RXADVANCE
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Third Quarter 2020 Drug Formulary and Clinical Updates

Date of Notice: 10/01/2020

Formulary Updates

Drug Name, Strength(s), & Dosage Form(s)	Description of Change	Formulary Status	Alternative Drug(s) (if applicable)	Effective Date (MM/DD/YYYY)
Artesunate (artesunate for injection)	Non-formulary; PA	Non-formulary	Coartem™, atovaquone-proguanil, quinine sulfate, mefloquine	10/01/2020
Barhemsys® (amisulpride)	Formulary addition; PA	Non-preferred brand	dexamethasone, droperidol, scopolamine patch, promethazine	10/01/2020
Breztri Aerosphere™ (budesonide, formoterol fumarate; glycopyrrolate)	Formulary addition	Non-preferred brand		10/01/2020
Darzalex Faspro™ (daratumumab and hyaluronidase-fihj)	Formulary addition; SP; PA;	Preferred brand, specialty drug	Ninlaro®, Velcade®, Kyprolis®, Revlimid®, Thalomid®	10/01/2020
Inqovi® (decitabine and cedazuridine)	Formulary addition; SP; PA; QL	Preferred brand, specialty drug	Jakafi®, Gleevec®, Inrebic®, Reblozyl®	10/01/2020
Lyumjev® (insulin lispro-aabc)	Formulary addition	Preferred brand		10/01/2020
Monjuvi® (tafasitamab-cxix)	Formulary addition; SP; PA	Preferred brand, specialty drug	Polivy®, Kymriah®, Yescarta®, Xpovio®	10/01/2020
Nexletol™/Nexlizet™ (bempedoic acid/bempedoic acid and ezetimibe)	Non-formulary; PA	Non-formulary		10/01/2020
Nurtec ODT (rimegepant)	Formulary addition; ST; QL	Preferred brand		10/01/2020
Nyvepria™ (pegfilgrastim-apgf)	Non-formulary; SP; PA; QL	Non-formulary, specialty drug		10/01/2020
Ongentys® (opicapone)	Formulary addition; PA; QL	Non-preferred brand		10/01/2020

Drug Name, Strength(s), & Dosage Form(s)	Description of Change	Formulary Status	Alternative Drug(s) (if applicable)	Effective Date (MM/DD/YYYY)
Isturisa® (osilodrostat)	Formulary addition; PA; QL	Preferred brand	Korlym®, Signifor®, Signifor® LAR	10/01/2020
Pemazyre® (pemigatinib)	Formulary addition; SP; QL; PA	Preferred brand, specialty drug	gemcitabine, paclitaxel, oxaliplatin, cisplatin, fluorouracil, capecitabine, and/or epirubicin	10/01/2020
Phesgo™ (pertuzumab; trastuzumab; hyaluronidase-zzxf)	Formulary addition; SP; PA	Preferred brand, specialty drug	Perjeta®, Herceptin®	10/01/2020
Pizensy (lactitol monohydrate)	Non-formulary; QL; PA	Non-formulary	psyllium, calcium polycarbophil, methylcellulose, sennosides, bisacodyl	10/01/2020
Qinlock™ (ripretinib)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug	Gleevec®, Ayvakit®, Sutent®, Stivarga®	10/01/2020
Retevmo® (selpercatinib)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug		10/01/2020
Trodelvy® (sacituzumab govitecan-hziy)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug	fluorouracil, epirubicin, cyclophosphamide IV, paclitaxel, atezolizumab	10/01/2020
Sarclisa® (isatuximab-irfc)	Formulary addition; PA; SP	Preferred brand, specialty drug		10/01/2020
Tabrecta (Capmatinib)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug	Tagrisso®, Cabometyx®, Xalkori®	10/01/2020
Tralement® (cupric sulfate; manganese sulfate; selenious acid; zinc sulfate)	Formulary addition	Preferred brand		10/01/2020
Dojolvi® (triheptanoin)	Formulary addition; PA; SP	Preferred brand, specialty drug		10/01/2020
Tukysa™ (tucatinib)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug		10/01/2020
Uplizna™ (inebilizumab-cdon)	Formulary addition; SP; PA	Preferred brand, specialty drug		10/01/2020
Xeglyze™ (abametapir)	Formulary addition; QL	Preferred brand		10/01/2020

