CENTENE PHARMACY THERAPEUTICS COMMITTEE
1Q2018 ELECTRONIC MEETING CENTENE COMBINED GUIDELINE SUMMARY TABLE

Coverage Criteria Guideline	Status	Applicable Business	Revision Summary Description
CP.PHAR.366 Acalabrutinib (Calquence®)	New	HIM Medicaid	Policy created
CP.PHAR.367 Letermovir (Prevymis®)	New	HIM Medicaid	Policy created
CP.PHAR.368 Pemetrexed (Alimta®)	New	Medicaid	Policy created
CP.PMN.89 Amantadine ER (Gocovri®)	New	HIM Medicaid	Policy created
CP.PMN.90 Benznidazole	New	HIM Medicaid	Policy created
CP.PMN.93 Dextromethorphan-Quinidine (Nuedexta®)	New	HIM Medicaid	Policy created
CP.PMN.95 Fluticasone Propionate (Xhance®)	New	HIM Medicaid	Policy created
CP.PMN.103 Secnidazole (Solosec®)	New	HIM Medicaid	Policy created
CP.PMN.108 Latanoprostene Bunod (Vyzulta®)	New	HIM Medicaid	Policy created
CP.PST.14 GLP-1 receptor agonists	New	HIM Medicaid	Policy created
CP.PST.18 DPP-4 inhibitors	New	HIM Medicaid	Policy created
CP.PST.19 SGLT2 inhibitors	New	HIM Medicaid	Policy created
HIM.PA.140 Conjugated estrogens-bazedoxifene (Duavee®)	New	HIM	Policy created
HIM.PA.141 Hydrocodone-chlorpheniramine (Vituz®)	New	HIM	Policy created
HIM.PA.142 Penicillamine (Cuprimine®)	New	HIM	Policy created

HIM.PA.143 Potassium Salts (Klor-Con®)	New	HIM	Policy created
HIM.PA.144 Quinine sulfate (Qualaquin®)	New	HIM	Policy created
HIM.PA.145 Sulfacetamide Sodium/Sulfur (Sumadan®)	New	HIM	Policy created
HIM.PA.146 Vorapaxar (Zontivity®)	New	HIM	Policy created
HIM.PA.147 Doxepin Hydrochloride Cream (Prudoxin®, Zonalon®)	New	HIM	Policy created
CP.PHAR.14 Hydroxyprogesterone caproate (Makena®)	No Significant Change	Medicaid	1Q18 annual review: - Combined policies for Medicaid and commercial - Medicaid: removed contraindications following the safety guidance - No significant changes from previous corporate approved policy - References reviewed and approved
CP.PHAR.115 Pegloticase (Krystexxa®) Retire NH.PHAR.115 Pegloticase as criteria are identical with the exception of initial approval of 12 to 6 month. Recommended to use 6 month instead of 12 month due to recommendation of gout level measurements on a frequent basis to determine effectiveness of medication trial. (All currently approved PA's would be honored)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Policies combined for Medicaid and Commercial lines of business - References reviewed and updated.
CP.PHAR.165 Ferumoxytol (Feraheme®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Converted to the new template - Dosing added

			- References reviewed and updated.
CP.PHAR.166 Ferric Gluconate (Ferrlecit®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Converted to the new template - Dosing added - References reviewed and updated.
CP.PHAR.167 Iron Sucrose (Venofer®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Converted to the new template - Dosing added - References reviewed and updated
CP.PHAR.177 Ecallantide (Kalbitor®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial business - No significant changes from previously approved corporate policy - Medicaid: added specialist requirement, removed "Other types of angioedema have been ruled out" from part of diagnosis due to its subjective nature, while specialist has been added - Added age limit - References reviewed and updated.
CP.PHAR.178 Icatibant (Firazyr®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Medicaid, HIM and commercial lines of business - No significant change from previously approved corporate policy - HIM/Medicaid: added specialist requirement, removed "Other types of angioedema have been ruled out" from part of diagnosis due to its subjective nature, while specialist has been added - Added age limit - References reviewed and updated
CP.PHAR.179 Romiplostim (Nplate®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business. New policy for Marketplace line of business. - No significant changes from previous corporate approved policy - Added age restriction per PI as safety and effectiveness in pediatric patients (< 18 years) have not been established.

			- Commercial: added requirements related to specialist involvement, insufficient response to corticosteroids and immunoglobulins, splenectomy (unless member has contraindications to surgery), and platelet count or active bleed; re-auth: added platelet count < 400 x 10^9/L within the last 90 days; modified initial/continued approval duration from 6 months or to member's renewal period (whichever is longer)/LOB to 6/12 months. - Medicaid: Removed "other causes (e.g., myelodysplastic syndrome) of thrombocytopenia has been ruled out with documentation supporting that ITP is not due to any other causes" since specialist is involved in care - References reviewed and updated
CP.PHAR.180 Eltrombopag (Promacta®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business. New policy for Marketplace line of business. - No significant change from previous corporate approved policy - Added age restriction per PI. - Commercial: for chronic ITP-added requirements related to specialist involvement, insufficient response to corticosteroids and immunoglobulins, splenectomy (unless member has contraindications to surgery), platelet count, and active bleed; for hepatitis-C associated thrombocytopenia, added requirements related to specialist involvement, concomitant use with interferon-based therapy, and platelet count; for aplastic anemia, added requirements related to specialist involvement and platelet count; modified initial approval duration from LOB to 6 months. On re-auth, added requirements related to platelet count < 400 x 10^9/L within the last 90 days, and for hepatitis C-associated thrombocytopenia, continuation of antiviral therapy; additional positive therapeutic response examples added; modified continued approval duration from LOB to 12 months, or 6 months for hepatitis C associated thrombocytopenia - References reviewed and updated.
CP.PHAR.181 Hemin (Panhematin®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - References reviewed and updated.
CP.PHAR.192 Epoprostenol (Flolan®, Veletri®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for commercial and Medicaid. - No significant changes from previous corporate approved policy

			- Medicaid: removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated.
CP.PHAR.193 Iloprost (Ventavis®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid - No significant changes from previous corporate approved policy. - Medicaid/HIM: removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated
CP.PHAR.194 Macitentan (Opsumit®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid - No significant changes from previous corporate approved policy. - Medicaid/HIM: removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated
CP.PHAR.195 Riociguat (Adempas®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid - No significant changes from previous corporate approved policy. - Medicaid/HIM: removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated
CP.PHAR.197 Sildenafil (Revatio®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid - No significant changes from previous corporate approved policy. - Medicaid/HIM: removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated.
CP.PHAR.198 Tadalafil (Adcirca®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid - No significant changes from previous corporate approved policy. - Medicaid/HIM: removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated.

