NH Healthy Families Q32020 Pharmacy & Therapeutics Committee Guideline Summary

Policy/ Coverage Criteria Guideline	Revision Summary Description
CP.PHAR.11 Burosumab-twza (Crysvita)	Clarified weight-based dosing limits in initial and continued approval criteria; references reviewed and updated.
CP.PHAR.14 Hydroxyprogesterone caproate (Makena)	Added requirement precluding concurrent therapy with Crinone or Endometrin.
CP.PHAR.16 Palivizumab (Synagis)	Seasonal coverage criteria are added to all indications; related AAP/CDC guidance is added to Appendix D.
NH.PHAR.55 Somatropin (Human Growth Hormone)	Policy converted Auxology updates: correction for age and sex, GH Research Society GF options, and Appendix D added. Converted to State Specific policy.
NH.PMN.226 Pancrelipase (Perzyte, Viokace, Pancreaze)	Converted to State Specific Policy. Retired CP.PMN.226.
NH.PMN.242 Adalimumab (Humira), Adalimumab-atto (Amjevita), Adalimumab-adbm (Cyltezo), Adalimumab-bwwd (Hadlima)	Converted to State Specific Policy. Retired CP.PMN.242
CP.PHAR.61 Cinacalcet (Sensipar)	References reviewed and updated.
CP.PHAR.89 Peginterferon Alfa-2a,b (Pegasys, PegIntron, Sylatron)	Added systemic mastocytosis with associated hematologic malignancy, aggressive systemic mastocytosis, osteopenia or osteoporosis with refractory bone pain and/or decreasing bone mineral density on bisphosphonate therapy as per NCCN compendium; specified myelofibrosis as low risk and symptomatic as per NCCN compendium; added specialist involvement for chronic hepatitis B infection; references reviewed and updated.
CP.PHAR.103 Immune Globulins	For dermatomyositis added a requirement for a prior trial of rituximab; added Indiana as another exception to the Section III exclusion for PANDAS; RT4: added new Hizentra prefilled syringe dosage form; references reviewed and updated.
CP.PHAR.130 Avatrombopag (Doptelet)	For chronic immune thrombocytopenia: added requirement that Doptelet is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP; revised systemic corticosteroid and immune globulin trial to tiered re-direction with immune globulin trial only if corticosteroid cannot be used per ASH 2011 guideline and specialist feedback.
CP.PHAR.146 Deferoxamine (Desferal)	References reviewed and updated.
CP.PHAR.150 Mecasermin (Increlex)	Open epiphyses added; auxology updated for acquired GH insensitivity to reconcile with somatropin policy; malignancy contraindication added; positive response removed in deference to growth criteria; references reviewed and updated.
CP.PHAR.168 Corticotropin (H.P. Acthar)	Revised multiple sclerosis approval duration from 4 weeks to 3 weeks and added max vial quantity of 6 vials total; revised Appendix D; references reviewed and updated.
CP.PHAR.173 Leuprolide Acetate (Lupron, Lupron Depot, Eligard, Lupaneta Pack, Fensolvi)	Added Fensolvi (new dosage form) to the policy for Central Precocious Puberty; added off-label NCCN indication and criteria for salivary gland tumor; references reviewed and updated.
CP.PHAR.179 Romiplostim (Nplate)	For immune thrombocytopenia: added requirement that Nplate is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP.
CP.PHAR.180 Eltrombopag (Promacta)	For chronic immune thrombocytopenia: added requirement that Promacta is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP.
CP.PHAR.210 Ivacaftor (Kalydeco)	Revised initial approval criteria requiring chart notes for pulmonary function test: added “for age > 2 years” for ppFEV1; added alternative option for ppFEV1 for age < 6 years to allow for LCI ≥ 7.4; revised continuation criteria to include stabilization in LCI if baseline was ≥ 7.4; added information regarding LCI in Appendix D.

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CP.PHAR.212 Dornase alfa (Pulmozyme)	Added pulmonologist prescriber requirement; added requirement of therapeutic plan including concomitant use of standard CF therapies as indicated in PI.