Drug Name, Strength(s), & Dosage Form(s)	Description of Change	Formulary Status	Alternative Drug(s) (if applicable)	Effective Date (MM/DD/YYYY)
Xpovio™ (Selinexor)	Formulary addition; PA	Non-preferred brand		10/01/2020
Zeposia® (ozanimod)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug	Aubagio®, Avonex®, Rebif®, Betaseron®, Extavia®, glatiramer acetate (Copaxone®, Glatopa®), Gilenya™, Tecfidera®, Mayzent®	10/01/2020
Zepzelca® (lurbinectedin)	Formulary addition; PA; SP; QL	Preferred brand, specialty drug	topotecan	10/01/2020

Legend: AL=Age Limit; OTC=Over-The-Counter; PA=Prior Authorization; SP=Specialty; ST=Step Therapy; QL=Quantity Limit; NF=Non-Formulary

New Prior Authorization Policies

- Trikafta® (elexacaftor/ivacaftor/tezacaftor; ivacaftor) (RxA.523)
- Dojolvi ® (triheptanoin) (RxA.632)
- Isturisa ® (osilodrostat) (RxA.633)
- Trodelvy ® (sacituzumab govitecan-hziy) (RxA.634)
- Pemazyre ® (pemigatinib) (RxA.635)
- Revetmo ®(selpercatinib) (RxA.636)
- Artesunate (RxA.637)
- Darzalex Faspro™ (daratumumab and hyaluronidase-fihj) (RxA.638)
- LA Injectable Antipsychotics (RxA.639)
- Phesgo™ (Pertuzumab;Trastuzumab; Hyaluronidase-zzxf) (RxA.639)
- Sarclisa® (isatuximab-irfc) (RxA.640)
- Tabrecta® (Capmatinib (Tabrecta) (RxA.641)
- Zepzelca® (lurbinectedin) (RxA.642)
- Pizensy™ (lactitol monohydrate) (RxA.643)
- Barhemsys® (amisulpride) (RxA.644)
- Inqovi ® (decitabine/cedazuridine) (RxA.645)
- Qinlock® (ripretinib) (RxA.646)
- Tukysa™ (tucatinib) (RxA.647)
- Uplinza™ (inebilizumab-cdon) (RxA.648)
- Zeposia® (ozanimod) (RxA.649)
- Monjuvi® (tafasitamab-cxix) (RxA.650)
- (Nexletol™_ Nexlizet™ (bempedoic acid) (RxA.651)
- Betaseron (Interferon beta-1b) (RxA.652)
- Extavia® (interferon beta-1b) (RxA.653)
- Vumerity® (diroximel fumarate) (RxA.654)

