Title: Q2 2019 PDL Changes

The following list of recommended Preferred Drug List (PDL) changes were reviewed and approved by the MHS Pharmacy & Therapeutics (P&T) Committee on April 17, 2019.

Table 1: Summary PDL Changes – Effective 3/1/2019

Drug:	Action:	Notes:
Albuterol HFA	Move to preferred	QL 2 inhalers per 30 days (exceptions allowed)
Fluticasone-Salmeterol Diskus	Move to preferred	QL 1 diskus per month
Xeljanz, Xeljanz XR (tofacitinib)	Move to preferred with PA	Remove trial and failure of Enbrel/Humira from PA criteria
Pifeltro (doravirine)	Move to preferred	QL 1 tab daily
Krintafel (tafenoquine succinate)	Move to preferred	QL 2 tabs per month
Ezetimibe	Move to preferred	Step Therapy through preferred statin
Perseris (Risperidone)	Move to preferred	Age Limit of 18 and older, QL syringe per month
Ezetimibe-Simvastatin	Move to preferred	Step Therapy through preferred statin
Xolair	Move to preferred	PA required
Arikayce	Move to preferred	PA required
Promacta	Move to preferred	PA required

Table 2: New Drug Specific PA Criteria: Full Medical Necessity Crieria Attacehd and also Posted at: https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html

Drug:	Criteria:
Mirvaso (brimonidine tartrate)	1. Diagnosis of persistent facial erythema associated with rosacea; 2. Age ≥ 18 years; 3. If papules or pustules are present, a failure of or concomitant treatment with any of the following agents, unless contraindicated or clinically significant adverse effects are experienced: topical metronidazole, oral doxycycline or Finacea; 4. Dose does not exceed 30 mg (1 tube) per month
Drug:	**Criteria:**

Motegrity (prucalopride)	1. Diagnosis of chronic idiopathic constipation; 2. Age ≥ 18 years; 3. Failure of one bulk forming laxative (e.g., psyllium , methylcellulose calcium polycarbophil) 4. Failure of one stimulant laxative (e.g., bisacodyl, senna), 5. Failure of polyethylene glycol (MiraLax®) 6. Dose does not exceed 2 mg (1 tablet) per day.
Siklos (hydroxyurea)	Sickle cell disease: 1. Age ≥ 2 years 2. Documentation supports inability to use generic hydroxyurea (e.g., contraindications to the excipients in generic hydroxyurea); 3. Dose does not exceed 35 mg/kg per day based on weight -OR- Diagnosis of one of the following: 1. Acute myeloid leukemia; Chronic myeloid leukemia; Head and neck cancer; Myeloproliferative neoplasms (myelofibrosis, polycythemia vera, essential thrombocythemia); 2. Age ≥ 2 years; 3. Documentation supports inability to use generic hydroxyurea (e.g., contraindications to the excipients in generic hydroxyurea); 4. Request meets one of the following (a or b): 5. Dose does not exceed 80 mg/kg per day based on weight; 6. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
Yupleri (revefenacin)	1. Diagnosis of COPD; 2. Age ≥ 18 years; 3. Dose does not exceed 175 mcg (1 vial) per day

Drug:	Criteria:
Aemcolo (rifamycin)	1. Diagnosis of Travelers' Diarrhea; 2. Age ≥ 18 years; 3. Failure of one of the following fluoroquinolone regimens, unless contraindicated or clinically significant adverse effects are experienced (a, b, or c): a. Ciprofloxacin 500 mg twice daily for 1-3 days; b. Levofloxacin 500 mg once daily for 1-3 days; c. Ofloxacin 200 mg twice daily for 1-3 days; 4. Failure of azithromycin 1,000 mg as a single dose, unless contraindicated or clinically significant adverse effects are experienced; 5. Dose does not exceed 776 mg per day (4 tablets per day).
Ravulizumab (Ultomiris)	1. Diagnosis of PNH; 2. Prescribed by or in consultation with a hematologist; 3. Age ≥ 18 years; 4. Flow cytometry shows detectable GPI-deficient hematopoietic clones or ≥ 5% PNH cells; 5. Member meets one of the following (a or b): a. History of ≥ 1 transfusion in the past 24 months and (i or ii): i. Documentation of hemoglobin < 7 g/dL in members without anemia symptoms; ii. Documentation of hemoglobin < 9 g/dL in members with anemia symptoms; b. History of thrombosis; 6. Dose does not exceed (a and b): a. Loading dose on Day 1 (i, ii, or iii): i. Weight ≥ 40 to < 60 kg: 2,400 mg; ii. Weight ≥ 60 to < 100 kg: 2,700 mg; iii. Weight ≥ 100 kg: 3,000 mg; b. Maintenance dose on Day 15 and every 8 weeks thereafter (i, ii, or iii): i. Weight ≥ 40 to < 60 kg: 3,000 mg; ii. Weight ≥ 60 to < 100 kg: 3,300 mg; iii. Weight ≥ 100 kg: 3,600 mg.
Caplacizumab (Cablivi)	1. Diagnosis of aTTP confirmed with a PLASMIC score of 6 to 7 (*see Appendix D*); *2.* Prescribed by or in consultation with a hematologist; 3. Age ≥ 18 years; 4. Prescribed in combination with plasma exchange therapy;

	5. Prescribed in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab); 6. Dose does not exceed (a and b): a. Loading dose on Day 1: 22 mg per day; b. Maintenance: 11 mg per day.
Esketamine (Spravato)	1. Diagnosis of treatment-resistant depression; 2. Age ≥ 18 years; 3. Failure of two antidepressants (e.g., selective serotonin reuptake inhibitor [SSRI], serotonin-norepinephrine reuptake inhibitor [SNRI], tricyclic antidepressant [TCA], bupropion, mirtazapine) from at least two different classes at up to maximally indicated doses but no less than the commonly recognized minimum therapeutic doses, each used for ≥ 8 weeks, unless contraindicated or clinically significant adverse effects are experienced; 4. Failure of two of the following antidepressant augmentation therapies, each used for ≥ 4 weeks, unless contraindicated or clinically significant adverse effects are experienced: second-generation antipsychotic, lithium, thyroid hormone; 5. Currently stabilized on an oral antidepressant for at least two weeks (must not be one of the aforementioned agents previously failed); 6. Dose does not exceed 168 mg (6 nasal spray devices) per week.
Overactive Bladder Agents	1. Diagnosis of overactive bladder; 2. Age ≥ 18 years; 3. Failure of 2 formulary generic overactive bladder agents (e.g., tolterodine, oxybutynin, trospium) each used for 30 days, unless contraindicated or clinically significant adverse effects are experienced; 4. Dose does not exceed the FDA-approved maximum recommended dose for the relevant drug.
Topical Tretinoin	1. Member's age exceeds the health plan-approved age limit 2. Diagnosis of acne vulgaris; *3.* Requested dose does not exceed health plan-approved quantity limit.