CP.PHAR.213 Lumacaftor-ivacaftor (Orkambi)	Revised initial approval criteria requiring chart notes for pulmonary function test: added "for age > 2 years" for ppFEV1; added alternative option for ppFEV1 for age < 6 years to allow for LCI ≥ 7.4; revised continuation criteria to include stabilization in LCI if baseline was ≥ 7.4; added information regarding LCI in Appendix D.
CP.PHAR.215 Factor VIII	Added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports. **Medical Benefit Use Only**
CP.PHAR.216 Factor VIII-von Willebrand (Alphanate, Humate-P, Vonvendi, Wilate)	Added Vonvendi to the policy; added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports. **Medical Benefit Only**
CP.PHAR.217 Anti-inhibitor Coagulant Complex (Feiba)	Added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports. **Medical Benefit Use Only**
CP.PHAR.218 Factor IX Human Recombinant	Added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports. **Medical Benefit Use Only**
CP.PHAR.221 Factor XIII Human (Corifact)	Added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports; **Medical Benefit Use Only**
CP.PHAR.222 Factor XIIIa Recombinant (Tretten)	Added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports; **Medical Benefit Use Only**
CP.PHAR.243 Alemtuzumab (Lemtrada)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; references reviewed and updated.
CP.PHAR.249 Dimethyl fumarate (Tecfidera), diroximel fumarate (Vumerity)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified all continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.251 Fingolimod (Gilenya)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.252 Glatiramer (Copaxone, Glatopa)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.255 Interferon beta-1a (Avonex, Rebif)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.

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CP.PHAR.256 Interferon beta-1b (Betaseron, Extavia)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.258 Mitoxantrone (Novantrone)	MS: added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; references reviewed and updated.
CP.PHAR.259 Natalizumab (Tysabri)	MS: added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.260 Rituximab (Rituxan, Ruxience, Truxima, Rituxan Hycela)	Added criteria for off-label indication of ITP; for RA, added specific diagnostic criteria for definite RA, baseline CDAI score requirement, and decrease in CDAI score as positive response to therapy.
CP.PHAR.262 Teriflunomide (Aubagio)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.270 Paricalcitol Injection (Zemplar)	References updated.
CP.PHAR.271 Peginterferon beta-1a (Plegridy)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.274 Daclatasvir (Daklinza)	Updated criteria to remove genotypes 2, 4, 5, and 6 along with dosing section V to reflect that AASLD/IDSA guidelines no longer support Daklinza-based regimens (FDA-labeled indication remains for genotypes 1 and 3 for a 12 week duration); revised initial authorization duration to 12 weeks from 24 weeks; references reviewed and updated.
NH.PHAR.275 Elbasvir-Grazoprevir (Zepatier)	Updated appendices and references.
NH.PHAR.281 Sofosbuvir (Sovaldi)	Updated FDA Approved Indications section. Updated initial approval criteria age and duration of approvals. Updated duration of approval for continued therapy. Updated appendices, dosing charts, and references.
CP.PHAR.285 Nintedanib (Ofev)	Criteria added for new FDA indication: chronic fibrosing ILD with a progressive phenotype; references updated.
CP.PHAR.286 Pirfenidone (Esbriet)	References reviewed and updated.
CP.PHAR.295 Sargramostim (Leukine)	For ARS indication added weight based dosing to criteria set; references updated.
CP.PHAR.297 Filgrastim (Neupogen, Zarxio, Granix, Nivestym)	For chemotherapy-induced neutropenia criteria set, added “For members receiving palliative chemotherapy, provider attestation that chemotherapy dose reduction has been considered”; added appendix F: dose rounding guidelines; added reference to appendix F within criteria; references updated.
CP.PHAR.335 Ocrelizumab (Ocrevus)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
NH.PHAR.347 Sofosbuvir-Velpatasvir-Voxilaprevir (Vosevi)	Updated duration of approval to up to 24 weeks. Updated appendices and references.
NH.PHAR.348 Glecaprevir-Pibrentasvir (Mavyret)	Updated FDA Approved Indications section. Updated appendices and references. Updated approval criteria with appropriate ages per indications as well as adding in Vosevi criteria.

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CP.PHAR.370 Emicizumab-kxwh (Hemlibra)	Added requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports.
CP.PHAR.379 Etelcalcetide (Parsabiv)	Added to Section I requirement that member does not have serum calcium less than the lower limit of the normal to align with prescribing information and similar Sensipar criteria requirements; references reviewed and updated.