Updated Prior Authorization Policies

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.145.Gilenya	Dosing information, Approval duration and General information updated.	10/01/2020
RxA.146.Copaxone Glatopa	General information updated.	10/01/2020
RxA.150.Gattex	Dosage form and approval duration updated.	10/01/2020
RxA.151.Gilotrif	Approval duration updated.	10/01/2020
RxA.156.GoNitro	Approval duration and abbreviations updated.	10/01/2020
RxA.157.Neupogen,Zarxio, Nivestym, Granix	Dosing information, Approval duration and abbreviations updated.	10/01/2020
RxA.158.H.P.Acthar Gel	Dosing information, initial and continued therapy criteria, General information updated.	10/01/2020
RxA.163.Ibrance	Initial criteria, approval duration and therapeutic alternatives updated.	10/01/2020
RxA.164.Ilaris	Indication, dosing information and abbreviations updated.	10/01/2020
RxA.166.Immunization coverage	Line of business updated.	10/01/2020
RxA.169.Iclusig	Approval criteria and approval duration updated.	10/01/2020
RxA.17.Arikayce	Continued therapy criteria, therapeutic alternatives and general information updated.	10/01/2020
RxA.170.Imbruvica	initial and continued therapy criteria and approval duration updated.	10/01/2020
RxA.175.Istodax	Background and dosage forms updated.	10/01/2020
RxA.176.Idhifa	Approval duration and therapeutic alternatives updated.	10/01/2020
RxA.177.Exjade, Jadenu	Background, dosing information, approval duration, contraindication and general information updated.	10/01/2020
RxA.179.Kadcyla	Approval duration updated.	10/01/2020
RxA.18.Aubagio	Initial approval criteria updated.	10/01/2020
RxA.181.Kisqali, Kisqali Femara	Approval duration updated.	10/01/2020
RxA.182.Krystexxa	Initial approval criteria, therapeutic alternatives and contraindications updated.	10/01/2020
RxA.183.Kymriah	Approval duration updated.	10/01/2020
RxA.184.Sancuso Sustol	Kytril removed from drug policy, Background, dosing information, initial approval criteria, therapeutic alternatives and approval duration updated.	10/01/2020
RxA.185.Kalbitor	Approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.186.Kanuma	Dosing information, appendices and approval duration updated.	10/01/2020
RxA.187.Kerydin	Dosage form, initial and continued therapy criteria and therapeutic alternatives updated.	10/01/2020
RxA.191.Keveyis	Approval duration updated.	10/01/2020
RxA.192.Keytruda	Dosing information, approval duration and appendices updated.	10/01/2020
RxA.194.Korlym	Dosing information, initial and continued therapy criteria, approval duration and boxed warning updated.	10/01/2020
RxA.197.Lamictal XR, Lamictal ODT	Approval duration updated.	10/01/2020
RxA.198.Lenvima	Dosing information and appendices updated.	10/01/2020
RxA.199. Leukine	Approval duration updated.	10/01/2020
RxA.200.Levitra Staxyn	Approval duration updated.	10/01/2020
RxA.201.Lindane Shampoo	Approval duration updated.	10/01/2020
RxA.202.Lemtrada	Initial approval criteria, approval duration, therapeutic alternatives and general information updated.	10/01/2020
RxA.204.Macugen	Continued therapy criteria and approval duration updated.	10/01/2020
RxA.205.Marqibo	Approval duration and therapeutic alternative updated.	10/01/2020
RxA.208.Mircera	Initial approval criteria and approval duration	10/01/2020
RxA.209.Ribavirin	Criteria for approval updated	10/01/2020
RxA.211.Moxidectin	Approval duration updated.	10/01/2020
RxA.213.Mavenclad	Initial approval criteria, approval duration and appendices updated.	10/01/2020
RxA.214.Mavyret	Dosing information and approval duration updated.	10/01/2020
RxA.215.Mayzent	Initial approval criteria and general information updated.	10/01/2020
RxA.216 Mekinist	Initial approval criteria, approval duration and therapeutic alternatives updated.	10/01/2020
RxA.217.Mepsevii	Approval duration updated.	10/01/2020
RxA.218.Solodyn, Ximino, Minolira, Arestin	Background and approval duration updated.	10/01/2020
RxA.219.Mirvaso	Indication and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.221.Mozobil	Approval duration updated.	10/01/2020
RxA.225.Marinol,Syndros	Continued therapy criteria and approval duration updated.	10/01/2020
RxA.226.Mektovi	Indication, Dosing information and therapeutic alternative updated.	10/01/2020
RxA.227.Mestinon	Approval duration and contraindication updated	10/01/2020
