mg	q24h	30 tabs	90 tabs	60 tabs	180 tabs

		(60 MME/day)	(60 MME/day)	(120 MME/day)	(120 MME/day)
Hysingla ER 80 mg	q24h	30 tabs (80 MME/day)	90 tabs (80 MME/day)	60 tabs (160 MME/day)	180 tabs (160 MME/day)
Hysingla ER 100 mg	q24h	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
Hysingla ER 120 mg	q24h	0***	0***	30 tabs (120 MME/day)	90 tabs (120 MME/day)
Kadian 10 mg	q12-24h	60 caps (20 MME/day)	180 caps (20 MME/day)	90 caps (30 MME/day)	270 caps (30 MME/day)
Kadian 20 mg	q12-24h	60 caps (40 MME/day)	180 caps (40 MME/day)	90 caps (60 MME/day)	270 caps (60 MME/day)
Kadian 30 mg	q12-24h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Kadian 40 mg	q12-24h	60 caps (80 MME/day)	180 caps (80 MME/day)	90 caps (120 MME/day)	270 caps (120 MME/day)
Kadian 50 mg	q12-24h	30 caps (50 MME/day)	90 caps (50 MME/day)	60 caps (100 MME/day)	180 caps (100 MME/day)
Kadian 60 mg	q12-24h	30 caps (60 MME/day)	90 caps (60 MME/day)	60 caps (120 MME/day)	180 caps (120 MME/day)
Kadian 70 mg	q12-24h	30 caps (70 MME/day)	90 caps (70 MME/day)	60 caps (140 MME/day)	180 caps (140 MME/day)
Kadian 80 mg	q12-24h	30 caps (80 MME/day)	90 caps (80 MME/day)	60 caps (160 MME/day)	180 caps (160 MME/day)
Kadian 100 mg	q12-24h	0***	0***	60 caps (200 MME/day)	180 caps (200 MME/day)
Kadian 130 mg	q12-24h	0***	0***	30 caps (130 MME/day)	90 caps (130 MME/day)
Kadian 150 mg	q12-24h	0***	0***	30 caps (150 MME/day)	90 caps (150 MME/day)
Kadian 200 mg	q12-24h	0***	0***	30 caps (200 MME/day)	90 caps (200 MME/day)
Methadone 10 mg/mL Intensol soln	q8-12h	90 mL (90 MME/day)	270 mL (90 MME/day)	120 mL (120 MME/day)	360 mL (120 MME/day)
Methadone 5 mg/5 mL Oral soln	q8-12h	450 mL (45 MME/day)	1350 mL (45 MME/day)	600 mL (60 MME/day)	1800 mL (60 MME/day)
Methadone 10 mg/5 mL Oral soln	q8-12h	450 mL (90 MME/day)	1350 mL (90 MME/day)	600 mL (120 MME/day)	1800 mL (120 MME/day)
Methadone 200 mg/20 mL inj	q8-12h	20 mL (1 multidose vial) (20 MME/day)	60 mL (3 multidose vials) (20 MME/day)	40 mL (2 multidose vials) (40 MME/day)	120 mL (6 multidose vials) (40 MME/day)
Methadose 5 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
Methadose 10 mg	q8-12h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	120 tabs (120 MME/day)	360 tabs (120 MME/day)
MorphaBond 15 mg	q12h	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
MorphaBond 30 mg	q12h	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
MorphaBond 60 mg	q12h	0***	0***	60 tabs (120 MME/day)	180 tabs (120 MME/day)
MorphaBond 100 mg	q12h	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
MS Contin 15 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
MS Contin 30 mg	q8-12h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	120 tabs (120 MME/day)	360 tabs (120 MME/day)
MS Contin 60 mg	q8-12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
MS Contin 100 mg	q8-12h	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
MS Contin 200 mg	q8-12h	0***	0***	60 tabs (400 MME/day)	180 tabs (400 MME/day)
Nucynta ER 50 mg	q12h, MAX 500 mg/day	60 tabs (40 MME/day)	180 tabs (40 MME/day)	90 tabs (60 MME/day)	270 tabs (60 MME/day)

Nucynta ER 100 mg	q12h, MAX 500 mg/day	60 tabs (80 MME/day)	180 tabs (80 MME/day)	90 tabs (120 MME/day)	270 tabs (120 MME/day)
Nucynta ER 150 mg	q12h, MAX 500 mg/day	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
Nucynta ER 200 mg	q12h, MAX 500 mg/day	0***	0***	60 tabs (160 MME/day)	180 tabs (160 MME/day)
Nucynta ER 250 mg	q12h, MAX 500 mg/day	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
Opana ER 5 mg	q12h	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
Opana ER 7.5 mg	q12h	60 tabs (45MME/day)	180 tabs (45 MME/day)	90 tabs (67.5 MME/day)	270 tabs (67.5 MME/day)
Opana ER 10 mg	q12h	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
Opana ER 15 mg	q12h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	90 tabs (135 MME/day)	270 tabs (135 MME/day)
Opana ER 20 mg	q12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
Opana ER 30 mg	q12h	0***	0***	60 tabs (180 MME/day)	180 tabs (180 MME/day)
Opana ER 40 mg	q12h	0***	0***	60 tabs (240 MME/day)	180 tabs (240 MME/day)
OxyContin 10 mg	q12h	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
OxyContin 15 mg	q12h	60 tabs (45 MME/day)	180 tabs (45 MME/day)	90 tabs (67.5 MME/day)	270 tabs (67.5 MME/day)
OxyContin 20 mg	q12h	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
OxyContin 30 mg	q12h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	90 tabs (135 MME/day)	270 tabs (135 MME/day)
OxyContin 40 mg	q12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
OxyContin 60 mg	q12h	0***	0***	60 tabs (180 MME/day)	180 tabs (180 MME/day)
OxyContin 80 mg	q12h	0***	0***	60 tabs (240 MME/day)	180 tabs (240 MME/day)
Targiniq ER 10 mg/5 mg	q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
Targiniq ER 20 mg/10 mg	q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
Targiniq ER 40 mg/20 mg	q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)	0***	0***	60 tabs (120 MME/day)	180 tabs (120 MME/day)
Tramadol ER 100 mg	1 tab qd, MAX 300 mg/day	30 tabs (10 MME/day)	90 tabs (10 MME/day)	60 tabs (20 MME/day)	180 tabs (20 MME/day)
Tramadol ER 150 mg	1 cap qd, MAX 300 mg/day	30 caps (15 MME/day)	90 caps (15 MME/day)	60 caps (30 MME/day)	180 caps (30 MME/day)
Tramadol ER 200 mg	1 tab qd, MAX 300 mg/day	0***	0***	30 tabs (20 MME/day)	90 tabs (20 MME/day)
Tramadol ER 300 mg	1 tab qd, MAX 300 mg/day	0***	0***	30 tabs (30 MME/day)	90 tabs (30 MME/day)
Troxyca ER 10 mg/1.2 mg	q12h	60 caps (30 MME/day)	180 caps (30 MME/day)	90 caps (45 MME/day)	270 caps (45 MME/day)
Troxyca ER 20 mg/2.4 mg	q12h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Troxyca ER 30 mg/3.6 mg	q12h	60 caps (90 MME/day)	180 caps (90 MME/day)	90 caps (135 MME/day)	270 caps (135 MME/day)
Troxyca ER 40 mg/4.8 mg	q12h	0***	0***	90 caps (180 MME/day)	270 caps (180 MME/day)
Troxyca ER 60 mg/7.2 mg	q12h	0***	0***	60 caps (180 MME/day)	180 caps (180 MME/day)
Troxyca ER 80 mg/9.6 mg	q12h	0***	0***	60 caps (240 MME/day)	180 caps (240 MME/day)

Ultram ER 100 mg	1 tab qd, MAX 300 mg/day	30 tabs (10 MME/day)	90 tabs (10 MME/day)	60 tabs (20 MME/day)	180 tabs (20 MME/day)
Ultram ER 200 mg	1 tab qd, MAX 300 mg/day	0***	0***	30 tabs (20 MME/day)	90 tabs (20 MME/day)
Ultram ER 300 mg	1 tab qd, MAX 300 mg/day	0***	0***	30 tabs (30 MME/day)	90 tabs (30 MME/day)
Vantrela ER 15 mg	q12h, MAX 90 mg q12h (180 mg/day)	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
Vantrela ER 30 mg	q12h, MAX 90 mg q12h (180 mg/day)	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
Vantrela ER 45 mg	q12h, MAX 90 mg q12h (180 mg/day)	60 tabs (90 MME/day)	180 tabs (90 MME/day)	90 tabs (135 MME/day)	270 tabs (135 MME/day)
Vantrela ER 60 mg	q12h, MAX 90 mg q12h (180 mg/day)	0***	0***	60 tabs (120 MME/day)	180 tabs (120 MME/day)
Vantrela ER 90 mg	q12h, MAX 90 mg q12h (180 mg/day)	0***	0***	60 tabs (180 MME/day)	180 tabs (180 MME/day)
Xtampza ER 9 mg	q12h, MAX 288 mg/day	60 caps (27 MME/day)	180 caps (27 MME/day)	90 caps (40.5 MME/day)	270 caps (40.5 MME/day)
Xtampza ER 13.5 mg	q12h, MAX 288 mg/day	60 caps (40.5 MME/day)	180 caps (40.5 MME/day)	90 caps (60.75 MME/day)	270 caps (60.75 MME/day)
Xtampza ER 18 mg	q12h, MAX 288 mg/day	60 caps (54 MME/day)	180 caps (54 MME/day)	90 caps (81 MME/day)	270 caps (81 MME/day)
Xtampza ER 27 mg	q12h, MAX 288 mg/day	60 caps (81 MME/day)	180 caps (81 MME/day)	90 caps (121.6 MME/day)	270 caps (121.6 MME/day)
Xtampza ER 36 mg	q12h, MAX 288 mg/day	0***	0***	90 caps (162 MME/day)	270 caps (162 MME/day)
Zohydro ER 10 mg	q12h	60 caps (20 MME/day)	180 caps (20 MME/day)	90 caps (30 MME/day)	270 caps (30 MME/day)
Zohydro ER 15 mg	q12h	60 caps (30 MME/day)	180 caps (30 MME/day)	90 caps (45 MME/day)	270 caps (45 MME/day)
Zohydro ER 20 mg	q12h	60 caps (40 MME/day)	180 caps (40 MME/day)	90 caps (60 MME/day)	270 caps (60 MME/day)
Zohydro ER 30 mg	q12h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Zohydro ER 40 mg	q12h	60 caps (80 MME/day)	180 caps (80 MME/day)	90 caps (120 MME/day)	270 caps (120 MME/day)
Zohydro ER 50 mg	q12h	0***	0***	60 caps (100 MME/day)	180 caps (100 MME/day)

*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

**Unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day.

***The initial limit is zero. All requests for this drug and strength will be considered through post limit prior authorization.

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 3/1/2018

Revision Information	
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DURATION LIMIT WITH QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	IMMEDIATE-RELEASE OPIOID ANALGESICS (BRAND AND GENERIC)*
generic name	
dosage form	(codeine sulfate oral solution, tablets)
	(hydromorphone hydrochloride oral liquid, suppositories, tablets)
	(levorphanol tartrate tablets)
	(meperidine hydrochloride oral solution, tablets)
	(morphine sulfate oral soln, oral soln concentrate, suppositories, tablets)
	(oxycodone hydrochloride capsules, oral soln, oral soln concentrate, tabs)
	(oxymorphone hydrochloride tablets)
	(pentazocine/naloxone tablets)
	(tapentadol tablets)
	(tramadol hydrochloride tablets)
Status: CVS Caremark Criteria	
Type: Initial Step; Duration Limit; Initial Limit; Post Limit PA	

* Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated.

POLICY

FDA-APPROVED INDICATIONS

Codeine Sulfate

Oral Solution

Codeine sulfate is an opioid analgesic indicated for the management of mild to moderately severe pain where the use of an opioid analgesic is appropriate.

Tablets

Codeine sulfate tablets are an opioid analgesic indicated for the relief of mild to moderately severe pain where the use of an opioid analgesic is appropriate.

Hydromorphone Hydrochloride

Oral Liquid, Tablets, Suppositories

Hydromorphone hydrochloride oral liquid, tablets, and suppositories are indicated for the management of pain in patients where an opioid analgesic is appropriate.

Levorphanol Tartrate

Levorphanol tartrate tablets are indicated for the management of moderate to severe pain where an opioid analgesic is appropriate.

Meperidine Hydrochloride

Oral Solution

Meperidine hydrochloride oral solution is indicated for the relief of moderate to severe pain.

Tablets

Meperidine tablets are indicated for the relief of moderate to severe pain.

Morphine Sulfate

Oral Solution and Oral Concentrate

Morphine sulfate oral solution (10 mg per 5 mL and 20 mg per 5 mL) are formulations of morphine, an opioid agonist, indicated for the relief of moderate to severe acute and chronic pain where use of an opioid analgesic is appropriate.

Morphine sulfate oral solution 100 mg per 5 mL (20 mg/mL) is an opioid analgesic indicated for the relief of moderate to severe acute and chronic pain in opioid-tolerant patients.

Morphine sulfate oral solution 100 mg per 5 mL (20 mg/mL) may cause fatal respiratory depression when administered to patients not previously exposed to opioids. Patients considered to be opioid tolerant are those who are taking at least 60 mg oral morphine per day, or at least 30 mg of oral oxycodone per day, or at least 12 mg hydromorphone per day, or an equianalgesic dose of another opioid, for a week or longer.

Tablets and Suppositories

Morphine sulfate is an opioid agonist indicated for the relief of moderate to severe acute and chronic pain where use of an opioid analgesic is appropriate.

Nucynta (tapentadol)

Nucynta is indicated for the management of moderate to severe acute pain in adults.

Oxycodone Hydrochloride

Capsules

Oxycodone hydrochloride capsule is an opioid analgesic, indicated for the management of moderate to severe acute and chronic pain where use of an opioid analgesic is appropriate.

Oral Solution

Oxycodone hydrochloride Oral Solution 5 mg per 5 mL, is an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe acute and chronic pain where the use of an opioid analgesic is appropriate.

Oxycodone hydrochloride Oral Solution 100 mg per 5 mL (20 mg/mL) is an opioid analgesic indicated for the management of moderate to severe acute and chronic pain in opioid-tolerant patients.

Oxycodone hydrochloride Oral Solution 100 mg per 5 mL (20 mg/mL) may cause fatal respiratory depression when administered to patients not previously exposed to opioids. Patients considered to be opioid tolerant are those who are taking at least 30 mg of oral oxycodone per day, or at least 60 mg oral morphine per day, or at least 12 mg hydromorphone per day, or an equianalgesic dose of another opioid, for a week or longer.

Tablets

Oxycodone hydrochloride tablets are an immediate-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain where the use of an opioid analgesic is appropriate.

Oxymorphone Hydrochloride

Oxymorphone hydrochloride tablets are indicated for the relief of moderate to severe acute pain where the use of an opioid is appropriate.

Pentazocine/Naloxone

Pentazocine/naloxone is indicated for the relief of moderate to severe pain. Pentazocine/naloxone is indicated for oral use only.

RoxyBond (oxycodone hydrochloride)

RoxyBond is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve RoxyBond for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Ultram (tramadol)

Ultram is indicated for the management of moderate to moderately severe pain in adults.

PROGRAM DESCRIPTION*

Neither acute pain duration limits nor quantity limits apply if the patient has a drug in claims history that indicates the patient is being treated for cancer in the past year.

Acute Pain Duration Limit

Coverage is provided for up to a 7-day supply of immediate-release opioids in situations where the patient does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history during the previous 3 months (i.e., this is the patient's first fill of an opioid). Prior authorization review is required to determine coverage for a quantity necessary for treatment beyond 7 days.

In situations where the patient has a cumulative ≥ 7 -day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days, the immediate-release opioid will adjudicate for up to the initial quantity limit.

Quantity Limit/Post Limit

Plans implementing morphine milligram equivalent (MME) based quantity limits on immediate-release opioids are providing coverage for an initial amount of 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below.

Prior authorization review is required to determine coverage for additional quantities above the initial limit. Post limit quantities are set to provide coverage for additional quantities of the prescribed opioid that do not exceed 200 MME per day. Post limit quantities will not apply to patients with cancer, a terminal condition, or pain being managed through hospice or palliative care.

**Acute Pain Duration Limit logic will apply first, followed by initial quantity limit logic.*

INITIAL STEP THERAPY

If the patient has filled a prescription for a ≥ 1 -day supply of a drug indicating the patient is being treated for cancer within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

For patients with no prescription claims of a cancer drug in the past 365 days:

If the patient has filled a prescription for a cumulative ≥ 7 -day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

If the patient does not have a least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid), then the Acute Pain Duration Limit criteria will apply to the incoming prescription drug. If the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply or submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

LIMIT CRITERIA*

Neither acute pain duration limits nor quantity limits apply if the patient has a drug in claims history that indicates the patient is being treated for cancer in the past year.

ACUTE PAIN DURATION LIMIT:

The acute pain duration limit portion of this program applies to patients identified with potential first fills of immediate-release opioid prescriptions for the treatment of non-cancer related pain. A first fill is defined as cumulative < 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history during the previous 3 months.

