Optima Health Pharmacy Changes

Effective: January 1, 2019

(For plans with pharmacy benefits administered by Optima Health)

DRUG NAME: Arnuity® Ellipta® (fluticasone furoate**)**		**INDICATION:** Asthma
RECOMMENDATION: Change to step-edit form with expanded age indication		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	No change	Change step-edit form
STANDARD FORMULARY	No change	Change step-edit form
EXCHANGE FORMULARY	No change	Change step-edit form
MEDICAID FORMULARY	No change	Change step-edit form
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: No change		

DRUG NAME: Basaglar® (insulin glargine injection)		**INDICATION:** Diabetes mellitus
RECOMMENDATION: Change to step-edit		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	No change	Step edit through 2 preferred brand products
STANDARD FORMULARY	No change	N/A
EXCHANGE FORMULARY	No change	N/A
MEDICAID FORMULARY	No change	N/A
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No change
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Brand Ophthalmic Antihistamines (Bepreve®, Lastacaft®, Pazeo®, Emadine®)		**INDICATION:** Eye symptoms of allergic conditions
RECOMMENDATION: Change to step-edit criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	3	Modified step-edit criteria
STANDARD FORMULARY	Non-formulary	N/A
EXCHANGE FORMULARY	Non-formulary	N/A
MEDICAID FORMULARY	Non-formulary	N/A
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: azelastine, epinastine, olopatadine 0.1%		

DRUG NAME: chlorzoxazone 250mg		**INDICATION:** Relief of discomfort due to painful musculoskeletal conditions
RECOMMENDATION: Exclude from all formularies		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Exclude	Exclude
STANDARD FORMULARY	Exclude	Exclude
EXCHANGE FORMULARY	Exclude	Exclude
MEDICAID FORMULARY	Exclude	Exclude
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES: chlorzoxazone 500mg		

November 14, 2018 (Jan – Mar 2019)

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DRUG NAME: Cimduo™ (lamivudine and tenofovir disoproxil fumarate)		**INDICATION:** HIV-1 Infection
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	
STANDARD FORMULARY	Specialty	
EXCHANGE FORMULARY	Specialty	
MEDICAID FORMULARY	Specialty	
QUANTITY LIMIT: #30/30		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Cinryze® (C1 esterase inhibitor [human])		**INDICATION:** Hereditary angioedema, prophylaxis
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION:** Yes
FORMULARY ALTERNATIVES:		

DRUG NAME: Crysvita® (burosumab-twza)		**INDICATION:** X-linked hypophosphatemia
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION:** N/A
FORMULARY ALTERNATIVES: No change		

DRUG NAME: Cuprimine® (penicillamine)		**INDICATION:** Wilson's disease, cystinuria, severe active rheumatoid arthritis
RECOMMENDATION: Add new Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA – Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	Add Prior Authorization
STANDARD FORMULARY	Specialty	Add Prior Authorization
EXCHANGE FORMULARY	Specialty	Add Prior Authorization
MEDICAID FORMULARY	Specialty	Add Prior Authorization
QUANTITY LIMIT: 16 tablets/day		**TRANSITION OF CARE LIMITATION**: Yes
FORMULARY ALTERNATIVES:		

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DRUG NAME: Erleada (apalutamide)		**INDICATION:** Nonmetastatic castration-resistant prostate cancer
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	
STANDARD FORMULARY	Specialty	
EXCHANGE FORMULARY	Specialty	
MEDICAID FORMULARY	Specialty	
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Firvanq™ (vancomycin hydrochloride) for oral solution		**INDICATION:** Treatment of *C. difficile* infection (CDI); treatment of enterocolitis caused by *Staphylococcus aureus* (including methicillin-resistant strains)
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	2	
STANDARD FORMULARY	2	
EXCHANGE FORMULARY	2	
MEDICAID FORMULARY	Formulary	
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Galafold™ (migalastat)		**INDICATION:** Fabry disease
RECOMMENDATION: New addition with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
MEDICAID FORMULARY	Specialty	Prior Authorization
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Gocovri™ ER (amantadine extended-release)		**INDICATION:** Dyskinesia with Parkinson's disease
RECOMMENDATION: Remove current Prior Authorization Form and Exclude from All Formularies		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Exclude	Remove Prior Authorization
STANDARD FORMULARY	Exclude	Remove Prior Authorization
EXCHANGE FORMULARY	Exclude	Remove Prior Authorization
MEDICAID FORMULARY	Exclude	Remove Prior Authorization
QUANTITY LIMIT: None		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: amantadine immediate-release		

