NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

Policy/ Coverage Criteria Guideline	Revision Summary Description
CP.PHAR.05 Hyaluronate derivatives	4Q 2020 annual review: added sports medicine physician as acceptable specialist; references reviewed and updated.
CP.PHAR.11 Burosumab-twza (Crysvita)	RT2: Criteria added for new FDA indication: TIO; references reviewed and updated.
CP.PHAR.58 Denosumab (Prolia Xgeva)	The MM/solid tumor common criteria line item, at risk for skeletal related event, is removed for solid tumor and for MM is replaced with receiving or initiating therapy for symptomatic disease per pivotal trials/NCCN; IV bisphosphonate trials are added per labels/NCCN to prostate/breast fracture prevention, MM/solid tumor (exception prostate/breast cancer), and systemic mastocytosis.
CP.PHAR.78 Thalidomide (Thalomid)	AIDS-related KS: specified that the liposomal form of doxorubicin should be tried; added bypass of trial requirements if member is intolerant or contraindicated.
CP.PHAR.89 Peginterferon Alfa-2a,b (Pegasys, PegIntron, Sylatron)	Added inadequate response or loss of response to hydroxyurea or interferon therapy if peginterferon alfa-2b or peginterferon alfa-2a naïve for polycythemia vera; added inadequate response or loss of response to hydroxyurea, anagrelide, or interferon therapy, if peginterferon alfa-2b or peginterferon alfa-2a naïve for essential thrombocytopenia; added NCCN-recommended (with Category 2A or above) off-label uses: primary cutaneous CD30+ T-cell lymphoproliferative disorder, adult T-cell leukemia or lymphoma; Mycosis fungoides or Sezary syndrome; NCCN references reviewed and updated.
CP.PHAR.93 Bevacizumab (Avastin, Mvasi, Zirabev)	4Q 2020 annual review: removed AIDS-related Kaposi sarcoma as an off label use as it is no longer NCCN supported; added additional NCCN supported regimens for colorectal cancer, non-squamous non-small cell lung cancer, renal cell carcinoma, cervical cancer, and epithelial ovarian, fallopian tube, or primary peritoneal cancer; added to Section IB metastatic spine tumors or brain metastases and vulvar cancer diagnoses which are supported by NCCN; added appendix F: dose rounding guidelines; added reference to appendix F within criteria; references reviewed and updated.
CP.PHAR.96 Naltrexone (Vivitrol)	Updated initial approval duration to 12 months for New Hampshire per regulations.
CP.PHAR.97 Eculizumab (Soliris)	For NMOSD: added requirement against concurrent use with rituximab, Enspryng, or Uplizna.
NH.PHAR.122 Long-Acting Inj Antipsychotics	Removed PA on Aristada/Aristada Initio product. Removed mention of Aristada/Aristada Initio from criteria. Added trial of Aristada to initial criteria for approval of other products.
CP.PHAR.128 Erenumab-aaoe (Aimovig)	HIM Line of business removed per September SDC and prior clinical guidance.
CP.PHAR.132 Nitisinone (Orfadin, Nityr)	4Q 2020 annual review: added requirement for adjunctive dietary restriction of tyrosine and phenylalanine, in line with the FDA-approved indication; removed references to HIM non-formulary policy for Nityr; references updated.
CP.PHAR.136 Elagolix (Orilissa), elagolix-estradiol-norethindrone (Oriahnn)	4Q 2020 annual review: for endometriosis, 3-month trial within the last year and non-contraceptive progestin added to reconcile with similar policies; RT2: Criteria added for new FDA-approved combination product and its indication: Oriahnn for management of heavy menstrual bleeding due to uterine fibroids; references reviewed and updated.
CP.PHAR.140 Pegvaliase-pqpz (Palynziq)	4Q 2020 annual review: added requirement for current and continued use of Phe-restricted diet; added requirement for a prior trial of Kuvan; referenced reviewed and updated.
CP.PHAR.141 Ribavirin (Copegus, Moderiba, Rebetol, Ribasphere)	4Q 2020 annual review: added Mavyret and Vosevi, removed Olysio & Technivie from combination use criterion as they are no longer commercially available; expanded prescriber requirement to include a “provider who has expertise in treating HCV based on a certified training program”; Appendix E (Healthcare Provider HCV Training) added; references reviewed and updated.
CP.PHAR.151 Levoleucovorin (Fusilev, Khapzory)	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added Khapzory to policy; updated FDA approved indications for addition of pediatric use; references reviewed and updated.
CP.PHAR.186 Ranibizumab (Lucentis)	Revised HIM “Medical Benefit” to HIM line of business
CP.PHAR.201 Belatacept (Nulojix)	4Q 2020 annual review: revised HIM-Medical Benefit to HIM line of business; Cellcept dosing information adjusted per prescribing information; references reviewed and updated.

NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

CP.PHAR.230 AbotulinumtoxinA (Dysport)	Updated FDA approved indication for spasticity which now includes cerebral palsy for upper limb spasticity in pediatric patients.
CP.PHAR.232 OnabotulinumtoxinA (Botox)	For chronic migraine, clarified requirement for use of two oral migraine preventative therapies that are from different therapeutic classes. RT4: updated FDA approved indication for spasticity which now includes cerebral palsy for lower limb spasticity in pediatric patients.
NH.PHAR.237 Epoetin Alfa (Epogen, Procrit), Epoetin Alfa-epbx (Retacrit)	New Policy Created
NH.PHAR.242 Adalimumab (Humira), Humira Biosimilars	Removed trial and failure of Enbrel from RA, PsA, JIA, and AS indications.
CP.PHAR.246 Canakinumab (Ilaris)	Criteria added for new FDA approved indication: AOSD; updated Appendix B; references reviewed and updated.
CP.PHAR.250 Etanercept (Enbrel)	Updated package availability to include new dosage form: single-dose vial, and alphabetized indications
CP.PHAR.257 Ixekizumab (Taltz)	Criteria added for new FDA indication: nr-axSpA; references reviewed and updated.
CP.PHAR.260 Rituximab (Rituxan, Ruxience, Truxima, Rituxan Hycela)	For NMOSD: added requirement against concurrent use with Soliris, Enspryng, or Uplizna; modified EDSS from ≤ 7 to ≤ 8 to align with Uplizna policy.
NH.PHAR.261 Secukinumab (Cosentyx)	New Policy Created
NH.PHAR.264 Ustekinumab (Stelara)	New Policy Created
NH.PHAR.288 Eteplirsen (Exondys 51)	Removed the following language from the FDA-approved indication: "A clinical benefit of Exondys 51 has not been established." Per an FDA-approved label update. Added Appendix D and updated references.
CP.PHAR.296 Pegfilgrastim (Neulasta, Fulphila, Udenyca, Ziextenzo)	Added redirection to a biosimilar pegfilgrastim if member is unable to use Zarxio; revised 11.19 update revision log to remove that redirection change to Zarxio came from SDC.
CP.PHAR.297 Filgrastim (Neupogen, Zarxio, Granix, Nivestym)	For peripheral blood progenitor cell collection indication, added option for off-label dosing per guidelines or peer-reviewed literature
CP.PHAR.313 Pralatrexate (Folotyn)	4Q 2020 annual review: added additional PTCL subtypes per NCCN; added Appendix D; updated HGTL use after 2 prior therapy regimens per NCCN; references reviewed and updated.
CP.PHAR.327 Nusinersen (Spinraza)	Updated criteria language to restrict concomitant use with Evryski; references reviewed and updated.
CP.PHAR.332 Pasireotide (Signifor, Signifor LAR)	4Q 2020 annual review: removed HIM-Medical Benefit line of business; references reviewed and updated.
CP.PHAR.334 Ribociclib (Kisqali, Kisqali Femara)	4Q 2020 annual review: added HIM line of business; removed option for combination use with tamoxifen as this is no longer NCCN supported; added that member has not previously failed another CDK 4/6 inhibitor therapy; references reviewed and updated.
CP.PHAR.354 Testosterone (Testopel, Jatenzo)	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; delayed puberty dosing added to appendix B; contraindications added to appendix C; references reviewed and updated.
CP.PHAR.364 Guselkumab (Tremfya)	RT2: Criteria added for new FDA indication: PsA; references reviewed and updated.
CP.PHAR.385 Corticosteroid Intravitreal Implants (Iluvien, Ozurdex, Retisert, Yutiq)	Revised dosing frequency for Ozurdex from q6 months to q4 months per literature review, guideline recommendations, market analysis, and specialist feedback.
CP.PHAR.390 Cholic Acid (Cholbam)	4Q 2020 annual review: updated criteria to require diagnosis confirmation, allow metabolic disease specialist, and require evidence of improvement in LFTs for continued therapy; shortened initial approval duration to 3 months from 6 months for Medicaid and HIM/Length of Benefit per PI stating that therapy should be discontinued if insufficient response or complete biliary obstruction occurs at 3 months; references reviewed and updated.
CP.PHAR.391 Lanreotide (Somatuline Depot)	4Q 2020 annual review: NET criteria consolidated into one section - off-label pheochromocytoma added; somatostatin receptor positive imaging and/or hormonal symptoms removed to include other uses per NCCN; examples of tumor types added to criteria and appendix D; references reviewed and updated.
CP.PHAR.395 Patisiran (Onpattro)	4Q 2020 annual review: genetic testing methodology examples removed from criteria with deference to appendix; references reviewed and updated.

NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

CP.PHAR.458 Inebilizumab-cdon (Uplizna)	Drug is now FDA approved - criteria updated per FDA labeling: added requirement that member does not have active HBV or TB since both are contraindications; added requirement against concurrent use with rituximab, Soliris, or Enspryng; modified approval durations from 26 weeks to 6 months; modified continued dose requirement from every 26 weeks to 6 months; references reviewed and updated.
CP.PHAR.472 Brexucabtagene autoleucel (Tecartus)	Drug is now FDA approved - criteria updated per FDA labeling as an RT1: clarified excluded use to include other CNS disorders and history of allogeneic stem cell transplant per clinical trial exclusion criteria; clarified requirement of 2 to 5 prior regimens; added requirement for baseline ALC ≥ 100/μL per clinical trial inclusion criteria; updated target and maximum dosing per prescribing information; added Actemra maximum doses for cytokine release syndrome to approval duration; references reviewed and updated.
CP.PHAR.477 Risdiplam (Evrysdi)	Drug is now FDA approved - criteria updated per FDA labeling: removed diagnosis language for specific type of SMA but added requirement that member is symptomatic; added age requirement; removed requirement that member does not have ophthalmological disease; removed BSID-III as an acceptable measure of response; added requirement for clinical deterioration if previously treated with Zolgensma; references reviewed and updated.
CP.PHAR.479 Decitabine-Cedazuridine (Inqovi)	Drug is now FDA approved - criteria updated per FDA labeling: MDS criteria collapsed given complexity of disease state/treatment guidelines and expert feedback; AML and MF criteria deleted pending NCCN Inqovi recommendations; references reviewed and updated.
CP.PHAR.484 Viltolarsen (Viltepso)	Drug is now FDA approved - criteria updated per FDA labeling; modified from requiring both 6MWT and TTSTAND to either 6MWT or TTSTAND; added requirement for stable cardiac and pulmonary function; references updated.
CP.PMN.35 Armodafinil (Nuvigil)	For narcolepsy indication added sleep medicine specialist as optional prescriber.
CP.PMN.39 Modafinil (Provigil)	For narcolepsy indication added sleep medicine specialist as optional prescriber.
CP.PMN.42 Sodium Oxybate (Xyrem)	Updated policy to only require 1 month T/F of armodafinil/modafinil for narcolepsy with EDS if member is ≥ 17 years given lack of evidence supporting use of armodafinil/modafinil in pediatric populations; references updated.
CP.PMN.47 Rifaximin (Xifaxan)	4Q 2020 annual review: deleted off-label Crohn's disease criteria set as use is not supported by treatment guidelines; references reviewed and updated.
CP.PMN.53 Off-Label Use	4Q 2020 annual review: removed criteria for drugs without existing coverage criteria and moved to separate policy per PA Ops request; added NCCN 2B as an acceptable level of evidence per Compliance; references reviewed and updated.
CP.PMN.80 Minocycline ER (Solodyn, Ximino, Minolira), Microspheres (Arestin), Foam (Zilxi)	RT2: added Zilxi to criteria with corresponding criteria set for rosacea indication.
CP.PMN.86 Oxymetazoline (Rhofade, Upneeq)	RT2: added Upneeq to policy with new criteria set for blepharoptosis; added HIM line of business.
CP.PMN.87 Plecanatide (Trulance)	4Q 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PMN.90 Benznidazole	Age removed to allow use at any age; 60 days of therapy limitation added to initial criteria; clarification added to initial and continuation criteria that the 60-day limitation refers to the current infection; Appendix D and references updated.
CP.PMN.116 L-glutamine (Endari)	4Q 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PMN.129 Pramlintide (Symlin)	4Q 2020 annual review; references reviewed and updated.
CP.PMN.164 Cannabidiol (Epidiolex)	Criteria added for updated FDA indication: seizures associated with TSC; RT4: updated pediatric age expansion to age ≥ 1 year for all indications.
CP.PMN.170 Eluxadoline (Viberzi)	4Q 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PMN.181 Calcipotriene-Betamethasone Dipropionate Foam (Enstilar)	4Q 2020 annual review: HIM line of business added; references reviewed and updated.

NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

CP.PMN.182 Betamethasone dipropionate (Sernivo)	4Q 2020 annual review: HIM line of business added; references reviewed and updated.
CP.PMN.199 Esketamine (Spravato)	Criteria added for new FDA-approved indication: MDD with acute suicidality; for TRD indication initial review: added a time frame to the PHQ-9 score of 4 weeks to ensure assessment is current, added criteria for either no previous use of Spravato or prior positive response to ensure appropriate use, and added requirement for psychiatrist prescriber; references reviewed and updated.
CP.PMN.209 Solriamfetol (Sunosi)	For narcolepsy indication added sleep medicine specialist as optional prescriber.
CP.PMN.210 Acyclovir buccal tab (Sitavig) ophthalmic ointment (Avaclyr)	Q4 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PMN.221 Pitolisant (Wakix)	Add sleep medicine specialist as optional prescriber.
CP.PMN.244 Tazarotene (Arazlo, Fabior, Tazorac)	4Q 2020 annual review: removed requirement for dermatologist for plaque psoriasis indication; references updated.
HIM.PA.04 Colonoscopy Preparation Products	4Q 2020 annual review: modified Suprep redirection to require down to age 12 per RT4 to address updated prescribing information for pediatric extension; references reviewed and updated.
HIM.PA.33 Formulary Medications without Specific Guidelines	4Q 2020 annual review: added NCCN 2B as an acceptable level of evidence for off-label use per Compliance; added criteria for combinations products and alternative dosage forms or strengths of existing drugs; added requirement for redirection to two preferred FDA-approved drugs.
HIM.PA.71 Topical Acne Treatment	4Q 2020 annual review: added topical acne agents BenzaClin (adopted from HIM.PA.31, policy to retire) and Evoclin (adopted from HIM.PA.21, policy to retire) to this policy; references reviewed and updated.
CP.PHAR.505 Continuous Insulin Delivery Systems (V-Go, Omnipod)	Policy created.
CP.PHAR.506 Antithymocyte Globulin (Atgam, Thymoglobulin)	Policy created.
CP.PHAR.509 Triheptanoin (Dojolvi)	Policy created.
CP.PMN.248 Ciprofloxacin-Dexamethasone (Ciprodex)	Policy created.
CP.PMN.249 Ciprofloxacin-Fluocinolone (Otovel)	Policy created.
CP.PMN.250 Colesevelam (Welchol)	Policy created.
CP.PMN.251 Lactic acid-citric acid-potassium bitartrate (Phexxi)	Policy created.
CP.PMN.252 Metoclopramide (Gimoti)	Policy created.
CP.PMN.253 Abametapir (Xeglyze)	Policy created.
NH.PMN.254 Budesonide-glycopyrrolate-formoterol fumarate (Breztri Aerosphere)	Policy created.
CP.PMN.255 No Coverage Criteria	Policy created.
CP.PMN.256 Nifurtimox (Lampit)	Policy created.
HIM.PA.01 Mometasone (Asmanex)	Policy created.
HIM.PA.150 Budesonide-glycopyrrolate-formoterol fumarate (Breztri Aerosphere)	Policy created.
CP.PHAR.130 Avatrombopag (Doptelet)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.139 Mogamulizumab-kpkc (Poteligeo)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.142 Adefovir (Hepsera)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.143 Betaine (Cystadane)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.149 Baclofen (Gablofen, Lioresal, Ozobax)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.172 Histrelin (Vantas, Supprelin LA)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.174 Nafarelin (Synarel)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.328 Asfotase Alfa (Strensiq)	4Q 2020 annual review: no significant changes; references updated.
CP.PHAR.389 Pegvisomant (Somavert)	4Q 2020 annual review: no significant changes; appendix D updated with 2018 consensus recommendations; references reviewed and updated.
CP.PHAR.392 Pegademase Bovine (Adagen)	4Q 2020 annual review: no significant changes; references reviewed and updated.

NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

CP.PHAR.393 Leucovorin Injection	4Q 2020 annual review: no significant changes; revised HIM-Medical Benefit to HIM line of business; updated Appendix D per NCCN Compendium; references reviewed and updated.
CP.PHAR.394 Migalastat (Galafold)	4Q 2020 annual review: no significant changes; added requirement for enzyme or genetic testing to confirm Fabry disease diagnosis, consistent with the previously P&T-approved approach for Fabry disease diagnosis confirmation for Fabrazyme; revised link to GLA mutation search tool; references reviewed and updated.
CP.PHAR.438 Trientine (Syprine)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.442 Fedratinib (Inrebic)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.13 Dose optimization	4Q 2020 annual review: no significant changes.
NH.PMN.16 Request for Non-Preferred Medically Necessary Drug not PDL	Annual review. No significant changes. Clarified claims history for non-PDL drug requests must support requirements for failure of preferred agents.
CP.PMN.17 Droxidopa (Northera)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.54 Clobazam (Onfi, Sympazan)	4Q 2020 annual review: no significant changes; for HIM line of business removed references to non-formulary policy for Sympazan; references reviewed and updated.
NH.PMN.59 Quantity Limit Override	Removed cross reference to the off-label use policy as a policy already exists for this.
CP.PMN.71 Linaclotide (Linzess)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.73 Lifitegrast (Xiidra)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.109 Suvorexant (Belsomra)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.112 Naldemedine (Symproic)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.142 Lubiprostone (Amitiza)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.143 Isotretinoin (Claravis, Absorica, Absorica LD, Myorisan, Zenatane, Amnesteem)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.153 Alosetron (Lotronex)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.161 Methadone (Dolophine)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.165 Fluorouracil Cream (Tolak)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.167 Neomycin-fluocinolone cream (Neo-Synalar)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.169 Methylnaltrexone Bromide (Relistor)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.171 Naloxegol (Movantik)	4Q 2020 annual review: no significant changes; references reviewed and updated.
NH.PMN.172 Zolpidem (Edluar, Intermezzo, Zolpimist)	4Q 2020 annual review: no significant changes; references reviewed and updated.
NH.PMN.173 Ramelteon (Rozerem)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.174 Perindopril-Amlodipine (Prestalia)	4Q 2020 annual review: no significant changes; references reviewed and updated.
NH.PMN.175 Doxepin (Silenor)	4Q 2020 annual review: no significant changes; references reviewed and updated.
NH.PMN.176 Amlodipine-Atorvastatin (Caduet)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.177 Glycopyrronium (Qbrexza)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.179 Megestrol Acetate Oral Suspension (Megace ES)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.180 Halobetasol Propionate Lotion (Bryhali, Lexette, Ultravate)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.184 Stiripentol (Diacomit)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.185 Baloxavir Marboxil (Xofluza)	4Q 2020 annual review: no significant changes; updated FDA Approved Indication section with revised indication to specify use in healthy or high risk patients; references reviewed and updated.
CP.PMN.213 Ferric maltol (Accrufer)	4Q 2020 annual review: no significant changes; removed references to HIM non-formulary policy and finalized HIM line of business; references reviewed and updated.
CP.PMN.214 Continuous Glucose Monitors	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.215 Non-preferred blood glucose monitors and test strips	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.216 Diazepam nasal spray (Valtoco)	4Q 2020 annual review: no significant changes; references reviewed and updated.

NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

Ophthalmic corticosteroids (Lotemax, Durezol, Alrex, Pred Mild, FML Forte, Maxidex)	4Q 2020 annual review: no significant changes; removed loteprednol from list of preferred generic ophthalmic corticosteroids as this product requires PA; references reviewed and updated.
HIM.PA.05 Dexlansoprazole (Dexilant)	4Q20 annual review: no significant changes; references reviewed and updated.
HIM.PA.15 Brinzolamide-Brimonidine (Simbrinza)	4Q20 annual review: no significant changes; references reviewed and updated.
HIM.PA.17 Methoxsalen (Uvadex)	4Q 2020 annual review: no significant changes; updated maximum methotrexate dose in Appendix B Therapeutic Alternatives per updated NCCN guideline recommendations; references updated.
HIM.PA.20 Halcinonide (Halog)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.87 Testosterone (Androderm)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.119 Azelaic Acid (Finacea gel)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.125 Levomilnacipran (Fetzima)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.129 Montelukast oral granules (Singulair)	4Q 2020 annual review: no significant changes; updated FDA-approved indication with revised indication for allergic rhinitis to specify that use should be reserved for patients with inadequate response to alternative therapies; updated Appendix C to include new boxed warning for neuropsychiatric events; references reviewed and updated.
HIM.PA.130 Naproxen oral suspension (Naprosyn)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.131 Nebivolol (Bystolic)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.147 Doxepin (Silenor, Prudoxin, Zonalon)	4Q 2020 annual review: no significant changes; added product specification for each diagnosis in Section II; references reviewed and updated.
HIM.PA.SP55 Uridine acetate (Vistogard)	4Q 2020 annual review: no significant changes; references reviewed and updated.
HIM.PA.SP59 Chlorambucil (Leukeran)	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.420 Insulin Infusion Pump (Omnipod, Omnipod DASH)	Retire, created an all encompassing inuslin delivery system policy: Continuous Insulin Delivery Systems (V-Go, Omnipod.
CP.PMN.30 paliperidone ER (Invega)	Retire, replaced by CP.PMN.16
CP.PMN.114 betrixaban (Bevyxxa)	Retire, use general prior auth criteria.
CP.PMN.162 Moxidectin	Retire, no need for criteria.
HIM.PA.11 unoprostone Isopropyl (Rescula)	Retire, product is discontinued.
HIM.PA.14 ciprofloxacin-fluocinolone (Otovel)	Retire replaced by combined criteria.
HIM.PA.16 antithymocyte globulin (Atgam, Thymoglobulin)	Retire replaced by combined criteria.
HIM.PA.19 Lomustine (Gleostine)	Retire, replaced by CP.PHAR.xx with Medicaid line of business added
HIM.PA.21 Clindamycin (Evoclin)	Retire added to HIM.PA.71 topical acne treatments
HIM.PA.31 Clindamycin-benzoyl peroxide (BenzaClin)	Retire added to HIM.PA.71 topical acne treatments
HIM.PA.42 mesalamine (Apriso)	Retire due to change of formulary without PA
HIM.PA.106 Umeclidinium-vilanterol (Anoro Ellipta)	Retire per August SDC
HIM.PA.120 ciprofloxacin-dexamethasone (Ciprodex)	Retire, replaced by CP.PMN.248
HIM.PA.121 colesevelam (Welchol)	Retire, replaced by CP.PMN.250
CC.PHAR.06_PBM Inquiry for Additional Info	Annual Review. Added clarification that approval notices are only mailed to members where required by the state. Added examples of information that prescribers need to provide in order for EPS to make a decision on a PA request. Added that all outreach attempts made by EPS to prescribers will be documented in the PA processing system. Added Policy EPS.PHARM.03A Medicaid Prior Authorization Review Process to the References section.
NH.PHAR.09_Pharmacy Program	Annual Review. Section IV. B. Practitioner requests for additions, deletions or changes to the PDL-removed reference to an attachment that no longer exists in policy NH.PHAR.10. Updated encounter reporting from 7 to 14 days. Added additional details to the DUR program section in line with new contractual requirements.

NH Healthy Families Pharmacy & Therapeutics Committee 20Q4 Combined Guideline Summary

NH.PHAR.10_Preferred Drug List	Updated Scope and Purpose Sections. Annual Review. Reformatted entire policy, making it easier to follow the process. Added criteria used to adopt pharmaceutical management procedures in Step 1. Added Step 5.b. to describe the process where health plan pharmacy directors have the ability to accept or reject PDL changes that are recommended by SDC. Added "on a quarterly basis" to clinical recommendations presented by CPAC to the Centene Corporate P&T Committee. SC ATC Addendum (Attachment A) was revised by the health plan
CC.PHAR.11_Requests for Pharmacy Profiles	Added HIPAA language and reference for scenarios where disclosure of records to providers is allowed without a member's consent form for the purpose of treatment, payment, and/or health care operations.
CC.PHAR.21 Precisions Drug Action Committee List	Added Vilepso and Tecartus to PDAC Drug List
CC.PHAR.22_Medicaid Preferred Drug List Audit Support	Annual Review- Minor grammatical updates. Added report name Weekly Change Update report to RxClaim testing section. Added FABM Reference Tools Sharepoint site as location of the Weekly Change Update report.