CP.PHAR.384 Lutetium Lu 177 dotatate (Lutathera)	Revised criteria requiring disease progression while on a long-acting somatostatin analog to allow short and long acting somatostatin analogs; updated Appendix B and D; references reviewed and updated.
CP.PHAR.385 Corticosteroid Intravitreal Implants (Iluvien, Ozurdex, Retisert, Yutiq)	References updated.
CP.PHAR.422 Cladribine (Mavenclad)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; references reviewed and updated.
CP.PHAR.427 Siponimod (Mayzent)	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.440 Elexacaftor-ivacaftor-tezacaftor (Trikafta)	Revised initial approval criteria: revised the requirement for evidence of clinical severity as defined by an average sweat chloride from > 86 mmol/L to > 60 mmol/L; removed in vitro testing requirement demonstrating a baseline chloride transport < 10% of wild type CFTR; removed requirement for lack of responsiveness to other CFTR modulators; removed for members currently using another CFTR modulator switching to Trikafta to show increase in chloride transport of < 10% over baseline; removed positive response requirement after at least 12 weeks of therapy to show chloride transport ≥ 10% since baseline requirement; revised Appendix D.
CP.PHAR.450 Luspatercept-aamt (Reblozyl)	Criteria added for new FDA indication: MDS; references reviewed and updated.
CP.PHAR.460 Monomethyl fumarate (Bafiertam)	Drug is now FDA approved - criteria updated per FDA labeling; modified CIS re-direction to include glatiramer per SDC; added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; added primary progressive MS as a diagnosis not covered; references updated.
CP.PHAR.462 Ozanimod (Zeposia)	Drug is now FDA approved - criteria updated per FDA labeling; modified CIS re-direction to include glatiramer per SDC; added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; added primary progressive MS as a diagnosis not covered; references updated.
CP.PHAR.465 Teprotumumab (Tepezza)	Added requirement that member has not had previous surgical intervention for TED consistent with clinical trial exclusion criteria.
CP.PHAR.476 Ubrogepant (Ubrelvy)	Revised requirement 'for monthly quantities > 1 box of 6 tablets per month' to 10 tablets per month as this is the smallest available package size. Updated Section VI to remove the 6 and 8 tablet package sizes.
CP.PMN.08 Lidocaine transdermal (Lidoderm, ZTlido)	References updated.
CP.PMN.14 SGLT2 inhibitors	Criteria added for Farxiga's new FDA indication: heart failure with reduced ejection fraction.
CP.PMN.40 Acitretin (Soriatane)	Added rheumatologist as a prescriber option; references reviewed and updated.
CP.PMN.44 Pyrimethamine (Daraprim)	Added requirement for use of generic products before brand product; references reviewed and updated. 3Q 2020 annual review: added requirement for use of generic products before brand product; references reviewed and updated
CP.PMN.76 Calcifediol (Rayaldee)	References reviewed and updated.

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CP.PMN.124 Itraconazole (Sporanox ,Onmel, Tolsura)	Added criteria for Sporotrichosis infection (off-label); added requirement for use of generic itraconazole capsules or oral solution; updated Appendix B; updated dosage and administration; references updated.
CP.PMN.132 Tadalafil BPH - ED (Cialis)	References reviewed
CP.PMN.163 Sodium zirconium cyclosilicate (Lokelma)	Clarified redirection to preferred sodium polystyrene sulfonate; added to Section III exclusion for emergency treatment of hyperkalemia to align with prescribing information limitation of use and Veltassa; references reviewed and updated.
CP.PMN.183 GLP-1 receptor agonists	Updated "FDA Approved Indications" section to include Trulicity's new FDA indication: cardiovascular risk reduction in patients with established cardiovascular disease or with multiple cardiovascular risk factors; modified criteria to allow Trulicity or Ozempic in patients with established cardiovascular disease or multiple cardiovascular risk factors if contraindicated to the preferred agent Victoza; added new exenatide contraindication to Appendix C; references updated.
CP.PMN.198 Overactive Bladder Agents	Added requirement for medical justification for inability to use generic for requests for brand Vesicare or Enablex; added requirement that request does not exceed health plan approved quantity limit; RT4: specified Vesicare is only indicated for adults per updated FDA labeling and added Vesicare LS with corresponding criteria.
