Summary of Utilization Management (UM) Program Changes

January 2019

Brand Name	Generic Name	Utilization Update Summary	Type	Effective Date
Inrebic	fedratinib	Initial authorization requires both of the following: 1) Diagnosis of one of the following: a) primary myelofibrosis, b) post-polycythemia vera myelofibrosis, or c) post-essential thrombocythemia myelofibrosis, and 2) Prescribed by or in consultation with a hematologist/oncologist. Reauthorization requires documentation of positive clinical response to therapy (e.g., symptom improvement, spleen volume reduction). Initial authorization and reauthorization duration is for 12 months.	New	03/09/2020
Rozlytrek	entrectinib	Initial authorization approval criteria for non-small cell lung cancer requires: 1) Diagnosis of NSCLC, 2) Patient has ROS1 rearrangement positive tumor(s), and 3) Prescribed by or in consultation with an oncologist. Approval duration is 12 months. Initial authorization approval criteria for solid tumors requires: 1) Patient has solid tumors with a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.), 2) Disease is without a known	New	03/09/2020

		acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions), 3) Disease is either metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity), 4) One of the following: a) Disease has progressed following previous treatment (e.g., surgery, radiation therapy, or systemic therapy) or b) Disease has no satisfactory alternative treatments, and 5) Prescribed by or in consultation with an oncologist. Approval duration is 12 months. Reauthorization is granted for 12 months for both indications as long as the patient does not show evidence of progressive disease while on therapy.		
Descovy	emtricitabine/tenofovir alafenamide	PA will only apply to patients who do not have Descovy or another antiretroviral (except Truvada) in their prescription history. - For HIV infection criteria requires confirmation that Descovy is being used for the treatment of HIV infection. Approval duration is 24 months. - For HIV preexposure prophylaxis, criteria requires a history of intolerance or contraindication to Truvada. Approval duration is 12 months.	New	03/09/2020
Ferriprox	deferiprone	Ferriprox tablets are now available in a new 1000 mg strength, indicated for the	Update	03/09/2020

		treatment of patients with transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate. This new strength will be added into the existing Standard Ferriprox guideline with criteria to mirror the other Ferriprox products.		
Octagam	immune globulins	New 30 gm/300 mL strength of Octagam available, indicated for primary humoral immunodeficiency diseases. This new strength will be added to the existing Immune Globulins guideline with criteria to mirror the other IVIG products.	Update	03/09/2020
Copper-chelating Agents	penicillamine (generic Cuprimine)	Added generic penicillamine where Cuprimine is stated.	Update	03/09/2020
Myobloc	neurotoxins	Addition of new indication: chronic sialorrhea. Initial criteria requires a diagnosis of chronic sialorrhea. Reauthorization criteria confirms documentation of positive clinical response to Myobloc therapy and at least 3 months have elapsed since the last treatment with Myobloc. Initial authorization and reauthorization approval duration is for 3 months for a single dose (up to 3,500 units).	Update	03/09/2020
Otezla	apremilast	Addition of new indication: treatment of adult patients with oral ulcers associated with Behçet's Disease. Initial criteria requires: 1) Diagnosis of Behçet's Disease, and 2) Patient has active oral ulcers. Reauthorization criteria	Update	03/09/2020

		requires documentation of positive clinical response to Otezla therapy (e.g., reduction in pain from oral ulcers or reduction in number of oral ulcers). Initial authorization and reauthorization approval duration is for 12 months.		
Taltz	ixekizumab	Addition of new indication: treatment of adult patients with active ankylosing spondylitis (AS). Initial criteria requires: 1) Diagnosis of AS, 2) Prescribed by or in consultation with a rheumatologist, 3) Trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs), and 4) One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: Cimzia, Humira, Simponi/Simponi Aria, AND Cosentyx, or b) For continuation of prior therapy.	Update	03/09/2020
Botox	onabotulinumtoxinA	Botox Cosmetic will be added to the Botox guideline, with a criteria section for Botox and Botox Cosmetic that states: "Requests for coverage of any Botox product for treating the appearance of facial lines are not authorized and will not be approved. These uses are considered cosmetic only" to ensure these products do not get approve for cosmetic use.	Update	03/09/2020
Kisqali; Kisqali Femara Co-pack	ribociclib; letrozole and ribociclib	Updated Kisqali criteria to remove "patient is a postmenopausal woman" to align with prescribing information and added	Update	03/09/2020

		requirement that pre/perimenopausal women be concurrently treated with an LHRH agonist.		
Zolinza	vorinostat	Added examples of other systemic therapies (e.g., Adcetris [brentuximab vedotin], Cytoxan [cyclophosphamide], Poteligeo [mogamulizumab], etc)	Update	03/09/2020