CP.PHAR.199 Treprostinil (Orenitram®, Remodulin®, Tyvaso®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid - No significant changes from previous corporate approved policy. - Medicaid/HIM: removed WHO/NYHA classifications from initial criteria since specialist is involved in care - References reviewed and updated.
CP.PHAR.210 Ivacaftor (Kalydeco®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid, Marketplace, and Commercial lines of business. - No significant changes. - References reviewed and updated.
CP.PHAR.213 Lumacaftor-ivacaftor (Orkambi®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business. - No significant changes from previous corporate approved policy - Commercial: Added age requirement per FDA labeling. Modified max dose criteria to be age-specific - References reviewed and updated.
CP.PHAR.214 Desmopressin (DDAVP®, Stimate®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Medicaid and HIM lines of business - No significant changes - Converted to new template - Marketplace policy included Stimate, therefore Stimate remains in policy - Added age limit for diabetes insipidus - - References reviewed and updated
CP.PHAR.223 Reslizumab (Cinqair®)	No Significant Change	Medicaid	1Q18 annual review: - Combined Medicaid and Commercial policies - No significant changes from previously approved corporate policy - Removed smoking cessation program requirements from existing Medicaid policy as this cannot be enforced. - Added “Acute bronchospasm or status astmaticus” to section III as indications for which coverage is not authorized per PI References reviewed and updated

CP.PHAR.234.Ferric Carboxymaltose (Injectafer®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Converted to the new template - Dosing added - References reviewed and updated.
CP.PHAR.235 Atezolizumab (Tecentriq®)	No Significant Change	Medicaid	1Q18 annual review: - Converted to new template - No significant changes - Added continuation of therapy for all covered indications - References reviewed and updated
NH.PHAR.288 Eteplirsen (Exondys 51®)	No Significant Change	HIM Medicaid	- Annual Review, No Changes
CP.PHAR.300 Bezlotoxumab (Zinplava®)	No Significant Change	Medicaid	1Q18 annual review: -Combined for Medicaid and commercial lines of business. - No significant change from previously approved corporate policy - Age added per safety guidance endorsed by Centene Medical Affairs - References reviewed and updated.
CP.PHAR.301 Erwinia Asparaginase (Erwinaze®)	No Significant Change	Medicaid	1Q18 annual review: -No significant changes -Converted to the new template and added dosing -Combined FDA approved criteria and NCCN recommendations, FDA indication covers both -References reviewed and updated
CP.PHAR.329 Siluximab (Sylvant®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - References reviewed and updated.
CP.PHAR.330 Protein C Concentrate Human (Ceprotin®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Converted to the new template - References reviewed and updated.
CP.PHAR.331 Deflazacort (Emflaza®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business - No significant changes from previous corporate approved policy

			- Medicaid: Removed time period in which prednisone trial must have occurred. - References reviewed and updated.
CP.PHAR.336 Dupilumab (Dupixent®)	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for HIM, Medicaid and commercial - No significant changes - References were reviewed and updated.
CP.PHAR.341 Deutetrabenazine (Austedo®)	No Significant Change	Medicaid	Policies combined for Centene Medicaid and Commercial lines of business.
CP.PHAR.350 Rucaparib (Rubraca®)	No Significant Change	Medicaid	1Q18 annual review: - No significant clinical changes - Added Age ≥18 years per PI - Updated Appendix B with additional acceptable prior treatment regimens based on NCCN Ovarian Cancer guidelines. - References reviewed and updated
CP.PHAR.40 Octreotide Acetate (Sandostatin®, Sandostatin LAR Depot®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business -Specialist added for oncology indications -Requests for non-oncology off-label indications and any oncology off-label indications not outlined above are directed to the off-label use policies referenced in Section I.F. - Positive therapeutic response examples (diarrhea, flushing, disease progression, unacceptable toxicity) are removed as they are not amenable to objective measurement. -References updated.
CP.PMN.05 rifapentine (Priftin®)	No Significant Change	Medicaid	1Q18 annual review: -No significant changes -References reviewed and updated.
CP.PMN.07 Levalbuterol (Xopenex®) Retire NH.PMN.07 Levalbuterol as corporate policy is 6 month initial duration of approval	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Marketplace lines of business - No significant changes from previous corporate approved policy - Medicaid: modified QL of inhalation solution from 3 vials/day to 4 vials (12 mL)/day - References reviewed and updated.

instead of 3 months and nearly identical criteria for approval			
CP.PMN.12 Clozapine orally disintegrating tablet (Fazaclo®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - References reviewed and updated.
CP.PMN.15 Asenapine (Saphris®) Retire NH.PMN.15 Asenapine (Saphris) as corporate policy is identical with the exception it adds in FDA approved ages which should be included in policy.	No Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial, HIM and Medicaid lines of business - No significant change from previous corporate approved policy - HIM: changed from failure of 1 atypical antipsychotic to failure of 2 for treatment of bipolar disorder. - References reviewed and updated.
NH.PMN.17 Droxidopa	No Significant Change	Medicaid	Annual Review, No Change
CP.PMN.20 Aspirin-dipyridamole (Aggrenox®) Retire NH.PMN.20 as the corporate policy is nearly identical with updated references and removes specialist requirements.	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Marketplace lines of business. - No significant changes from previous corporate approved policy - HIM: Removed criterion directing requests for the branded product to the generic product since the branded product is not on formulary. - References reviewed and updated.
CP.PMN.21 Becaplermin (Regranex®) Retire NH.PMN.21 Becaplermin as corporate policy is less restrictive not requiring nutritional status for approval.	No Significant Change	Medicaid	1Q18 annual review: - No significant changes. - Age added per safety guidance endorsed by Centene Medical Affairs. - References reviewed and updated.
NH.PMN.36 Lisdexamphetamine (Vyvanse)	No Significant Change	Medicaid	Annual Review, No Changes

CP.PMN.34 Ranolazine (Ranexa®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial -No significant clinical changes from previously approved corporate policy - Commercial: added the requirement of first line generic agent trial -Age added -References reviewed and updated.
CP.PMN.52 Omega-3-Acid Ethyl Esters (Lovaza®)	No Significant Change	Medicaid	1Q18 annual review: - Age added - No significant changes - References reviewed and updated.
CP.PMN.54 Clobazam (Onfi) Retire NH.PMN.54 Clobazam (Onfi) due to corporate policy being less restrictive on trial and failures while maintaining identical duration of approvals	Significant Change	Medicaid	Retiring of NH.PMN.54 Clobazam as the corporate policy is less restrictive with trial and failures while maintaining identical duration of approvals
CP.PMN.77 Ezetimibe-Simvastatin (Vytorin®) Retire NH.PMN.06 Zetia/Vytorin as the corporate policy is nearly identical criteria with identical durations of approval	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial lines of business [CP.CPA.62 Pitavastatin (Livalo), Ezetimibe/Simvastatin (Vytorin 10/10 mg) and CP.CPA.169 (Vytorin 10/80 mg)]. Retired Livalo from CP.CPA.62 (previously combined with Vytorin 10/10)-refer to CP.CPA.190 Formulary Exceptions policy. - No significant changes from previous corporate approved policy - Age added per safety guidance endorsed by Centene Medical Affairs. - Commercial: removed “One of the following (a or b): a. Failure to achieve NCEP goals; b. Failure of one generic formulary statin unless contraindicated or clinically significant adverse effects are experienced” and replaced it with the use of high-, moderate-, or low-intensity statin for 3 months; added adherence to statin therapy as a requirement; updated policy provides a pathway to approval for patients with HeFH and ASCVD with involvement of a specialist. - Medicaid: for HoFH, HeFH, ASCVD, and re-auth- updated to allow use of the 10/80-mg dose of Vytorin in patients who have been taking simvastatin 80 mg for 12 months or more. - References reviewed and updated.

