To:	**Jai Medical Providers**
From:	**ProCare Rx**
Date:	**March 31, 2023**
Subject:	**Formulary Updates March 2023**

Effective 4/1/2023, the following products will be added to the formulary:

- Alogliptin (generic Nessina) 6.25mg, 12.5mg, 25mg – With Step Therapy Edit
- Insulin Aspart (generic Novolog) 100u/mL
- Freestyle Libre (Sensors and Readers) – Added with PA requirement
- Taltz 80mg/ml – Added with PA requirement
- Skyrizi 60mg/ml, 150mg/ml – Added with PA requirement
- Rinvoq 15mg, 30mg, 45mg – Added with PA requirement
- Xolair 75mg/ml, 150mg/ml – Added with PA requirement
- Dupixent 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml – Added with PA requirement
- Imatinib (generic Gleevec) 100mg, 400mg – Added with QL

Effective 4/1/2023, the following changes will be made to medications on the formulary:

- Santyl Ointment – A QL of 90g per month was added (larger quantities may be obtained through the medical/DME benefit with proper PCP referral)
- Januvia 25mg, 50mg, 100mg – The PA was removed and a Step Therapy Edit was added; members already approved for Januvia will be able to continue therapy

Effective 5/1/23, further restrictions are being added to opioid medications:

- Members will be limited to no more than 3 prescribers for opioid prescriptions per calendar year
- Members will be limited to no more than 3 pharmacies for opioid prescriptions per calendar year
- Further opioid management criteria for any request to receive an opioid in greater than fourteen (14) days supply
  Indications:
  - Diagnosis of Cancer OR
  - Diagnosis of Sickle Cell Disease OR
  - Residence and/or diagnosis of Hospice Care OR
  - Residence and/or diagnosis of Palliative Care OR
  - Residence and/or diagnosis of Long-term facility (LTC) and/or skilled nursing facility (SNF) OR
  - Non-Cancer pain

  Criteria:

- For Cancer, Sickle Cell Disease, Hospice Care, Palliative Care, Long-Term Facility (LTC) and/or Skilled Nursing Facility (SNF), no additional medical information will be required.
- For Non-Cancer Pain for **MORE THAN FOURTEEN (14) DAYS SUPPLY**
  - Physician must document the diagnosis on the prior authorization request.
  - Prior to the start of therapy with an opioid:
    - Prescriber documents that the patient is not taking more than two-hundred (200) MME per day AND
    - Prescriber documents that the patient is not taking two (2) or more opioid potentiators (e.g., benzodiazepines, muscle relaxants, sedative hypnotics, gabapentinoids, etc.) with concurrent opioids AND
    - Prescriber documents that the patient is not taking medication assisted treatments (e.g., buprenorphine with or without naloxone, etc.) with concurrent opioids AND
    - Prescriber certifies that the patient tried at least two (2) other specific non-opioid treatments for pain relief as appropriate, in the past sixty (60) days, such as:
      - Physical therapy
      - NSAIDs
      - Topical pain medications

Step Therapy criteria:

Alogliptin (Generic Nessina) Step Therapy Criteria:

Recent trial of metformin or sulfonylurea or thiazolidinedione - Cumulative days' supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill

Januvia Step Therapy Criteria:

Recent trial of formulary product Alogliptin - Cumulative days' supply for more than sixty (60) days with at least one (1) fill within the last one-hundred and eighty (180) days.

Prior Authorization Criteria:

GENERIC: FLASH GLUCOSE SENSOR
BRAND: FREESTYLE LIBRE®
INDICATIONS:

1. Treatment of patients indicated for the management of diabetes in persons aged 4 years and older.

Criteria:

1. Diagnosed with Type I or Type II Diabetes mellitus; and
2. Actively seeing an Endocrinologist (at least one visit within past 6 months); and
3. Blood glucose testing at least 4x/day for more than sixty (60) days; and

4. Insulin injections at least 3x/day; and
5. The member must have been assessed by the prescriber for ability to adhere to the CGM monitor regimen and any adherence/compliance issues must have been addressed and resolved by the prescriber; and
6. Frequent adjustments to amount of injected insulin based on glucose testing results; and
7. Wide variance in blood sugar levels OR unexplained or severe hypoglycemia OR hypoglycemic unawareness

Taltz PA Criteria:

GENERIC: IXEKIZUMAB
BRAND: TALTZ®
INDICATIONS:

1. Treatment of pediatric patients aged ≥ 6 years with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.
2. Treatment of adult patients with active psoriatic arthritis
3. Treatment of adults with active ankylosing spondylitis.
4. Adults with active non-radiographic axial spondyloarthritis (nrAxSpA) with objective signs of inflammation.

Criteria:

1. First Prescription and every 12 months: The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment.
2. For adult patients with plaque psoriasis, psoriatic arthritis, ankylosing spondylitis, and nrAxSpA
   a. Previous treatment, or intolerance of, with Enbrel for more than sixty (60) days; and
   b. Previous treatment, or intolerance of, with Humira for more than sixty (60) days

Skyrizi PA Criteria:

GENERIC: RISANKIZUMAB
BRAND: SKYRIZI®
INDICATIONS:

1. Treatment of adult patients with moderate-to-severe plaque psoriasis (Ps) who are candidates for systemic therapy or phototherapy.
2. Treatment of adult patients with active psoriatic arthritis (PsA)
3. Treatment of adults with moderately to severely active Crohn's disease (CD).

