BlueCross BlueShield of Alabama
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Pharmacy News

October 2022

Drug Guide and Clinical Program Updates

Prime Therapeutics'® Pharmacy and Therapeutics (P&T) Committee, in association with Blue Cross and Blue Shield of Alabama's Formulary Business Committee, recently approved updates to the Drug Guides and made clinical program changes to select medications. Members will receive a letter from Blue Cross if they are negatively affected by a formulary change that is not a result of a new generic being available.

Formulary and Clinical Programs – Effective October 1, 2022

Click the links below to view updated formularies and clinical programs. If members have questions about their benefits, they should call the Customer Service number on the back of their Blue Cross member ID card.

- Standard Prescription Drug Guide Updates
- Generics Plus Drug Guide Updates
- High-Cost Exclusion Updates
- Source+Rx 1.0 Prescription Drug List
- Source+Rx 2.0 Prescription Drug List
- Source Rx Formulary Updates
- NetResults Formulary Updates
- Clinical Programs
  - Prior Authorization
  - Step Therapy
  - Quantity Limit

New or Revised Provider-Administered (Medical) Drug Policies

Policy Name	Type of Policy	Coverage Criteria and Changes
Amvuttra	Medical PA	**NEW – Effective 10/1/22 –** New policy for Polyneuropathy due to Hereditary Transthyretin-mediated (hATTR) Amyloidosis.
Breyanzi	Oncology PA	**REVISED – Effective 11/1/22 –** Added new FDA-approved expanded indication for the treatment of adults with large B-cell lymphoma who have refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy or refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for HSCT.
Enhertu	Oncology PA	**REVISED – Effective 9/1/22 –** Added new FDA-approved expanded indication that allows treatment in neoadjuvant or adjuvant setting for patients who have developed disease recurrence during or within six months of completing therapy after receiving a prior anti-HER2 regimen.
Krystexxa	Medical PA	**REVISED – Effective 11/1/22 –** To Universal Criteria: updated baseline serum uric acid level to now read ≥ 7 mg/dL as per the updated PI; to Chronic gout indication: clarified criteria about subcutaneous tophi to say at least one (1) tophi to align with the pivotal trial and ACR guidelines; also added criteria that Krystexxa can be used in combination with methotrexate or as a single agent if methotrexate is contraindicated or clinically not appropriate.
Kymriah	Oncology PA	**REVISED – Effective 10/1/22 –** Added new FDA-approved expanded indication for the treatment of relapsed/refractory follicular lymphoma after at least two prior lines of systemic therapy.

Policy Name	Type of Policy	Coverage Criteria and Changes
Opdivo	Oncology PA	**REVISED – Effective 10/1/22 –** Added new FDA-approved indication for first-line therapy of ESCC in combination with fluoropyrimidine and platinum-containing chemotherapy or with ipilimumab.
Pegfilgrastim	Oncology PA	**REVISED – Effective 09/1/22 –** Added the new FDA-approved biosimilar to Neulasta called Fylnetra (pegfilgrastim-pbbk) to the policy.
Rituximab_IV	Oncology and Medical PA	**REVISED – Effective 09/1/22 –** To B-Cell Lymphomas, specified that use in Non-Gastric MALT Lymphoma is for the noncutaneous type per NCCN. To B-Cell Lymphomas, changed use for histologic transformation of Follicular or Nodal Marginal Zone Lymphoma to DLBCL to use for histologic transformation of Indolent Lymphomas to DLBCL per the most recent NCCN B-Cell Lymphomas guideline update.
Skyrizi IV	Medical PA	**NEW – Effective 8/12/22 –** New policy for IV Skyrizi to be administered as an induction dose for Crohn's disease.
Soliris	Medical PA	**REVISED – Effective 09/1/22 –** Revised the "no combo therapy" criterion to also include Enspryng, Uplizna and Empaveli.
Spinraza	Medical PA	**REVISED – Effective 11/1/22 –** To the diagnostic criteria, on the criterion for ≤3 copies of survival motor neuron (SMN) gene, added a note that patients with >3 copies will be reviewed on a case by case basis.
Ultomiris	Medical PA	**REVISED – Effective 09/1/22 –** Revised the "no combo therapy" criterion to also include Enspryng, Uplizna and Empaveli.
Yervoy	Oncology PA	**REVISED – Effective 10/1/22 –** Added new FDA-approved indication for first-line therapy of ESCC in combination with nivolumab.
Zolgensma	Medical PA	**REVISED – Effective 11/1/22 –** Added criteria for hepatic function monitoring prior and subsequent to start of therapy.

Note: Prior Authorization is abbreviated as PA.

The Prime Therapeutics P&T Committee — consisting of doctors, pharmacists and other healthcare professionals — advises and makes recommendations based on clinical appropriateness. The Blue Cross and Blue Shield of Alabama Formulary Business Committee gives final approval of these clinical recommendations before implementation.

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).