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DRUG NAME: Hizentra® (immune globulin)		**INDICATION:** Chronic inflammatory demyelinating polyneuropathy, primary immunodeficiency
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES: No change		

DRUG NAME: Inflectra® (infliximab-dyyb)		**INDICATION:** Crohn's disease, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES: No change		

DRUG NAME: Kalydeco® (ivacaftor)		**INDICATION:** Cystic fibrosis
RECOMMENDATION: Change to Prior Authorization criteria with expanded age indication		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	No change	Change Prior Authorization criteria
STANDARD FORMULARY	No change	Change Prior Authorization criteria
EXCHANGE FORMULARY	No change	Change Prior Authorization criteria
MEDICAID FORMULARY	No change	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: No change		

DRUG NAME: Levemir® vial/FlexTouch®		**INDICATION:** Diabetes mellitus
RECOMMENDATION: Downtier to preferred brand and remove step-edit		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	2	Remove Step-Edit criteria
STANDARD FORMULARY	2	Remove Step-Edit criteria
EXCHANGE FORMULARY	2	Remove Step-Edit criteria
MEDICAID FORMULARY	Formulary	
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: N/A		

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DRUG NAME: Lucemyra™ (lofexidine)		**INDICATION:** mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation in adults
RECOMMENDATION: Exclude from all formularies		
FORMULARY	**TIER**	**CRITERIA**
OPEN FORMULARY	Exclude	Exclude
STANDARD FORMULARY	Exclude	Exclude
EXCHANGE FORMULARY	Exclude	Exclude
MEDICAID FORMULARY	Exclude	Exclude
QUANTITY LIMIT: N/A		**TRANSITION OF CARE LIMITATION**: N/As
FORMULARY ALTERNATIVES: clonidine		

DRUG NAME: Mepsevii™ (vestronidase alpha-vjbk)		**INDICATION:** Mucopolysaccharidosis type VII
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES:		

DRUG NAME: Movantik® (naloxegol)		**INDICATION:** Opioid-induced constipation in adults with chronic non-cancer pain
RECOMMENDATION: Change to copay tier and prior authorization criteria		
FORMULARY	**TIER**	**CRITERIA**
OPEN FORMULARY	2	Change Prior Authorization criteria
STANDARD FORMULARY	2	Change Prior Authorization criteria
EXCHANGE FORMULARY	2	Change Prior Authorization criteria
MEDICAID FORMULARY	Formulary	Change Prior Authorization criteria
QUANTITY LIMIT: 25mg/day		**TRANSITION OF CARE LIMITATION**: Yes
FORMULARY ALTERNATIVES:		

DRUG NAME: Norvir® (ritonavir) oral powder		**INDICATION:** HIV-1 Infection
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	
STANDARD FORMULARY	Specialty	
EXCHANGE FORMULARY	Specialty	
MEDICAID FORMULARY	Specialty	
QUANTITY LIMIT: #360/30		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

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DRUG NAME: **Nucala™ SQ** (mepolizumab)		**INDICATION**: Eosinophilic Granulomatosis with Polyangiitis (EGPA)
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA**
OPEN FORMULARY	No change	Change to Prior Authorization criteria
STANDARD FORMULARY	No change	Change to Prior Authorization criteria
EXCHANGE FORMULARY	No change	Change to Prior Authorization criteria
MEDICAID FORMULARY	No change	Change to Prior Authorization criteria
QUANTITY LIMIT: N/A		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: olopatadine (generic Patanol® and Pataday®)		**INDICATION:** Eye symptoms of allergic conditions
RECOMMENDATION: Downtier and remove step-edit requirements		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	1	Remove Step-Edit
STANDARD FORMULARY	1	Remove Step-Edit
EXCHANGE FORMULARY	1	Remove Step-Edit
MEDICAID FORMULARY	1	Remove Step-Edit
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: **Olumiant®** (baricitinib)		**INDICATION**: Rheumatoid arthritis
RECOMMENDATION: New addition with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
MEDICAID FORMULARY	Specialty	Prior Authorization
QUANTITY LIMIT: 2mg/day		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Orkambi® (lumacaftor/ ivacaftor)		**INDICATION:** Cystic fibrosis
RECOMMENDATION: Change to Prior Authorization criteria with expanded age indication		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	No change	Change Prior Authorization criteria
STANDARD FORMULARY	No change	Change Prior Authorization criteria
EXCHANGE FORMULARY	No change	Change Prior Authorization criteria
MEDICAID FORMULARY	No change	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: No change		

