PROVIDERUpdate

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Pharmacy Information and Formulary Changes – 1st Quarter 2019

THIS UPDATE APPLIES TO:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

STATE:

- ● Oregon
- ● Washington

LINES OF BUSINESS:

- ● EPO
- ● POS
- ● PPO
- ● CommunityCare
- ○ Medicare Advantage (HMO/PPO)

PROVIDER SERVICES

www.healthnet.com

EPO, POS, PPO, & CommunityCare: 1-888-802-7001

2019 MAC POLICY CHANGES

Effective January 1, 2019, there will be changes to the MAC (maximum Allowable Charge) policies offered for Oregon Small and Large Group. Oregon Small Group products will only offer MAC A policies. Oregon Large Group products will now offer both No MAC and MAC A. This change does not apply to Washington Small Group or Large Group. Washington Small and Large Group will continue to offer No MAC for 2019.

MAC A will enforce that the member receives a brand name medication when there is a generic available. If the member choses to fill a brand name product, the member will pay the applicable copayment of the brand drug PLUS the difference between the generic and brand cost.

Offering MAC A enables us to more effectively manage healthcare costs. If a member has a medically necessary need for the higher cost brand drug and cannot take the generic equivalent, Providers can submit a Prior Authorization request to the Health Net Pharmacy team to request the brand name drug to be dispensed without applying the penalty (difference in cost between generic and brand drug). The prior authorization must request brand name and request an exception to the penalty or to the MAC A policy. If prior authorization is approved, applicable tier cost-shares will apply for the tier level the brand name drug is assigned to.

No MAC	Brand name drugs with generic equivalents available are subject to Tier 3 copayment/coinsurance as soon as generic is available
MAC A	Member must pay the difference between the generic and brand cost plus applicable copayment/coinsurance if a brand is requested.
MAC B	Same as MAC A except if the Physician writes “dispense as written (DAW)” on the script, member is not responsible for the difference in cost between brand and generic.
MAC U	Brand drugs with a generic equivalent available are not covered without Prior Authorization and Medical Necessity

FORMULARY REMOVAL OF BRAND DRUGS WITH GENERIC AVAILABLE

Certain brand drugs with a generic available (“O” drug (originator drug)) will be removed from the formulary effective January 1, 2019. If the member continues to use the brand “O” drug, they will be responsible for the full cost of the medication. If the member has a medically necessary need for the “O” drug, providers can submit a prior authorization request to the Health Net Pharmacy team.

*Members and prescribers affected by either the MAC policy changes or the formulary removal of brand drugs with generic available have been notified.

AVAILABLE SEATS ON THE PHARMACY AND THERAPEUTICS COMMITTEE

Seats are open on the combined Trillium Community Health Plan and Health Net of Oregon Pharmacy and Therapeutics (P&T) Committee. We are looking for community-based practitioners representing various clinical specialties who adequately represent the membership of our health plans. If you are interested in learning more or attending a quarterly meeting please contact Susan Van Horn via email at: Susan.E.VanHorn@TrilliumCHP.com. Meetings are held once a quarter and are comprised of a remote review of clinical drug information and coverage guidelines, electronic vote and committee meetings. Individuals who are selected to join by the committee are eligible to receive an honorarium to compensate them for the time spent reviewing materials and attending meetings.

OUTPATIENT PHARMACEUTICALS SUBMITTED UNDER THE MEDICAL BENEFIT

See the list below for all HCPCS codes affected by changes as of January 1, 2019. "New" indicates new requirements, "Existing" indicates current requirements, and "Step Therapy" indicates step therapy requirements added to existing criteria.

For Health Net Health Plan of Oregon, Inc. commercial, newly approved medications may require prior authorization.

ADDITIONAL INFORMATION

For additional information regarding changes to the Health Net formularies, contact Health Net by telephone at 1-888-802-7001.For the most current version of the formularies, visit the Health Net provider website at provider.healthnet.com under *Pharmacy Information* > *Pharmacy Information Overview* > *Drug Lists*.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by telephone at 1-888-802-7001.