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CP.PMN.78 Ezetimibe (Zetia®) Retire NH.PMN.06 Zetia/Vytorin as the corporate policy is nearly identical criteria with identical durations of approval	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Age added per safety guidance endorsed by Centene Medical Affairs. - Added "unless contraindicated" to requirement related to adherence to statin therapy - References reviewed and updated.
CP.PMN.88 Alendronate (Binosto®, Fosamax plus D®)	No Significant Change	HIM	New policy created - Split from HIM.PA.51 and CP.CPA.212 – oral bisphosphonates. - Combined policy for marketplace and commercial lines of business - No significant changes from previous corporate approved policy. - References reviewed and updated.
CP.PMN.91 Cariprazine (Vraylar®)	No Significant Change	Medicaid	1Q18 annual review: - Policy generated from existing commercial policy – CP.CPA.221 - No significant change from previously approved corporate policy - New for Medicaid - Age added for schizophrenia per safety guidance endorsed by Centene Medical Affairs.
CP.PMN.92 CNS Stimulants Retire NH.PMN.10 Daytrana. Criteria matches new policy but corporate policy encompasses the other extended release products currently following non-formulary policy.	No Significant Change	Medicaid	New policy created - Policies created from existing Medicaid and Commercial lines of business policies for CNS Stimulants - No significant changes from previous corporate approved policy - Age requirement is new for the Centene Commercial and changed requirement from failure of 2 methylphenidate products to failure of 1 methylphenidate and 1 amphetamine - References reviewed and updated.
CP.PMN.94 Etidronate (Didronel®)	No Significant Change	Medicaid	New policy created - Split from CP.PMN.43 – oral bisphosphonates - No significant changes from previous corporate approved policy - References reviewed and updated.
CP.PMN.96 Ibandronate Oral (Boniva®)	No Significant Change	Medicaid	New policy created - Split from CP.PMN.43 – oral bisphosphonates - No significant changes from previous corporate approved policy - References reviewed and updated

CP.PMN.98 Pimecrolimus (Elidel®)	No Significant Change	HIM	1Q18 annual review: - Policies combined for HIM and Commercial lines of business. - Renaming to PMN due to multiple line of business usage - References reviewed and updated.
CP.PMN.99 Prasterone (Intrarosa®)	No Significant Change	Medicaid	1Q18 annual review: - Policies combined for Centene Commercial and Medicaid lines of business -No significant changes - Added age limit. - Added specific formulary alternative vaginal estrogens. - Added example of what constitutes a response to therapy for reauthorization - References reviewed and updated.
CP.PMN.100 Risedronate (Actonel®, Atelvia®)	No Significant Change	HIM Medicaid	New policy created - Policy split from existing oral bisphosphonate policy for all lines for business - No significant change from previous corporate approved policy. - Combined policy for Medicaid, market place and commercial lines of business. - References reviewed and updated.
CP.PMN.101 Rivastigmine (Exelon®)	No Significant Change	Medicaid	1Q18 annual review: - No significant changes - Policy number changes from CP.PPA.22 to CP.PMN.101 - Age added per safety guidance endorsed by Centene Medical Affairs - Referenced reviewed and updated
CP.PMN.105 Tavaborole (Kerydin®)	No Significant Change	Medicaid	New policy created - Policy split from CP.CPA.54 Efinaconazole (Jublia), Tavaborole (Kerydin) for Centene commercial line of business-retired. - New policy for Medicaid line of business. - Age added per safety guidance endorsed by Centene Medical Affairs. - Specified duration of trial of oral terbinafine for toenail onychomycosis per PI and a timeframe of within the past 12 months - References reviewed and updated.
CP.PMN.106 Tiludronate (Skelid®)	No Significant Change	Medicaid	New policy created - Split from CP.PMN.43 – oral bisphosphonates. - No significant changes from previousl corporate approved policy. - References reviewed and updated.

CP.PMN.107 Topical Immunomodulators	No Significant Change	Medicaid	1Q18 annual review: - Policy changed from CP.PPA to CP.PMN. - Changed authorization duration limits from 3/6 months to 6/12 months - Removed restriction against coverage for vitiligo - References reviewed and updated.
CP.PMN.109 Suvorexant (Belsomra®)	No Significant Change	HIM Medicaid	1Q18 annual review: - No significant changes - Existing HIM policy (HIM.PA.22), new policy for Medicaid - Added age and references reviewed and updated.
CP.PST.08 Mesalamine Oral Therapy Retiring NH.PST.08 Mesalamine Oral Therapy as corporate policy is identical with the exception it is more lenient duration of initial approval of 12 months.	No Significant Change	Medicaid	1Q18 annual review: - No significant changes. - References reviewed and updated.
HIM.PA.103 Brand Name Override and Non-Formulary Medications	No Significant Change	HIM	1Q18 annual review: -No significant changes. - References added.
HIM.PA.34 Non-formulary Test Strips	No Significant Change	HIM	1Q18 annual review: - No significant changes.
HIM.PA.71 Topical Acne Treatment	No Significant Change	HIM	1Q18 annual review: -Added Cleocin-T and Neuac to criteria. -Added age limit of ≥ 12 years per HIM formulary. Changed requirement from 2 to ≥ 2.
CP.PHAR.01 Omalizumab (Xolair®) Retiring NH.PHAR.125 Omalizumab as corporate policy is less stringent and longer	Significant Change	HIM Medicaid	1Q18 annual review: - Converted to new template - Combined Medicaid and commercial policies. - New policy for HIM line of business. - Removed smoking cessation program requirements from existing Medicaid policy as this cannot be enforced. - Added “Acute bronchospasm or status asthmaticus” to