Criteria:

1. First Prescription and every 12 months: The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment.
2. For adult patients with Ps and PsA - Previous treatment, or intolerance of, with Taltz for more than sixty (60) days

3. For adult patients with CD - Previous treatment, or intolerance of, with Humira for more than sixty (60) days

Rinvoq PA Criteria:

GENERIC: UPADACITINIB
BRAND: RINVOQ®
INDICATIONS:

1. Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with rheumatoid arthritis (RA).
2. Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active psoriatic arthritis (PsA).
3. Treatment of pediatric patients 12 years and older, who have had an inadequate response or intolerance to other systemic drug products, including biologics, with active atopic dermatitis (AD).
4. Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active ulcerative colitis (UC).
5. Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active ankylosing spondylitis (AS).
6. Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active non-radiographic axial spondyloarthritis (nr-axSpA).

Criteria:

1. First Prescription and every 12 months:
   a. The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment.
   b. The patient had a NEGATIVE hepatitis B and C viral screening
2. For adult patients with RA
   a. Previous treatment, or intolerance of, with Enbrel for more than sixty (60) days; and
   b. Previous treatment, or intolerance of, with Humira for more than sixty (60) days
3. For adult patients with PsA
   a. Previous treatment, or intolerance of, with Enbrel for more than sixty (60) days; and
   b. Previous treatment, or intolerance of, with Humira for more than sixty (60) days; and
   c. Previous treatment, or intolerance of, with Taltz for more than sixty (60) days
4. For pediatric patients 12 years and older with AD
   a. Previous treatment, or intolerance of, with Dupixent, or intolerance of, for more than sixty (60) days
5. For adult patients with UC

a. Previous treatment, or intolerance of, with Humira for more than sixty (60) days

6. For adult patients with AS and nr-asSpA
   a. Previous treatment, or intolerance of, with Taltz for more than sixty (60) days

Xolair PA Criteria:

GENERIC: OMALIZUMAB
BRAND: XOLAIR®
INDICATIONS:

1. Treatment of moderate to severe persistent asthma in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids.
2. Treatment of adult patients, as an add-on maintenance treatment, chronic rhinosinusitis with nasal polyposis (CRSwNP).
3. Treatment of adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment with chronic spontaneous urticaria (CSU).

Criteria:

1. For pediatric patients 6 years and older with asthma
   a. Documentation of baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL
   b. Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen
   c. Previous treatment, or intolerance of, with two (2) or more inhaled medium to high dose LABA+ICS for more than sixty (60) days; and
   d. Patients must be reevaluated after 6 months
2. For adult patients with asthma
   a. Documentation of baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL
   b. Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen
   c. Previous treatment, or intolerance of, with LAMA+LABA+ICS for more than sixty (60) days; and
   d. Patients must be reevaluated after 6 months
3. For adult patients with CRSwNP
   a. Previous treatment, or intolerance of, with two (2) or more intranasal corticosteroid for more than ninety (90) days; and
   b. Previous treatment, or intolerance of, with oral corticosteroid
4. For pediatric patients 12 years and older with CSU
   a. Previous treatment with two (2) H1-antihistamines for more than sixty (60) days within the past ninety (90) days

Dupixent PA Criteria:

GENERIC: DUPILUMAB

BRAND: DUPIXENT®

INDICATIONS:

1. Treatment of pediatric patients 6 months and older, who have had an inadequate response or intolerance to topical drug products, with active atopic dermatitis (AD).
2. Treatment of pediatric patients 6 years and older, characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma, with moderate-to-severe asthma.
3. Treatment of adult patients, as an add-on maintenance treatment, chronic rhinosinusitis with nasal polyposis (CRSwNP).
4. Treatment of pediatric patients 12 years and older with eosinophilic esophagitis (EoE).
5. Treatment of adult patients with prurigo nodularis (PN).

Criteria:

1. For pediatric patients 6 months and older with AD and PN
   a. Previous treatment, or intolerance of, with TCS for more than sixty (60) days; and
   b. Previous treatment, or intolerance of, with TCI for more than sixty (60) days
2. For pediatric and adult patients 6 years and older with asthma
   a. Previous treatment, or intolerance of, with Xolair for more than sixty (60) days; and
   b. Patients must be reevaluated after 6 months
3. For adult patients with CRSwNP
   a. Previous treatment, or intolerance of, with Xolair for more than sixty (60) days; and
   b. Previous treatment, or intolerance of, with oral corticosteroid
4. For pediatric patients 12 years and older with EoE
   a. Confirmed diagnosis with endoscopic esophageal biopsy showing the presence of eosinophils (≥15 eosinophils per high-power field); and
   b. Previous treatment with proton-pump inhibitor (PPI) for more than sixty (60) days; and
   c. Previous treatment with oral corticosteroid; and
   d. Attestation of dietary modifications (e.g., avoidance of food allergen triggers)

Providers can contact ProCare's Prior-Authorization Department at 800-555-8513 for assistance with PA requests or questions regarding clinical guidelines. Our PA Department is available Monday through Friday from 8:30 am-5:30 pm EST. For assistance with PA requests during non-business hours please contact our 24 hour customer service department at 800-213-5640.