Coverage is provided for up to a 7-day supply of immediate-release opioids in situations where the patient does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history during the previous 3 months (i.e., this is the patient's first fill of an opioid).

In situations where the patient has a cumulative \geq 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days, the immediate-release opioid will adjudicate for up to the initial quantity limit.

INITIAL QUANTITY LIMIT:

Morphine milligram equivalent (MME) quantity limits for immediate-release opioids provide coverage for an initial amount of 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below. Prior authorization review is required to determine coverage for additional quantities above the initial limit.

**Acute Pain Duration Limit logic will apply first, followed by initial quantity limit logic.*

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care

OR

- The patient can safely take the requested dose based on their history of opioid use

AND

- The patient has been evaluated and will be monitored regularly for the development of opioid use disorder

AND

- The requested drug is being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate. [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]

AND

- The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety

OR

- The patient requires extended treatment beyond 7 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate

Quantity Limits may apply.

Opioid Analgesics IR Quantity Limits Chart

Coverage is provided without prior authorization (for patients not identified as potential first fills) for 30-day or 90-day IR opioid prescriptions for an amount \leq 90 MME/day. Coverage for quantities \leq 200 MME/day for a 30-day or 90-day supply is provided through prior authorization when coverage conditions are met.

These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc.)

		COLUMN A	COLUMN B	COLUMN C	COLUMN D
Drug/Strength**	Labeled Dosing	Initial 1 Month Limit* \leq 90 MME/day (per 25 days)	Initial 3 Month Limit* \leq 90 MME/day (per 75 days)	Post 1 Month Limit* \leq 200 MME/day (per 25 days)	Post 3 Month Limit* \leq 200 MME/day (per 75 days)
Codeine sulfate oral soln 30 mg/5 mL	15 to 60 mg (2.5 mL to 10 mL) q4h. Max Daily Dose 360 mg.	210 mL*** (27 MME/day)	210 mL*** (27 MME/day)	840 mL*** (54 MME/day)	840 mL*** (54 MME/day)
Codeine sulfate tab 15 mg	15 to 60 mg q4h. Max Daily Dose 360 mg.	42 tabs*** (13.5 MME/day)	42 tabs*** (13.5 MME/day)	84 tabs*** (13.5 MME/day)	84 tabs*** (13.5 MME/day)
Codeine sulfate tab 30 mg	15 to 60 mg q4h. Max Daily Dose 360 mg.	42 tabs*** (27 MME/day)	42 tabs*** (27 MME/day)	84 tabs*** (27 MME/day)	84 tabs*** (27 MME/day)
Codeine sulfate tab 60 mg	15 to 60 mg q4h. Max Daily Dose 360 mg.	42 tabs*** (54 MME/day)	42 tabs*** (54 MME/day)	84 tabs*** (54 MME/day)	84 tabs*** (54 MME/day)
Hydromorphone liquid 1 mg/mL	2.5 mg – 10 mg (2.5 mL to 10 mL) q3-6h	600 mL (80 MME/day)	1800 mL (80 MME/day)	1500 mL (200 MME/day)	4500 mL (200 MME/day)
Hydromorphone supp 3 mg	1 supp q6-8h	120 supps (48 MME/day)	360 supps (48 MME/day)	180 supps (72 MME/day)	540 supps (72 MME/day)
Hydromorphone tab 2 mg	2-4 mg q4-6h	180 tabs (48 MME/day)	540 tabs (48 MME/day)	270 tabs (72 MME/day)	810 tabs (72 MME/day)
Hydromorphone tab 4 mg	2-4 mg q4-6h	150 tabs (80 MME/day)	450 tabs (80 MME/day)	225 tabs (120 MME/day)	675 tabs (120 MME/day)
Hydromorphone tab 8 mg	2-4 mg q4-6h	60 tabs (64 MME/day)	180 tabs (64 MME/day)	90 tabs (96 MME/day)	270 tabs (96 MME/day)
Levorphanol tab 2 mg	2 mg q6-8h	120 tabs (88 MME/day)	360 tabs (88 MME/day)	180 tabs (132 MME/day)	540 tabs (132 MME/day)
Meperidine oral soln 50 mg/5 mL	50-150 mg (5-15 mL) q3-4h	90 mL*** (30 MME/day)	90 mL*** (30 MME/day)	120 mL*** (40 MME/day)	120 mL*** (40 MME/day)
Meperidine tab 50 mg	50-150 mg q3-4h	18 tabs*** (30 MME/day)	18 tabs*** (30 MME/day)	24 tabs*** (40 MME/day)	24 tabs*** (40 MME/day)
Meperidine tab 100 mg	50-150 mg q3-4h	18 tabs*** (60 MME/day)	18 tabs*** (60 MME/day)	24 tabs*** (80 MME/day)	24 tabs*** (80 MME/day)
Morphine sulfate (conc) oral soln 20 mg/mL (100 mg/5 mL)	10-20 mg q4h	135 mL (90 MME/day)	405 mL (90 MME/day)	270 mL (180 MME/day)	810 mL (180 MME/day)
Morphine sulfate oral soln 10 mg/5 mL	10-20 mg q4h	900 mL (60 MME/day)	2700 mL (60 MME/day)	1350 mL (90 MME/day)	4050 mL (90 MME/day)
Morphine sulfate oral soln 20 mg/5 mL	10-20 mg q4h	675 mL (90 MME/day)	2025 mL (90 MME/day)	1350 mL (180 MME/day)	4050 mL (180 MME/day)
Morphine sulfate supp 5 mg	10-20 mg q4h	180 supps (30 MME/day)	540 supps (30 MME/day)	270 supps (45 MME/day)	810 supps (45 MME/day)
Morphine sulfate supp 10 mg	10-20 mg q4h	180 supps (60 MME/day)	540 supps (60 MME/day)	270 supps (90 MME/day)	810 supps (90 MME/day)
Morphine sulfate supp 20 mg	10-20 mg q4h	120 supps (80 MME/day)	360 supps (80 MME/day)	270 supps (180 MME/day)	810 supps (180 MME/day)
Morphine sulfate supp 30 mg	10-20 mg q4h	90 supps (90 MME/day)	270 supps (90 MME/day)	180 supps (180 MME/day)	540 supps (180 MME/day)
Morphine sulfate tab 15 mg	15-30 mg q4h	180 tabs (90 MME/day)	540 tabs (90 MME/day)	270 tabs (135 MME/day)	810 tabs (135 MME/day)
Morphine sulfate tab 30 mg	15-30 mg q4h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Oxycodone cap 5 mg	5-15 mg q4-6h	180 caps	540 caps	270 caps	810 caps

		(45 MME/day)	(45 MME/day)	(67.5 MME/day)	(67.5 MME/day)
Oxycodone oral concentrate 100 mg/5 mL (20 mg/mL)	5-15 mg q4-6h	90 mL (90 MME/day)	270 mL (90 MME/day)	180 mL (180 MME/day)	540 mL (180 MME/day)
Oxycodone soln 5 mg/5 mL	5-15 mg q4-6h	900 mL (45 MME/day)	2700 mL (45 MME/day)	2700 mL (135 MME/day)	8100 mL (135 MME/day)
Oxaydo 5 mg	5-15 mg every 4-6h	180 tabs (45 MME/day)	540 tabs (45 MME/day)	270 tabs (67.5 MME/day)	810 tabs (67.5 MME/day)
Oxaydo 7.5 mg	5-15 mg every 4-6h	180 tabs (67.5 MME/day)	540 tabs (67.5 MME/day)	270 tabs (101.25 MME/day)	810 tabs (101.25 MME/day)
Oxycodone tab 5 mg	5-15 mg q4-6h	180 tabs (45 MME/day)	540 tabs (45 MME/day)	270 tabs (67.5 MME/day)	810 tabs (67.5 MME/day)
Oxycodone tab 10 mg	5-15 mg q4-6h	180 tabs (90 MME/day)	540 tabs (90 MME/day)	270 tabs (135 MME/day)	810 tabs (135 MME/day)
Oxycodone tab 15 mg	5-15 mg q4-6h	120 tabs (90 MME/day)	360 tabs (90 MME/day)	180 tabs (135 MME/day)	540 tabs (135 MME/day)
Oxycodone tab 20 mg	5-15 mg q4-6h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Oxycodone tab 30 mg	5-15 mg q4-6h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	120 tabs (180 MME/day)	360 tabs (180 MME/day)
Oxymorphone tab 5 mg	10-20 mg q4-6h	180 tabs (90 MME/day)	540 tabs (90 MME/day)	360 tabs (180 MME/day)	1080 tabs (180 MME/day)
Oxymorphone tab 10 mg	10-20 mg q4-6h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Pentazocine/naloxone 50/0.5 mg	1 tab q3-4h. Total daily dose should not exceed 12 tablets.	120 tabs*** (74 MME/day)	120 tabs*** (74 MME/day)	300 tabs*** (185 MME/day)	300 tabs*** (185 MME/day)
RoxyBond 5 mg	5-15 mg q4-6h	180 tabs (45 MME/day)	540 tabs (45 MME/day)	270 tabs (67.5 MME/day)	810 tabs (67.5 MME/day)
RoxyBond 15 mg	5-15 mg q4-6h	120 tabs (90 MME/day)	360 tabs (90 MME/day)	180 tabs (135 MME/day)	540 tabs (135 MME/day)
RoxyBond 30 mg	5-15 mg q4-6h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	120 tabs (180 MME/day)	360 tabs (180 MME/day)
Tapentadol 50 mg	50 mg, 75 mg, or 100 mg every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	120 tabs (80 MME/day)	360 tabs (80 MME/day)	240 tabs (160 MME/day)	720 tabs (160 MME/day)
Tapentadol 75 mg	50 mg, 75 mg, or 100 mg every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Tapentadol 100 mg	50 mg, 75 mg, or 100 mg every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	60 tabs (80 MME/day)	180 tabs (80 MME/day)	120 tabs (160 MME/day)	360 tabs (160 MME/day)
Tramadol 50 mg	50-100 mg q4-6h, MAX = 400 mg/day	180 tabs (30 MME/day)	540 tabs (30 MME/day)	240 tabs (40 MME/day)	720 tabs (40 MME/day)

*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

**The limit criteria apply to both brand and generic, if available.

***This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit.

****Due to risk of accumulation, the 30-day and 90-day initial limit allows a 3-day supply only and the 30-day and 90-day post limit allows a 4-day supply only.

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 3/1/2018

Revision Information	
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DURATION LIMIT CRITERIA

DRUG CLASS ACETAMINOPHEN/ASPIRIN/IBUPROFEN CONTAINING OPIOID ANALGESICS (BRAND AND GENERIC)

BRAND NAME (generic) N/A

(acetaminophen and codeine)

(acetaminophen and hydrocodone)

(acetaminophen and oxycodone)

(acetaminophen and pentazocine)

(acetaminophen and tramadol)

(acetaminophen, caffeine, and dihydrocodeine)

(aspirin and oxycodone)

(aspirin, caffeine, and dihydrocodeine)

(ibuprofen and hydrocodone)

(ibuprofen and oxycodone)

Status: CVS Caremark Criteria

Type: Initial Step; Quantity Limit; Post Limit Criteria

This program may be used as a stand-alone criteria OR in combination with Opioids IR APAP-ASA-IBU Combo Products Limit.

POLICY

FDA-APPROVED INDICATIONS

Acetaminophen/opioid analgesic or aspirin/opioid analgesic combination products

Acetaminophen/opioid analgesic or aspirin/opioid analgesic combination products are indicated for the relief of mild to moderately severe pain.

Hydrocodone bitartrate/ibuprofen

Carefully consider the potential benefits and risks of hydrocodone bitartrate/ibuprofen tablets and other treatment options before deciding to use hydrocodone bitartrate and ibuprofen tablets. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Hydrocodone bitartrate/ibuprofen tablets are indicated for the short-term (generally less than 10 days) management of acute pain. Hydrocodone bitartrate and ibuprofen tablets are not indicated for the treatment of such conditions as osteoarthritis or rheumatoid arthritis.

Oxycodone/ibuprofen

Carefully consider the potential benefits and risks of oxycodone HCl/ibuprofen and other treatment options before deciding to use oxycodone HCl/ibuprofen. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Oxycodone HCl/ibuprofen tablets are indicated for the short term (no more than 7 days) management of acute, moderate to severe pain.

Tramadol/acetaminophen

Ultracet (tramadol/acetaminophen) is indicated for the short-term (five days or less) management of acute pain.

PROGRAM DESCRIPTION**

Acute pain duration limits do not apply if the patient has a drug in claims history that indicates the patient is being treated for cancer in the past year.

Coverage is provided for up to a 7-day supply of immediate-release opioids in situations where the patient does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history during the previous 3 months (i.e., this is the patient's first fill of an opioid). Prior authorization review is required to determine coverage for a quantity necessary for treatment beyond 7 days.

In situations where the patient has a cumulative \geq 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days, then the requested immediate-release opioid will be paid under the prescription benefit.

For hydrocodone/ibuprofen tablets, oxycodone/ibuprofen tablets, tramadol/acetaminophen tablets:

A quantity of 28 tablets/month of oxycodone/ibuprofen tablets, 40 tablets/month of tramadol/acetaminophen tablets, or 50 tablets/month of hydrocodone/ibuprofen tablets is provided upon approval of the PA to allow coverage consistent with product labeling.

***This program may be used as a stand-alone criteria OR in combination with Opioids IR APAP-ASA-IBU Combo Products Limit.*

INITIAL STEP THERAPY

If the patient has filled a prescription for a \geq 1-day supply of a drug indicating the patient is being treated for cancer within the past 365 days under a prescription benefit administered by CVS Caremark, then 1) when using this program in combination with Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H, the claim will proceed to the subsequent initial quantity limit criteria (1365-H) OR 2) when using this as a stand-alone program, the requested drug will be paid under that prescription benefit.

For patients with no prescription claims of a cancer drug in the past 365 days:

If the patient has filled a prescription for a cumulative \geq 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then 1) when using this program in combination with Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H, the claim will proceed to the subsequent initial quantity limit criteria (1365-H) OR 2) when using this as a stand-alone program, the requested drug will be paid under that prescription benefit.

If the patient does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid), then the Opioid IR APAP-ASA-IBU Combo Products Acute Pain Duration Limit 1358-E criteria will apply to the incoming prescription drug. If the incoming prescription drug is being filled for more than a cumulative 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply or submit a prior authorization (PA) for additional days supply quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If using this program in combination with Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H, then subsequent initial quantity limits would apply.

LIMIT CRITERIA (DAY SUPPLY)**

Acute pain duration limits do not apply if the patient has a drug in claims history that indicates the patient is being treated for cancer in the past year.

Coverage is provided for up to a 7-day supply of immediate-release opioids in situations where the patient does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history during the previous 3 months (i.e., this is the patient's first fill of an opioid). Prior authorization review is required to determine coverage for a quantity necessary for treatment beyond 7 days.

In situations where the patient has a cumulative \geq 7-day supply of an opioid agent (immediate- or extended-release) in prescription claim history in the past 90 days, then the requested immediate-release opioid will be paid under the prescription benefit.

For hydrocodone/ibuprofen tablets, oxycodone/ibuprofen tablets, tramadol/acetaminophen tablets:

A quantity of 28 tablets/month of oxycodone/ibuprofen tablets, 40 tablets/month of tramadol/acetaminophen tablets, or 50 tablets/month of hydrocodone/ibuprofen tablets is provided upon approval of the PA to allow coverage consistent with product labeling.

***This program may be used as a stand-alone criteria OR in combination with Opioids IR APAP-ASA-IBU Combo Products Limit.*

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

For hydrocodone/ibuprofen tablets, oxycodone/ibuprofen tablets, tramadol/acetaminophen tablets:

- The patient will not require use of MORE than any of the following: A) 50 tablets/month of hydrocodone/ibuprofen tablets B) 28 tablets/month of oxycodone/ibuprofen tablets, C) 40 tablets/month of tramadol/acetaminophen tablets

For acetaminophen/codeine, acetaminophen/hydrocodone, acetaminophen/oxycodone, acetaminophen/pentazocine, acetaminophen/caffeine/dihydrocodeine, aspirin/oxycodone, aspirin/caffeine/dihydrocodeine:

- The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care
- OR**
- The requested drug is being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate. [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]
- OR**
- The patient requires extended treatment beyond 7 days for ongoing management of ACUTE pain

Quantity Limit may apply.

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 3/1/2018

Revision Information	
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QUANTITY LIMIT CRITERIA

DRUG CLASS ACETAMINOPHEN/ASPIRIN/IBUPROFEN CONTAINING OPIOID ANALGESICS

BRAND NAME (generic) N/A

(acetaminophen and codeine)

(acetaminophen and hydrocodone)

(acetaminophen and oxycodone)

(acetaminophen and pentazocine)

(acetaminophen and tramadol)

(acetaminophen, caffeine, and dihydrocodeine)

(aspirin and oxycodone)

(aspirin, caffeine, and dihydrocodeine)

(ibuprofen and hydrocodone)

(ibuprofen and oxycodone)

Status: CVS Caremark Criteria

Type: Quantity Limit

**Please note that Xartemis XR is on a separate criteria.*

POLICY

FDA-APPROVED INDICATIONS

Acetaminophen/opioid analgesic or aspirin/opioid analgesic combination products

Acetaminophen/opioid analgesic or aspirin/opioid analgesic combination products are indicated for the relief of mild to moderately severe pain.

