The following list of recommended PDL changes were reviewed and approved by the MHS P&T Committee on April 18th, 2018.

Table 1: Summary PDL Changes

Drug	Action	Notes:
Rosuvastatn	Add QL 1 tab/day	All strengths
Loperamide tabs/caps	Add QL of 8/day	
Loperamide 1mg/5ml	Add QL 40ml/day	
Shingrix (Zoster Vaccine)	Add to PDL	Age Limit ≥ 50; benefit limit of 2 injections
Enbrel Mini (etanercept)	Add to PDL	Line extension of current Enbrel
Juluca (dolutegravir/ rilpivirine)	Add to PDL	
Bydureon BCise (exenatide)	Add to PDL	Line Extnsion of Bydureon (keep current ST, QL 3.4ml/28 days)
Bevyxxa (betrixaban)	Add to PDL	QL 42 caps/42 days

Summary of New Drugs with Proposed Criteria

1. **Codeine and hydrocodone containing cough products – Add Age Limit to limit under 18 years of age;**
    a. Diagnosis of cough due to viral or bacterial infection;
    b. Prescribed agent is FDA-approved for the treatment of cough;
    c. Failure of at least two of the following agents at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced: dextromethorphan, benzonatate, guaifenesin;
    d. Member is concurrently receiving appropriate therapy for the underlying cause of the cough (e.g., antihistamines, decongestants, bronchodilators, oral and/or inhaled corticosteroids, antibiotics);
    e. Dose does not exceed the FDA-approved maximum recommended dose.

    Approval duration: 14 days

2. Codeine Containing Pain Medicine - Add Age Limit 12 years and older and Tramadol Containing Pain Medicine – Add Age Limit 18 years and older

Pain (must meet all):

***In addition to meeting these criteria, requests for all opioids are subject to the criteria outlined in the opioid analgesic policy*

1. Prescribed for pain management;
2. Prescribed agent is FDA-approved for pain management;
3. Member meets one of the following (a or b):
   a. Failure of at least two non-opioid ancillary treatments (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], acetaminophen, anticonvulsants, antidepressants) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   b. Prescribed by or in consultation with an oncologist, hematologist, hospice provider, or pain specialist for cancer, palliative care, or sickle cell disease;
4. Failure of at least two age-appropriate opioid analgesics (e.g., morphine, oxycodone), unless contraindicated or clinically significant adverse effects are experienced;
5. Use is not for pain post-tonsillectomy or post-adenoidectomy;
6. Dose does not exceed health plan's approved quantity limit.

Approval duration:

Non-cancer pain - 7 days

Cancer, sickle cell, or palliative care - 12 months

3. Fasrena (benralizumab) – Add PA Criteria

Severe Asthma (must meet all)**:**

1. Diagnosis of asthma with absolute blood eosinophil count ≥ 150 cells/mcL within the past 3 months;
2. Prescribed by or in consultation with a pulmonologist or allergist;
3. Age ≥ 12 years;
4. Member has experienced ≥ 2 exacerbations within the last 12 months, requiring any of the following despite adherent use of controller therapy (i.e., high-dose inhaled corticosteroid (ICS) plus either a long-acting $beta_2$ agonist (LABA) or leukotriene modifier (LTRA) if LABA contraindication/intolerance):
   a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
   b. Urgent care visit or hospital admission;
   c. Intubation;
5. Fasenra is prescribed concomitantly with an ICS plus either a LABA or LTRA;
6. Dose does not exceed 30 mg every 4 weeks for the first 3 doses, then 30 mg every 8 weeks thereafter.

Approval duration: 6 months

4. **Siliq (brodalumab) – Add PA**
   Plaque Psoriasis (must meet all)**:**
   1. Diagnosis of PsO;
   2. Prescribed by or in consultation with a dermatologist or rheumatologist;
   3. Age ≥ 18 years;
   4. Member meets one of the following (a or b):
      a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
      b. If intolerance or contraindication to MTX *(see Appendix C)*, failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   5. Failure of etanercept (*Enbrel® is preferred*) AND adalimumab (*Humira® is preferred*) each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization is required for etanercept and adalimumab*
   6. Dose does not exceed 210 mg at weeks 0, 1, and 2, followed by maintenance dose of 210 mg every 2 weeks.
      Approval duration: 6 months

5. **Erleada (apalutamide) – Add PA Criteria**
   Prostate Cancer (must meet all):
   1. Diagnosis of non-metastatic CRPC, as evidenced by disease progression despite bilateral orchiectomy or other androgen deprivation therapy (*see Appendix C*);
   2. Prescribed by or in consultation with an oncologist;
   3. Age ≥ 18 years;
   4. Member will use a gonadotropin-releasing hormone (GnRH) analog concurrently or has had a bilateral orchiectomy;
   5. Dose does not exceed 240 mg (four 60 mg tablets) daily.

   Approval duration: 12 months

6. **Rhopressa (netarsudil) - Add PA Criteria**
   Open-Angle Glaucoma (must meet all)**:**
   1. Diagnosis of open-angle glaucoma or ocular hypertension;
   2. Age ≥ 18 years;
   3. Failure of two different classes of generic ophthalmic agents from the following, at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced: prostaglandin analog (e.g., latanoprost), ophthalmic beta-blocker (e.g., timolol), ophthalmic alpha-2 adrenergic agonist (e.g., brimonidine), parasympathomimetics (e.g., pilocarpine), or carbonic anhydrase inhibitors (e.g. dorzolamide);
   4. Dose does not exceed 1 drop/eye/day (2 bottles or 5 mL/30 days).

   Approval duration: 12 months

7. **Xepi (ozenoxacin) – Add PA Criteria**
   mpetigo (must meet all)**:**
   1. Diagnosis of impetigo;
   2. Age ≥ 2 months;
   3. Failure of a trial of mupirocin 2% ointment or cream (at up to maximally indicated doses) unless contraindicated or clinically significant adverse effects are experienced;
   4. Dose does not exceed BID topical application for five days.

   Approval duration: 1 month (1 tube)