A Public Entity

Inland Empire Health Plan

PHARMACY TIMES

BY IEHP PHARMACEUTICAL SERVICES DEPARTMENT

January 1, 2019

IEHP FORMULARY CHANGES: January 2019 P&T UPDATE

We would like to inform you of the following changes to the 2019 IEHP Formulary that were approved by the Pharmacy and Therapeutics Subcommittee in November 2018.

AF = Add to Formulary
BOLD = Brand Name

DS = Days Supply
QL = Quantity Limit
ST = Step Therapy
R-QL = Remove Quantity Limit

AR = Age Restriction
C1 = Code 1 drugs are restricted to certain medical conditions or specific circumstances
PA = Prior Authorization
RF = Remove from Formulary
R-PA = Remove Prior Authorization

NOTE: IEHP is a generic mandated health plan. Brand name drugs are not covered unless indicated or if generic is not available. The FDA recommended maximum dosage limit is applied.

IEHP MEDI-CAL FORMULARY UPDATES		
Drug Name	**Strength & Dosage Form**	**Status Change**
fentanyl	75 mcg/hr transdermal patch 100 mcg/hr transdermal patch	• QL = 10/30 ds
hydrocodone/acetaminophen	5 mg/325 mg tablet 7.5 mg/325 mg tablet 10 mg/325 mg tablet 7.5 mg/325 mg/15 ml oral solution	• QL = 120/30 ds (tablets) • QL = 1800/30 ds (oral solution)
Janumet	50 mg/500 mg tablet 50 mg/1000 mg tablet	• RF
Janumet XR	50 mg/500 mg extended release tablet 50 mg/1000 mg extended release tablet 100 mg/1000 mg extended release tablet	• RF

Januvia	25 mg tablet 50 mg tablet 100 mg tablet	• RF
Lantus	100 units/mL Solostar 100 units/mL vial	• RF
Morphine sulfate	10 mg/5 mL oral sol 20 mg/5 mL (4 mg/mL) oral sol 100 mg/5 mL (20 mg/mL) concentrate oral sol	• QL = 900/30 ds (10 mg/5 mL) • QL = 450/30 ds (20 mg/5 mL) • QL = 120/30 ds (100 mg/5mL)
morphine sulfate	15 mg immediate release tablet 30 mg immediate release tablet	• QL = 180/30 ds
morphine sulfate	15 mg extended release tablet 30 mg extended release tablet 60 mg extended release tablet 100 mg extended release tablet 200 mg extended release tablet	• QL = 90/30 ds
morphine sulfate	30 mg extended release 24-hour multiphase capsule 60 mg extended release 24-hour multiphase capsule	• QL = 30/30 ds
oxycodone/acetaminophen	5 mg/325 mg tablet 7.5 mg/325 mg tablet 10 mg/325 mg tablet	• QL = 120/30 ds
tramadol	50 mg tablet	• QL = 240/30 ds

IEHP MEDICARE FORMULARY UPDATES		
Drug Name	**Strength & Dosage Form**	**Status Change**
Arnuity (fluticasone furoate)	50 mcg inhalation	• AF
Cimduo (laminudine/tenofovir)	300 mg/300 mg tablet	• AF • QL = 4/30 ds
Humira Pen Crohn-UC-HS Starter (adalimumab)	80 mg/0.8 ml pen injection kit	• AF • PA
Humira Pen Psor-Uvei (adalimumab)	80 mg/40 mg pen injection kit	• AF • PA
hydroxyzine hcl	10 mg tablet 25 mg tablet 50 mg tablet	• AF • PA
miglustat	100 mg capsule	• AF • PA (New Starts)

oxacillin sodium	1 g vial port 1 g vial	• AF
Palynziq (pegvaliase/pqpz)	10 mg/0.5 ml syringe 20 mg/ml syringe 2.5 mg/0.5 ml syringe	• AF • PA (New Starts)
Yonsa (abiraterone acet, submicronized)	125 mg tablet	• AF • PA (New Starts) • QL = 124/31 ds
Zenpep (lipase/protease/amylase)	3 k/10 k/14 k capsule dr 15 k/47 k/63 k capsule dr	• AF • QL = 31/31 ds (3k/10k/14k) • QL = 4/30 ds (15k/47k/63k)

