BlueCross BlueShield of Alabama
An Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy News

January 2024

Drug Guide and Clinical Program Updates

The Prime Therapeutics® Pharmacy and Therapeutics 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 January 1, 2024

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 Formulary Updates
- NetResults Formulary Updates
- **Clinical Programs**
  - Prior Authorization
  - Step Therapy
  - Quantity Limit

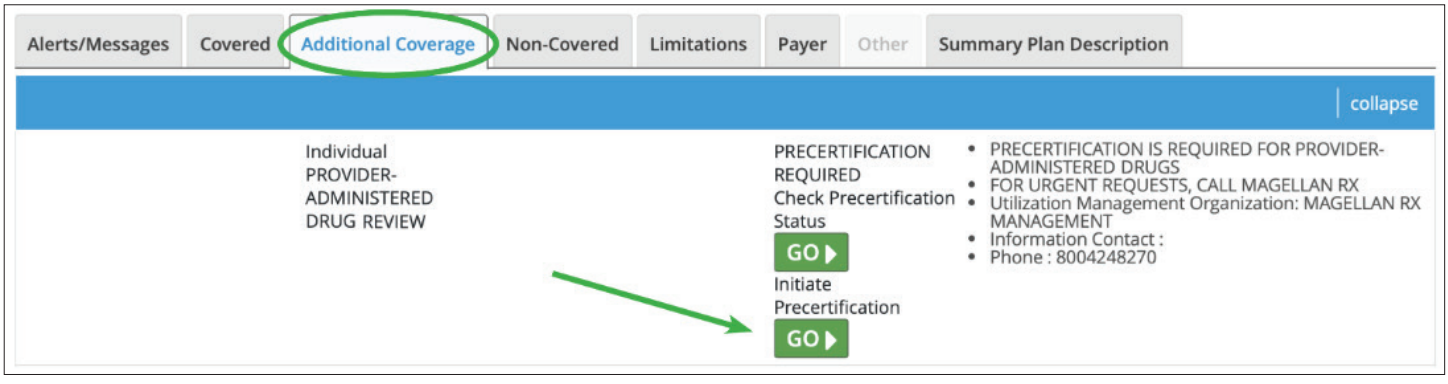
Oncology Provider-Administered Drug Preauthorizations

Effective January 1, 2024, Magellan Rx Management will perform precertification reviews of oncology therapies that are part of our Provider-Administered Drug Program.

The policies for managing oncology therapies by Magellan Rx will be the same as those currently used by Carelon Medical Benefits Management.

To minimize patient impact, existing drug authorizations will remain in place for the duration authorized. Upon expiration of the existing authorization, a new authorization will need to be obtained through Magellan Rx.

Go to Eligibility and Benefits on *ProviderAccess*, and you will be routed to the Magellan Rx portal to request precertification for select oncology therapies.



New Provider-Administered Drugs

Effective January 1, 2024, two drugs will be added to the Provider-Administered Precertification Drug Program managed by Magellan Rx:

- Halaven (eribulin mesylate)
- Jevtana (cabazitaxel)

Patients who have received these therapies in the 2023 calendar year will be allowed to continue with their therapies through March 31, 2024. Providers will need to obtain a precertification for patients who will continue to receive these therapies beyond March 31, 2024.

Mandatory Drug Wastage Program

Effective January 1, 2024, Blue Cross and Blue Shield of Alabama will implement the Mandatory Drug Wastage Program. This program will identify specific authorizations for a targeted list of drugs and require rounding the dosage down (within 10% of the requested dose) to allow for more efficient vial-size utilization when clinically appropriate.