Brand (Generic Name)	HCPC Code	Commercial (EPO, POS, PPO, Community Care)
CHANGES, EFFECTIVE JANUARY 1, 2019		
Actemra (tocilizumab)	J3262	Existing
Aranesp (darbepoetin)	J0881/J0882	Existing**
Botox (onabotulinumtoxin a)	J0585	Existing
Cimzia (certolizumab pegol)	J0717	Existing
Epogen, Procrit (epoetin alfa)	J0885	Existing**
Exondys 51 (eteplirsen)	J1428	Existing
Eylea (aflibercept)	J0178	Existing
Acthar HP (corticotropin inj gel)	J0800	Existing
Kymriah (tisagenlecleucel)	Q2040	Existing
Lucentis (ranibizumab)	J2778	Existing
Macugen (pegaptanib)	J2503	Existing
Mircera (methoxy polyethylene glycol epoetin beta)	J0887	Existing
Ocrevus (ocrelizumab)	J2350	Existing
Remicade (infliximab)	J1745	Existing
Rituxan Hycela (rituximab-hyaluronidase)	J9467/C9467	Existing
Rituxan (rituximab)	J9310	Existing (non-oncology only)
Tysabri (natalizumab)	J2323	Existing
Visudyne (verteporfin)	J3396	Existing
Yescarta (axicabtagene ciloleucel)	Q2041	Existing
Neulasta (pegfilgrastim)	J2505	Existing**
Crysvita (burosumab-twza)	C9399/J3590	New

Brand (Generic Name)	HCPC Code	Commercial (EPO, POS, PPO, Community Care)
Elaprase (idursulfase)	J1743	New
Mepsevii (vestronidase alfa-vjbk)	J3590	New
Vimizim (elosulfase alfa)	J1322	New
Fasenra (benralizumab)	J3590	New
Trogarzo (Ibalizumab-uiyk)	J3590	New

**Self injectables, when used as chemotherapy adjunct, do not require prior authorization.

PHARMACEUTICALS COVERED UNDER THE PHARMACY BENEFIT

Brand Name	Generic Name	Therapeutic Category & Indication	Comments
TIER 1 ADDITIONS AND CHANGES			
vancomycin	vancomycin oral capsules	Antiinfective Agent - glycopeptide antibiotic Treatment of various susceptible bacterial infections.	Generic available at Tier 1 (EDL only) Prior authorization required
TIER 2 ADDITIONS AND CHANGES			
Atripla®	efavirenz-emtricitabine-tenofovir disoproxil fumarate tablet	Antiinfective agent - antiviral combination Treatment of human immunodeficiency (HIV) virus.	Tier 2 Step therapy - must try Symfi.
Biktarvy®	Bictegravir-emtricitabine-tenofovir alafenamide fumarate tablet	Antiinfective agent - antiviral combination Treatment of human immunodeficiency (HIV) virus.	Tier 2
Cimduo™	lamivudine-tenofovir disoproxil fumarate tablet	Antiinfective agent - antiviral combination Treatment of human immunodeficiency (HIV) virus.	Tier 2
Complera®	emtricitabine-rilpivirine-tenofovir disoproxil fumarate tablet	Antiinfective agent - antiviral combination Treatment of human immunodeficiency (HIV) virus.	Tier 2 Step therapy - must try Symfi.
Odefsey®	emtricitabine-rilpivirine-tenofovir alafenamide fumarate tablet	Antiinfective agent - antiviral combination Treatment of human immunodeficiency (HIV) virus.	Tier 2 Step therapy - must try Symfi.
Symfi/Symfi Lo™	efavirenz-lamivudine-tenofovir disoproxil fumarate tablet	Antiinfective agent - antiviral combination Treatment of human immunodeficiency	Tier 2

Brand Name	Generic Name	Therapeutic Category & Indication	Comments
		(HIV) virus.	

Brand Name	Generic Name	Therapeutic Category & Indication	Comments
TIER 3 ADDITIONS AND CHANGES			
Lucemyra™	lofexidine HCL tablet	Substance abuse agents- withdrawal agents Treatment of opiate agonist withdrawal symptoms to facilitate abrupt opiate discontinuation.	Tier 3 (OR EDL/ADL ONLY) Added limit of #224 tablets per 14 day supply. PA required for more than a 30 day supply per year.
Osmolex ER™	amantadine extended-release tablet	Neurological agents - antiparkinsonian agent Treatment of Parkinson's disease and for the treatment of drug-induced extrapyramidal reactions.	Tier 3 Prior authorization required
Siklos®	hydroxyurea tablet	Antineoplastic agent – antimetabolite Indicated to reduce the frequency of painful crises and to reduce the need for blood transfusions in pediatric patients, 2 years of age and older, with sickle cell anemia with recurrent moderate to severe painful crises.	Tier 3 Added age limit of less than 19 years.
Stimate®	desmopressin nasal spray	Hematological agents – hemostatics Indicated for the management of spontaneous bleeding or trauma-induced hemorrhage or for bleeding prophylaxis in patients with hemophilia A or mild to moderate von Willebrand's disease type 1.	Tier 3 (EDL only) Prior authorization added
Symtuza™	darunavir-cobic-emtricitab-tenofov AF Tablet	Antiviral agents – HIV-1 Indicated as a complete regimen for treatment of HIV-1 infection in adults who have no prior treatment history or who are virologically suppressed on a stable regimen for at least 6 months and have no known substitutions assoc with resistance to darunavir or tenofovir.	Tier 3 Step therapy - must try Symfi