duration of approval with these recent changes.			section III as indications for which coverage is not authorized per PI. For CIU, modified length of trials from 4 to 2 weeks each - References reviewed and updated
CP.PPA.15 Minacipran (Savella) Retire NH.PPA.15 Savella. Corporate policy is more lenient criteria for approval with identical durations of approval.	Significant Change	Medicaid	Retire NH Policy in lieu of corporate policy which is more lenient criteria for approval.
CP.PPA.01 Celecoxib (Celebrex) Retire NH.PPA.01 Celecoxib (Celebrex) as the corporate criteria is less restrictive and the duration of approvals is more strict for one situation and less restrictive for other conditions.	Significant Change	Medicaid	Retire NH Policy in lieu of corporate policy which is more lenient criteria for approval and both more and less restrictive duration of approval.
CP.PHAR.100 Axitinib (Inlyta®) Retiring NH.PHAR.100 Axitinib as corporate policy has added other cancer criteria and is more lenient duration of approval than state specific criteria	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business. - Age, specialist and dosing added. - Renal cell carcinoma: definition of “advanced” removed given the additional requirement of a prior systemic therapy. - References reviewed updated.
CP.PHAR.101 Mifepristone (Korlym®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business. - Age added. “Adherence to an anti-diabetic regimen” is removed due to verification challenge. - The following contraindications are removed due to verification challenge: history of unexplained vaginal bleeding; endometrial hyperplasia with atypia or endometrial carcinoma.

			-"Dose does not exceed 1200 mg/day or 20 mg/kg per day, whichever is less" is edited to "Dose does not exceed 1200 mg/day". - - References reviewed and updated.
CP.PHAR.111 Cabozantinib (Cabometyx®, Cometriq®) Retiring NH.PHAR.111 Cabozantinib as the corporate policy is more lenient and adds all conditions medication treats per FDA guidelines. More lenient durations of approval.	Significant Change	Medicaid	1Q18 annual review: - Combined Medicaid and commercial policies. - Removed safety requirement for hemorrhage and hemoptysis per CPAC safety guidance endorsed by medical affairs - For RCC, modified redirection to apply only for clear cell histology, requiring NCCN Category 1 recommended alternatives. - Added off-label use for RCC with non-clear cell histology and NSCLC - References reviewed and updated.
CP.PHAR.114 Teduglutide (Gattex®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business. - Age added - Preferencing for Zorptive added - The following criteria are removed given the 12-month PN requirement: colonosopy; PN ≥ 3 times per week; use of antimotility and antisecretory agents. - "Consecutive" removed from the 12-month PN requirement. - Initial duration is increased from 6 to 12 months to allow more time for therapeutic response; continued therapy duration is increased from 6 to 12 months. - References reviewed and updated.
CP.PHAR.119 Ramucirumab (Cyramza®)	Significant Change	Medicaid	1Q18 annual review: - Age, dosing, specialist added. - NCCN recommendations removed for lung and colon cancer. - References reviewed and updated.
CP.PHAR.121 Nivolumab (Opdivo®)	Significant Change	Medicaid	New indication addition: - Added coverage criteria for the new FDA-approved indication of hepatocellular carcinoma.
CP.PHAR.125 Palbociclib (Ibrance®)	Significant Change	Medicaid	1Q18 annual review: - Converted to new template - Added prescriber specialty requirement; - Added max dosing criteria;

			- Added criteria for off-label use for soft tissue sarcoma. - References reviewed and updated.
CP.PHAR.168 Corticotropin (H.P. Acthar®)	Significant Change	Medicaid	1Q18 annual review: - Combined Medicaid and commercial policies. - Removed indications not supported by well-designed clinical trials as noted in Appendix C - West syndrome – removed EEG requirement to confirm diagnosis; added neurologist prescriber requirement. - MS- approval duration reduced to one month for initial as this medication is not indicated to used chronically and for continued approval for MS was referred to the initial criteria - References reviewed and updated.
CP.PHAR.184 Aflibercept (Eylea®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial lines of business For Medicaid: - Added bevacizumab redirection except for members with baseline visual acuity worse than 20/50 due to clinical superiority of Eylea - Moved initial and continued therapy criterion “not used concomitantly with other VEGF therapies” to section III. Diagnoses/indications NOT authorized. - Added specialist requirement - Removed criteria checking for contraindications (ocular infections) due to its ophthalmic nature and addition of specialist requirement - Added age limit following safety guidance endorsed by Medical Affairs - References reviewed and updated.
CP.PHAR.185 Pegaptanib (Macugen®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial For Medicaid: - Added bevacizumab redirection - Added specific documentation of positive response to therapy required for continued approval - Added “not used concomitantly with other VEGF therapies” to section III. Diagnoses/indications NOT authorized. - Added specialist requirement

			- Removed criteria checking for contraindications (ocular infections) due to its ophthalmic nature and addition of specialist requirement - Added age limit following safety guidance - - References reviewed and updated.
CP.PHAR.186 Ranibizumab (Lucentis®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial - Added fluorescein angiography as an acceptable documentation for positive response to therapy Medicaid: - Added specialist requirement - Removed criteria checking for contraindications (ocular infections) due to its ophthalmic nature and addition of specialist requirement - Moved initial and continued therapy criterion “not used concomitantly with other VEGF therapies” to section III. Diagnoses/indications NOT authorized. - Added bevacizuamb redirection - Added age limit - References reviewed and updated
CP.PHAR.187 Verteporfin (Visudyne®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Mediaid and commercial lines of business For Medicaid: - Added specialist requirement - Removed fluorescein angiography for diagnosis due to addition of specialist - Added age limit - Expanded VEGF requirement for AMD and pathologic myopia specifically to bevacizumab or other VEGF inhibitors - Added redirection to Lucentis for mCNV due to clinical superiority - Removed allowed indication for occult CNV per limitation of use - References reviewed and updated.
CP.PHAR.188 Teriparatide (Forteo®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for commercial and Medicaid. - Converted to new template. - Removed criteria for evidence of diagnosis. Removed member characteristic requirements for gender and type of osteoporosis.

			- Added specialist requirement. Modified age requirement. Modified trial and failure requirements to a bisphosphonate (alendronate is preferred) - Removed requirement regarding admin of last dose of Reclast. - Modified approval duration to 6 months (initial) and 12 months (continuation). - Defined positive response in continued therapy criteria - References reviewed and updated.
CP.PHAR.189 Ibandronate injection (Boniva®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for commercial and Medicaid - Removed criteria for evidence of diagnosis - Modified trial and failure requirements to a bisphosphonate - Removed requirement regarding admin of last dose of Reclast - Removed hypocalcemia monitoring requirement - Added definition for positive response to therapy - References reviewed and updated.
CP.PHAR.190 Ambrisentan (Letairis®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for HIM and Medicaid. - Converted to new template - Removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated.
CP.PHAR.191 Bosentan (Tracleer®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for HIM and Medicaid - Converted to new template - Removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated.
CP.PHAR.196 Selexipag (Uptravi®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for HIM and Medicaid - Converted to new template - Removed WHO/NYHA classifications from initial criteria since specialist is involved in care. - References reviewed and updated.
CP.PHAR.200 Mepolizumab (Nucala®)	Significant Change	Medicaid	1Q18 annual review - Combined Medicaid and Commercial policies.