Hydrocodone bitartrate/ibuprofen

Carefully consider the potential benefits and risks of hydrocodone bitartrate/ibuprofen tablets and other treatment options before deciding to use hydrocodone bitartrate and ibuprofen tablets. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Hydrocodone bitartrate/ibuprofen tablets are indicated for the short-term (generally less than 10 days) management of acute pain. Hydrocodone bitartrate and ibuprofen tablets are not indicated for the treatment of such conditions as osteoarthritis or rheumatoid arthritis.

Oxycodone/ibuprofen

Carefully consider the potential benefits and risks of oxycodone HCl/ibuprofen and other treatment options before deciding to use oxycodone HCl/ibuprofen. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Oxycodone HCl/ibuprofen tablets are indicated for the short term (no more than 7 days) management of acute, moderate to severe pain.

Tramadol/acetaminophen

Ultracet (tramadol/acetaminophen) is indicated for the short-term (five days or less) management of acute pain.

PROGRAM DESCRIPTION

Coverage is provided without prior authorization for 30-day or 90-day IR opioid combination product prescriptions for an amount that does not exceed the maximum daily dose listed in labeling. Quantities are also ≤ 90 MME and contain ≤ 4 g APAP or ASA and ≤ 3200 mg ibuprofen. Due to safety concerns for acetaminophen doses greater than 4 grams (4000 mg) per day, aspirin doses greater than 4 grams (4000 mg) per day, and ibuprofen doses greater than 3200 mg per day, post limit consideration will not be given.

If the patient is requesting more than the initial quantity limit the claim will reject with a message indicating that quantity limits are exceeded.

Opioid Analgesics IR Combo Products Quantity Limits Chart

Coverage is provided without prior authorization for 30-day or 90-day IR opioid combo product prescriptions for an amount ≤ 90 MME; quantity limits are set at ≤ 4 g APAP or ASA and ≤ 3200 mg ibuprofen OR the maximum recommended dose based on prescribing information, whichever is lower. If the patient is requesting more than the initial quantity limit, then the claim will reject with a message indicating that quantity limits are exceeded.

This quantity limit will accumulate drugs in the following 4 groups up to highest quantity listed in each group depending on the order the claims are processed: 1) Acetaminophen-containing solutions, suspensions, elixirs accumulate together, 2) Acetaminophen-containing tablets and capsules accumulate together, 2a) Acetaminophen-containing tablets with the same 1 month and 3 month limit accumulate together, 3) Aspirin-containing tablets and capsules accumulate together, 4) Ibuprofen-containing tablets accumulate together. See Accumulation Group column in chart below for more detail.

Accumulation Group	Drug/Strength	Labeled Dosing	Initial 1 Month Limit* ≤ 90 MME/day and ≤ 4 g APAP or ASA and ≤ 3200 mg IBU (per 25 days)	Initial 3 Month Limit* ≤ 90 MME/day and ≤ 4 g APAP or ASA and ≤ 3200 mg IBU (per 75 days)
1	APAP/codeine soln 120-12 mg/5 mL	15 mL q4h prn, MAX 360 mg codeine/day	2700 mL (32.4 MME/day)	8100 mL (32.4 MME/day)
1	APAP/codeine susp 120-12 mg/5 mL	15 mL q4h prn, MAX 360 mg codeine/day	2700 mL (32.4 MME/day)	8100 mL (32.4 MME/day)

1	Hydrocodone/APAP soln 7.5/325 mg/ 15 mL	15 mL q4-6h prn, MAX 90 mL/day	2700 mL (45 MME/day)	8100 mL (45 MME/day)
1	Hydrocodone/APAP soln 7.5/500 mg/15 mL	15 mL q4-6h prn, MAX 90 mL/day	2700 mL (45 MME/day)	8100 mL (45 MME/day)
1	Hydrocodone/APAP elixir 10/300 mg/15 mL	11.25 mL q4-6h prn, MAX 67.5 mL/day	2025 mL (45 MME/day)	6075 mL (45 MME/day)
1	Hydrocodone/APAP soln 10/325 mg/ 15 mL	15 mL q4-6h prn, MAX 90 mL/day	2700 mL (60 MME/day)	8100 mL (60 MME/day)
1	Hydrocodone/APAP soln 10/500 mg/15 mL	15 mL q4-6h prn, MAX 90 mL/day	2700 mL (60 MME/day)	8100 mL (60 MME/day)
1	Oxycodone/APAP soln 5-325 mg/5 mL	5 mL q6h prn, MAX 60 mL/day	1800 mL (90 MME/day)	5400 mL (90 MME/day)
2	APAP/codeine tab 300/15 mg	15-60 mg codeine q4h, MAX 360 mg codeine/day	400 tabs (30 MME/day)	1200 tabs (30 MME/day)
2	APAP/codeine tab 300/30 mg	15-60 mg codeine q4h, MAX 360 mg codeine/day	360 tabs (54 MME/day)	1080 tabs (54 MME/day)
2	APAP/codeine tab 300/60 mg	15-60 mg codeine q4h, MAX 360 mg codeine/day	180 tabs (54 MME/day)	540 tabs (54 MME/day)
2	APAP/caffeine/dihydrocodeine cap 320.5/30/16 mg	2 caps q4h prn, MAX 10 caps/day	300 caps (40 MME/day)	900 caps (40 MME/day)
2	APAP/caffeine/dihydrocodeine tab 325/30/16 mg	2 tabs q4h prn, MAX 10 tabs/day	300 tabs (40 MME/day)	900 tabs (40 MME/day)
2	APAP/caffeine/dihydrocodeine cap 356.4/30/16 mg	2 caps q4h prn, MAX 10 caps/day	300 caps (40 MME/day)	900 caps (40 MME/day)
2	APAP/caffeine/dihydrocodeine tab 712.8/60/32 mg	1 tab q4h prn, MAX 5 tabs/day	150 tabs (40 MME/day)	450 tabs (40 MME/day)
2	Hydrocodone/APAP tab 2.5/325 mg	1-2 tabs q 4-6h prn, MAX 12 tabs/day	360 tabs (30 MME/day)	1080 tabs (30 MME/day)
2	Hydrocodone/APAP tab 2.5/500 mg	1-2 tabs q 4-6h prn, MAX 8 tabs/day	240 tabs (20 MME/day)	720 tabs (20 MME/day)
2	Hydrocodone/APAP tab 5/300 mg	1-2 tabs q 4-6h prn, MAX 8 tabs/day	240 tabs (40 MME/day)	720 tabs (40 MME/day)
2	Hydrocodone/APAP tab 5/325 mg	1-2 tabs q 4-6h prn, MAX 8 tabs/day	240 tabs (40 MME/day)	720 tabs (40 MME/day)
2	Hydrocodone/APAP tab 5/400 mg	1-2 tabs q 4-6h prn, MAX 8 tabs/day	240 tabs (40 MME/day)	720 tabs (40 MME/day)
2	Hydrocodone/APAP tab 5/500 mg	1-2 tabs q 4-6h prn, MAX 8 tabs/day	240 tabs (40 MME/day)	720 tabs (40 MME/day)
2	Hydrocodone/APAP tab 7.5/300 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (45 MME/day)	540 tabs (45 MME/day)
2	Hydrocodone/APAP tab 7.5/325 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (45 MME/day)	540 tabs (45 MME/day)
2	Hydrocodone/APAP tab 7.5/400 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (45 MME/day)	540 tabs (45 MME/day)
2	Hydrocodone/APAP tab 7.5/500 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (45 MME/day)	540 tabs (45 MME/day)
2	Hydrocodone/APAP tab 7.5/650 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (45 MME/day)	540 tabs (45 MME/day)
2	Hydrocodone/APAP tab 7.5/750 mg	1 tab q4-6h, MAX 5 tabs/day	150 tabs (37.5 MME/day)	450 tabs (37.5 MME/day)
2	Hydrocodone/APAP tab 10/300 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (60 MME/day)	540 tabs (60 MME/day)
2	Hydrocodone/APAP tab 10/325 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (60 MME/day)	540 tabs (60 MME/day)
2	Hydrocodone/APAP tab 10/400 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (60 MME/day)	540 tabs (60 MME/day)

2	Hydrocodone/APAP tab 10/500 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (60 MME/day)	540 tabs (60 MME/day)
2	Hydrocodone/APAP tab 10/650 mg	1 tab q4-6h, MAX 6 tabs/day	180 tabs (60 MME/day)	540 tabs (60 MME/day)
2	Hydrocodone/APAP tab 10/660 mg	1 tab q4-6h, MAX 5 tabs/day	150 tabs (50 MME/day)	450 tabs (50 MME/day)
2	Hydrocodone/APAP tab 10/750 mg	1 tab q4-6h, MAX 5 tabs/day	150 tabs (50 MME/day)	450 tabs (50 MME/day)
2	Oxycodone/APAP tab 2.5/325 mg	1-2 tabs q6h, MAX 12 tabs/day	360 tabs (45 MME/day)	1080 tabs (45 MME/day)
2	Oxycodone/APAP tab 5/300 mg	1 tab q6h, MAX 12 tabs/day	360 tabs (90 MME/day)	1080 tabs (90 MME/day)
2	Oxycodone/APAP tab 5/325 mg	1 tab q6h, MAX 12 tabs/day	360 tabs (90 MME/day)	1080 tabs (90 MME/day)
2	Oxycodone/APAP tab 5/400 mg	1 tab q6h, MAX 10 tabs/day	300 tabs (75 MME/day)	900 tabs (75 MME/day)
2	Oxycodone/APAP cap 5/500 mg	1 cap q6h, MAX 8 caps /day	240 caps (60 MME/day)	720 caps (60 MME/day)
2	Oxycodone/APAP tab 7.5/300 mg	1 cap q6h, MAX 8 tabs/day	240 tabs (90 MME/day)	720 tabs (90 MME/day)
2	Oxycodone/APAP tab 7.5/325 mg	1 tab q6h prn, MAX 8 tabs/day	240 tabs (90 MME/day)	720 tabs (90 MME/day)
2	Oxycodone/APAP tab 7.5/400 mg	1 tab q6h prn, MAX 8 tabs/day	240 caps (90 MME/day)	720 caps (90 MME/day)
2	Oxycodone/APAP tab 7.5/500 mg	1 tab q6h prn, MAX 8 tabs/day	240 caps (90 MME/day)	720 caps (90 MME/day)
2	Oxycodone/APAP tab 10/300 mg	1 tab q6h prn, MAX 6 tabs/day	180 tabs (90 MME/day)	540 tabs (90 MME/day)
2	Oxycodone/APAP tab 10/325 mg	1 tab q6h prn, MAX 6 tabs/day	180 tabs (90 MME/day)	540 tabs (90 MME/day)
2	Oxycodone/APAP tab 10/400 mg	1 tab q6h prn, MAX 6 tabs/day	180 tabs (90 MME/day)	540 tabs (90 MME/day)
2	Oxycodone/APAP tab 10/500 mg	1 tab q6h prn, MAX 6 tabs/day	180 tabs (90 MME/day)	540 tabs (90 MME/day)
2	Oxycodone/APAP tab 10/650 mg	1 tab q6h prn, MAX 6 tabs/day	180 tabs (90 MME/day)	540 tabs (90 MME/day)
2	Pentazocine/APAP tab 25/650 mg	1 cap q4h, MAX 6 caps/day	180 caps (55.5 MME/day)	540 caps (55.5 MME/day)
2a	Tramadol/APAP 37.5/325 mg	2 tabs q4-6h, MAX 8 tabs/day. Use for 5 days only.	40 tabs (30 MME/day)	40 tabs (30 MME/day)
3	ASA/caffeine/dihydrocodeine cap 356.4/30/16 mg	2 caps q4h prn, MAX 10 caps/day	300 caps (40 MME/day)	900 caps (40 MME/day)
3	Oxycodone/ASA tab 4.8355/325 mg	1 tab q6h prn, MAX 12 tabs/day	360 tabs (87 MME/day)	1080 tabs (87 MME/day)
4	Hydrocodone/ibuprofen tab 2.5/200 mg	1 tab q4-6h, MAX 5 tabs/day	50 tabs (12.5 MME/day)	50 tabs (12.5 MME/day)
4	Hydrocodone/ibuprofen tab 5/200 mg	1 tab q4-6h, MAX 5 tabs/day	50 tabs (25 MME/day)	50 tabs (25 MME/day)
4	Hydrocodone/ibuprofen tab 7.5/200 mg	1 tab q4-6h, MAX 5 tabs/day	50 tabs (37.5 MME/day)	50 tabs (37.5 MME/day)
4	Hydrocodone/ibuprofen tab 10/200 mg	1 tab q4-6h, MAX 5 tabs/day	50 tabs (50 MME/day)	50 tabs (50 MME/day)
4	Oxycodone/ibuprofen tab 5/400 mg	1 tab qd, MAX 4 tabs/day	28 tabs (30 MME/day)	28 tabs (30 MME/day)

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

REFERENCES

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 3/1/2018

Revision Information	
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QUANTITY LIMIT CRITERIA

BRAND NAME*

(generic)

XARTEMIS XR

(oxycodone hydrochloride / acetaminophen extended-release)

Status: CVS Caremark Criteria

Type: Quantity Limit

* Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated.

POLICY

FDA-APPROVED INDICATIONS

Xartemis XR is indicated for the management of acute pain severe enough to require opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, misuse, overdose, and death with opioids, even at recommended doses, reserve Xartemis XR for use in patients for whom alternative treatment options (e.g., non-opioid analgesics):

- Have not been tolerated or are not expected to be tolerated.
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

LIMIT CRITERIA

Drug

1 Month Limit and 3 Months Limit*

Xartemis XR
(oxycodone hydrochloride/acetaminophen extended-release)

120 tablets/25 days**
(45 MME/day)

*The duration of 25 days is used for a 30-day fill period to allow time for refill processing.

** This drug is indicated for acute use; therefore, the 1 month, 3 month, retail, and mail limit will be the same. The intent is for prescriptions of Xartemis XR to be filled one month at a time; there should be no 3 month supplies filled.

REFERENCES

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 3/1/2018

Revision Information	
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Specialty Drug Management Strategies

1. Specialty Quantity Limit Program

- Quantity limits based on the following:
 - Dosage recommendations in product labeling
 - FDA guidance
 - Standards of medical practice
 - Evidence-based drug information
 - Published guidelines
- Prior Authorization is available for greater amounts based on clinical exceptions:
 - Loading doses
 - Compendial supported dosing
 - Drug interactions
 - Dosing by body weight or body surface area
 - Dose adjustment using a particular strength of a drug
- Effective January 1, 2018

2. Specialty Day Supply Limit

- 30-Day supply allowance on most specialty medications
 - Reinforce REMS programs
 - Increased clinical monitoring
 - Ensures tolerance to the drug regimen
 - Limits pharmacy waste from commonly discontinued medications
- Extended Day Supply Allowance on certain specialty medications
 - Drugs packaged and administered in long-term quantities
 - Drugs exhibiting high adherence rates
 - Drugs requiring no dose stabilization
 - Drugs unlikely to be discontinued or contribute to pharmacy waste
- Proposed January 26, 2016 – never implemented

3. Starter Fill

- Targets new utilizers on high cost therapies with poor tolerability and high discontinuation rates to reduce drug waste
 - Partial medication fills (2 week supply) for the first 3 months of therapy
 - Prorated copay or coinsurance based on supply
 - Patient representatives & pharmacist follow-up with each fill
 - After 3 months members may obtain full-month supplies
- Therapies include:
 - Oral Oncology,
 - Hepatitis B,
 - Cystic Fibrosis, &
 - Hematological Disorders
- Can be implemented within 60 days

Know Your Limit:

Check If Your Medication Is In The Specialty Quantity Limit Program



Your pharmacy benefit plan is part of the Specialty Quantity Limit Program. This program supports safe, clinically-appropriate and cost-effective use of specialty medications. Both your plan sponsor and CVS Caremark® want to make sure you receive the correct amount of medicine to effectively treat your condition.

Please check the list below to see if your medications are included in the quantity limit program and note the quantity that will be covered by your prescription benefit.

If you are taking more than the quantity covered by your benefit: Ask your doctor if a smaller amount will work for you. Your doctor can write or call in the new prescription to be filled at your current pharmacy or through CVS Specialty™.

If your current prescription includes an amount less than these limits: No further action from your doctor is needed.

If you need more medicine than the quantity limit allows due to your medical situation: Ask your doctor to contact our Prior Authorization Department for approval of a larger amount for select drugs on the list.