Brand Name	Generic Name	Therapeutic Category & Indication	Comments
SPECIALTY TIER AND OTHER ADDITIONS AND CHANGES			
Aimovig™	erenumab solution for injection	Neurological agents – anti-migraine agents Indicated for preventive treatment of migraine in adults.	Tier SP (EDL) Tier 3 (ADL) Prior authorization required
Braftovi™	envorafenib capsule	Antineoplastic agents – kinase inhibitor For use in combination with binimetinib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.	Tier AC Prior authorization required
Ilumya™	tildrakizumab-asmn solution for injection	Biologic response modifier – interleukin inhibitor Treatment of moderate to severe plaque psoriasis in patients who are candidates for systemic therapy or phototherapy.	Tier SP (EDL) Tier 3 (ADL) Prior authorization required
Jynarque®	tolvaptan tablet	Renal agents - selective vasopressin V_2-receptor antagonist Treatment of autosomal dominant polycystic kidney disease (ADPKD) to slow kidney function decline in patients at risk of developing rapidly progressing ADPKD.	Tier SP (EDL) Tier 3 (ADL) Prior authorization required
Kevzara® Auto-injector	sarilumab solution for injection	Disease Modifying Antirheumatic Drugs (DMARDs) – interleukin inhibitors Treatment of moderate to severe rheumatoid arthritis inpatients who have had an inadequate response or intolerance to one or more disease modifying antirheumatic drugs.	Tier SP (EDL) Tier 3 (ADL) Prior authorization required
Mektovi®	binimetinib tablet	Antineoplastic agents – MEK inhibitor For use in combination with encorafenib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.	Tier AC Prior authorization required
Nuplazid®	pimavanserin tartrate tablet	Atypical antipsychotic Treatment of hallucinations and delusions associated with Parkinson's disease psychosis.	Tier SP (EDL) Tier 3 (ADL) Prior authorization required

Brand Name	Generic Name	Therapeutic Category & Indication	Comments
Panretin®	alitretinoin 1% gel	Antineoplastic agents - topical retinoid Treatment of cutaneous lesions in patients with AIDs-related Kaposi's sarcoma.	Tier AC (WA EDL only) Prior authorization added
Purixan®	mercaptopurine suspension	Antineoplastic agents – purine analog Treatment of acute lymphocytic leukemia (ALL)	Tier AC (EDL only) Prior authorization added
Talzenna™	talazoparib capsule	Antineoplastic agents – poly (ADP-ribose) polymerase (PARP) inhibitor Treatment of deleterious or suspected deleterious germline BRCA-mutated (gBRCAm), HER2-negative locally advanced or metastatic breast cancer.	Tier AC Prior authorization added
Tavalisse™	fostamatinib disodium tablet	Hematological agents – hemostatics Treatment of thrombocytopenia in patients with chronic idiopathic thrombocytopenic purpura (ITP).	Tier SP (EDL) Tier 3 (ADL) Prior authorization required
Vizimpro®	dacomitinib tablet	Antineoplastic agents – epidermal growth factor (EGFR) kinase inhibitor Treatment of non-small cell lung cancer (NSCLC).	Tier AC Prior authorization added

[1] Changes listed in the table apply to EDL and ADL unless a specific formulary is noted.

[2] Tier 1*, Tier 2*, Tier 3*, PV - *These preventive medications are covered at $0 cost share if you have a Preventive Pharmacy benefit

DEFINITIONS

ADL – AonActive Drug List

EDL – Essential Rx Drug List

NF – Non Formulary

SP – Specialty

AC – Anti-cancer

Step Therapy – Prior authorization is required if Step Therapy is not met.

Drug List at www.healthnet.com

Please be sure to visit our website at www.healthnet.com to view the most current version of our drug lists.