			- Removed smoking cessation program requirements from existing Medicaid policy as this cannot be enforced. - Added "Acute bronchospasm or status asthmaticus" to section III as indications for which coverage is not authorized per PI. - References reviewed and updated.
CP.PHAR.202 C1 Esterase Inhibitors (Berinert®, Cinryze®, Haegarda®, Ruconest®)	Significant Change	Medicaid	1Q18 annual review: Policies combined for commercial and Medicaid. - Added Haegarda into the policy. - Medicaid: added specialist requirement, removed "Other types of angioedema have been ruled out" from part of diagnosis due to its subjective nature, while specialist has been added; removed qualifying descriptions of "abdominal, facial, or laryngeal attacks" for Berinert as there is no evidence that there is lack of efficacy in other forms of HAE; added short-term prophylaxis for plasma-derived C1 esterase inhibitors according to AOW treatment guidelines. - References reviewed and updated.
CP.PHAR.203 Cosyntropin (Cortrosyn®)	Significant Change	Medicaid	1Q18 annual review: - Modified max dose criteria from 0.125 mg to 0.25 mg for age $\leq$ 2 years since 0.125 is not a true max per labeling, plus partial vials cannot be dispensed so a dose of 0.125 is unenforceable post-approval. References reviewed and updated.
CP.PHAR.204 Trabectedin (Yondelis®)	Significant Change	Medicaid	1Q18 annual review: - Initial: Added age requirement as safety and efficacy have not been established in pediatric patients. - Removed criteria around specific FDA/NCCN uses that are under the purview of the provider, and added prescriber requirement to ensure appropriate use. - Require that use be for palliative therapy or for metastatic or unresectable disease - Re-auth: Added COC for STS. Modified requirement for no disease progression or unacceptable toxicity to requirement for positive response to therapy. - Both: Added max dosing criteria. - References reviewed and updated
CP.PHAR.208 Sodium phenylbutyrate (Buphenyl®)	Significant Change	Medicaid	1Q18 annual review: - Converted to new template. - Removed dietary protein restriction requirements as this cannot be confirmed References reviewed and updated

CP.PHAR.209 Aztreonam (Cayston®)	Significant Change	Medicaid	1Q18 annual review: - Initial: Modified age restriction from ≥ 7 to ≥ 6 years per ATS guideline recommendations. - Removed baseline FEV requirement. - Added Appendix C: General Information - References reviewed updated.
CP.PHAR.211 Tobramycin	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business. - Medicaid: Removed baseline FEV requirement. - Commercial: Added requirement for no concurrent/alternating use with aztreonam. - Added Appendix B: General Information - References reviewed and updated
CP.PHAR.212 Dornase alfa (Pulmozyme®)	Significant Change	HIM Medicaid	1Q18 annual review: - Medicaid: Removed initial requirement that therapeutic plan includes concomitant use of standard CF therapies as this is non-specific. - HIM: policy revised to apply to this line of business - References review and updated
CP.PHAR.224 Enoxaparin (Lovenox®).	Significant Change	Medicaid	1Q18 annual review: - Combined policies for Medicaid and commercial lines of business - Section I.A., Venous Thrombosis, is changed to “Thrombosis and Thromboembolism” so as not to restrict to venous thrombi. Section I.A criteria are edited to encompass CHEST guidelines for neonates and children (seen primarily under implantable devices), and the criteria is collapsed to maximize consistency across the Lovenox, Fragmin and Arixtra policies. - Per specialist recommendation an additional indication is added for short-term prophylaxis to or from oral anticoagulation. Continuation criteria added for pregnancy. - References reviewed and updated.
CP.PHAR.225 Dalteparin (Fragmin®)	Significant Change	Medicaid	1Q18 annual review: - Combined policies for Medicaid and commercial lines of business - Section I.A., Venous Thrombosis, is changed to “Thrombosis and Thromboembolism” so as not to restrict to venous thrombi. Section I.A criteria are edited to encompass CHEST guidelines for neonates and children (seen primarily

			under implantable devices), and the criteria is collapsed to maximize consistency across the Lovenox, Fragmin and Arixtra policies. - Per specialist recommendation an additional indication is added for short-term prophylaxis to or from oral anticoagulation. Continuation criteria added for pregnancy. - References reviewed and updated.
CP.PHAR.226 Fondaparinux (Arixtra®)	Significant Change	Medicaid	1Q18 annual review: - Combined policies for Medicaid and commercial lines of business - Section I.A., Venous Thrombosis, is changed to "Thrombosis and Thromboembolism" so as not to restrict to venous thrombi. Section I.A criteria are edited to encompass CHEST guidelines for neonates and children (seen primarily under implantable devices), and the criteria is collapsed to maximize consistency across the Lovenox, Fragmin and Arixtra policies. - Per specialist recommendation an additional indication is added for short-term prophylaxis to or from oral anticoagulation. Continuation criteria added for pregnancy. - References reviewed and updated.
NH.PHAR.289 Buprenorphine Implant (Probuphine®)	Significant Change	Medicaid	Added age restriction as safety and effectiveness of Probuphine have not been established in children or adolescents < 16 years of age; removed "No evidence or reports of illicit opioid use (confirmed with at least one random urine drug screen within the last 3 months), significant withdrawal symptoms, significant desire/need to use illicit opioids, hospitalizations, emergency room visits or crisis interventions for addiction or mental health issues, and non-adherence to clinic visits or drug abuse counseling as recommended"; removed requirement for participation in drug abuse counseling to shift the responsibility of appropriate monitoring and use to the prescriber; added requirement for medical justification to support why oral (e.g., sublingual, buccal) formulations of buprenorphine cannot be continued; re-auth: removed that if a supplemental buprenorphine containing product was prescribed, it was prescribed only intermittently rather than on an ongoing basis
CP.PHAR.298 Afatinib (Gilotrif®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Marketplace lines of business. - Initial: Added age requirement as safety and efficacy have not been established in pediatric patients.