Drug Label Name	Approved Quantity
ACTHAR HP INJ 80 UNIT	35 ml per 21 days
ADCIRCA TAB 20 MG	60 per 30 days
ADEMPAS TAB 0.5 MG	90 per 30 days
ADEMPAS TAB 1.5 MG	90 per 30 days
ADEMPAS TAB 1 MG	90 per 30 days
ADEMPAS TAB 2.5 MG	90 per 30 days
ADEMPAS TAB 2 MG	90 per 30 days
AFINITOR TAB 10 MG	30 per 30 days
AFINITOR TAB 2.5 MG	30 per 30 days
AFINITOR TAB 5 MG	30 per 30 days
AFINITOR TAB 7.5 MG	30 per 30 days

Drug Label Name	Approved Quantity
AMPYRA TAB 10 MG	60 per 30 days
APTIVUS CAP 250 MG	120 per 30 days
APTIVUS SOL 100 MG/ML	300 ml per 30 days
ARCALYST INJ 220 MG	4 per 28 days
ATRIPLA TAB	30 per 30 days
AUBAGIO TAB 14 MG	30 per 30 days
AUBAGIO TAB 7 MG	30 per 30 days
AVONEX KIT 30 MCG	4 inj per 28 days
AVONEX PEN KIT 30 MCG	4 inj per 28 days
AVONEX PREFL KIT 30 MCG	4 inj per 28 days
AVONEX PREFL KIT 30 MCG	4 inj per 28 days

Drug Label Name	Approved Quantity
BETASERON INJ 0.3 MG	14 per 28 days
BETHKIS NEB 300/4 ML	224 per 28 days
BOSULIF TAB 100 MG	120 per 30 days
BOSULIF TAB 500 MG	30 per 30 days
CAPRELSA TAB 100 MG	60 per 30 days
CAPRELSA TAB 300 MG	30 per 30 days
CAYSTON INH 75 MG	84 per 28 days
CERDELGA CAP 84 MG	60 per 30 days
CIMZIA PREFL KIT 200 MG/ML	2 syringes per 28 days
CIMZIA STARTER KIT	6 syringes per 28 days
COMBIVIR TAB 150-300	60 per 30 days
COMETRIQ KIT 100 MG	1 box (56) per 28 days
COMETRIQ KIT 140 MG	1 box (112) per 28 days
COMETRIQ KIT 60 MG	1 box (84) per 28 days
COMPLERA TAB	30 per 30 days
COPAXONE INJ 20 MG/ML	30 per 30 days
COPAXONE INJ 40 MG/ML	12 per 28 days
CRIVAN CAP 200 MG	450 per 30 days
CRIVAN CAP 400 MG	180 per 30 days
DAKLINZA TAB 30 MG	28 per 28 days
DAKLINZA TAB 60 MG	28 per 28 days
DAKLINZA TAB 90 MG	28 per 28 days
DESCOVY TAB 200/25	30 per 30 days
EDURANT TAB 25 MG	60 per 30 days
EMTRIVA CAP 200 MG	30 per 30 days
EMTRIVA SOL 10 MG/ML	680 ml per 28 days
ENBREL INJ 25/0.5 ML	8 per 28 days
ENBREL INJ 50 MG/ML	8 per 28 days
EPCLUSA TAB 400-100	28 per 28 days
EPIVIR SOL 10 MG/ML	900 ml per 30 days
EPIVIR TAB 150 MG	60 per 30 days
EPIVIR TAB 300 MG	30 per 30 days
EPZICOM TAB 600-300	30 per 30 days
ERIVEDGE CAP 150 MG	30 per 30 days
ESBRIET CAP 267 MG	270 per 30 days
EVOTAZ TAB 300-150	30 per 30 days
EXTAVIA INJ 0.3 MG	15 per 30 days
FORTEO SOL 600/2.4	2.4 ml per 28 days

Drug Label Name	Approved Quantity
FUZEON INJ 90 MG	60 per 30 days
GATTEX KIT 5 MG	30 per 30 days
GENVOYA TAB	30 per 30 days
GILENYA CAP 0.5 MG	30 per 30 days
GILOTRIF TAB 20 MG	30 per 30 days
GILOTRIF TAB 30 MG	30 per 30 days
GILOTRIF TAB 40 MG	30 per 30 days
GLATOPA	30 per 30 days
GLEEVEC TAB 100 MG	90 per 30 days
GLEEVEC TAB 400 MG	60 per 30 days
HARVONI TAB 90-400 MG	28 per 28 days
HETLIOZ CAP 20 MG	30 per 30 days
HUMIRA INJ 10 MG/0.2	2 per 28 days
HUMIRA INJ 40 MG/0.8	4 per 28 days
HUMIRA KIT 20 MG/0.4	2 per 28 days
HUMIRA PEDIATRIC CROHNS D	6 syringes per 28 days
HUMIRA PEN INJ CROHNS	6 syringes per 28 days
HUMIRA PEN-PSORIASIS STAR	4 syringes per 28 days
IBRANCE CAP 100 MG	21 per 28 days
IBRANCE CAP 125 MG	21 per 28 days
IBRANCE CAP 75 MG	21 per 28 days
ICLUSIG TAB 15 MG	60 per 30 days
ICLUSIG TAB 45 MG	30 per 30 days
IMBRUVICA CAP 140 MG	120 per 30 days
INLYTA TAB 1 MG	180 per 30 days
INLYTA TAB 5 MG	120 per 30 days
INTELENCE TAB 25 MG	120 per 30 days
INTELENCE TAB 100 MG	120 per 30 days
INTELENCE TAB 200 MG	60 per 30 days
INVIRASE CAP 200 MG	300 per 30 days
INVIRASE TAB 500 MG	120 per 30 days
ISENTRESS CHW 25 MG	180 per 30 days
ISENTRESS POW 100 MG	60 per 30 days
ISENTRESS CHW 100 MG	180 per 30 days
ISENTRESS TAB 400 MG	120 per 30 days
JAKAFI TAB 10 MG	60 per 30 days
JAKAFI TAB 15 MG	60 per 30 days
JAKAFI TAB 20 MG	60 per 30 days

Drug Label Name	Approved Quantity
JAKAFI TAB 25 MG	60 per 30 days
JAKAFI TAB 5 MG	60 per 30 days
JUXTAPID CAP 10 MG	28 per 28 days
JUXTAPID CAP 20 MG	84 per 28 days
JUXTAPID CAP 5 MG	28 per 28 days
KALETRA SOL	390 per 30 days
KALETRA TAB 100-25 MG	240 per 30 days
KALETRA TAB 200-50 MG	120 per 30 days
KALYDECO PAK 50 MG	60 per 30 days
KALYDECO PAK 75 MG	60 per 30 days
KALYDECO TAB 150 MG	60 per 30 days
KINERET INJ	240 per 30 days
KORLYM TAB	120 per 30 days
KYNAMRO INJ 200 MG/ML	4 per 28 days
LETAIRIS TAB 10 MG	30 per 30 days
LETAIRIS TAB 5 MG	30 per 30 days
LEXIVA SUS 50 MG/ML	1680 ml per 30 days
LEXIVA TAB 700 MG	120 per 30 days
LYNPARZA CAP 50 MG	480 per 30 days
MEKINIST TAB 0.5 MG	90 per 30 days
MEKINIST TAB 2 MG	30 per 30 days
NEULASTA INJ 6 MG/0.6 M	2 per 28 days
NEXAVAR TAB 200 MG	120 per 30 days
NORTHERA CAP 100 MG	90 per 30 days
NORTHERA CAP 200 MG	180 per 30 days
NORTHERA CAP 300 MG	180 per 30 days
NORVIR CAP 100 MG	360 per 30 days
NORVIR SOL 80 MG/ML	450 ml per 30 days
NORVIR TAB 100 MG	360 per 30 days
OCALIVA TAB 10 MG	30 per 30 days
OCALIVA TAB 5 MG	30 per 30 days
ODEFSEY TAB	30 per 30 days
OFEV CAP 100 MG	60 per 30 days
OFEV CAP 150 MG	60 per 30 days
OLYSIO CAP 150 MG	28 per 28 days
OPSUMIT TAB 10 MG	30 per 30 days
ORENCIA INJ 125 MG/ML	4 per 28 days
OTEZLA TAB 30 MG	60 per 30 days

Drug Label Name	Approved Quantity
OTREXUP INJ 10 MG	4 inj per 28 days
OTREXUP INJ 15 MG	4 inj per 28 days
OTREXUP INJ 20 MG	4 inj per 28 days
OTREXUP INJ 25 MG	4 inj per 28 days
PEGASYS INJ	4 per 28 days
PEGASYS KIT	4 per 28 days
PLEGRIDY 125 MCG/0.5 ML	1 per 28 days
POMALYST CAP 1 MG	21 per 21 days
POMALYST CAP 2 MG	21 per 21 days
POMALYST CAP 3 MG	21 per 21 days
POMALYST CAP 4 MG	21 per 21 days
PRALUENT INJ 150 MG/ML	2 per 28 days
PRALUENT INJ 75 MG/ML	2 per 28 days
PREZCOBIX TAB 800-150	30 per 30 days
PREZISTA TAB 150 MG	180 per 30 days
PREZISTA TAB 75 MG	300 per 30 days
PREZISTA SUS 100 MG/ML	360 ml per 30 days
PREZISTA TAB 600 MG	60 per 30 days
PREZISTA TAB 800 MG	30 per 30 days
PROMACTA TAB 12.5 MG	30 per 30 days
PROMACTA TAB 25 MG	30 per 30 days
PROMACTA TAB 50 MG	60 per 30 days
PROMACTA TAB 75 MG	60 per 30 days
PULMOZYME SOL 1 MG/ML	150 ml per 30 days
RASUVO INJ 10 MG	4 inj per 28 days
RASUVO INJ 12.5 MG	4 inj per 28 days
RASUVO INJ 15 MG	4 inj per 28 days
RASUVO INJ 17.5 MG	4 inj per 28 days
RASUVO INJ 20 MG	4 inj per 28 days
RASUVO INJ 22.5 MG	4 inj per 28 days
RASUVO INJ 25 MG	4 inj per 28 days
RASUVO INJ 27.5 MG	4 inj per 28 days
RASUVO INJ 30 MG	4 inj per 28 days
RASUVO INJ 7.5 MG	4 inj per 28 days
REBIF INJ 22/0.5	12 (6 ml) per 28 days
REBIF INJ 44/0.5	12 (6 ml) per 28 days
REBIF TITRTN SOL PACK	12 (4.2 ml) per 28 days
REMICADE INJ 100 MG	10 vials per 28 days

Drug Label Name	Approved Quantity
REPATHA INJ 140 MG/ML	2 per 28 days
REPATHA PUSH INJ 420/3.5	1 per 28 days
RESCRIPTOR TAB 100 MG	900 per 30 days
RESCRIPTOR TAB 200 MG	450 per 30 days
RETROVIR CAP 100 MG	180 per 30 days
RETROVIR SYP 50 MG/5 ML	1800 ml per 30 days
RETROVIR TAB 300 MG	60 per 30 days
REVIATIO SUS 10 MG/ML	180 per 30 days
REVLIMID CAP 10 MG	28 per 28 days
REVLIMID CAP 15 MG	21 per 28 days
REVLIMID CAP 2.5 MG	28 per 28 days
REVLIMID CAP 20 MG	21 per 28 days
REVLIMID CAP 25 MG	21 per 28 days
REVLIMID CAP 5 MG	28 per 28 days
REYATAZ CAP 150 MG	30 per 30 days
REYATAZ CAP 200 MG	60 per 30 days
REYATAZ CAP 300 MG	30 per 30 days
REYATAZ POW 50 MG	180 packets per 30 days
RUBRACA TAB 200 MG	120 per 30 days
RUBRACA TAB 300 MG	120 per 30 days
SABRIL POW 500 MG	180 per 30 days
SABRIL TAB 500 MG	180 per 30 days
SELZENTRY TAB 150 MG	60 per 30 days
SELZENTRY TAB 300 MG	120 per 30 days
SENSIPAR TAB 60 MG	60 per 30 days
SENSIPAR TAB 90 MG	120 per 30 days
SIGNIFOR 0.3 MG/ML	60 per 30 days
SIGNIFOR 0.6 MG/ML	60 per 30 days
SIGNIFOR 0.9 MG/ML	60 per 30 days
SIGNIFOR LAR 20 MG KIT	1 kit per 28 days
SIGNIFOR LAR 40 MG KIT	1 kit per 28 days
SIGNIFOR LAR 60 MG KIT	1 kit per 28 days
SILDENAFIL TAB 20 MG	90 per 30 days
SIMPONI INJ 100 MG/ML	1 per 28 days
SIMPONI INJ 50/0.5 ML	1 per 28 days
SOVALDI TAB 400 MG	28 per 28 days
SPRYCEL TAB 100 MG	30 per 30 days
SPRYCEL TAB 140 MG	30 per 30 days

Drug Label Name	Approved Quantity
SPRYCEL TAB 20 MG	30 per 30 days
SPRYCEL TAB 50 MG	30 per 30 days
SPRYCEL TAB 70 MG	30 per 30 days
SPRYCEL TAB 80 MG	30 per 30 days
STELARA INJ 45 MG/0.5	1 per 12 weeks
STELARA INJ 90 MG/ML	1 per 8 weeks
STIVARGA TAB 40 MG	112 per 28 days
STRIBILD TAB	30 per 30 days
SUSTIVA CAP 200 MG	90 per 30 days
SUSTIVA CAP 50 MG	90 per 30 days
SUSTIVA TAB 600 MG	30 per 30 days
SUTENT CAP 12.5 MG	30 per 30 days
SUTENT CAP 25 MG	30 per 30 days
SUTENT CAP 37.5 MG	30 per 30 days
SUTENT CAP 50 MG	30 per 30 days
SYLATRON KIT 200 MCG	4 per 28 days
SYLATRON KIT 300 MCG	4 per 28 days
SYLATRON KIT 600 MCG	4 per 28 days
TAFINLAR CAP 50 MG	120 per 30 days
TAFINLAR CAP 75 MG	120 per 30 days
TARCEVA TAB 100 MG	30 per 30 days
TARCEVA TAB 150 MG	30 per 30 days
TARCEVA TAB 25 MG	60 per 30 days
TASIGNA CAP 150 MG	120 per 30 days
TASIGNA CAP 200 MG	120 per 30 days
TECFIDERA CAP 120 MG	14 per 7 days
TECFIDERA CAP 240 MG	60 per 30 days
TECHNIVIE TAB	56 per 28 days
THALOMID CAP 100 MG	28 per 28 days
THALOMID CAP 150 MG	56 per 28 days
THALOMID CAP 200 MG	56 per 28 days
THALOMID CAP 50 MG	28 per 28 days
TIVICAY TAB 10 MG	60 per 30 days
TIVICAY TAB 25 MG	60 per 30 days
TIVICAY TAB 50 MG	60 per 30 days
TOBI NEB 300/5 ML	280 per 28 days
TOBI PODHALR CAP 28 MG	224 caps per 28 days
TOBRAMYCIN NEB 300/5 ML	280 per 28 days

Drug Label Name	Approved Quantity
TRACLEER TAB 125 MG	60 per 30 days
TRACLEER TAB 62.5 MG	60 per 30 days
TRIUMEQ TAB	30 per 30 days
TRIZIVIR TAB	60 per 30 days
TRUVADA TAB 100-150	30 per 30 days
TRUVADA TAB 133-200	30 per 30 days
TRUVADA TAB 167-250	30 per 30 days
TRUVADA TAB 200-300	30 per 30 days
TYBOST TAB 150 MG	30 per 30 days
TYKERB TAB 250 MG	180 per 30 days
TYSABRI 300 MG/15ML	300 mg/15 ml per 28 days
TYVASO SOL 0.6 MG/ML	28 amps per 28 days
VENTAVIS SOL 10 MCG/ML	270 per 30 days
VENTAVIS SOL 20 MCG/ML	270 per 30 days
VICTRELIS CAP 200 MG	336 per 28 days
VIDEX SOL 2 GM	1200 ml per 30 days
VIDEX SOL 4 GM	1200 ml per 30 days
VIDEX EC CAP 125 MG	30 per 30 days
VIDEX EC CAP 200 MG	30 per 30 days
VIDEX EC CAP 250 MG	30 per 30 days
VIDEX EC CAP 400 MG	30 per 30 days
VIEKIRA PAK TAB	1 pak (112) per 28 days
VIEKIRA XR TAB	84 per 28 days
VIRACEPT TAB 250 MG	300 per 30 days
VIRACEPT TAB 625 MG	120 per 30 days
VIRAMUNE SUS 50 MG/5 ML	1200 ml per 30 days
VIRAMUNE TAB 200 MG	60 per 30 days
VIRAMUNE XR TAB 100 MG	90 per 30 days
VIRAMUNE XR TAB 400 MG	30 per 30 days
VIREAD POW 40 MG/GM	240 gm per 30 days
VIREAD TAB 150 MG	30 per 30 days

Drug Label Name	Approved Quantity
VIREAD TAB 200 MG	30 per 30 days
VIREAD TAB 250 MG	30 per 30 days
VIREAD TAB 300 MG	30 per 30 days
VITEKTA TAB 150 MG	30 per 30 days
VITEKTA TAB 85 MG	30 per 30 days
VIVITROL INJ 380 MG	380 mg per 30 days
VOTRIENT TAB 200 MG	120 per 30 days
XALKORI CAP 200 MG	60 per 30 days
XALKORI CAP 250 MG	60 per 30 days
XELJANZ TAB 5 MG	60 per 30 days
XELODA TAB 150 MG	120 per 30 days
XELODA TAB 500 MG	300 per 30 days
XENAZINE TAB 12.5 MG	240 per 30 days
XENAZINE TAB 25 MG	120 per 30 days
XOLAIR SOL 150 MG	6 per 28 days
XTANDI CAP 40 MG	120 per 30 days
ZAVESCA CAP 100 MG	90 per 30 days
ZELBORAF TAB 240 MG	240 per 30 days
ZEPATIER TAB 50-100 MG	28 per 28 days
ZERIT CAP 15 MG	60 per 30 days
ZERIT CAP 20 MG	60 per 30 days
ZERIT CAP 30 MG	60 per 30 days
ZERIT CAP 40 MG	60 per 30 days
ZERIT SOL 1 MG/ML	2400 ml per 30 days
ZIAGEN SOL 20 MG/ML	900 per 30 days
ZIAGEN TAB 300 MG	60 per 30 days
ZOLINZA CAP 100 MG	120 per 30 days
ZYDELIG TAB 100 MG	60 per 30 days
ZYDELIG TAB 150 MG	60 per 30 days
ZYKADIA CAP 150 MG	150 per 30 days
ZYTIGA TAB 250 MG	120 per 30 days

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

The medicines indicated above, along with their quantity limits, are subject to change.