*NOTE: Listed below are **ONLY** revisions that were approved. For criteria details please reference the Prior Authorization Table.*

IEHP PRIOR AUTHORIZATION REVISED CRITERIA	
Drug Name/Drug Class	**Medi-Cal PA Criteria Revision**
Absorica (isotretinoin)	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove metronidazole topical
adapalene topical	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove oral alternatives (e.g. isotretinoin, doxycycline) and metronidazole topical
adapalene-benzoyl peroxide topical gel	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove oral alternatives (e.g. isotretinoin, doxycycline) and metronidazole topical
Albenza (albendazole)	**PRIOR AUTHORIZATION UPDATES:** • Removed criteria for off-labeled diagnoses • Removed Pin-X (obsolete) as step through agent for enterobius and adjusted the required step thro9ugh drugs' names from brand to generic name
Amitiza (lubiprostone)	**PRIOR AUTHORIZATION UPDATES:** • Revised required medical information to remove trial and failure of Linzess
Amnesteem (isotretinoin)	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove metronidazole topical
Bicillin L-A (penicillin G benzathine)	**QUANTITY LIMIT:** • 600,00 units/mL: 3 mL per 28 days • 1.2 million units/2mL: 6 mL per 28 days • 2.4 million units/4mL: 12 mL per 28 days
calcipotriene topical cream	**PRIOR AUTHORIZATION UPDATES:** • Adjusted formulary topical corticosteroid alternatives: o Removed betamethasone dip 0.05% gel o Added betamethasone dip 0.05% cream, betamethasone valerate 0.1% cream, clobetasol-emollient 0.05% topical

	cream, fluocinolone 0.25% cream, Fluocinonide-E 0.05% topical cream, triamcinolone 0.1% lotion and triamcinolone 0.5% cream
ciclopirox nail solution	**QUANTITY LIMIT:** • 6.6 mL per 30 days
Claravis (isotretinoin)	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove metronidazole topical
clindamycin 1.2%-benzoyl peroxide 5% topical gel	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove oral alternatives (e.g. isotretinoin, doxycycline) and metronidazole topical
crotan 10% lotion	**QUANTITY LIMIT:** • 60 g (1 tube) per 30 days
Delzicol (mesalamine)	**PRIOR AUTHORIZATION UPDATES:** • Crohn's: Revised required medical information to remove trial and failure of sulfasalazine
Emverm (mebendazole)	**PRIOR AUTHORIZATION UPDATES:** • Removed Pin-X (obsolete) as step through agent for enterobius and adjusted the required step thro9ugh drugs' names from brand to generic name
Entocort EC (budesonide DR)	**PRIOR AUTHORIZATION UPDATES:** • Revised required medical information to remove trial and failure of sulfasalazine
Eucrisa (crisaborole)	**PRIOR AUTHORIZATION UPDATES:** • Adjusted formulary topical corticosteroid alternatives: o Removed betamethasone dip 0.05% gel o Added betamethasone dip 0.05% cream, betamethasone valerate 0.1% cream, clobetasol-emollient 0.05% topical cream, fluocinolone 0.25% cream, Fluocinonide-E 0.05% topical cream, triamcinolone 0.1% lotion and triamcinolone 0.5% cream
Flumist Quad 2018-2019 (flu vaccine qv live 2018)	**AGE RESTRICTION:** • Age of 18 years or above QUANTITY LIMIT: • 1 dose per 365 days
Heplisav-B (Hepatitis B vaccine/CPG1018/PF) (PF) 20 mcg/0.5 mL intramusclar	**AGE RESTIRCTION:** • Age of 18 years or above **QUANTITY LIMIT:** • 1 dose per 365 days
itraconazole	**PRIOR AUTHORIZATION UPDATES:** • Removed non-FDA labeled indications: endocarditis and osteomyelitis • Adjusted indications: prophylaxis for fungal infection in HIV patients, oropharyngeal candidiasis, candidiasis of the esophagus
ivermectin	**PRIOR AUTHORIZATION UPDATES:** • Removed off-labeled indications • Added infestation by phthirus pubis per Micromedex
Lialda	**PRIOR AUTHORIZATION UPDATES:**