New or Revised Provider-Administered (Medical) Drug Policies

Policy Name	Type of Policy	Coverage Criteria and Changes
Actemra_IV	Medical PA	**REVISED – Effective 1/1/24 –** To the universal criteria, added IL-inhibitors to list of agents patient cannot be treated concurrently with and updated non-biologic agents to include abrocitinib and deucravacitinib. To immune checkpoint inhibitor toxicity, added treatment for polymyalgia rheumatica when unable to taper or no improvement from prednisone per NCCN and updated criteria for use in inflammatory arthritis to allow use for moderate or severe disease in no improvement after holding immunotherapy or if unable to taper steroids. Also added footnote to allow for additional doses on a case-by-case basis.
Aflibercept	Medical PA	**REVISED – Effective 12/1/23 –** Renamed EYLEA policy to AFLIBERCEPT and added the newly FDA-approved formulation of Eylea HD.
Benlysta_IV	Medical PA	**REVISED – Effective 12/1/23 –** Updated diagnosis/disease severity criteria for systemic lupus erythematosus (SLE) to align with the 2019 ACR/EULAR updates. Also updated the SLE diagnostic criteria within the Lupus Nephritis criteria to align with that of SLE and added a footnote under Lupus Nephritis that patients with class III, IV or V disease that do not meet the SLE diagnostic criteria will be reviewed on a case-by-case basis based on the guidelines in 2019 EULAR/ERA-EDTA guidelines.
Cerezyme	Medical PA	**REVISED – Effective 12/1/23 –** From the Initial and Renewal Criteria, removed angina from the examples of symptomatic disease as it does not apply to Type 1 Gaucher Disease. Removed the Initial Criteria stating that the disease manifestation criteria only applied to adults as baseline values are required in peds as well per UpToDate.
Cinqair	Medical PA	**REVISED – Effective 1/1/24 –** To Universal criteria, excluded use in combination with IgG2 lambda MABs to keep at parity with Tezspire policy.
Cinryze	Medical PA	**REVISED – Effective 1/1/24 –** To Hereditary Angioedema (HAE) prophylaxis indication updated criteria to now say a history of at least one HAE attack per month.
Elelyso	Medical PA	**REVISED – Effective 12/1/23 –** From the Initial and Renewal Criteria, removed angina from the examples of symptomatic disease as it does not apply to Type 1 Gaucher Disease. Removed the Initial Criteria stating that the disease manifestation criteria only applied to adults as baseline values are required in peds as well per UpToDate. To the dosing table, adding criteria for dosing in patients switching from treatment with imiglucerase to Elelyso and criteria for dose adjustments per the package insert.
Elrexfio	Medical PA	**New – Effective 1/1/24 –** New policy for the treatment of multiple myeloma.
Entyvio	Medical PA	**REVISED – Effective 1/1/24 –** To the Length of Authorizations, updated guidance on 3-month approval window with subsequent 6-month renewal periods following dose escalation for Crohn's disease and ulcerative colitis.