This is not an all-inclusive list of available drug alternative considerations.

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SPECIALTY POST LIMIT QUANTITY EXCEPTION CRITERIA

I. PROGRAM DESCRIPTION

Coverage is provided for an amount of drug sufficient for most members based on the most common uses of the drug. The submitted prescription is covered up to this standard limit without a review process. In situations where an additional quantity of drug is needed to adequately treat the member, prior authorization is required to determine if clinical exceptions are met.

Coverage for an additional quantity of drug is provided for duration sufficient for most uses (e.g., shorter period of time to accommodate loading doses or dose titration when a member requires additional amounts to adequately treat his/her condition).

In situations where coverage for additional quantities is not approved through the prior authorization process, an appeals process exists to review specific or unique cases where additional drug may be necessary.

II. RATIONALE

The intent of this program is to provide coverage for quantities sufficient for treatment for most members based on the most common uses of the drug. Quantity limits are based on dosage recommendations in product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. In situations where greater amounts of drug are needed, prior authorization criteria allow approval of these quantities based on clinical exceptions such as to accommodate loading doses, compendial supported dosing, drug interactions, or dosing by body weight or body surface area, and to allow for dose adjustments using a particular strength of the drug.

III. CRITERIA FOR APPROVAL

The use of medication at the requested quantity is supported by the manufacturer's prescribing information or dosing guidelines found in the compendia or current literature (e.g., AHFS, Micromedex DrugDex, NCCN compendia, current treatment guidelines) and the member meets the criteria sets A, B or C.

- A. Authorization for a quantity up to the exception limit may be provided for up to 90 days for initiation of treatment at a higher dose or frequency of administration (e.g., loading dose).
- B. Authorization for a quantity up to the exception limit may be provided for 6 months when a greater quantity is necessary to adjust the dose using a lower strength due to intolerance to the recommended maintenance dose.
- C. Authorization for a quantity up to the exception limit may be granted for 12 months in the following situations:
 1. Member is prescribed a drug dosed by weight or body surface area and requires a greater quantity to achieve the appropriate dose OR
 2. A greater quantity is necessary to accommodate a higher dose following an inadequate response OR
 3. A greater quantity is necessary for a compendial use or an FDA-approved indication OR
 4. A greater quantity is necessary to adjust the dose or frequency of administration to account for a drug interaction.

IV. COVERED QUANTITIES

Coverage is provided without prior authorization up to the standard limit. Coverage for an amount up to the exception limit is provided with prior authorization.

Table. Initial and Post Limits

Medication	FDA-recommended dosing	Standard Limit	Exception Limit
Afinitor (everolimus) tablet 10 mg	<ul style="list-style-type: none"> • 10 mg per day • 20 mg per day if co-administered with a strong inducer of CYP3A4. Titrate using 5 mg increments or less.	30 per 30 days	60 per 30 days
Afinitor (everolimus) tablet 5 mg		30 per 30 days	90 per 30 days
Arcalyst (rilonacept) injection 220 mg vial	<ul style="list-style-type: none"> • Day 1: 320 mg (2 vials) • Subsequent doses: 160 mg (1 vial) weekly 	4 per 28 days	5 per 28 days
Cerezyme (imiglucerase) injection 400 units vial	Dosing range: 2.5 U/kg three times a week to 60 U/kg per 14 days	15 per 14 days	30 every 14 days
Cosentyx (secukinumab): 150 mg pen or syringe	Psoriatic arthritis or Ankylosing spondylitis: <ul style="list-style-type: none"> • Loading doses (optional): 150 mg at weeks 0, 1, 2, 3, 4 • Maintenance dose: 150 mg every 4 weeks Plaque psoriasis, with or without coexistent psoriatic arthritis: <ul style="list-style-type: none"> • Loading doses: 300 mg at weeks 0, 1, 2, 3, 4 • Maintenance dose: 300 mg every 4 weeks (150 mg every 4 weeks may be acceptable) 	1 per 28 days	5 per 35 days
Cosentyx (secukinumab): 300 mg dose carton containing (2) 150 mg pens or (2) 150 mg syringes		1 per 28 days	5 per 35 days
Dupixent (dupilumab) 300 mg/2 mL pre-filled syringe	Initial dose of 600 mg (two 300 mg injections), followed by 300 mg given every other week.	600 mg per 28 days	Initial dose: 600 mg per 14 days
Elelyso (taliglucerase alfa) injection 200 units vial	60 units/kg infusion every other week	30 per 14 days	60 every 14 days
Follitropin Beta (Follistim AQ) 75 unit vial	Ovulation induction: starting dose of 75 IU daily for at least 7 days, increased by 25 to 50 IU at weekly intervals until adequate ovarian response. Maximum daily dose of 300 IU. Assisted reproductive technology: starting dose of 150 to 225 IU daily for at least 4 days with subsequent doses adjusted based upon	60 vials per 30 days*	None

Medication	FDA-recommended dosing	Standard Limit	Exception Limit
	ovarian response. Maximum daily dose of 600 IU. Induction of spermatogenesis: 450 IU per week		
Follitropin Beta (Follistim AQ) 300 unit cartridge	Ovulation induction: starting dose of 50 IU daily for at least 7 days, increased by 25 to 50 IU at weekly intervals until adequate ovarian response. Maximum daily dose of 250 IU. Controlled ovarian stimulation as part of an in vitro fertilization or intracytoplasmic sperm injection cycle: starting dose of 200 IU daily for at least 7 days with subsequent doses adjusted up or down based upon ovarian response. Maximum daily dose of 500 IU. Induction of spermatogenesis: 450 IU per week	15 cartridges per 30 days*	None
Follitropin Beta (Follistim AQ) 600 unit cartridge		8 cartridges per 30 days*	10 cartridges per 30 days*
Follitropin Beta (Follistim AQ) 900 unit cartridge		5 cartridges per 30 days*	7 cartridges per 30 days*
Follitropin Alfa (Gonal-F) 450 units vial	Ovulation induction: first cycle starting dose of 75 IU daily with incremental adjustment of up to 37.5 IU after 14 days. If necessary, increase dose by same magnitude every 7 days (in general up to 35 days of treatment). The initial dose in subsequent cycles is individualized based on prior response. Maximum daily dose of 300 IU. Assisted reproductive technology: starting dose of 150 IU per day until adequate follicular development (up to 10 days of therapy in most cases). In patients whose endogenous gonadotropin levels are suppressed, starting dose of 225 IU daily. Consider dose adjustment after 5 days based on response (adjust no more frequently than every 3-5 days by no more than 75-150 IU). Maximum daily dose of 450 IU. Hypogonadotropic hypogonadism: 150 IU three times per week.	10 vials per 30 days*	None
Follitropin Alfa (Gonal-F) 1050 units vial		5 vials per 30 days*	6 vials per 30 days*

Medication	FDA-recommended dosing	Standard Limit	Exception Limit
	Maximum dose of 300 IU three times per week.		
Follitropin Alfa (Gonal-F RFF) 300/0.5ml pen injector	Ovulation induction: first cycle starting dose of 75 IU daily for 14 days. If indicated by the ovarian response after the initial 14 days, adjust dose by up to 37.5 IU every 7 days. Continue until adequate ovarian response (up to 35 days). The initial dose in subsequent cycles is based on prior response. Maximum daily dose of 300 IU. Assisted reproductive technology: starting dose of 150 IU per day until adequate follicular development (up to 10 days of therapy in most cases). In patients whose endogenous gonadotropin levels are suppressed, starting dose of 150 IU per day (if under 35 years old) or 225 IU per day (if 35 years old or older). Adjust dose after 5 days based on response (adjust no more frequently than every 3-5 days by no more than 75-150 IU). Maximum daily dose of 450 IU.	15 cartridges per 30 days*	None
Follitropin Alfa (Gonal-F RFF) 450/0.75ml pen injector		10 cartridges per 30 days*	None
Follitropin Alfa (Gonal-F RFF) 900/1.5ml pen injector		5 cartridges per 30 days*	7 cartridges per 30 days*
Follitropin Alfa (Gonal-F RFF) 75 unit vial	Ovulation induction: first cycle starting dose of 75 IU daily with incremental adjustment of up to 37.5 IU after 14 days. If necessary, increase dose by same magnitude every 7 days (in general up to 35 days of treatment). The initial dose in subsequent cycles is individualized based on prior response. Maximum daily dose of 300 IU. Assisted reproductive technology: starting dose of 150 IU per day until adequate follicular development (up to 10 days of therapy in most cases). In patients whose endogenous gonadotropin levels are suppressed, starting dose of 150 IU per day (if under 35 years old) or 225 IU per day (if 35 years old or older). Adjust dose after 5 days based on response	60 vials per 30 days*	None

Medication	FDA-recommended dosing	Standard Limit	Exception Limit
	(adjust no more frequently than every 3-5 days by no more than 75-150 IU). Maximum daily dose of 450 IU.		
Gattex (teduglutide) Kit 5 mg	• 0.05 mg/kg daily	One 30-vial kit per 30 days	Two 30-vial kits per 30 days
Kineret (anakinra) injection 100 mg/0.67 mL	<ul style="list-style-type: none"> • Rheumatoid arthritis: 100 mg per day • Cryopyrin-Associated Periodic Syndromes (CAPS)/Neonatal-Onset Multisystem Inflammatory Disease (NOMID): up to 8 mg/kg per day 	240 per 30 days	360 per 30 days
Radicava 30 mg/100mL per IV bag	<p><u>Initial Treatment Cycle:</u> 60 mg/day for 14 days, followed by a 14-day drug-free period</p> <p><u>Subsequent Treatment Cycles:</u> 60 mg/day for 10 days out of 14 days, followed by a 14-day drug-free period</p>	600 mg (20 bags) per 28 days	Initial Treatment Cycle: 840 mg (28 bags) per 28 days
Remicade injection 100 mg	<ul style="list-style-type: none"> • Crohn's disease (CD): 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks (May increase the dose up to 10 mg/kg for loss of response) • Pediatric CD, Ulcerative colitis (UC), Pediatric UC, psoriatic arthritis and plaque psoriasis: 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks • Rheumatoid arthritis: In combination with methotrexate, 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks (May increase the dose up to 10 mg/kg or treating as often as every 4 weeks) • Ankylosing spondylitis: 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks 	10 per 28 days	<p>Induction dose</p> <ul style="list-style-type: none"> • Up to 100 kg: 30 per 42 days • Above 100 kg: up to 60 per 42 days <p>Maintenance dose</p> <ul style="list-style-type: none"> • Up to 20 vials per 4 weeks
Repatha (evolocumab) injection 140 mg/mL	<ul style="list-style-type: none"> • 140 mg every 2 weeks or 420 mg once monthly • For HoFH, 420 mg once monthly 	2 per 28 days	No post limit; Repatha 420 mg/ 3.5 mL available to members without a review process
Revatio (sildenafil) tablet 20 mg	• Up to 20 mg three times a day	90 per 30 days	360 per 30 days

Medication	FDA-recommended dosing	Standard Limit	Exception Limit
Siliq (brodalumab) 210 mg/ 1.5mL prefilled syringe	<ul style="list-style-type: none"> Loading doses: 210 mg at week 0, 1, and 2 Maintenance dose: 210 mg every 2 weeks 	2 per 28 days	4 per 35 days
Simponi (golimumab) injection 100 mg/mL prefilled syringe	<ul style="list-style-type: none"> Ulcerative colitis: 200 mg at Week 0, 100 mg at Week 2, and then 100 mg every 4 weeks Other FDA-approved indications: 50 mg once monthly 	1 per 28 days	3 per 15 days
Spinraza (nusinersen) injection 12 mg/5 mL vial	<ul style="list-style-type: none"> 12 mg at Day 0, 14, 28 and 58; then once every 4 months 	1 per 4 months	Loading doses: 4 per 58 days
Stelara (ustekinumab) 130 mg/26 ml vial	<p>Crohn's disease, initial one-time infusion:</p> <ul style="list-style-type: none"> Up to 55 kg: 260 mg (2 vials) Greater than 55 kg to 85 kg: 390 mg (3 vials) Greater than 85 kg: 520 mg (4 vials) 	4 vials (one dose)	No post limit necessary
Stelara (ustekinumab) injection 45 mg/0.5mL vial/ syringe	<p>Psoriasis with or without co-existent psoriatic arthritis:</p> <ul style="list-style-type: none"> Less than or equal to 100 kg: 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks Greater than 100 kg: 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks 	1 per 12 weeks	2 per 35 days
Stelara (ustekinumab) injection 90 mg/mL vials/syringe	<p>Psoriatic arthritis, without co-existent plaque psoriasis (adult):</p> <ul style="list-style-type: none"> 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks <p>Crohn's disease, maintenance dose (adult):</p> <ul style="list-style-type: none"> 90 mg 8 weeks after the initial intravenous dose, then every 8 weeks thereafter 	1 per 8 weeks	2 per 35 days
Taltz (ixekizumab) 80 mg/ml injection	<ul style="list-style-type: none"> Loading doses: 160 mg at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12 Maintenance dose: 80 mg every 4 weeks 	1 per 28 days	8 per 90 days
Tarceva (erlotinib) tablet 100 mg	<ul style="list-style-type: none"> Non-small cell lung cancer (NSCLC): 150 mg daily 	30 per 30 days	120 per 30 days
Tarceva (erlotinib) tablet 150 mg	<ul style="list-style-type: none"> Pancreatic cancer: 100 mg daily Up to 300 mg if cigarette smoker 	30 per 30 days	90 per 30 days

Medication	FDA-recommended dosing	Standard Limit	Exception Limit
	<ul style="list-style-type: none"> Up to 450 mg if co-administered with a strong CYP3A4 inducer 		
Tecfidera (dimethyl fumarate) capsule 120 mg	<ul style="list-style-type: none"> Starting dose: 120 mg BID Intolerance to maintenance dosing: 120 mg BID for 4 weeks 	14 per 6 months	70 per 6 months
Thalomid (thalidomide) capsule 200 mg	<ul style="list-style-type: none"> Multiple myeloma: 200 mg orally once daily Erythema nodosum leprosum (ENL): 100 to 300 mg per day for an episode of cutaneous. Up to 400 mg per day for severe cutaneous ENL. 	60 per 30 days	240 per 30 days
Tremfya (guselkumab) 100 mg/mL prefilled syringe	<ul style="list-style-type: none"> Loading doses: 100 mg at week 0 and 4 Maintenance dose: 100 mg every 8 weeks thereafter 	1 per 56 days	2 per 28 days
VPRIV (velaglucerase) injection 400 units vial	60 units/kg infusion every other week	15 per 14 days	30 every 14 days
Xtandi (enzalutamide) capsule 40 mg	<ul style="list-style-type: none"> 160 mg per day 240 mg per day if co-administered with a strong CYP3A4 inducer 	120 per 30 days	180 per 30 days
Zytiga (abiraterone) tablet 250 mg	<ul style="list-style-type: none"> 1000 mg per day 2000 mg per day if co-administered with a strong CYP3A4 inducer 	120 per 30 days	240 per 30 days
Zytiga (abiraterone) tablet 500 mg		60 per 30 days	120 per 30 days

*Standard Limit allows 4500 units and Exception Limit allows 6000 units of each product/strength per 30 days.

IU=international unit

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POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

Original Implementation Date: 1/1/2018

Revision Information	
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Starter Fill Program: Dispense Partial Supply of Medication to Help Minimize Potential Waste

WHAT IS STARTER FILL?

- A program that targets new utilizers on high cost therapies poor tolerability and high discontinuation rates*
- Provides a provisional period for new-to-therapy patients in order to establish tolerability and minimize wasteful dispensing of expensive drugs

WHY CONSIDER?

- The program allows time to help ensure a new-to-therapy patient can tolerate medication prior to full dispenses
- Provides an increase in cost savings for the client and member by decreasing drug waste

WHAT THERAPIES ARE INCLUDED?

- An advisory committee evaluates applicable therapies for inclusion in the Starter Fill program
- Therapies include:
 - Oral Oncology
 - Hepatitis B
 - Cystic Fibrosis
 - Hematological Disorders

*Full-month supply is dependent on the allowable amount as determined by the plan design or the prescription as written by the physician.