CP.PMN.199 Esketamine (Spravato)	Added requirements for PHQ-9 score of at least 15 for initial approval with a decrease of at least 50% from baseline for continued approval.
CP.PMN.208 Halobetasol-Tazarotene (Duobrii)	Added rheumatologist as prescriber involvement for plaque psoriasis; references reviewed and updated.
CP.PHAR.487 Osilodrostat (Isturisa)*	Policy created.
CP.PHAR.488 Apomorphine (Apokyn)	Policy created.
CP.PHAR.489 Eptinezumab (Vyepti)*	Policy created.
CP.PHAR.490 Rimegepant (Nurtec ODT)*	Policy created.
CP.PHAR.491 Setmelanotide (RM-493)	Policy created.
CP.PHAR.492 Teplizumab	Policy created.
CP.PHAR.493 Infusion Therapy Site of Care Optimization	Policy created.
CP.PMN.236 Amisulpride (Barhemsys)	Policy created.
CP.PMN.237 Bempedoic acid (Nexletol), bempedoic acid-ezetimibe (Nexlizet)*	Policy created.
CP.PMN.238 Carbidopa-Levodopa ER Capsules (Rytary)	Policy created.
CP.PMN.239 Chenodiol (Chenodal)	Policy created.
CP.PMN.240 Gabapentin ER (Gralise, Horizant)	Policy created.
CP.PMN.241 Lactitol (Pizensy)*	Policy created.
CP.PMN.242 Minocycline micronized foam (Amzeeq)	Policy created.
CP.PMN.243 Progesterone (Crinone, Endometrin, Milprosa)	Policy created.
CP.PMN.244 Tazarotene (Arazlo, Fabior, Tazorac)	Policy created.
CP.PMN.245 Opicapone (Ongentys)*	Policy created.
NH.PMN.56 Atypical Antipsychotics	Annual Review. No changes
NH.PMN.59 Quantity Limit Overrides	Annual Review. No changes
NH.PMN.127 Vortioxetine (Trintellix)	Added dosing and diagnosis requirements. Added Appendices section. Updated references.
NH.PMN.36 Lisdexamfetamine (Vyvanse)	Annual Review. No changes

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NH.PMN.22 Brand Name Override	Annual Review. No changes
NH.PMN.16 Request for non-preferred medically necessary drug	Annual Review. No changes
NH.PHAR.122 Long-Acting Injectable Antipsychotics	Annual Review, No changes
NH.PHAR.289 Buprenorphine Implant, Injectable (Probuphine, Sublocade)	Annual Review. No changes
NH.PHAR.288 Eteplirsen (Exondys 51)	Annual Review. No changes
NH.PPA.12 Opioid Analgesics	Annual Review. No changes
CP.PHAR.27 Tolvaptan (Jynarque, Samsca)	No significant changes; updated product availability; updated Jynarque boxed warnings as per updated prescribing information; references reviewed and updated.
CP.PHAR.28 Immunization coverage	No significant changes; references reviewed and updated.
CP.PHAR.41 Enfuvirtide (Fuzeon)	No significant changes; references reviewed and updated.
CP.PHAR.82 Collagenase (Xiaflex)	No significant changes; references reviewed and updated.
CP.PHAR.88 Belimumab (Benlysta)	No significant changes; references reviewed and updated.
CP.PHAR.95 Thyrotropin alfa (Thyrogen)	No significant changes; references reviewed and updated.
CP.PHAR.109 Tesamorelin (Egrifta SV)	No significant changes; replaced old formulation Egrifta with new formulation Egrifta SV; references updated.
CP.PHAR.145 Deferasirox (Exjade, Jadenu)	No significant changes; references reviewed and updated.
CP.PHAR.147 Deferiprone (Ferriprox)	No significant changes; added new tri-scored 1,000 mg tab formulation; references reviewed and updated.
CP.PHAR.169 Vigabatrin (Sabril)	No significant changes; references reviewed and updated.
NH.PHAR.268 Sofosbuvir-Velpatasvir (Epclusa)	Updated FDA Approved indications section; updated initial approval criteria with authorized generic. Updated dosing in criteria for approval. Updated appendices and references.