			- Removed criteria around specific FDA/NCCN uses that are under the purview of the provider, and added prescriber requirement to ensure appropriate use. - Re-auth: Added COC for NSCLC. Removed criteria around use after disease progression on Gilotrif since it is not objective and is under the purview of the provider - References reviewed and updated.
CP.PHAR.327 Nusinersen (Spinraza®)	Significant Change	Medicaid	1Q18 annual review: -Policies combined for Medicaid and commercial - Expanded indication to SMA types 1-3 with SMN2 copies up to 4. - References reviewed and updated
CP.PHAR.333 Avelumab (Bavencio®)	Significant Change	Medicaid	1Q18 annual review: - Specialist added to MCC and UC. - Age added to MCC. - Dose added to UC; -"Locally advanced or metastatic" removed given inclusion of criteria requiring progression following platinum-based chemotherapy - NCCN bladder cancer use delineating "as a single agent" removed. - References reviewed and updated.
CP.PHAR.334 Ribociclib (Kisqali®, Kisqali Femara®)	Significant Change	Medicaid	1Q18 annual review: - Combined with CP.CPA.222. Converted to new template Added requirement for prescriber specialty - Added criteria for off-label use in men - References reviewed and updated.
CP.PHAR.345 Abaloparatide (Tymlos®)	Significant Change	HIM Medicaid	1Q18 annual review: - Combined Medicaid and commercial policies - New policy for HIM - Removed criteria for evidence of diagnosis - Added specialist requirement - Modified age requirement to include pediatric members with closed epiphyses - Modified trial and failure requirements to a bisphosphonate (oral or IV acceptable) - Modified approval duration to 6 months (initial) and 12 months (continuation) - Defined positive response in continued therapy criteria - References reviewed and updated.

CP.PHAR.43 Sapropterin (Kuvan®)	Significant Change	Medicaid	1Q18 annual review: - The diagnostic description "BH4 responsive" in relation to PKU is deleted as it may not be determined until after a therapeutic trial. - Use in conjunction with a Phe-restricted diet is removed. - Initial approval duration increased from 2 to 3 months to allow adequate time for follow-up. Continuation criteria that refers to an increase in dietary Phe tolerance or improvement in neuropsychiatric symptoms is deleted leaving reduction of Phe levels per the PI. - References reviewed and updated.
CP.PHAR.52 Interferon Gamma- 1b (Actimmune®)	Significant Change	HIM Medicaid	1Q18 annual review: - Combined Medicaid and Commercial policies. - New policy for HIM line of business. - Removed diagnostic confirmatory tests and replaced with specialty prescriber requirement - References reviewed and updated
CP.PHAR.59 Zoledronic Acid (Reclast®, Zometa®)	Significant Change	Medicaid	1Q18 annual review: - Converted to new template. - Modified diagnoses and removed requirements for evidence of diagnoses for Reclast indications - Removed contraindication of hypocalcemia - Modified approval duration of 24 months to apply only to postmenopausal osteoporosis prevention - Removed requirements for calcium and vitamin D supplementation - Added definitions for positive response to therapy. Added requirement for continuation of standard antineoplastic therapy for multiple myeloma and bone metastases - Modified approval duration for other diagnoses/indications to 6 months - References reviewed and updated.
CP.PHAR.61 Cinacalcet (Sensipar®)	Significant Change	Medicaid	1Q18 annual review: - Included calcium acetate as the required formulary alternative phosphate binder. - Removed the requirement for parathyroidectomy (medical procedure) - Converted to new template - References reviewed and updated.

CP.PHAR.63 Everolimus (Afinitor®, Afinitor Disperz®)	Significant Change	Medicaid	1Q18 annual review: - Combined Medicaid and Commercial policies - Removed dose form requirement by indication, no clinical difference expected (dosing is equivalent for SEGA indication) - For RCC, included list of first line therapies per NCCN guidelines. - For breast cancer, removed compendium supported use after tamoxifen as this was removed from the 1.2017 NCCN guideline update. - Added the following off-label NCCN compendium supported uses: GIST, lymphoplasmacytic lymphoma, osteosarcoma, endometrial carcinoma - References reviewed and updated.
CP.PHAR.74 Erlotinib (Tarceva®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid, Marketplace and Commercial lines of business - Added age to FDA approved indications - For Medicaid NSCLC/ Pancreatic Cancer: replaces specific disease conditions with general language to ensure coverage of both NCCN recommended uses and FDA approved uses - References reviewed and updated
CP.PHAR.80 Vandetanib (Caprelsa®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Medicaid and HIM lines of business - Added non-small cell lung cancer as a covered off-label indication per NCCN 2A recommendation. - Added oncologist and age limit restrictions. - Added requirement of prior trials of lenvatinib and sorafenib for non-medullary thyroid carcinoma; removed requirement for prior trial of iodine. - Extended reauthorization duration from 6 months to 12 months. - Allowed for Continuation of Care requirements for reauthorization - References reviewed and updated
CP.PHAR.91 Vemurafenib (Zelboraf®)	Significant Change	HIM Medicaid	1Q18 annual review: -Policies combined for Centene Medicaid, Marketplace and Commercial lines of business. -Added oncologist and age limit requirements for the melanoma indication. Added off-label usages per NCCN recommendations, including new coverage for thyroid carcinoma and brain metastases (2A recommendations).

			-Changed Approval Durations for Medicaid and HIM from 3/6 months to 6/12 months. -Added Erdheim-Chester disease as a new FDA-approved indication
CP.PHAR.93 Bevacizumab (Avastin®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined from Medicaid and commercial - Specialist involvement in care added to all indications - Added specific criteria for off-label uses for ophthalmic indications - Added allowable off-label oncology indications as reflected in the NCCN compendium - References reviewed and updated
CP.PHAR.94 Alpha-1 Proteinase Inhibitors	Significant Change	HIM Medicaid	1Q18 annual review: - Combined existing policies for Medicaid and commercial business - Medicaid: removed requirement for supportive measures (avoidance of cigarette smoking and vaccinations) due to lack of actionability and objectivity; - Medicaid: protective threshold value per nephelometry changed from 57 mg/dL to 50 mg/dL per American Thoracic Society 2003 guidelines. - Medicaid: added "If the member has an AAT level >11 umol/L, then the member must have one of the high-risk phenotypes (i.e. PiZZ, PiZnull, Pi(null, null), or one of a few rare phenotypes [e.g. Pi(Malton, Malton)]" to allow treatment before clinical deterioration due to definite diagnosis; - Added prescriber requirement due to the complexity of disease diagnosis and management; - Changed minimally significant change in FEV from 120 mL to 100 mL per ATC guidelines and specialist feedback -References reviewed and updated.
CP.PHAR.97 Eculizumab (Soliris®)	Significant Change	Medicaid	Added generalized myasthenia gravis indication and criteria for approval.
CP.PHAR.98 Ruxolitinib (Jakafi®) Retire NH.PHAR.98 Ruxolitinib as corporate policy is more lenient. Criteria reduces only initial approval to 6 months but continued criteria is for 12	Significant Change	Medicaid	1Q18 annual review: - Removed request for bloodwork. - Removed NCCN off-label use for myelofibrosis. - References reviewed and updated.