(mesalamine)	• Crohn's: Revised required medical information to remove trial and failure of sulfasalazine
malathion 0.5% lotion	**QUANTITY LIMIT:** • 118 mL (equivalence of 2 bottles) per 30 days
Movantik (naloxegol)	**PRIOR AUTHORIZATION UPDATES:** • Revised required medical information to require: o Documentation of chronic opioid use in the past 90 days; o Trial and failure of 3 formulary conventional laxative alternatives
Mycamine (micafungin)	**PRIOR AUTHORIZATION UPDATES:** • Simplified diagnosis: candidemia and prophylaxis of candida infection in blood stem cell transplantation
Myorisan (isotretinoin)	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove metronidazole topical
Prevacid SoluTab (lansoprazole disintegrating DR)	**PRIOR AUTHORIZATION UPDATES:** • Revised required medical information to remove trial and failure of Nexium granule and Protonix granule
Prilosec (omeprazole granule)	**PRIOR AUTHORIZATION UPDATES:** • Revised required medical information to remove trial and failure of Nexium granule and Protonix granule
Relistor injectable (methylnaltrexone)	**PRIOR AUTHORIZATION UPDATES:** • **Covered Uses:** Opioid-induced constipation (non-cancer) **Exclusion criteria**: N/A **Required Medical Information**: Must meet all of the following requirements: a. Failure or clinically significant adverse effects to "1" of the alternatives: fiber, polyethylene glycol powder or psyllium b. Failure or clinically significant adverse effects to "1" of the alternatives: bisacodyl, lactulose or senna c. Failure or clinically significant adverse effects to the alternative: Amitiza and Movantik **Age Restrictions:** N/A **Prescriber Restrictions:** N/A • **Covered Uses:** Opioid-induced constipation (advanced illness or cancer) **Exclusion Criteria**: N/A **Required Medical Information**: Must meet all of the following requirements: a. Documentation of advanced illness receiving palliative or hospice care b. Must meet "1" of the following: i. Documentation of difficulty swallowing ii. Failure or clinically significant adverse effects to "1" drug from any "2" of the groups: 1. fiber or psyllium 2. polyethylene glycol powder or lactulose 3. bisacodyl or senna **Age Restrictions:** N/A **Prescriber Restrictions:** N/A