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DRUG NAME: Orilissa™ (elagolix) tablets		**INDICATION:** Endometriosis
RECOMMENDATION: New addition with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	3	Prior Authorization
STANDARD FORMULARY	3	Prior Authorization
EXCHANGE FORMULARY	3	Prior Authorization
MEDICAID FORMULARY	Non-formulary	N/A
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Osmolex ER™ (amantadine extended-release)		**INDICATION:** Parkinson's disease and drug-induced extrapyramidal reactions in adults
RECOMMENDATION: Exclude from All Formularies		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Exclude	Exclude
STANDARD FORMULARY	Exclude	Exclude
EXCHANGE FORMULARY	Exclude	Exclude
MEDICAID FORMULARY	Exclude	Exclude
QUANTITY LIMIT: None		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: amantadine immediate-release		

DRUG NAME: Relistor® (methylnaltrexone)		**INDICATION:** Opioid-induced constipation in adults with chronic non-cancer pain
RECOMMENDATION: Change to Prior Authorization and formulary status for Medicaid		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	No change	Change Prior Authorization criteria
STANDARD FORMULARY	No change	Change Prior Authorization criteria
EXCHANGE FORMULARY	No change	Change Prior Authorization criteria
MEDICAID FORMULARY	Formulary	Prior Authorization
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: Yes
FORMULARY ALTERNATIVES:		

DRUG NAME: Remicade® (infliximab)		**INDICATION:** Crohn's disease, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis
RECOMMENDATION: Change to Prior Authorization criteria		
OPEN FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES: No change		

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DRUG NAME: Renflexis® (infliximab-abda)		**INDICATION:** Crohn's disease, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical benefit	Change Prior Authorization criteria
STANDARD FORMULARY	Medical benefit	Change Prior Authorization criteria
EXCHANGE FORMULARY	Medical benefit	Change Prior Authorization criteria
MEDICAID FORMULARY	Medical benefit	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES: No change		

DRUG NAME: Siklos® (hydroxyurea)		**INDICATION:** Reduction of frequency of painful crises and need for blood transfusions in children ≥2 years, adolescents and adults with sickle cell anemia
RECOMMENDATION: Exclude from all formularies		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Exclude	Exclude
STANDARD FORMULARY	Exclude	Exclude
EXCHANGE FORMULARY	Exclude	Exclude
MEDICAID FORMULARY	Exclude	Exclude
QUANTITY LIMIT:	**TRANSITION OF CARE LIMITATION**:	
FORMULARY ALTERNATIVES: hydroxyurea		

DRUG NAME: Sucraid® (sacrosidase)		**INDICATION**: Congenital sucrase-isomaltase deficiency
RECOMMENDATION: Update to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA**
OPEN FORMULARY	No change	Update Prior Authorization criteria
STANDARD FORMULARY	No change	Update Prior Authorization criteria
EXCHANGE FORMULARY	No change	Update Prior Authorization criteria
MEDICAID FORMULARY	No change	Update Prior Authorization criteria
QUANTITY LIMIT: 236mL/30 days		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES:		

DRUG NAME: Symfi™ (efavirenz, lamivudine, and tenofovir disoproxil fumarate)		**INDICATION:** HIV-1 Infection
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	
STANDARD FORMULARY	Specialty	
EXCHANGE FORMULARY	Specialty	
MEDICAID FORMULARY	Specialty	
QUANTITY LIMIT: #30/30		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Symfi Lo™ (efavirenz, lamivudine, and tenofovir disoproxil fumarate)		**INDICATION:** HIV-1 Infection
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	
STANDARD FORMULARY	Specialty	
EXCHANGE FORMULARY	Specialty	
MEDICAID FORMULARY	Specialty	
QUANTITY LIMIT: #30/30 days		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Symproic® (naldemedine)		**INDICATION:** Opioid-induced constipation in adults with chronic non-cancer pain
RECOMMENDATION: New addition with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA**
OPEN FORMULARY	2	Prior Authorization
STANDARD FORMULARY	2	Prior Authorization
EXCHANGE FORMULARY	2	Prior Authorization
MEDICAID FORMULARY	Formulary	Prior Authorization
QUANTITY LIMIT: 0.2mg/day		**TRANSITION OF CARE LIMITATION**: Yes
FORMULARY ALTERNATIVES:		