How the Starter Fill Program Works

1. FIRST FILL



Patient receives partial medication fills (usually a two-week supply at a time) for the first 3 months of therapy

The copay or coinsurance is prorated based on the supply received

2. COMPREHENSIVE SUPPORT



Patient Service Representative will engage members prior to subsequent fills

Transitioned to therapy specific pharmacist if patient has concerns or questions about side effects

3. SUBSEQUENT FILLS



After 3 months, if patient demonstrates tolerance, program requirements are met and a patient may then fill a full-month supply* for all subsequent fills

Patient will not be required to go through the program if a brand new prescription for the same drug is written

*Full-month supply is dependent on the allowable amount as determined by the plan design or the prescription as written by the physician.



Medications Included in the Starter Fill Program

MEDICATIONS ARE EVALUATED FOR PROGRAM INCLUSION BY ADVISORY COMMITTEE BASED ON MANUFACTURER GUIDELINES, SAFETY & PACKAGING

ORAL ONCOLOGY

Afinitor (everolimus)	Sprycel (dasatinib)
Bosulif (bosutinib)	Sutent (sunitinib)
Cometriq (carbozantinib)	Tafinlar (dabrafenib)
Erivedge (vismodegib)	Tagrisso (osimertinib)
Gleevec (imatinib)	Tarceva (erlotinib)
Imbruvica (ibrutinib)	Targretin (bexarotene)
Inlyta (axitinib)	Tasigna (nilotinib)
Iressa (gefitinib)	Votrient (pazopanib)
Jakafi (ruxolitinib)	Xalkori (crizotinib)
Lynpaza (olaparib)	Xtandi (enzalutamide)
Nerlynx (neratinib)	Zolinza (vorinostat)
Nexavar (sorafenib)	Zykadia (ceritinib)
Odomzo (sonidegib)	Zytiga (abiraterone)
Rubraca (rucaparib)	

HEPATITIS B

Baraclude (entecavir)
Epivir (lamivudine)

CYSTIC FIBROSIS

Kalydeco (ivacaftor)
Orkambi (ivacaftor/lumacaftor)

HEMATOLOGICAL DISORDERS

Exjade (deferasirox)
Jadenu (deferasirox)

List last updated September 2017. List is subject to change based on new drug approvals or changes to dispensing regulations.

Because of cycle-based dosing or federal risk evaluation and mitigation strategy requirements, not all oral oncology or hepatitis B medications can be partially filled. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty.

Starter Fill Drug List

To help manage the rising cost of specialty treatment, some clients have requested starter fill programs for patients. This program targets toxic therapies that demonstrate high discontinuation rates for new to therapy patients who more likely to discontinue therapy. A partial fill is dispensed for the first three months, which will equal a total of six split fills. If the patient demonstrates tolerability they will receive a full month's supply for the targeted therapy. Therapies are reviewed for side effect profile, tolerability, dosing, stability, packaging, and storability before being added to the list. CVS Specialty™ is able to support partial fill dispensing for the following medications:

Oncology

- **Afinitor** (everolimus)
- **Bosulif** (bosutinib)
- **Cometriq** (cabozantinib)
- **Erivedge** (vismodegib)
- **Gleevec** (imatinib)
- **Imbruvica** (ibrutinib)
- **Inlyta** (axitinib)
- **Iressa** (gefitinib)
- **Jakafi** (ruxolitinib)
- **Lynparza** (olaparib)
- **Nerlynx** (neratinib)
- **Nexavar** (sorafenib)
- **Odomzo** (sonidegib)
- **Rubraca** (rucaparib)
- **Sprycel** (dasatinib)
- **Tagrisso** (osimertinib)
- **Tarceva** (erlotinib)
- **Targretin tablets** (bexarotene)
- **Tasigna** (nilotinib)
- **Votrient** (pazopanib)
- **Xalkori** (crizotinib)
- **Xtandi** (enzalutamide)
- **Zolinza** (vorinostat)
- **Zykadia** (ceritinib)
- **Zytiga** (abiraterone)

Cystic Fibrosis

- **Kalydeco** (ivacaftor)
- **Orkambi** (ivacaftor/lumacaftor)

Hematological Disorders

- **Exjade** (deserasirox)
- **Jadenu** (deserasirox)

Hepatitis B

- **Baraclude** (entecavir)
- **Epivir HBV** (lamivudine)

Parkinson's Disease Psychosis

- **Nuplazid** (pimavanserin)

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS/caremark. A plan member's specific benefit plan design may not cover certain products or categories, regardless of their appearance on this document. Listing is subject to change

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS LONG ACTING INSULIN /GLP-1 AGONIST

BRAND NAME
(generic)

SOLIQUA
(insulin glargine/lixisenatide injection)

XULTOPHY
(insulin degludec/liraglutide injection)

Type: Initial Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS

Soliqua

Soliqua is a combination of insulin glargine and lixisenatide and is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (less than 60 units daily) or lixisenatide.

Important Limitations of Use

- Soliqua has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.
- Soliqua is not recommended for use in combination with any other product containing lixisenatide or another GLP-1 receptor agonist.
- Soliqua is not indicated for use in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.
- Soliqua has not been studied in patients with gastroparesis and is not recommended in patients with gastroparesis.
- Soliqua has not been studied in combination with prandial insulin.

Xultophy

Xultophy is a combination of insulin degludec and liraglutide and is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (less than 50 units daily) or liraglutide (less than or equal to 1.8mg daily).

Important Limitations of Use

- Xultophy is not recommended as first line therapy for patients who have inadequate glycemic control controlled on diet and exercise
- Xultophy has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.
- Xultophy is not recommended for use in combination with any other product containing liraglutide or another GLP-1 receptor agonist.
- Xultophy is not indicated for use in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.
- Xultophy has not been studied in combination with prandial insulin.

Quantity Limit may apply.

COVERAGE CRITERIA

Long Acting Insulin/GLP-1 Agonist combinations will be covered with prior authorization when the following criteria are met:

- The patient has been receiving the requested drug for at least 3 months and has demonstrated an expected reduction in A1c (hemoglobin A1c) since starting combination insulin and GLP-1 Agonist therapy.

OR

- The requested drug is being prescribed for type 2 diabetes mellitus

AND

- The patient has experienced an inadequate treatment response, contraindication or intolerance to metformin OR a sulfonylurea OR a thiazolidinedione

OR

- The patient requires combination therapy AND has an A1c (hemoglobin A1c) of 7.5 percent or greater

At maximum approved dosing for Soliqua 10 prefilled pens (2 packages of 5 x 3mL), a total of 10 pens (30mL) will be allowed for a 30 day supply.

At maximum approved dosing for Xultophy 5 prefilled pens (1 package of 5 x 3mL), a total of 5 pens (15mL) will be allowed for a 30 day supply.

REFERENCES

1. Soliqua [package insert]. Bridgewater, NJ: Sanofi-aventis U.S. LLC; November 2016.
2. Xultophy [package insert]. Plainsboro, NJ: Novo Nordisk U.S. LLC; November 2016.
3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed December 2016
4. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed December 2016
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6. Garber AJ, et al. AACE/ACE Comprehensive Diabetes Management Algorithm 2016, *Endocr Pract.* 2016; 22:84-113.
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STEP THERAPY CRITERIA

DRUG CLASS HMG-COA REDUCTASE INHIBITOR (STATIN)

BRAND NAME VYTORIN 10/80 MG STRENGTH ONLY
(generic) (ezetimibe/simvastatin 10/80mg)

ZOCOR 80 MG STRENGTH ONLY
(simvastatin 80mg)

Status: CVS Caremark Criteria

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Therapy with lipid-altering agents should be only one component of multiple risk factor intervention in individuals at significantly increased risk for atherosclerotic vascular disease due to hypercholesterolemia. Drug therapy is indicated as an adjunct to diet when the response to a diet restricted in saturated fat and cholesterol and other nonpharmacologic measures alone has been inadequate.

Vytorin

Primary Hyperlipidemia

Vytorin is indicated for the reduction of elevated total cholesterol (total-C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), triglycerides (TG), and non-high-density lipoprotein cholesterol (non-HDL-C), and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary (heterozygous familial and non-familial) hyperlipidemia or mixed hyperlipidemia.

Homozygous Familial Hypercholesterolemia (HoFH)

Vytorin is indicated for the reduction of elevated total-C and LDL-C in patients with homozygous familial hypercholesterolemia, as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable.

Limitations of Use

No incremental benefit of Vytorin on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin has been established. Vytorin has not been studied in Fredrickson type I, III, IV, and V dyslipidemias.

Zocor

Reductions in Risk of CHD Mortality and Cardiovascular Events

In patients at high risk of coronary events because of existing coronary heart disease, diabetes, peripheral vessel disease, history of stroke or other cerebrovascular disease, Zocor is indicated to:

- Reduce the risk of total mortality by reducing CHD deaths.
- Reduce the risk of non-fatal myocardial infarction and stroke.
- Reduce the need for coronary and non-coronary revascularization procedures.

Hyperlipidemia

Zocor is indicated to:

- Reduce elevated total cholesterol (total-C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), and triglycerides (TG), and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary

hyperlipidemia (Fredrickson type IIa, heterozygous familial and nonfamilial) or mixed dyslipidemia (Fredrickson type IIb).

- Reduce elevated TG in patients with hypertriglyceridemia (Fredrickson type IV hyperlipidemia).
- Reduce elevated TG and VLDL-C in patients with primary dysbetalipoproteinemia (Fredrickson type III hyperlipidemia).
- Reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia (HoFH) as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable.

Adolescent Patients with Heterozygous Familial Hypercholesterolemia (HeFH)

Zocor is indicated as an adjunct to diet to reduce total-C, LDL-C, and Apo B levels in adolescent boys and girls who are at least one year post-menarche, 10-17 years of age, with HeFH, if after an adequate trial of diet therapy the following findings are present:

1. LDL cholesterol remains ≥ 190 mg/dL; or
2. LDL cholesterol remains ≥ 160 mg/dL and
 - There is a positive family history of premature cardiovascular disease (CVD) or
 - Two or more other CVD risk factors are present in the adolescent patient.

The minimum goal of treatment in pediatric and adolescent patients is to achieve a mean LDL-C < 130 mg/dL. The optimal age at which to initiate lipid-lowering therapy to decrease the risk of symptomatic adulthood CAD has not been determined.

Limitations of Use

Zocor has not been studied in conditions where the major abnormality is elevation of chylomicrons (i.e., hyperlipidemia Fredrickson types I and V).

INITIAL STEP THERAPY

If the patient has filled a prescription for a 290 day supply of 10/80 mg strength of ezetimibe/simvastatin (Vytorin) or 80 mg strength of simvastatin (Zocor) within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

Vytorin 10/80 mg (ezetimibe/simvastatin 10/80 mg) and Zocor 80 mg (simvastatin 80 mg) will be covered with prior authorization when the following criteria are met:

- The patient has been prescribed the 10/80 mg strength of ezetimibe/simvastatin (Vytorin) OR the 80 mg strength of simvastatin (Zocor) chronically for 12 months or more.

REFERENCES

1. Vytorin [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; March 2015.
2. Zocor [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; March 2015.
3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed November 2016.
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STEP THERAPY CRITERIA

BRAND NAME
(generic)

GRALISE
(gabapentin extended release tablet)

HORIZANT
(gabapentin enacarbil extended release tablet)

LYRICA
(pregabalin)

Status: CVS Caremark Criteria

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Gralise

Gralise is indicated for the management of postherpetic neuralgia.

Gralise is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

Horizant

Treatment of Restless Legs Syndrome

Horizant (gabapentin enacarbil) Extended-Release Tablets are indicated for the treatment of moderate-to-severe primary Restless Legs Syndrome (RLS) in adults.

Horizant is not recommended for patients who are required to sleep during the daytime and remain awake at night.

Management of Postherpetic Neuralgia

Horizant (gabapentin enacarbil) Extended-Release Tablets are indicated for the management of postherpetic neuralgia (PHN) in adults.

Lyrica

Lyrica is indicated for:

- Management of neuropathic pain associated with diabetic peripheral neuropathy
- Management of postherpetic neuralgia
- Adjunctive therapy for adult patients with partial onset seizures
- Management of fibromyalgia
- Management of neuropathic pain associated with spinal cord injury

Compendial Uses

Cancer-Related Neuropathic Pain

INITIAL STEP THERAPY CRITERIA

If the patient has filled a prescription for at least a 30 day supply of regular-release generic gabapentin within the past 120 days under a prescription benefit administered by CVS/caremark, then the requested Gralise, Horizant, or Lyrica will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has experienced an inadequate treatment response, intolerance, or contraindication to regular-release generic gabapentin
- OR**
- Lyrica (pregabalin) is being prescribed for the management of fibromyalgia, the management of neuropathic pain associated with diabetic peripheral neuropathy, or the management of neuropathic pain associated with spinal cord injury
- OR**
- Horizant (gabapentin enacarbil) being prescribed for the treatment of Restless Legs Syndrome

REFERENCES

1. Gralise [package insert]. North Chicago, IL: Abbott Laboratories; September 2015.
2. Horizant [package insert]. Research Triangle Park, NC: GlaxoSmithKline; July 2013.
3. Lyrica [package insert]. New York, NY: Pfizer Inc.; December 2013.
4. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed May 2016.
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6. Neurontin [package insert]. New York, NY: Parke-Davis Division of Pfizer Inc; September 2015.
7. Hooten WM, Timming R, Belgrade M, et al. Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain. Sixth Edition/November 2013. www.icsi.org. Accessed May 2016.
8. Dworkin RH, O'Connor AB, Backonja M, et al. Pharmacologic Management of Neuropathic Pain: Evidence-based Recommendations. *Pain* 2007;132(3):237-251.
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15. NCCN Guidelines. Version 2.2016 Adult Cancer Pain. http://www.nccn.org/professionals/physician_gls/pdf/pain.pdf. Accessed May 2016.
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Specialty Guideline Management Criteria

Currently Effective or on 1/1/2018 Due to Formulary Add Back

POLICY	EFFECTIVE DATE
Tysabri	Current
Feiba	Current
Rituxan Hycela	1/1/2018
Lynparza	Current
Epogen, Procrit	1/1/2018
Ibrance	Current
Alecensa	1/1/2018
Uptravi	Current
Prolia	1/1/2018
Makena	Current
Simponi	1/1/2018
Remicade, Inflectra, Renflexis	1/1/2018
Otezla	1/1/2018
Orencia	1/1/2018
Praluent	1/1/2018
Cimzia	1/1/2018
Cosentyx	1/1/2018

SPECIALTY GUIDELINE MANAGEMENT

TYSABRI (natalizumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

- A. Moderately to severely active Crohn's disease (CD)
- B. Relapsing forms of multiple sclerosis (MS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active Crohn's disease (CD)

1. Authorization of 24 months may be granted to members who have received Tysabri or any other biologic indicated for the treatment of Crohn's disease in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Tysabri.
2. Authorization of 24 months may be granted for members who have an inadequate response, intolerance or contraindication to BOTH of the following:
 - a. At least ONE conventional therapy option (See Appendix)
 - b. At least ONE TNF-alpha inhibitor indicated for CD:
 - i. Humira (adalimumab)
 - ii. Remicade (infliximab)
 - iii. Cimzia (certolizumab)

B. Relapsing forms of multiple sclerosis (MS)

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

A. Crohn's disease

Authorization of 24 months may be granted for all members (including new members) who meet ALL initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Tysabri as evidenced by low disease activity or improvement in signs and symptoms of the condition.

B. Multiple sclerosis (MS)

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria.

IV. APPENDIX

Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
 - a. Oral budesonide, oral mesalamine
 - b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
 - a. Prednisone, methylprednisolone intravenously (IV)
 - b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission
 - a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission
 - a. Azathioprine, mercaptopurine
 - b. Alternative: methotrexate IM

V. REFERENCES

1. Tysabri [package insert]. Cambridge, MA: Biogen Inc; May 2016.
2. Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. *Am J Gastroenterol.* 2011;106(Suppl 1):S2-S25.

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SPECIALTY GUIDELINE MANAGEMENT

FEIBA (anti-inhibitor coagulant complex [human])

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

- A. FDA-Approved Indication
Hemophilia A and hemophilia B with inhibitors
- B. Compendial Use
Acquired hemophilia A

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

- A. **Hemophilia A with Inhibitors**
Indefinite authorization may be granted for treatment of hemophilia A with inhibitors (see Appendix) when the inhibitor titer is ≥ 5 Bethesda units per milliliter (BU/mL).
- B. **Hemophilia B with Inhibitors**
Indefinite authorization may be granted for treatment of hemophilia B with inhibitors (see Appendix) when the inhibitor titer is ≥ 5 Bethesda units per milliliter (BU/mL).
- C. **Acquired Hemophilia A**
Indefinite authorization may be granted for treatment of acquired hemophilia A.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. APPENDIX

Appendix: Inhibitors - Bethesda Units (BU)

The presence of inhibitors is confirmed by a specific blood test called the Bethesda inhibitor assay.