CP.PHAR.277 Cytomegalovirus Immune Globulin (Cytogam)	No significant changes; references reviewed and updated.
CP.PHAR.278 Dasabuvir-Ombitasvir-Paritaprevir-Ritonavir (Viekira Pak)	No significant changes; removed discontinued Viekira XR from policy; references reviewed and updated.
NH.PHAR.279 Ledipasvir-Sofosbuvir (Harvoni)	Updated FDA approved indications section, age requirements for approval, appendix B and D, Dosage and administration, product availability and updated references.
CP.PHAR.287 Obeticholic acid (Ocaliva)	No significant changes; references reviewed and updated.
CP.PHAR.296 Pegfilgrastim (Neulasta, Fulphila, Udenyca, Ziextenzo)	No significant changes; references reviewed and updated.
CP.PHAR.338 Cerliponase alfa (Brineura)	No significant changes; references reviewed and updated.
CP.PHAR.351 Daptomycin (Cubicin, Cubicin RF)	No significant changes; references reviewed and updated.
CP.PHAR.425 Metreleptin (Myalept)	No significant changes; references reviewed and updated.
CP.PHAR.429 Valproate (Depacon)	No significant changes; references reviewed and updated
CP.PHAR.430 Alpelisib (Piqray)	No significant changes; references reviewed and updated
CP.PHAR.432 Tafamidis (Vyndaqel, Vyndamax)	No significant changes; references reviewed and updated
CP.PMN.09 Lindane shampoo	No significant changes; references reviewed and updated
CP.PMN.31 Fluticasone-salmeterol (Advair Diskus, Advair HFA)	No significant changes; references reviewed and updated.
CP.PMN.46 Roflumilast (Daliresp)	No significant changes; references reviewed and updated.
CP.PMN.60 SSRI SNRI Duplicate Thearapy	No significant changes; references reviewed and updated.
CP.PMN.83 Short ragweed pollen allergen extract (Ragwitek)	No significant changes; references reviewed and updated.

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CP.PMN.84 Timothy grass pollen allergen extract (Grastek)	No significant changes; references reviewed and updated.
CP.PMN.85 Mixed pollens allergen extract (Oralair)	No significant changes; references reviewed and updated.
CP.PMN.111 House dust mite allergen extract (Odactra)	No significant changes; references reviewed and updated.
CP.PMN.139 Naloxone (Evzio)	No significant changes; references reviewed and updated.
CP.PMN.140 Pimavanserin (Nuplazid)	No significant changes; references reviewed and updated.
CP.PMN.144 Epinephrine (Auvi-Q, Epipen, Epipen Jr) Quantity Limit	No significant changes; references reviewed and updated.
NH.PPA.16 Vilazodone (Viibryd)	Added appendix B through E. Updated References. Updated dosing limits per FDA dosing guidelines in criteria for approval. Added requirement for diagnosis and age limit in initial criteria.
CP.PMN.146 Fluticasone-umeclidinium-vilanterol (Trelegy Ellipta)	No significant changes; updated FDA approved indication language to reflect most recent labeling; modified preferred ICS/LABA to generic Symbicort and generic Advair Diskus per SDC meeting on 2/4/20; added Striverdi Respimat as a preferred LABA option and removed Incruse Ellipta as a preferred LAMA option per core Medicaid formulary status; references reviewed and updated.
CP.PMN.147 Indacaterol-glycopyrrolate (Utibron Neohaler)	No significant changes; modified preferred ICS/LABA to generic Symbicort and generic Advair Diskus per SDC meeting on 2/4/20; added Striverdi Respimat as a preferred LABA option and removed Incruse Ellipta as a preferred LAMA option per core Medicaid formulary status; updated Appendix C to reflect revised CI language and that the asthma-related death boxed warning was removed; references reviewed and updated.
CP.PMN.148 Tiotropium-olodaterol (Stiolto Respimat)	No significant changes; modified preferred ICS/LABA to generic Symbicort and generic Advair Diskus per SDC meeting on 2/4/20; added Striverdi Respimat as a preferred LABA option and removed Incruse Ellipta as a preferred LAMA option per core Medicaid formulary status; updated Appendix C to reflect revised CI language and that the asthma-related death boxed warning was removed; references reviewed and updated.