DRUG NAME: Symtuza™ (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide**)**		**INDICATION:** HIV-1 Infection
RECOMMENDATION: New addition		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	
STANDARD FORMULARY	Specialty	
EXCHANGE FORMULARY	Specialty	
MEDICAID FORMULARY	Specialty	
QUANTITY LIMIT: #30/30 days		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES:		

DRUG NAME: Takhzyro™ (lanadelumab-flyo)		**INDICATION:** Hereditary angioedema, prophylaxis
RECOMMENDATION: New addition with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
MEDICAID FORMULARY	Specialty	Prior Authorization
QUANTITY LIMIT: 600mg (4mL)/month		**TRANSITION OF CARE LIMITATION**:
FORMULARY ALTERNATIVES:		

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DRUG NAME: Tavalisse™ (fostamatinib disodium hexahydrate) tablets		**INDICATION:** Immune thrombocytopenia (chronic, refractory)
RECOMMENDATION: New with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
MEDICAID FORMULARY	Specialty	Prior Authorization
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**:
FORMULARY ALTERNATIVES:		

DRUG NAME: Tresiba® FlexTouch® (insulin degludec injection)		**INDICATION:** Diabetes mellitus
RECOMMENDATION: Downtier to Preferred Brand and remove Step-Edit		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	2	Remove Step-Edit criteria
STANDARD FORMULARY	2	Remove Step-Edit criteria
EXCHANGE FORMULARY	2	Remove Step-Edit criteria
MEDICAID FORMULARY	Formulary	
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No change
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Trogarzo™ (Ibalizumab-uiyk) injection		**INDICATION:** Treatment of HIV-1 infection in combination with other antiretrovirals in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen
RECOMMENDATION: New addition with Prior Authorization		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical	Prior Authorization
STANDARD FORMULARY	Medical	Prior Authorization
EXCHANGE FORMULARY	Medical	Prior Authorization
MEDICAID FORMULARY	Medical	Prior Authorization
QUANTITY LIMIT: 14 vials per month		**TRANSITION OF CARE LIMITATION: N**o
FORMULARY ALTERNATIVES:		

DRUG NAME: Uraliss 35% cream		**INDICATION:** Hyperkeratotic Conditions
RECOMMENDATION: Exclude from all formularies		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Exclude	Exclude
STANDARD FORMULARY	Exclude	Exclude
EXCHANGE FORMULARY	Exclude	Exclude
MEDICAID FORMULARY	Exclude	Exclude
QUANTITY LIMIT:		**TRANSITION OF CARE LIMITATION**:
FORMULARY ALTERNATIVES: urea 40% cream		

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DRUG NAME: Yescarta (axicabtagene ciloleucel)		**INDICATION:** Large B-cell lymphoma, relapsed or refractory
RECOMMENDATION: New addition with Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Medical	Prior Authorization
STANDARD FORMULARY	Medical	Prior Authorization
EXCHANGE FORMULARY	Medical	Prior Authorization
MEDICAID FORMULARY	Medical	Prior Authorization
QUANTITY LIMIT: 1 infusion only		**TRANSITION OF CARE LIMITATION**: N/A
FORMULARY ALTERNATIVES:		

DRUG NAME: Xolair® (omalizumab)		**INDICATION:** Moderate to severe persistent asthma and chronic idiopathic urticaria
RECOMMENDATION: Change to Prior Authorization criteria		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	No change	Change Prior Authorization criteria
STANDARD FORMULARY	No change	Change Prior Authorization criteria
EXCHANGE FORMULARY	No change	Change Prior Authorization criteria
MEDICAID FORMULARY	No change	Change Prior Authorization criteria
QUANTITY LIMIT: No change		**TRANSITION OF CARE LIMITATION**: No
FORMULARY ALTERNATIVES: No change		

DRUG NAME: ZTlido™ (lidocaine topical)		**INDICATION:** relief of pain associated with post- herpetic neuralgia (PHN)
RECOMMENDATION: Exclude from all formularies		
FORMULARY	**TIER**	**CRITERIA- Prior Authorization/Step-Edit**
OPEN FORMULARY	Exclude	Exclude
STANDARD FORMULARY	Exclude	Exclude
EXCHANGE FORMULARY	Exclude	Exclude
MEDICAID FORMULARY	Exclude	Exclude
QUANTITY LIMIT: N/A		**TRANSITION OF CARE LIMITATION:** No
FORMULARY ALTERNATIVES: lidocaine 5% patch, gabapentin, nortriptyline		