- High-titer inhibitors:
 - ≥ 5 BU/mL
 - Inhibitors act strongly and quickly neutralize factor
- Low-titer inhibitors:
 - < 5 BU/mL
 - Inhibitors act weakly and slowly neutralize factor

V. REFERENCES

1. FEIBA [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; November 2013.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed December 20, 2016.
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SPECIALTY GUIDELINE MANAGEMENT

RITUXAN HYCELA (rituximab and hyaluronidase human)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Adult patients with follicular lymphoma (FL):
 - a. Relapsed or refractory, follicular lymphoma as a single agent
 - b. Previously untreated follicular lymphoma in combination with first line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single-agent maintenance therapy
 - c. Non-progressing (including stable disease), follicular lymphoma as a single agent after first-line CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy
2. Adult patients with previously untreated diffuse large B-cell lymphoma (DLBCL) in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or other anthracycline-based chemotherapy regimens
3. Adult patients with previously untreated and previously treated chronic lymphocytic leukemia (CLL), in combination with fludarabine and cyclophosphamide (FC)

Limitations of Use:

1. Initiate treatment with Rituxan Hycela only after patients have received at least one full dose of a rituximab product by intravenous infusion.
2. Rituxan Hycela is not indicated for the treatment of non-malignant conditions.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Prior to initiating therapy, all members must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.

A. Diffuse large B-cell lymphoma (DLBCL)

Authorization of 12 months may be granted for treatment of CD20 positive DLBCL in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens in previously untreated disease.

B. Chronic lymphocytic leukemia (CLL)

Authorization of 12 months may be granted for treatment of CLL in combination with fludarabine and cyclophosphamide.

C. Follicular lymphoma (FL)

Authorization of 12 months may be granted for treatment of CD20 positive FL when used in any of the following settings:

1. As a single agent for relapsed or refractory disease
2. In combination with first line chemotherapy in previously untreated disease
3. As a single agent for maintenance therapy when member has achieved a complete or partial response to rituximab in combination with chemotherapy
4. As a single agent in non-progressing disease after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Rituxan Hycela [package insert]. South San Francisco, CA: Genentech, Inc.; June 2017.

POLICY IMPLEMENTATION/REVISION INFORMATION

Prior Authorization

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SPECIALTY GUIDELINE MANAGEMENT

LYNPARZA (olaparib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

- A. Maintenance Treatment of Recurrent Ovarian Cancer
Lynparza is indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy.
- B. Advanced *gBRCA*-mutated Ovarian Cancer After 3 or More Lines of Chemotherapy
Lynparza is indicated for the treatment of adult patients with deleterious or suspected deleterious germline *BRCA*-mutated (*gBRCAm*) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for Lynparza.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of advanced or recurrent ovarian cancer when the member has received prior treatment with chemotherapy.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Lynparza™ Capsules [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2014.
2. Lynparza® Tablets [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; August 2017.

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SPECIALTY GUIDELINE MANAGEMENT

EPOGEN, PROCRIT (epoetin alfa)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Epoetin alfa is indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and not on dialysis to decrease the need for red blood cell (RBC) transfusion.
2. Epoetin alfa is indicated for the treatment of anemia due to zidovudine administered at ≤ 4200 mg/week in HIV-infected patients with endogenous serum erythropoietin levels of ≤ 500 mUnits/mL.
3. Epoetin alfa is indicated for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy.
4. Epoetin alfa is indicated to reduce the need for allogeneic RBC transfusions among patients with perioperative hemoglobin > 10 to ≤ 13 g/dL who are at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery. Epoetin alfa is not indicated for patients who are willing to donate autologous blood preoperatively.

Limitations of Use:

1. Epoetin alfa has not been shown to improve quality of life, fatigue, or patient well-being.
2. Epoetin alfa is not indicated for use:
 - In patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy.
 - In patients with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure.
 - In patients scheduled for surgery who are willing to donate autologous blood.
 - In patients undergoing cardiac or vascular surgery.
 - As a substitute for RBC transfusions in patients who require immediate correction of anemia.

B. Compendial Uses

1. Symptomatic anemia in patients with myelodysplastic syndromes (MDS)
2. Anemia in congestive heart failure
3. Anemia in rheumatoid arthritis
4. Anemia due to hepatitis C treatment with ribavirin in combination with either interferon alfa or peginterferon alfa
5. Anemia in patients whose religious beliefs forbid blood transfusions
6. Symptomatic anemia in patients with primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Note: Requirements regarding pretreatment hemoglobin level exclude values due to a recent transfusion.

A. Anemia Due to CKD

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

B. Anemia Due to Myelosuppressive Chemotherapy

Authorization of 12 weeks may be granted for members with nonmyeloid malignancy who meet ALL of the following criteria:

1. The intent of chemotherapy is non-curative
2. Pretreatment hemoglobin < 10 g/dL

C. Anemia in MDS

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

D. Reduction of Allogeneic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery

Authorization of 12 weeks may be granted for members scheduled to have an elective, noncardiac, nonvascular surgery when the pretreatment hemoglobin is > 10 to ≤ 13 g/dL.

E. Anemia in Congestive Heart Failure (CHF)

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 9 g/dL.

F. Anemia in Rheumatoid Arthritis (RA)

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

G. Anemia Due to Hepatitis C Treatment

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL who are receiving ribavirin in combination with either interferon alfa or peginterferon alfa.

H. Anemia Due to Zidovudine in HIV-infected Patients

Authorization of 12 weeks may be granted for members currently receiving zidovudine with pretreatment hemoglobin < 10 g/dL.

I. Anemia in Members Whose Religious Beliefs Forbid Blood Transfusions

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

J. Anemia in Primary Myelofibrosis (MF), Post-polycythemia Vera MF, and Post-Essential Thrombocythemia MF

Authorization of 12 weeks may be granted for members who meet ALL of the following criteria:

1. Member has symptomatic anemia
2. Pretreatment hemoglobin < 10 g/dL
3. Pretreatment serum erythropoietin level < 500 mU/mL

III. CONTINUATION OF THERAPY

Note: Requirements regarding current hemoglobin level exclude values due to a recent transfusion.

For all indications below: all members (including new members) requesting authorization for continuation of therapy after at least 12 weeks of ESA treatment must show a response with a rise in hemoglobin of ≥ 1 g/dL. Members who completed less than 12 weeks of ESA treatment and have not yet responded with a rise in hemoglobin of ≥ 1 g/dL may be granted authorization of up to 12 weeks to allow for sufficient time to demonstrate a response.

A. Anemia Due to CKD

Authorization of 12 weeks may be granted for continuation of therapy when the current hemoglobin is \leq 12 g/dL.

B. Anemia Due to Myelosuppressive Chemotherapy

Authorization of 12 weeks may be granted for the continuation of therapy in members with nonmyeloid malignancy who meet BOTH of the following criteria:

1. The intent of chemotherapy is non-curative
2. Current hemoglobin is $<$ 11 g/dL

C. Anemia in MDS

Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is \leq 12 g/dL.

D. Anemia in CHF, RA

Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is \leq 12 g/dL.

E. Anemia Due to Hepatitis C Treatment

Authorization of 12 weeks may be granted for continuation of treatment when the member meets ALL of the following criteria:

1. The member is receiving ribavirin in combination with either interferon alfa or peginterferon alfa
2. The current hemoglobin is \leq 12 g/dL.

F. Anemia Due to Zidovudine in HIV-infected Patients

Authorization of 12 weeks may be granted for continuation of therapy in members receiving zidovudine when the current hemoglobin is \leq 12 g/dL.

G. Anemia in Members Whose Religious Beliefs Forbid Blood Transfusions

Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is \leq 12 g/dL.

H. Anemia in Primary Myelofibrosis, Post-polycythemia Vera Myelofibrosis, and Post-Essential Thrombocythemia Myelofibrosis

Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is \leq 12 g/dL.

IV. REFERENCES

1. Epogen [package insert]. Thousand Oaks, CA: Amgen Inc.; March 2016.
2. Procrit [package insert]. Horsham, PA: Janssen Products.; March 2016.
3. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. <http://www.nccn.org>. Accessed October 16, 2016.
4. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed October 18, 2016.
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POLICY IMPLEMENTATION/REVISION INFORMATION

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SPECIALTY GUIDELINE MANAGEMENT

IBRANCE (palbociclib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

Ibrance is indicated for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with:

1. an aromatase inhibitor as initial endocrine based therapy in postmenopausal women, or
2. fulvestrant in women with disease progression following endocrine therapy.

B. Compendial Uses

Soft tissue sarcoma: well-differentiated/dedifferentiated retroperitoneal liposarcoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. **Breast cancer**

Authorization of 12 months may be granted for the treatment of HR-positive HER2-negative breast cancer when one of the following criteria is met:

1. Ibrance is used in combination with an aromatase inhibitor (eg, anastrozole, exemestane, letrozole) for a postmenopausal member
2. Ibrance is used in combination with fulvestrant

B. **Soft tissue sarcoma**

Authorization of 12 months may be granted for treatment of well-differentiated/dedifferentiated retroperitoneal liposarcoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Ibrance [package insert]. New York, NY: Pfizer Inc.; March 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed January 9, 2017.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Breast Cancer. Version 2. 2016. http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed January 18, 2017.

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SPECIALTY GUIDELINE MANAGEMENT

ALECENSA (alectinib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication

Alecensa is indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib.

B. Compendial Uses
Recurrent NSCLC

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review: Anaplastic lymphoma kinase (ALK) mutation status

III. CRITERIA FOR INITIAL APPROVAL

A. **Non-Small Cell Lung Cancer (NSCLC)**

Authorization of 12 months may be granted for the treatment of recurrent or metastatic NSCLC when all of the following criteria are met:

1. The tumor is ALK-positive.
2. Member has progressed on prior therapy with crizotinib (Xalkori) OR member has experienced intolerance to crizotinib.
3. Alecensa is used as a single agent.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines

VI. REFERENCES

1. Alecensa [package insert]. South San Francisco, CA: Genentech USA, Inc.; December 2015.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed September 15, 2016.
3. The NCCN Clinical Practice Guidelines in Oncology® Non-Small Cell Lung Cancer (Version 4.2016).© 2016 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed September 15, 2016.

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SPECIALTY GUIDELINE MANAGEMENT

Uptravi (selexipag)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Pulmonary Arterial Hypertension

Uptravi is indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for treatment of PAH when ALL of the following criteria are met:

A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix)

B. PAH was confirmed by either criterion (1) or criterion (2) below:

1. Pretreatment right heart catheterization with all of the following results:
 - mPAP \geq 25 mmHg
 - PCWP \leq 15 mmHg
 - PVR $>$ 3 Wood units
2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
 - Post cardiac surgery
 - Chronic heart disease
 - Chronic lung disease associated with prematurity
 - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for members with PAH who are currently receiving Uptravi therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension

WHO Group 1. Pulmonary Arterial Hypertension (PAH)

1.1 Idiopathic (IPAH)

1.2 Heritable PAH

1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)

1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)

- 1.2.3 Unknown
- 1.3 Drug- and toxin-induced
- 1.4. Associated with:
 - 1.4.1 Connective tissue diseases
 - 1.4.2 HIV infection
 - 1.4.3 Portal hypertension
 - 1.4.4 Congenital heart diseases
 - 1.4.5 Schistosomiasis
- 1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
- 1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease

- 2.1 Systolic dysfunction
- 2.2 Diastolic dysfunction
- 2.3 Valvular disease
- 2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia

- 3.1 Chronic obstructive pulmonary disease
- 3.2 Interstitial lung disease
- 3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
- 3.4 Sleep-disordered breathing
- 3.5 Alveolar hypoventilation disorders
- 3.6 Chronic exposure to high altitude
- 3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms

- 5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
- 5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
- 5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
- 5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

PROLIA (denosumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Treatment of postmenopausal women with osteoporosis at high risk for fracture
2. Treatment to increase bone mass in men with osteoporosis at high risk for fracture
3. Treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy (ADT) for non-metastatic prostate cancer
4. Treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer

B. Compendial Uses

Prevention or treatment of osteoporosis during androgen deprivation therapy for patients with high fracture risk

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. **Osteoporosis in Postmenopausal Women**

Authorization of 24 months may be granted to postmenopausal female members when ANY of the following criteria are met:

1. Member has a history of fragility fractures
2. Member has a pre-treatment T-score of ≤ -2.5 OR member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B) and meets ANY of the following criteria:
 - a. Member has indicators of higher fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores, or increased fall risk)
 - b. Member has failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo])
 - c. Member has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate (See Appendix A)

B. **Osteoporosis in Men**

Authorization of 24 months may be granted to male members with osteoporosis when ANY of the following criteria are met:

1. Member has a history of an osteoporotic vertebral or hip fracture
2. Member has a pre-treatment T-score of ≤ -2.5
3. Member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B)

C. **Breast Cancer**

Authorization of 24 months may be granted to members who are receiving adjuvant aromatase inhibitor therapy for breast cancer.

D. Prostate Cancer

Authorization of 24 months may be granted to members who are receiving androgen deprivation therapy for prostate cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. APPENDIX

Appendix A. Clinical reasons to avoid oral bisphosphonate therapy

- Esophageal abnormality that delays emptying such as stricture of achalasia
- Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
- Inability to stand or sit upright for at least 30 to 60 minutes
- Inability to take at least 30 to 60 minutes before first food, drink, or medication of the day
- Renal insufficiency (creatinine clearance <30 mL/min)
- History of intolerance to an oral bisphosphonate

Appendix B. WHO Fracture Risk Assessment Tool

- High FRAX fracture probability: 10 year major osteoporotic fracture risk \geq 20% or hip fracture risk \geq 3%.
- 10-year probability; calculation tool available at: <http://www.shef.ac.uk/FRAX/tool.jsp>

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

Makena (hydroxyprogesterone caproate injection)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Makena is indicated to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. The effectiveness of Makena is based on improvement in the proportion of women who delivered < 37 weeks of gestation. There are no controlled trials demonstrating a direct clinical benefit, such as improvement in neonatal mortality and morbidity.

Limitations of use: While there are many risk factors for preterm birth, safety and efficacy of Makena has been demonstrated only in women with a prior spontaneous singleton preterm birth. **It is not intended for use in women with multiple gestations or other risk factors for preterm birth.**

All other indications are considered experimental/investigational and are not covered benefits.

II. EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions:

- A. Current or history of thrombosis or thromboembolic disorders
- B. Known or suspected breast cancer, other hormone-sensitive cancer, or a history of these conditions
- C. Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
- D. Cholestatic jaundice of pregnancy
- E. Liver tumors, benign or malignant, or active liver disease
- F. Uncontrolled hypertension

III. CRITERIA FOR INITIAL APPROVAL

Prevention Of Preterm Birth

Authorization of 21 weeks or through 36 weeks, 6 days of gestational age, whichever is less, may be granted for the prevention of preterm birth when all of the following criteria are met:

- A. The current pregnancy is a singleton pregnancy.
- B. The member has a history of singleton spontaneous preterm birth, defined as delivery at less than 37 weeks gestation following preterm labor, preterm rupture of membranes, and cervical insufficiency.
- C. Makena will be initiated between 16 weeks, 0 days and 24 weeks, 6 days of gestation.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Makena [package insert]. Waltham, MA: Lumara Health Inc.; April 2016.
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SPECIALTY GUIDELINE MANAGEMENT

SIMPONI (golimumab for subcutaneous injection)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)
4. Moderately to severely active ulcerative colitis (UC)

B. Compendial Uses

1. Axial spondyloarthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. **Moderately to severely active rheumatoid arthritis (RA)**

1. Authorization of 24 months may be granted for members who have received Simponi or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit in the previous 120 days of the initial request for Simponi. Simponi must be prescribed in combination with methotrexate unless the member has a contraindication or intolerance to methotrexate (see Appendix A).
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when all of the following criteria are met:
 - a. Member is prescribed Simponi in combination with methotrexate or has a contraindication or intolerance to methotrexate.
 - b. Member meets any of the following criteria:
 - i. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
 - ii. Member has an intolerance or contraindication to methotrexate.

B. **Active psoriatic arthritis (PsA)**

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

C. **Active ankylosing spondylitis (AS) and axial spondyloarthritis**

1. Authorization of 24 months may be granted for members who have received Simponi or any other biologic DMARD indicated for active ankylosing spondylitis in a paid claim through a pharmacy or medical benefit in the previous 120 days of the initial request for Simponi.

2. Authorizations of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.
 - b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix B).