months. Criteria only requires attestation of responding positively to therapy on continued approval which then garners 12 month approval.			
CP.PHAR.369 Alectinib (Alecensa®)	Significant Change	Medicaid	Policy created for Centene Medicaid and updated for commercial lines of business. Age and specialist requirements added. Labeled indication is updated to include either first- or second-line ALK tyrosine kinase inhibitor therapy for ALK-positive metastatic NSCLC.
CP.PMN.04 Non-Calcium Phophate Binders	Significant Change	Medicaid	1Q18 annual review: - Combined Medicaid and commercial non-calcium phosphate binder policies - Added trial duration of 4 weeks per guideline recommendations for monitoring frequency - Added additional requirement for trial of generic Fosrenol or generic Renvela - References reviewed and updated
NH.PMN.22 Brand Name Override	Significant Change	Medicaid	1Q18 annual review: - Removed requirement for FDA MedWatch form to be completed and submitted. - Updated References
CP.PMN.24 Ciclopirox (Penlac®)	Significant Change	Medicaid	1Q18 annual review: - Converted to new template. Removed laboratory testing related to confirmation of diagnosis and requirement that member is immunocompetent; modified dosing requirement of terbinafine 250 mg/day to “at up to maximally indicated doses” and specified a time frame of trial within the past 12 months. - Re-auth: removed requirement that member has not used ciclopirox daily ≥48 weeks as this would be difficult to verify objectively; modified approval duration from “up to 48 weeks total” to 48 weeks. - References reviewed and updated.
CP.PMN.25 Efinaconazole (Jublia®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business. - Added age restriction as safety and effectiveness in pediatrics have not been established; specified a timeframe of within the past 12 months for oral terbinafine trial; - Commercial: specified duration of trial of oral terbinafine for toenail onychomycosis per PI; added QL.

			- Medicaid: Removed laboratory testing related to confirmation of fungal infection; re-auth: removed requirement that member has not used Jublia daily ≥48 weeks as this would be difficult to verify objectively; modified approval duration from "up to 48 weeks total" to 48 weeks. - References reviewed and updated.
CP.PMN.57 Febuxostat (Uloric®) Retire NH.PMN.57 Febuxostat as corporate policy is nearly identical criteria for approval and identical duration of approval limits.	Significant Change	HIM Medicaid	1Q18 annual review: Policies combined for HIM and Medicaid; - Added age limit following the safety guidance endorsed by Medical Affairs; - Added drug interactions with azathioprine and mercaptopurine following the safety guidance - References reviewed and updated.
NH.PMN.62 Tedizolid (Sivextro®)	Significant Change	HIM Medicaid	Annual Review, No Changes
CP.PST.17 Atomoxetine (Strattera) Retire NH.PMN.01 Atomoxetine as the corporate policy is significantly less restrictive with 12 month approval for both initial and continued treatment	Significant Change	Medicaid	Retire NH.PMN.01 Atomoxetine as the corporate policy is significantly less restrictive with 12 month approval for both initial and continued treatment
CP.PMN.67 Sacubitril and valsartan (Entresto®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Centene Medicaid, Marketplace and Commercial lines of business. - No significant change from previous corporate approved policy. - Commercial: added age restriction as safety and effectiveness in pediatric patients have not been established; modified LVEF from < 40% to ≤ 35% per PARADIGM-HF clinical trial; added contraindications related to DDI per PI; updated re-auth to allow COC for heart failure. Added requirement for positive response to therapy.

			- Marketplace and Medicaid: added age restriction and contraindications related to DDI per PI (Marketplace only); removed "previously tolerated an ACEI or ARB at therapeutic doses for ≥ 30 days" since specialist is involved in care - References reviewed and updated.
CP.PMN.71 Linaclotide (Linzess®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for Medicaid and marketplace lines of business - Removed duration and timeframe of trial related to laxative use since they are available OTC and may not be verifiable via claims history - Medicaid: modified initial approval duration from 6 to 12 months for both indications - References reviewed and updated.
CP.PMN.87 Plecanatide (Trulance®)	Significant Change	Medicaid	1Q18 annual review: - Policies combined for Medicaid and commercial lines of business. - Modified criterion to require trial of all 3 different laxatives recommended per ACG (bulk-forming, polyethylene glycol, and stimulant) and removed stool softeners as an option since there is little evidence to support the use of such agents in chronic constipation. - Updated max dose requirement to include QL of 1 tablet/day. - Modified initial approval from 6 to 12 months - References reviewed and updated.
CP.PMN.102 Rolapitant (Varubi®)	Significant Change	HIM Medicaid	1Q18 annual review: - Added trial of aprepitant (Emend) since it's generically available. - Added Medicaid line of business as new criteria References reviewed and updated.
CP.PMN.104 Tasimelteon (Hetlioz®)	Significant Change	HIM Medicaid	1Q18 annual review: - Policies combined for HIM and commercial; - Medicaid line of business was added to criteria - Added specialist requirement - Added trial and failure of melatonin - Removed diagnosis with "confirmed by at least 14 days of documentation of progressively shifting sleep-wake times" due to added specialist requirement - References reviewed and updated
HIM.PA.117 Tavaborole (Kerydin®)	Significant Change	HIM	1Q18 annual review: - Age added per safety guidance endorsed by Centene Medical Affairs.

			- Modified duration of trial of terbinafine from 3 months to 12-weeks per Lamisil PI; specified a timeframe of within the past 12 months for oral terbinafine trial; removed duration of trial for ciclopirox - Re-auth: removed requirement that member has not received Kerydin daily ≥48 weeks as this would be difficult to verify objectively; modified approval duration from "up to 48 weeks of treatment (total)" to 48 weeks - References reviewed and updated.
HIM.PA.123 Diclofenac sodium topical gel (Solaraze®, Voltaren®)	Significant Change	HIM	Coverage criteria added for diclofenac 3% gel (Solaraze) for actinic keratosis
HIM.PA.139 Opioid Analgesics	Significant Change	HIM	1Q18 annual review: -Added step therapy criteria adapted from HIM.PA.97, which will be retired. - Since all long acting agents may require prior authorization, step therapy requirement changed to require 2 short acting agents, adequately dosed - References reviewed and updated.
HIM.PA.25 Efinaconazole (Jublia®)	Significant Change	HIM	1Q18 annual review: - Removed laboratory testing related to confirmation of fungal infection; added age restriction as safety and effectiveness in pediatrics have not been established. - Modified duration of trial of terbinafine from 3 months to 12-weeks per Lamisil PI and American Family Physician; specified a timeframe of within the past 12 months for oral terbinafine trial - Re-auth: removed requirement that member has not used Jublia daily ≥48 weeks as this would be difficult to verify objectively; modified approval duration from "up to 48 weeks of treatment (total)" to 48 weeks - References reviewed and updated.
HIM.PA.35 Buprenorphine-Naloxone (Suboxone®)	Significant Change	HIM	1Q18 annual review - Removed XDEA number (DATA2000 waiver) as a requirement since prescription use of this product is limited under the Drug Addiction Treatment Act. - Removed criteria related to participation in drug abuse counseling and urine drugs screens (e.g., submission of at least 2 negative random urine drug screens) to shift the responsibility of appropriate monitoring and use to the prescriber. - Added Bunavail as an option for MHS Indiana members only since it is a MHS Indiana formulary agent that requires a PA.