CP.PMN.149 Umeclidinium-vilanterol (Anoro Ellipta)	No significant changes; modified preferred ICS/LABA to generic Symbicort and generic Advair Diskus per SDC meeting on 2/4/20; added Striverdi Respimat as a preferred LABA option and removed Incruse Ellipta as preferred LAMA option per core Medicaid formulary status; updated Appendix C to reflect revised CI language; references reviewed and updated.
CP.PMN.152 Lofexidine (Lucemyra)	No significant changes; references reviewed and updated.
CP.PMN.155 lacosamide (Vimpat)	No significant changes; references reviewed and updated.
CP.PMN.156 Perampanel (Fycompa)	No significant changes; references reviewed and updated.
CP.PMN.157 Rufinamide (Banzel)	No significant changes; references reviewed and updated.
CP.PMN.164 Cannabidiol (Epidiolex)	No significant changes; references reviewed and updated.
CP.PMN.200 Aclidinium-formoterol (Duaklir Pressair)	No significant changes; modified preferred ICS/LABA to generic Symbicort and generic Advair Diskus per SDC meeting on 2/4/20; added Striverdi Respimat as a preferred LABA option and removed Incruse Ellipta as a preferred LAMA option per core Medicaid formulary status; references updated.
CP.PMN.201 Arformoterol tartrate (Brovana)	No significant changes; updated Appendix C to reflect revised CI language and that the asthma-related death boxed warning was removed; references reviewed and updated.
CP.PMN.202 Benzyl alcohol (Ulesfia)	No significant changes; references reviewed and updated.
CP.PMN.203 Indacaterol (Arcapta Neohaler)	No significant changes; added Striverdi Respimat as a preferred LABA option per core Medicaid formulary status; references reviewed and updated.

CP.PMN.204 Olodaterol (Striverdi Respimat)	No significant changes; references reviewed and updated.
CP.PMN.205 Patiromer (Veltassa)	No significant changes; references reviewed and updated.
CP.PMN.206 Tegaserod (Zelnorm)	No significant changes; references reviewed and updated.
CP.PMN.207 Triclabendazole (Egaten)	No significant changes; references reviewed and updated.
CP.PMN.211 Midazolam (Nayzilam)	No significant changes; references reviewed and updated.
CP.PMN.229 Fluticasone-vilanterol (Breo Ellipta)	No significant changes; references reviewed and updated.
CP.PMN.230 Mometasone-formoterol (Dulera)	No significant changes; references reviewed and updated.
CP.PST.17 Atomoxetine (Strattera)	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.276 Ombitasvir/Paritaprevir/Ritonavir (Technivie)	Retire, since drug is off the market and drug will be obsolete by 8/2020
CP.PHAR.280 Simeprevir (Olysio)	Retire, since drug is off the market and drug will be obsolete by 8/2020
CP.PMN.75 Age Limit for Tazarotene (Tazorac, Arazlo)	Retire, replaced by CP.PMN.244 Tazarotene (Arazlo, Fabior, Tazorac) to accommodate for SDC recommendation to add Arazlo and Fabior

Coverage Criteria Guideline	**Revision Summary Description**
CC.PHAR.03 Drug Recall Notification	Updated DART process to match EPS Policy. Updated the market withdrawal definition to match with the FDA's definition. Updated Attachments A, B, C, and D to include current letter templates.
NH.PHAR.08 Pharmacy PA and MN Criteria	Added two policies to References section: EPS.PHARM.31 Creating and Revising Drug Prior Authorization Policies and EPS.PHARM.03A Medicaid Prior Authorization Review Process. Revised section that said when a medication is approved or denied a notation is made in the pharmacy claims processing system to say in the PA processing system. Revised the section that describes member denial letters being sent by EPS to all Centene health plans on a daily basis. Member denial letters are only provided to the health plans daily if they are requested.
NH.PHAR.09 Pharmacy Program	Added Substance Use Disorder Section.
CC.PHAR.14 Generic Drug Additions to PDL	Annual Review- Changed "plans" to "drugs", that are maintained at either GPI or NDC level.
CC.PHAR.15 Line Extension Additions to PDL	Removed needles from being added to PDL based on cost.