D. Moderately to severely active ulcerative colitis (UC)

1. Authorization of 24 months may be granted for members who have received Simponi or any other biologic indicated for moderately to severely active ulcerative colitis in a paid claim through a pharmacy or medical benefit in the previous 120 days of the initial request for Simponi.
2. Authorization of 24 months may be granted for treatment of moderately to severely active UC when any of the following criteria is met:
 - a. Member has corticosteroid dependence as evidenced by any of the following:
 - i. Member requires continuous corticosteroid therapy.
 - ii. Corticosteroids cannot be successfully tapered without a return of ulcerative colitis symptoms.
 - b. Member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix C).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Simponi as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Simponi or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit in the previous 120 days of the continuation request are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Contraindications to the Use of NSAIDs

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

Appendix C: Examples of Conventional Therapy Options for UC

1. Mild to moderate disease – induction of remission:
 - a. Oral mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa), balsalazide, olsalazine
 - b. Rectal mesalamine (e.g., Canasa, Rowasa)
 - c. Rectal hydrocortisone (e.g., Colocort, Cortifoam)
 - d. Alternatives: prednisone, azathioprine, mercaptopurine, sulfasalazine
2. Mild to moderate disease – maintenance of remission:
 - a. Oral mesalamine, balsalazide, olsalazine, rectal mesalamine
 - b. Alternatives: azathioprine, mercaptopurine, sulfasalazine
3. Severe disease – induction of remission:
 - a. Prednisone, hydrocortisone IV, methylprednisolone IV
 - b. Alternatives: cyclosporine IV, tacrolimus, sulfasalazine
4. Severe disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternative: sulfasalazine
5. Pouchitis: Metronidazole, ciprofloxacin
 - a. Alternative: rectal mesalamine

VI. REFERENCES

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POLICY IMPLEMENTATION/REVISION INFORMATION

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Revision Information	
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SPECIALTY GUIDELINE MANAGEMENT

REMICADE (infliximab) INFLECTRA (infliximab-dyyb) RENFLEXIS (infliximab-abda)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Moderately to severely active Crohn's disease
2. Moderately to severely active ulcerative colitis
3. Moderately to severely active rheumatoid arthritis in combination with methotrexate
4. Active ankylosing spondylitis
5. Active psoriatic arthritis
6. Chronic severe plaque psoriasis

B. Compendial Uses

1. Axial spondyloarthritis
2. Behçet's syndrome
3. Granulomatosis with polyangiitis (Wegener's granulomatosis)
4. Hidradenitis suppurativa
5. Juvenile idiopathic arthritis
6. Pyoderma gangrenosum
7. Sarcoidosis
8. Takayasu's arteritis
9. Uveitis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active Crohn's disease (CD)

1. Authorization of 24 months may be granted for members who have received Remicade, Inflectra, or any other biologic indicated for the treatment of Crohn's disease in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Remicade or Inflectra.
2. Authorization of 24 months may be granted for treatment of moderately to severely active CD when any of the following criteria is met:
 - a. Member has fistulizing disease.
 - b. Member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix A).

B. Moderately to severely active ulcerative colitis (UC)

1. Authorization of 24 months may be granted for members who have received Remicade, Inflectra, or any other biologic indicated for moderately to severely active ulcerative colitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Remicade or Inflectra.
2. Authorization of 24 months may be granted for treatment of moderately to severely active UC when the member has an inadequate response, intolerance or contraindication to at least ONE conventional therapy option (see Appendix B).

C. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have received Remicade, Inflectra, or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for the medication. Remicade or Inflectra must be prescribed in combination with methotrexate or leflunomide unless the member has a clinical reason not to use methotrexate or leflunomide.
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when all of the following criteria are met:
 - a. Member is prescribed Remicade or Inflectra in combination with methotrexate or leflunomide, or has a clinical reason not to use methotrexate or leflunomide.
 - b. Member has any of the following:
 - i. Inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week)
 - ii. Intolerance or contraindication to methotrexate (see Appendix C)

D. Active ankylosing spondylitis (AS) and axial spondyloarthritis

1. Authorization of 24 months may be granted for members who have received Remicade, Inflectra, or any other biologic DMARD indicated for active ankylosing spondylitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Remicade or Inflectra.
2. Authorization of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.
 - b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix D).

E. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

F. Chronic severe plaque psoriasis

1. Authorization of 24 months may be granted for members who have received Remicade, Inflectra, Otezla, or any other biologic DMARD indicated for the treatment of severe psoriasis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Remicade or Inflectra.
2. Authorization of 24 months may be granted for treatment of chronic severe plaque psoriasis when all of the following criteria are met:
 - a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
 - b. Member meets any of the following criteria:
 - i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
 - ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix E).

iii. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

G. Behçet's syndrome

Authorization of 24 months may be granted for treatment of Behçet's syndrome.

H. Granulomatosis with polyangiitis (Wegener's granulomatosis)

Authorization of 24 months may be granted for treatment of granulomatosis with polyangiitis.

I. Hidradenitis suppurativa

Authorization of 24 months may be granted for treatment of severe, refractory hidradenitis suppurativa.

J. Juvenile Idiopathic arthritis (JIA)

1. Authorization of 24 months may be granted for members who have received Remicade or Inflectra in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Remicade or Inflectra.
2. Authorization of 24 months may be granted for treatment of JIA when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor indicated for JIA (e.g., Enbrel or Humira).
 - b. Member has experienced an intolerable adverse event (e.g., hypersensitivity reaction) to a self-injectable TNF inhibitor indicated for JIA.
 - c. Member has developed antibodies against Enbrel or Humira.

K. Pyoderma gangrenosum

Authorization of 24 months may be granted for treatment of pyoderma gangrenosum.

L. Sarcoidosis

Authorization of 24 months may be granted for treatment of sarcoidosis.

M. Takayasu's arteritis

Authorization of 24 months may be granted for treatment of Takayasu's arteritis.

N. Uveitis

Authorization of 24 months may be granted for treatment of uveitis in members who have experienced an inadequate response or intolerance or have a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Remicade or Inflectra as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Remicade, Inflectra, or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit within the previous 120 days of the continuation request are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
 - a. Oral budesonide, oral mesalamine
 - b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
 - a. Prednisone, methylprednisolone intravenously (IV)
 - b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission
 - a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission
 - a. Azathioprine, mercaptopurine
 - b. Alternative: methotrexate IM

Appendix B: Examples of Conventional Therapy Options for UC

1. Mild to moderate disease – induction of remission:
 - a. Oral mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa), balsalazide, olsalazine
 - b. Rectal mesalamine (e.g., Canasa, Rowasa)
 - c. Rectal hydrocortisone (e.g., Colocort, Cortifoam)
 - d. Alternatives: prednisone, azathioprine, mercaptopurine, sulfasalazine
2. Mild to moderate disease – maintenance of remission:
 - a. Oral mesalamine, balsalazide, olsalazine, rectal mesalamine
 - b. Alternatives: azathioprine, mercaptopurine, sulfasalazine
3. Severe disease – induction of remission:
 - a. Prednisone, hydrocortisone IV, methylprednisolone IV
 - b. Alternatives: cyclosporine IV, tacrolimus, sulfasalazine
4. Severe disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternative: sulfasalazine
5. Pouchitis: Metronidazole, ciprofloxacin
 - a. Alternative: rectal mesalamine

Appendix C: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix D: Examples of Contraindications to the Use of NSAIDs

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

Appendix E: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

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POLICY IMPLEMENTATION/REVISION INFORMATION

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Revision Information	
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SPECIALTY GUIDELINE MANAGEMENT

OTEZLA (apremilast)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Moderate to severe plaque psoriasis
2. Active psoriatic arthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. **Moderate to severe plaque psoriasis**

1. Authorization of 24 months may be granted for members who have received Otezla or any biologic disease-modifying antirheumatic drug (DMARD) indicated for the treatment of moderate to severe plaque psoriasis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Otezla.
2. Authorization of 24 months may be granted for treatment of moderate to severe plaque psoriasis when all of the following criteria are met:
 - a. At least 5% of BSA is affected OR crucial body areas (i.e., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
 - b. Member meets any of the following criteria:
 - i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
 - ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix A).

B. **Active psoriatic arthritis (PsA)**

1. Authorization of 24 months may be granted for members who have received Otezla in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Otezla.
2. Authorization of 24 months may be granted for treatment of active psoriatic arthritis when any of the following criteria is met:
 - a. Member has had an inadequate response to at least a 3-month trial of at least one prior biologic DMARD indicated for PsA (see Appendix B).
 - b. Member has experienced an intolerance or adverse event to a trial of at least one prior biologic DMARD indicated for PsA.
 - c. All biologic DMARDs indicated for PsA are not appropriate for the member (e.g., due to comorbidities or a history of infections contraindicating any biologic DMARD).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Otezla as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. APPENDICES

Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease, or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Appendix B: Biologic DMARDs Indicated for Psoriatic Arthritis

1. Cimzia® (certolizumab pegol)
2. Cosentyx® (secukinumab)
3. Enbrel® (etanercept)
4. Humira® (adalimumab)
5. Remicade® (infliximab)
6. Simponi® (golimumab)
7. Stelara® (ustekinumab)

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

ORENCIA (abatacept)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis in adults
2. Moderately to severely active polyarticular juvenile idiopathic arthritis in patients 2 years of age or older
3. Active psoriatic arthritis in adults

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have received Orenzia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Orenzia.
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
 - b. Member has an intolerance or contraindication to methotrexate (see Appendix).

B. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)

1. Authorization of 24 months may be granted for members who have received Orenzia or Actemra in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Orenzia.
2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least a 3-month trial of a TNF inhibitor.
 - b. Member has intolerance or contraindication to a TNF inhibitor.

C. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Orencia as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Orencia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit within the previous 120 days of the continuation request are exempt from requirements related to TB screening in this Policy.

V. APPENDIX: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

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POLICY IMPLEMENTATION/REVISION INFORMATION

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SPECIALTY GUIDELINE MANAGEMENT

PRALUENT (alirocumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Praluent is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease, who require additional lowering of low density lipoprotein cholesterol (LDL-C).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. **Clinical atherosclerotic cardiovascular disease (ASCVD)**

Authorization of 12 months may be granted for members who meet ALL of the criteria listed below:

1. Member has a history of clinical ASCVD (See Appendix A).
2. Member meets at least ONE of the following requirements [a or b]:
 - a. Member has a current LDL-C level ≥ 70 mg/dL after at least three months of treatment with a high-intensity statin dose (e.g., atorvastatin ≥ 40 mg or rosuvastatin ≥ 20 mg daily) plus ezetimibe 10 mg daily. If the member is unable to tolerate a high-intensity statin dose, a moderate-intensity statin dose (e.g., atorvastatin 20 mg or equivalent) may be used.
 - b. Member has a current LDL-C level ≥ 70 mg/dL with contraindication or intolerance to statins (See Appendix B and C).

B. **Heterozygous Familial Hypercholesterolemia (HeFH)**

Authorization of 12 months may be granted for members who meet ALL of the criteria listed below:

1. Member has a diagnosis of familial hypercholesterolemia (See Appendix D).
2. Member meets at least ONE of the following requirements [a, b, c or d]:
 - a. With ASCVD: See Section A.
 - b. Without ASCVD: Member has a current LDL-C level ≥ 100 mg/dL after at least three months of treatment with a high-intensity statin dose (i.e., atorvastatin ≥ 40 mg or rosuvastatin ≥ 20 mg daily) plus ezetimibe 10 mg daily.
 - c. Member has a current LDL-C level ≥ 100 mg/dL with contraindication or intolerance to statins (See Appendices B and C) and is taking ezetimibe 10mg daily.
 - d. Member has a current LDL-C level ≥ 100 mg/dL and contraindication to both statins and ezetimibe (See Appendix C).

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for members who have received Praluent through a pharmacy or medical benefit and who achieve or maintain an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C).

IV. APPENDICES

APPENDIX A. Clinical ASCVD

- Acute coronary syndromes
- Myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization procedure (e.g., percutaneous coronary angioplasty [PTCA], coronary artery bypass graft [CABG] surgery)
- Stroke of presumed atherosclerotic origin
- Transient ischemic attack (TIA)
- Non-cardiac peripheral arterial disease of presumed atherosclerotic origin (e.g., carotid artery stenosis)
- Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)

APPENDIX B. Statin-associated muscle symptoms (SAMS) and statin re-challenge

- Intolerable SAMS persisting at least two weeks, which subsided when the medication was discontinued, and reemerged with a statin re-challenge.
NOTE: Re-challenge must be with a different statin.
- Statin-associated elevation in CK level ≥ 10 times upper limit of normal (ULN)
NOTE: Statin re-challenge is NOT required for members who have experienced an elevation of CK level greater than or equal to 10 times ULN after receiving lipid-lowering therapy (LLT) with a statin.

APPENDIX C. Contraindications to statins and ezetimibe

- Contraindications to statins
 - Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase (ALT) level ≥ 3 times ULN)
 - Women who are pregnant or may become pregnant
 - Nursing mothers
- Contraindication to ezetimibe
 - Hypersensitivity reactions (e.g., anaphylaxis, angioedema, rash and urticaria)

APPENDIX D: Diagnosis of familial hypercholesterolemia (FH)

A diagnosis of FH is made when one of the following diagnostic criteria is met:

- Genetic confirmation
 - An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation
- Simon-Broome Diagnostic Criteria for FH
 - Total cholesterol > 290 mg/dL or LDL-C > 190 mg/dL in patients over 16 years of age or total cholesterol > 260 mg/dl or LDL-C > 155 mg/dl in patients less than 16 years of age and one of the following
 - Tendon xanthomas in the patient, first (parent, sibling or child) or second degree relative (grandparent, uncle or aunt)
 - Family history of myocardial infarction in a first degree relative before the age of 60 or in a second degree relative before the age of 50
 - Total cholesterol greater than 290 mg/dl in an adult first or second degree relative
 - Total cholesterol greater than 260 mg/dl in a child, brother, or sister aged younger than 16 years
- Dutch Lipid Clinic Network Criteria for FH
 - Total score > 5 points

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SPECIALTY GUIDELINE MANAGEMENT

CIMZIA (certolizumab pegol)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis (RA)
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)
4. Moderately to severely active Crohn's disease (CD)

B. Compendial Uses

1. Axial spondyloarthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. **Moderately to severely active rheumatoid arthritis (RA)**

1. Authorization of 24 months may be granted for members who have received Cimzia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Cimzia.
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
 - b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B. **Active psoriatic arthritis (PsA)**

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

C. **Active ankylosing spondylitis (AS) and axial spondyloarthritis**

1. Authorization of 24 months may be granted for members who have received Cimzia or any other biologic DMARD indicated for active ankylosing spondylitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Cimzia.
2. Authorization of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.
 - b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix B).

D. Moderately to severely active Crohn's disease (CD)

1. Authorization of 24 months may be granted for members who have received Cimzia or any other biologic indicated for the treatment of Crohn's disease in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Cimzia.
2. Authorization of 24 months may be granted for treatment of moderately to severely active CD when the member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix C).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Cimzia as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Cimzia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit within the previous 120 days of the continuation request are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Contraindications to the Use of NSAIDs

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

Appendix C: Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
 - a. Oral budesonide, oral mesalamine
 - b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:

- a. Prednisone, methylprednisolone intravenously (IV)
 - b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternative: methotrexate IM
 5. Perianal and fistulizing disease – induction of remission:
 - a. Metronidazole ± ciprofloxacin
 6. Perianal and fistulizing disease – maintenance of remission:
 - a. Azathioprine, mercaptopurine
 - b. Alternative: methotrexate IM

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SPECIALTY GUIDELINE MANAGEMENT

COSENTYX (secukinumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Moderate to severe plaque psoriasis (PsO)
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderate to severe plaque psoriasis

1. Authorization of 24 months may be granted for members who are 18 years of age or older who have received Cosentyx, Otezla, or any other biologic DMARD indicated for the treatment of moderate to severe plaque psoriasis in a paid claim through a pharmacy or medical benefit in the previous 120 days of the initial request for Cosentyx.
2. Authorization of 24 months may be granted for treatment of moderate to severe plaque psoriasis in members who are 18 years of age and older when all of the following criteria are met:
 - a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
 - b. Member meets any of the following criteria:
 - i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
 - ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix A).
 - iii. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

B. Active psoriatic arthritis (PsA)

1. Authorization of 24 months may be granted for members who are 18 years of age or older and who have received Cosentyx, Stelara or Otezla in a paid claim through a pharmacy or medical benefit in the previous 120 days of the initial request for Cosentyx.
2. Authorization of 24 months may be granted for treatment of active PsA in members 18 years of age or older when any of the following criteria is met:
 - a. Member has had an inadequate response to at least a 3-month trial of at least one TNF inhibitor indicated for PsA (see Appendix B).
 - b. Member has experienced an intolerance or adverse event to a trial of at least one TNF inhibitor indicated for PsA.
 - c. All TNF inhibitors indicated for PsA are not appropriate for the member (e.g., due to comorbidities or a history of infections).

C. Active ankylosing spondylitis (AS)

1. Authorization of 24 months may be granted for members who are 18 years of age or older and who have received Cosentyx or any other biologic DMARD indicated for active ankylosing spondylitis in a paid claim through a pharmacy or medical benefit within the previous 120 days of the initial request for Cosentyx.
2. Authorizations of 24 months may be granted for treatment of active AS in members 18 years of age or older when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.
 - b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix C).

III. CONTINUATION OF THERAPY

A. For plaque psoriasis:

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Cosentyx as evidenced by low disease activity or improvement in signs and symptoms of the condition.

B. For psoriatic arthritis and ankylosing spondylitis:

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Cosentyx as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Cosentyx or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) in a paid claim through a pharmacy or medical benefit in the previous 120 days of the continuation request are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Appendix B: TNF Inhibitors Indicated for Psoriatic Arthritis

1. Cimzia® (certolizumab pegol)
2. Enbrel® (etanercept)
3. Humira® (adalimumab)
4. Remicade® (infliximab)
5. Simponi® (golimumab)

Appendix C: Examples of Contraindications to the Use of NSAIDs

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

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