RxA.229.Mulpleta	Initial approval criteria, approval duration and dosing information updated.	10/01/2020
RxA.231.Myobloc	Background, dosing information, initial approval criteria, therapeutic alternative, general information and approval duration updated.	10/01/2020
RxA.232.Mytesi	Continued therapy criteria and approval duration updated.	10/01/2020
RxA.233.Naglazyme	Approval duration updated.	10/01/2020
RxA.235.Jatenzo, Testin, Vogelxo, Natesto, Testopel,Xyosted	Dosing information, approval duration, abbreviation and boxed warnings updated.	10/01/2020
RxA.237.Nexavar	Initial and continued therapy criteria and approval duration updated.	10/01/2020
RxA.238.Nityr Orfadin	Dosing information updated	10/01/2020
RxA.239.Nplate	Initial and continued therapy criteria, dosing information, dosage form, appendices and approval duration updated	10/01/2020
RxA.240.Nuedexta	Approval duration updated.	10/01/2020
RxA.241.Nuvessa	Approval duration and therapeutic alternatives updated.	10/01/2020
RxA.242.Namenda XR, Namzaric	Approval duration updated.	10/01/2020
RxA.244.Natpara	Appendices and approval duration updated.	10/01/2020
RxA.245.Nerlynx	Background, initial approval criteria and approval duration updated.	10/01/2020
RxA.247.Palynziq	Dosing information and approval duration updated.	10/01/2020
RxA.248.Pegasys, PegIntron, Sylatron	Approval duration and contraindication updated.	10/01/2020
Rxa.249.Perjeta	Approval duration updated.	10/01/2020
RxA.250.Piqray	Continued therapy criteria updated.	10/01/2020
RxA.251.Polivy	Dosing information, abbreviations and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.254.Qualaquin	Dosing information, contraindication and approval duration updated.	10/01/2020
RxA.257.Qudexy XR, Trokendi XR	Approval duration updated.	10/01/2020
RxA.258.Orenitram, Remodulin, Tyvaso	Approval duration updated.	10/01/2020
RxA.261.Ravicti	Approval duration and contraindication updated.	10/01/2020
RxA.263.Reclast, Zometa	Initial approval criteria and approval duration updated.	10/01/2020
RxA.264.Repatha	Initial and continued therapy criteria, dosing information, dosage form, appendices and approval duration updated.	10/01/2020
RxA.265.Epogen, Procrit, Retacrit	Continued therapy criteria updated.	10/01/2020
RxA.266.Revcovi	Dosing information and abbreviation updated.	10/01/2020
RxA.267.Rhofade	Initial approval criteria, therapeutic alternatives, dosing information, dosage form and approval duration updated.	10/01/2020
RxA.269.Rocklatan Rhopressa	Initial approval criteria, therapeutic alternatives, dosage form and approval duration updated.	10/01/2020
RxA.270.Rozlytrek	Initial and continued therapy criteria and approval duration updated.	10/01/2020
RxA.271.Rydapt	Initial approval criteria, abbreviations and approval duration updated.	10/01/2020
RxA.272.Ragwitek	Therapeutic alternatives, contraindications, boxed warnings and approval duration updated.	10/01/2020
RxA.274.Avonex, Rebif	Continued therapy criteria and approval duration updated.	10/01/2020
RxA.275.Relistor	Continued therapy criteria updated.	10/01/2020
RxA.277.Jynarque Samsca	Approval duration updated.	10/01/2020
RxA.278.Sandostatin, Sandostatin LAR Depot	Initial and continued therapy criteria and approval duration updated.	10/01/2020
RxA.279.Seroquel XR	Dosing information and approval duration updated.	10/01/2020
RxA.280.Seysara	Background, Dosing information, therapeutic alternatives and approval duration updated.	10/01/2020
RxA.281.Siklos	Dosing information, contraindications and approval duration updated.	10/01/2020
RxA.282.Sitavig, Avaclyr	Initial approval criteria, contraindications and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.284.Sporanox, Onmel, Tolsura	Abbreviations and approval duration updated.	10/01/2020
RxA.286.Uceris, Entocort, Ortikos	Entocort EC, Ortikos added to drug applied, background, Dosing information, initial and continued therapy criteria and dosage form updated.	10/01/2020
RxA.287.Ulesfia	Approval duration updated.	10/01/2020
RxA.289.Ultomiris	Background, initial and continued therapy criteria, dosing information, dosage form, appendices and approval duration updated.	10/01/2020
RxA.290.Uptravi	Approval duration updated.	10/01/2020