			- Removed requirement related to adherence to therapy on re-auth and added requirement for positive response to therapy - References reviewed and updated
HIM.PA.SP30 Sucroferric oxyhydroxide (Velphoro®)	Significant Change	HIM	1Q18 annual review: - Added trial duration of 4 weeks per guideline recommendations for monitoring frequency - Added additional requirement for trial of generic Fosrenol or generic Renvela - Provided an additional measure of positive response to therapy - References reviewed and updated
HIM.PA.22 suvorexant (Belsomra®)	Retire	HIM	Replaced by CP.PMN.109 Suvorexant (Belsomra®)
HIM.PA.23 linaclotide (Linzess®)	Retire	HIM	Replaced by CP.PMN.71 linaclotide (Linzess®)
HIM.PA.24 sacubitril; valsartan (Entresto®)	Retire	HIM	Replaced by CP.PMN.67 sacubitril-valsartan (Entresto®)
HIM.PA.26 buprenorphine (Subutex®)	Retire	HIM	Replaced by CP.PMN.82 buprenorphine (Subutex®)
HIM.PA.27 tasimelteon (Hetlioz®)	Retire	HIM	Replaced by CP.PMN.104 Tasimelteon (Hetlioz®)
HIM.PA.28 rolapitant (Varubi®)	Retire	HIM	Replaced by CP.PMN.102 Rolapitant (Varubi®)
HIM.PA.29 icosapent ethyl (Vascepa®)	Retire	HIM	Converted to electronic step therapy
HIM.PA.30 brexipiprazole (Rexulti®)	Retire	HIM	Replaced by CP.PMN.68 brexpiprazole (Rexulti®)
HIM.PA.44 quetiapine fumarate (Seroquel XR®)	Retire	HIM	Replaced by CP.PMN.64 quetiapine ER (Seroquel XR®)
HIM.PA.51 Oral Bisphosphonates	Retire	HIM	Split into individual drug policies
HIM.PA.53 Glucagon-Like Peptide-1 Agonists (GLP-1 Agonists)	Retire	HIM	Replaced by CP.PST.14 GLP-1 receptor agonists (converted to electronic step therapy)
HIM.PA.55 aspirin dipyridamole (Aggrenox®)	Retire	HIM	Replaced by CP.PMN.20 aspirin dipyridamole (Aggrenox®)

HIM.PA.58 Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Retire	HIM	Replaced by CP.PST.18 DPP-4 inhibitors (converted to electronic step therapy)
HIM.PA.61 desmopressin acetate (DDAVP®)	Retire	HIM	Replaced by CP.PHAR.214 Desmopressin (DDAVP®, Stimate®)
HIM.PA.67 febuxostat (Uloric®)	Retire	HIM	Replaced by CP.PMN.57 febuxostat (Uloric®)
HIM.PA.75 levalbuterol (Xopenex®)	Retire	HIM	Replaced by CP.PMN.07 levalbuterol MDI Inhalation Solution (Xopenex®)
HIM.PA.91 SGLT2 Inhibitors	Retire	HIM	Replaced by CP.PST.19 SGLT2 inhibitors (converted to electronic step therapy)
HIM.PA.97 Long Acting Opioids	Retire	HIM	Replaced by HIM.PA.139 Opioid analgesic
HIM.PA.118 tedizolid (Sivextro®)	Retire	HIM	Replaced by CP.PMN.62 tedizolid (Sivextro®)
HIM.PA.SP4 ambrisentan (Letairis®)	Retire	HIM	Replaced by CP.PHAR.190 ambrisentan (Letairis®)
HIM.PA.SP5 bosentan (Tracleer®)	Retire	HIM	Replaced by CP.PHAR.191 bosentan (Tracleer®)
HIM.PA.SP12 icatibant (Firazyr®)	Retire	HIM	Replaced by CP.PHAR.178 icatibant (Firazyr®)
HIM.PA.SP13 iloprost (Ventavis®)	Retire	HIM	Replaced by CP.PHAR.193 iloprost (Ventavis®)
HIM.PA.SP16 macitentan (Opsumit®)	Retire	HIM	Replaced by CP.PHAR.194 macitentan (Opsumit®)
HIM.PA.SP20 riociguat (Adempas®)	Retire	HIM	Replaced by CP.PHAR.195 riociguat (Adempas®)
HIM.PA.SP21 sildenafil (Revatio®)	Retire	HIM	Replaced by CP.PHAR.197 sildenafil (Revatio®)
HIM.PA.SP23 tadalafil (Adcirca®)	Retire	HIM	Replaced by CP.PHAR.198 tadalafil (Adcirca®)
HIM.PA.SP33 etaplirsen (Exondys 51®)	Retire	HIM	Replaced by CP.PHAR.288 eteplirsen (Exondys 51®)
HIM.PA.SP42 afatinib (Gilotrif®)	Retire	HIM	Replaced by CP.PHAR.298 afatinib (Gilotrif®)

HIM.PA.SP56 ivacaftor (Kalydeco®)	Retire	HIM	Replaced by CP.PHAR.210 ivacaftor (Kalydeco®)
HIM.PA.SP57 dupilumab (Dupixent®)	Retire	HIM	Replaced by CP.PHAR.336 dupilumab (Dupixent®)
NH.PMN.01 Atomoxetine (Strattera®)	Retire	Medicaid	Policy has been replaced by step therapy policy CP.PST.17
CP.PPA.05 Topical Immunomodulators	Retire	Medicaid	Replaced by CP.PMN.107 Topical Immunomodulator
NH.PPA.17 Aripiprazole (Abilify®)	Retire	Medicaid	PA will be removed in 1Q2018
NH.PPA.13 Xarelto	Retire	Medicaid	PA will be removed in 1Q2018
CP.PPA.21 GLP-1	Retire	Medicaid	Replaced by CP.PST.14 GLP-1 receptor agonists (converted to electronic step therapy)
CP.PPA.22 Rivastigmine (Exelon®)	Retire	Medicaid	Replaced by CP.PMN.101 Rivastigmine (Exelon®)
CP.PPA.23 Dipeptidyl Peptidase-4 (DDP-4) Inhibitors	Retire	Medicaid	Replaced by CP.PST.18 DPP-4 inhibitors (converted to electronic step therapy)
CP.PPA.24 Soldium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	Retire	Medicaid	Replaced by CP.PST.19 SGLT2 inhibitors (converted to electronic step therapy)