Policy Name	Type of Policy	Coverage Criteria and Changes
Fasenra	Medical PA	**REVISED – Effective 1/1/24 –** To Universal Criteria, excluded use in combination with IgG Lambda MABs to keep at parity with Tezspire policy.
Haegarda	Medical PA	**REVISED – Effective 1/1/24 –** To Hereditary Angioedema (HAE) prophylaxis indication updated criteria to say a history of at least one HAE attack per month.
Hyaluronic Acid Derivatives	Medical PA	**REVISED – Effective 1/1/24 –** To Length of Authorization changed to 6-month initial and 12-month renewal auth to reduce the prior authorization burden on providers after initially confirming efficacy.
Ilaris	Medical PA	**REVISED – Effective 1/1/24 –** Added newly expanded FDA-approved indication for use in gout flares along with applicable criteria, dosing and ICD-10 codes.
Infliximab	Medical PA	**REVISED – Effective 1/1/24 –** To the Universal Criteria, added interleukin inhibitors to list of agents patient should not be on concurrent treatment with. Removed criteria for needing to assess baseline disease severity using objective tool and moved that to indications where applicable.
Izervay	Medical PA	**New – Effective 12/1/23 –** New policy for the treatment of geographic atrophy.
Jemperli	Oncology PA	**REVISED – Effective 11/1/23 –** Added the new FDA-approved indication for endometrial cancer in combination with carboplatin and paclitaxel for 6 doses followed by monotherapy for up to 3 years (30 doses).
Keytruda	Oncology PA	**REVISED – Effective 2/1/24 –** Added FDA-approved expanded indication for the treatment of patients with resectable (tumors ≥4 cm or node positive) NSCLC in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery.
Lemtrada	Medical PA	**REVISED – Effective 1/1/24 –** Removed GVHD indication and all corresponding references as this is no longer an NCCN recommended indication for use for Lemtrada.
Leqvio	Medical PA	**REVISED – Effective 11/1/23 –** Updated the Treatment heading and Dosage table for use in Heterozygous Familial Hypercholesterolemia (HeFH)/Atherosclerotic Cardiovascular Disease (ASCVD) to now state Primary Hyperlipidemia per the recent package insert update.
Natalizumab	Medical PA	**REVISED – Effective 12/1/23 –** Ad hoc review to add the newly approved 505b2 formulation of Tyruko which is at full parity to the Tysabri policy. As a result, the name of the policy has been changed from Tysabri and renamed Natalizumab.
Opdivo	Oncology PA	**REVISED – Effective 2/1/24 –** Added the FDA-approved expanded indication for the adjuvant treatment of completely resected Stage IIB/C melanoma in patients 12 years and older.
Reblozyl	Oncology PA	**REVISED – Effective 1/1/24 –** Added the new FDA-approved expanded indication for the treatment of anemia due to MDS in ESA-naïve patients with very low- to intermediate-risk MDS.
Rituximab_IV	Medical PA	**REVISED – Effective 12/1/23 –** To cGVHD, removed step therapy with ibrutinib per NCCN/cost analysis review. Added systemic lupus erythematosus (SLE) indication for moderate to severe refractory disease to Initial Approval Criteria, Renewal Criteria, Dosage/Administration section and added ICD-10 codes related to SLE (M32.10-M32.13, M32.15, M32.19, M32.8, M32.9). To neuromyelitis optica spectrum disorder (NMOSD), updated core clinical characteristics criteria and typical MRI findings criteria per NEMOS 2023 recommendations and reformatted renewal criteria to align with Uplizna, Soliris and Enspryng policies. To Autoimmune Hemolytica Anemia (AIHA) dosing section added additional dosing option of 1,000 mg IV on days 1 and 15 for warm-reactive disease per literature review.
Roctavian	Medical PA	**NEW – Effective 11/1/23 –** New policy for the treatment of Hemophilia A.
Rystiggo	Medical PA	**NEW – Effective 11/1/23 –** New policy for the treatment of generalized myasthenia gravis.