RxA.296.Vantas, Supprelin LA	Therapeutic alternatives, contraindications and approval duration updated.	10/01/2020
RxA.302.Flolan Veletri	Approval duration and therapeutic alternatives updated.	10/01/2020
RxA.303.Xadago	Abbreviations, contraindications, and approval duration updated.	10/01/2020
RxA.305.Xermelo	Approval duration updated.	10/01/2020
RxA.306.Xiaflex	Dosing information and approval duration updated.	10/01/2020
RxA.309.Xyrem	Approval duration updated.	10/01/2020
RxA.310.Xalkori	Continued therapy criteria, therapeutic alternatives, general information, and approval duration updated.	10/01/2020
RxA.312.Xeomin	Approval duration updated.	10/01/2020
RxA.313.Prolia, Xgeva	General information and approval duration updated.	10/01/2020
RxA.314.Xifaxan	Initial approval criteria and approval duration updated.	10/01/2020
RxA.316.Xolair	Initial and continued therapy approval criteria updated.	10/01/2020
RxA.317.Xospata	General information, boxed warning and approval duration updated.	10/01/2020
RxA.318.Xtandi	Background, initial approval criteria, dosing information, abbreviation and approval duration updated.	10/01/2020
RxA.319.Xartemis XR	Background, contraindication and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.320.Xeloda	Initial and continued therapy approval criteria and approval duration updated	10/01/2020
RxA.321.Xepi	Therapeutic alternatives and approval duration	10/01/2020
RxA.322.Yervoy	Criteria for approval and approval duration updated.	10/01/2020
RxA.324.Yondelis	Approval duration updated.	10/01/2020
RxA.325.Zytiga, Yonsa	Indication, initial approval criteria, appendices and approval duration updated.	10/01/2020
RxA.326.Yupelri	Approval duration updated.	10/01/2020
RxA.327.Zaltrap	Initial approval criteria, therapeutic alternatives and approval duration updated.	10/01/2020
RxA.329.Zinecard, Totect	Approval duration updated.	10/01/2020
RxA.330.Zinplava	Appendices updated.	10/01/2020
RxA.331.Aczone	Background, Initial approval criteria, dosing information and appendices updated.	10/01/2020
RxA.332.Adcirca, Alyq	Alyq added to drug applied and approval duration updated.	10/01/2020
RXA.335.Alecensa	Approval duration updated.	10/01/2020
RxA.336.Ampyra	Dosing information and approval duration updated.	10/01/2020
RxA.340.Addyi	Approval duration updated.	10/01/2020
RxA.341.Aemcolo	Continued therapy criteria updated.	10/01/2020
RxA.344.Annovera	Approval duration updated.	10/01/2020
RxA.345. Arakoda	Initial approval criteria, dosing information and appendices updated.	10/01/2020
RXA.346.Aranesp	Approval duration updated.	10/01/2020
RxA.347.Oncaspar, Asparlas	Approval duration updated.	10/01/2020
RxA.349.Austedo	Contraindication, boxed warnings and approval duration updated.	10/01/2020
RxA.350.Alimta	Indication, initial approval criteria and appendices updated.	10/01/2020
RxA.352.Bendeka, Treanda	Approval duration updated.	10/01/2020
RxA.354.Buphenyl	Approval duration updated.	10/01/2020
RxA.355.Basaglar	Dosage form, Initial approval criteria and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.356.Baxdela	Background, initial approval criteria, dosing information, abbreviations and approval duration updated.	10/01/2020
RxA.360.Copiktra	Approval duration updated.	10/01/2020
RxA.361.Cotellic	Initial approval criteria and approval duration updated.	10/01/2020
RxA.362.Doptelet	Initial and continued therapy criteria and appendices updated.	10/01/2020
RxA.363.Eligard, Lupaneta Pack, Lupron Depot, Lupron Depot-Ped	Approval duration updated.	10/01/2020
RxA.364.Emflaza	Continued therapy criteria updated.	10/01/2020
RxA.365.Empliciti	Continued therapy criteria updated.	10/01/2020
RxA.366.Endari	Approval duration updated.	10/01/2020
RxA.367.Crinone, Endometrin, Prometrium	Prometrium added to drug applied, Initial and continued therapy approval criteria and approval duration updated.	10/01/2020
RxA.370.Epidiolex	Therapeutic alternatives and approval duration updated.	10/01/2020
RxA.371.Epiduo Forte	Initial and continued therapy criteria and appendices updated.	10/01/2020
RxA.374.Erbitux	Continued therapy criteria updated.	10/01/2020
RxA.376.Erleada	Background and appendices updated.	10/01/2020
RxA.377.Erwinaze	Approval duration updated.	10/01/2020
RxA.378.Esbriet	Dosing and general information, and approval duration updated.	10/01/2020