Relistor oral (methylnaltrexone)	**PRIOR AUTHORIZATION UPDATES:** • **Covered Uses:** Opioid-induced constipation (non-cancer) **Exclusion Criteria:** N/A **Required Medical Information:** Must meet all of the following requirements: a. Failure or clinically significant adverse effects to "1" of the alternatives: fiber, polyethylene glycol powder or psyllium b. Failure or clinically significant adverse effects to "1" of the alternatives: bisacodyl, lactulose or Senna c. Failure or clinically significant adverse effects to the alternative: Amitiza and Movantik **Age Restrictions:** N/A **Prescriber Restrictions:** N/A
Sklice (ivermectin)	**PRIOR AUTHORIZATION UPDATES:** • Adjusted formulary topical antiparasitic alternative: removed Ulesfia and added spinosad
Tazorac (tazarotene)	**PRIOR AUTHORIZATION UPDATES:** • Acne: revised formulary alternatives to remove oral alternatives (e.g. isotretinoin, doxycycline) and metronidazole topical • Plaque Psoriasis: adjusted formulary topical corticosteroid alternatives: o Removed betamethasone dip 0.05% gel o Added betamethasone dip 0.05% cream, betamethasone valerate 0.1% cream, clobetasol-emollient 0.05% topical cream, fluocinolone 0.25% cream, Fluocinonide-E 0.05% topical cream, triamcinolone 0.1% lotion and triamcinolone 0.5% cream
tretinoin topical cream 0.025%, 0.05%, 0.1%	**AGE RESTRICTION:** • 35 years or older **QUANTITY LIMIT:** • 45 g per 30 days
tretinoin topical gel 0.01%, 0.025%	**AGE RESTRICTION:** • 35 years or older **QUANTITY LIMIT:** • 45 g per 30 days
valganciclovir	**PRIOR AUTHORIZATION UPDATES:** • Adjusted CMV disease to CMV infection • Combined criteria for both indications since the criteria content are the same
vancomycin hcl (capsule)	**QUANTITY LIMIT:** • 145 capsules per 180 days, not to exceed 4 capsules per day
Vaxchora (cholera vaccine, live)	**AGE RESTRICTION:** • Age of 18 years or above
voriconazole	**PRIOR AUTHORIZATION UPDATES:** • Added indication of candidemia, invasive aspergillosis prophylaxis • Adjusted indications to candidiasis of the esophagus, invasive candidiasis of the skin in abdomen, kidney, bladder wall, and wounds, specified scedosporium apiospermum, scedosporium prolificans infections

	• Removed off-label indications: Endophthalmitis, meningitis, osteoarticular infections involving the spine, discitis, epidural abscess or vertebral osteomyelitis, osteoarticular infection not involving the spine
Xarelto 2.5mg (rivaroxaban)	**PRIOR AUTHORIZATION UPDATES:** • Added coverage criteria for coronary artery disease and peripheral artery disease • **Covered Uses:** Coronary Artery Disease (CAD) or Peripheral Artery Disease (PAD) **Exclusion Criteria:** N/A **Required Medical Information:** Must meet all of the following requirements: a. Documentation of concurrent use with aspirin b. Documentation of "1" of the following: i. Atherosclerosis involving at least two vascular beds ii. Atherosclerosis with at least "2" additional cardiovascular risks: current smoking, diabetes mellitus, impaired renal function or GFR less than 60 mL per minute, heart failure or history of ischemic stroke iii. Peripheral arterial disease with "1" of the following: 1. Symptomatic with ankle brachial index (ABI) less than 0.90 2. Asymptomatic carotid artery stenosis greater than or equal to 50% 3. History of carotid revascularization procedure 4. Ischemic disease of one or both lower extremities **Age Restrictions:** N/A **Prescriber Restrictions:** Cardiologist, Vascular Medicine Specialist or Vascular Surgeon
Zenatane (isotretinoin)	**PRIOR AUTHORIZATION UPDATES:** • Revised formulary alternatives to remove metronidazole topical

Prior Authorization table available at: www.iehp.org > For Providers > Pharmaceutical Services > Clinical Information > PA Drug Treatment Criteria

CLINICAL PRACTICE GUIDELINE UPDATES		
Clinical Practice Guideline	**Academy/Association**	**Status**
Hepatitis C AASLD	American Association for the Study of Liver Diseases and Infectious Diseases Society of America - 2018	Renew
Sexually Transmitted Diseases – Summary of CDC Treatment Guidelines	Centers for Disease Control and Prevention (CDC) – 2015	Renew

Gastroesophageal Reflux Disease - Adults	American College of Gastroenterology - 2013	Renew
Gastroesophageal Reflux Disease - Pediatrics	North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) and European Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) - 2018	Update

For any questions, suggestions, or if you would like a printed copy of the IEHP Formulary Book or Clinical Practice Guideline, please call us at (909) 890-2049. As a reminder, the updated formulary information and Clinical Practice Guidelines are available at www.iehp.org.

Sincerely,

IEHP Pharmaceutical Services