Policy Name	Type of Policy	Coverage Criteria and Changes
Saphnelo	Medical PA	**REVISED – Effective 12/1/23 –** To systemic lupus erythematosus (SLE) updated initial and renewal criteria to align with the new 2019 ACR/EULAR updates and the pivotal trials. Also included Classification Criteria for SLE table as per 2019 ACR/EULAR updates to assist in calculating the SLE criteria score.
Simponi_ARIA	Medical PA	**REVISED – Effective 1/1/24 –** To the Universal Criteria, added interleukin inhibitors to list of agents with which patient should not be on concurrent treatment.
Skyrizi IV	Medical PA	**REVISED – Effective 11/1/23 –** To the Dosing Limits section, specified quantity of 1 vial per dose, 3 vials total. To Initial Approval Criteria, added requirement for baseline levels for liver enzymes and bilirubin per package insert and updated the examples of other excluded non-biologic agents.
Soliris	Medical PA	**REVISED – Effective 12/1/23 –** To generalized myasthenia gravis (gMG), clarified the criteria for an inadequate response after a minimum one-year trial with two or more immunosuppressive therapies to indicate that the one-year is the concurrent use of two agents and is not implied to be sequent one-year courses of two separate agents. To gMG Renewal Criteria, updated that the patient is to have improvement (i.e., reduction) of at least 1-point from baseline in the MG-ADL total score OR QMG score AND improvement from baseline in muscle strength to align with the Rystiggo policy.
Spinraza	Medical PA	**REVISED – Effective 11/1/23 –** Added a Universal Criteria heading and moved criteria for no previous treatment with SMA gene therapy or other agents for SMA, criteria for non-use in advanced disease, and criteria for labs at baseline and before each dose under this heading.
Stelara	Medical PA	**REVISED – Effective 1/1/24 –** To Length of Approval, updated duration of treatment for ulcerative colitis/Crohn's disease after dose escalation to 3 months. To Universal Criteria, added interleukin-inhibitors to list of agents with which patient cannot be treated concurrently.
Syfovre	Medical PA	**REVISED – Effective 1/1/24 –** To Quantity Limit, updated verbiage to 1 vial per eye rather than 1 injection per eye for clarity and to align with other eye policies.
Takhzyro	Medical PA	**REVISED – Effective 1/1/24 –** To Length of Authorization updated initial approval to say 12 months to align with the rest of prophylaxis of Hereditary Angioedem (HAE) policies. To Universal Criteria, added ARBs as potential triggers for HAE attacks to be avoided as per WAO/EAACI guideline for the management of hereditary angioedema – the 2021 revision and update. Also to HAE prophylaxis indication, updated criteria to say a history of at least one HAE attack per month.
Talvey	Medical PA	**New – Effective 1/1/24 –** New policy for the treatment of multiple myeloma.
Testopel	Medical PA	**REVISED – Effective 12/1/23 –** Removed criteria for psychological support as adds little value. Added a post-criteria note stating that use in transgender transition will be reviewed on a case-by-case basis.
Ultomiris	Medical PA	**REVISED – Effective 12/1/23 –** To gMG, updated to clarify patient is to have an inadequate response after a minimum one-year trial with concurrent use of two or more immunosuppressive therapies and relocated criteria. To Renewal Criteria, updated that patient is to have an improvement of at least 1-point from baseline in the MG-ADL total score OR QMG score to align with Rystiggo policy.
Veopaz	Medical PA	**New – Effective 12/1/23 –** New policy for the treatment of CHAPLE disease.
Vivitrol	Medical PA	**REVISED – Effective 12/1/23 –** Changed the authorization approval length from 6 months to 12 months (with renewal) to remove barriers to care in this high-risk group.
VPRIV	Medical PA	**REVISED – Effective 12/1/23 –** From the Initial and Renewal Criteria, removed angina from the examples of symptomatic disease as it does not apply to Type 1 Gaucher Disease. Removed the Initial Criteria stating that the disease manifestation criteria only applied to adults as baseline values are required in peds as well per UpToDate.

Policy Name	Type of Policy	Coverage Criteria and Changes
Vyvgart_IV	Medical PA	**REVISED – Effective 12/1/23 –** Ad hoc review to clarify the criteria for an inadequate response after a minimum one-year trial with two or more immunosuppressive therapies to indicate that the one-year is the concurrent use of two agents and is not implied to be sequent one-year courses of two separate agents. Updated the renewal criteria to now state improvement (i.e., reduction) of at least 1-point from baseline in the MG-ADL total score OR QMG score to align with criteria in the Rystiggo policy based on the Rystiggo Key Opinion Leader (KOL).
Vyvgart_SQ	Medical PA	**REVISED – Effective 12/1/23 –** Ad hoc review to clarify the criteria for an inadequate response after a minimum one-year trial with two or more immunosuppressive therapies to indicate that the one-year is the concurrent use of two agents and is not implied to be sequent one-year courses of two separate agents. Updated the renewal criteria to now state improvement (i.e., reduction) of at least 1-point from baseline in the MG-ADL total score OR QMG score to align with criteria in the Rystiggo policy based on the Rystiggo Key Opinion Leader (KOL).
Xenpozyme	Medical PA	**REVISED – Effective 11/1/23 –** Updated the Dosing table to indicate that treatment should always be initiated via a dose escalation regimen followed by a maintenance dose.
Xipere	Medical PA	**REVISED – Effective 11/1/23 –** Updated the Max Units in the Dosing Limits section to reflect 72 billable units (72 mg; 2 vials) every 12 weeks.

Magellan Rx Management℠ is an independent company providing medical review services on behalf of Blue Cross and Blue Shield of Alabama.

Carelon Medical Benefit Management, an independent company, is contracted to provide precertification services for Blue Cross and Blue Shield of Alabama.

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. Prime Therapeutics LLC is an independent company contracted by Blue Cross and Blue Shield of Alabama to provide pharmacy benefit management services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association. 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).