RxA.380.Evenity	Initial approval criteria and general information updated.	10/01/2020
RxA.385.Gazyva	Continued criteria for approval and approval duration updated.	10/01/2020
RxA.387.Aloxi	Initial and continued therapy criteria, dosage form and approval duration updated.	10/01/2020
RxA.388.Halaven	Initial approval criteria and general information updated.	10/01/2020
RxA.389.Hemangeol	Dosing information, contraindication and approval duration updated.	10/01/2020
RxA.393.Imfinzi	Indication, initial approval criteria and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.394.Injectafer	Dosing information, dosage form and approval duration updated.	10/01/2020
RxA.396.Lonsurf	Indication, initial approval criteria, general information and approval duration updated.	10/01/2020
RxA.398.Lucentis	Dosing information, therapeutic alternatives and approval duration updated.	10/01/2020
RxA.399.Lutathera	Approval duration updated.	10/01/2020
RxA.400.Lumoxiti	Dosage form and abbreviations updated.	10/01/2020
RxA.402.Luxturna	Indication, dosing information updated.	10/01/2020
RxA.403.Leucovorin Injection	Approval duration updated.	10/01/2020
RxA.404.Xyzal	Dosing information and approval duration updated.	10/01/2020
RxA.405.Lidoderm, Ztlido	Therapeutic alternatives and approval duration updated.	10/01/2020
RxA.407.Lorbrena	Dosing information updated.	10/01/2020
RxA.410.Lucemyra	Approval duration updated.	10/01/2020
RxA.412.Myobloc	Dosing information, initial approval criteria and appendices updated.	10/01/2020
RxA.413.mitoxantrone	Removed Novantrone from drug applied, dosing information, initial approval criteria, appendices and approval duration updated.	10/01/2020
RxA.414.Nubeqa	Initial approval criteria and approval duration updated.	10/01/2020
RxA.415.Nulojix	Approval duration updated.	10/01/2020
RxA.416.Nuvigil	Approval duration updated.	10/01/2020
RxA.417.Nayzilam	Contraindication and approval duration updated.	10/01/2020
RxA.418.Ninlaro	Approval duration updated.	10/01/2020
RxA.420.Northera	Dosing information updated.	10/01/2020
RxA.421.Nuplazid	Continued criteria for approval and approval duration updated.	10/01/2020
RxA.423.Ocrevus	Therapeutic alternatives updated.	10/01/2020
RxA.424.Odactra	General information and approval duration updated.	10/01/2020
RxA.428.Oncaspar	Approval duration updated.	10/01/2020
RxA.429.Onfi, Sympazan	Approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.431.Opdivo	Background, dosing information, initial approval criteria, abbreviations and approval duration updated.	10/01/2020
RxA.433.Opsumit	Dosing information and appendices updated.	10/01/2020
RxA.435.Orkambi	Appendices updated.	10/01/2020
RxA.437.Oxaydo, Roxybond	Background, contraindications, boxed warning and approval duration updated.	10/01/2020
RxA.438.Oxervate	Dosing information and approval duration updated.	10/01/2020
RxA.440.Ofev	Indication, dosing information, initial approval criteria and appendices updated.	10/01/2020
RxA.441.Probuphine, Sublocade	Background, dosing information, contraindications, boxed warning, and approval duration updated.	10/01/2020
RxA.442.Panhematin	Background, general information, and approval duration updated.	10/01/2020
RxA.443.Parsabiv	Approval duration updated.	10/01/2020
RxA.445.Perseris, Risperdal, Consta	Contraindications, general information, and approval duration updated.	10/01/2020
RxA.446.Plegridy	Dosage form updated.	10/01/2020
RxA.449.Prevymis	Approval duration updated.	10/01/2020
RxA.450.Provenge	Initial approval criteria, general information and approval duration updated.	10/01/2020
RxA.454.Praluent	Continued therapy criteria, therapeutic alternatives and approval duration updated.	10/01/2020
RxA.457.Promacta	Background, dosing information, initial and continued therapy criteria, therapeutic alternative and approval duration updated.	10/01/2020
RxA.463.Rubraca	Background, dosing information, initial and continued therapy criteria, therapeutic alternative and approval duration updated.	10/01/2020
RxA.464.Rytary	Approval duration updated.	10/01/2020
RxA.505.Tecfidera	Initial approval criteria, therapeutic alternative, general information, and approval duration updated.	10/01/2020
RxA.532.Tysabri	Initial approval criteria, therapeutic alternative, general information and approval duration updated.	10/01/2020

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.537.Vancocin	Initial approval criteria, dosing information and approval duration updated.	10/01/2020
RxA.147.Gralise	Approval duration updated.	10/01/2020
RxA.149.Galafold	Continued therapy criteria updated.	10/01/2020
RxA.153.Gocovri, Osmolex ER	Approval duration updated.	10/01/2020
RxA.159.Hemlibra	Initial and continued therapy criteria, approval duration updated.	10/01/2020
RxA.167.Inlyta	Background and dosing information updated.	10/01/2020
RxA.172.Ingrezza	Appendices and approval duration updated.	10/01/2020
RxA.173.Inrebic	Approval duration updated.	10/01/2020
RxA.190.Kalydeco	Approval duration updated.	10/01/2020
RxA.193.Bethkis, Kitabis Pak, TOBI, TOBI Podhaler	Background and approval duration updated.	10/01/2020
RxA.203.Letairis	Contraindication and approval duration updated.	10/01/2020
RxA.230.Myalept	Background, dosing information, contraindication and approval duration updated.	10/01/2020
RxA.236.Neo-Synalar	Approval duration updated.	10/01/2020
RxA.246.Ocaliva	Approval duration updated.	10/01/2020
RxA.252.Poteligeo	Appendices updated.	10/01/2020
RxA.260.Radicava	Continued therapy criteria updated.	10/01/2020
RxA.283.Somavert	Continued therapy criteria updated.	10/01/2020
RxA.323.Yescarta	Dosing information and appendices updated.	10/01/2020
RxA.338.Aripiprazole orally disintegrating tablet (ODT)	Continued therapy criteria updated.	10/01/2020
RxA.390.Hetlioz	Abbreviations, general information and approval duration updated.	10/01/2020
RxA.401.Lynparza	Indication, initial approval criteria, therapeutic alternatives, general information and approval duration updated.	10/01/2020
RxA.422.Nuzyra	Approval duration updated.	10/01/2020
RxA.451.Pulmozyme	Initial and continued therapy criteria and approval duration updated.	10/01/2020
RxA.452.Panretin	Approval duration was updated.	10/01/2020
RxA.453.Portrazza	Approval duration updated.	10/01/2020
RxA.460.Request for Medically Necessary Drug Not on the PDL	Approval duration updated.	10/01/2020

Updated Prior Authorization Policies

Policy Name	Policy Changes	Effective Date (MM/DD/YYYY)
RxA.189.Kyanmro	Policy archived.	10/01/2020
RxA.206.Megace ES	Policy archived.	10/01/2020
RxA.243.Narcotic Quantity Limits	Policy archived.	10/01/2020
RxA.342.Age Limit for Topical Tretinoin	Policy archived.	10/01/2020
RxA.351.Bunavail, Suboxone, Zubsolv, Cassipa	Policy archived.	10/01/2020
RxA.426.Olysio	Policy archived.	10/01/2020
RxA.427.Omnipod, Omnipod DASH	Policy archived.	10/01/2020