Quarter 4 2021 - Quarter 1 2022 Drug Formulary and Clinical Updates

Date of Notice: April 1, 2022

Formulary Updates

Drug Name, Strength(s), & Dosage Form(s)	Description of Change	Formulary Status	Alternative Drug(s) (if applicable)	Effective Date
Cartia XT 120 mg capsule ER, Cartia XT 180 mg capsule ER, Cartia XT 240 mg capsule ER	Formulary Update; QL Update	Non-Preferred Brand		04.01.2022
Livmarli 9.5 mg/mL oral solution (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred Brand		04.01.2022
Qulipta 10 mg tablet (New Drug), Qulipta 30 mg tablet (New Drug), Qulipta 60 mg tablet (New Drug)	Formulary Addition; PA Addition; QL Addition	Non-Preferred Brand		04.01.2022
Welireg 40 mg tablet (New Drug)	Formulary Addition; PA Addition; QL Addition	Non-Preferred Brand		04.01.2022
Exkivity 40 mg capsule (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred Brand		04.01.2022
Tivdak 40 mg IV solution (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred Brand		04.01.2022
Zimhi 5 mg/0.5 mL injection syringe (New Drug)	Formulary Addition; QL Addition	Non-Preferred Brand		04.01.2022
Temazepam 7.5 mg capsule	QL Addition	Generic		04.01.2022
Matzim LA 420 mg tablet ER, Matzim LA 360 mg tablet ER, Matzim LA 300 mg tablet ER, Matzim LA 240 mg tablet ER, Matzim LA 180 mg tablet ER	Formulary Update; QL Addition	Non-Preferred Brand		04.01.2022
Taztia XT 240 mg capsule ER, Taztia XT 180 mg capsule ER, Taztia XT 120 mg capsule ER,	Formulary Update; QL Addition	Non-Preferred Brand		04.01.2022

Taztia XT 300 mg capsule ER, Taztia XT 360 mg capsule ER				
Dilt-XR 240 mg capsule ER, Dilt-XR 180 mg capsule ER, Dilt-XR 120 mg capsule ER	Formulary Update; QL Addition	Non-Preferred Brand		04.01.2022
Moviprep 100 gram-7.5 gram-2.691 gram oral powder packet	QL Addition	Non-Preferred Brand		04.01.2022
Plenvu 140 gram-9 gram-5.2 gram powder packs	QL Addition	Non-Preferred Brand		04.01.2022
Apriso 0.375 gram capsule ER	PA Deletion; QL Addition	Non-Preferred Brand		04.01.2022
Akynzeo (fosnetupitant) 235 mg-0.25 mg IV powder for solution, Akynzeo (fosnetupitant) 235 mg-0.25 mg/20 mL IV solution	Formulary Update; QL Addition	Non-Preferred Brand		04.01.2022
Livtencity 200 mg tablet (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred Brand		04.01.2022
Voxzogo 0.4 mg subcutaneous solution (New Drug), Voxzogo 0.56 mg subcutaneous solution (New Drug), Voxzogo 1.2 mg subcutaneous solution (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Preferred Brand		04.01.2022
Qtern 10 mg-5 mg tablet, Qtern 5 mg-5 mg tablet	Formulary Update	Non-Preferred Brand		04.01.2022
Dexilant 30 mg capsule DR, Dexilant 60 mg capsule DR	Formulary Update; ST Deletion	Preferred Brand		04.01.2022
Entresto 24 mg-26 mg tablet, Entresto 49 mg-51 mg tablet, Entresto 97 mg-103 mg tablet	Formulary Update; PA Deletion; QL Deletion	Preferred Brand		04.01.2022
Soliqua 100/33 100 unit-33 mcg/mL subcutaneous insulin pen	Formulary Update; ST Deletion	Preferred Brand		04.01.2022
Loreev XR 2 mg capsule ER (New Drug), Loreev XR 1 mg capsule ER (New Drug), Loreev XR 3 mg capsule ER (New Drug)	Formulary Update; PA Addition	Non-Preferred Brand		04.01.2022
Nexviazyme 100 mg IV solution (New Drug)	Formulary Addition; PA Addition	Non-Preferred Brand		04.01.2022
Opzelura 1.5 % topical cream (New Drug)	Formulary Addition; PA Addition	Non-Preferred Brand		04.01.2022
Trudhesa 0.725 mg/pump act. (4 mg/mL) nasal spray (New Drug)	Formulary Addition; PA Addition	Non-Preferred Brand		04.01.2022

Tyrvaya 0.03 mg/spray nasal spray (New Drug)	Formulary Addition; PA Addition	Non-Preferred Brand		04.01.2022
Skytrofa 5.2 mg subcutaneous cartridge (New Drug), Skytrofa 3 mg subcutaneous cartridge (New Drug), Skytrofa 11 mg subcutaneous cartridge (New Drug), Skytrofa 4.3 mg subcutaneous cartridge (New Drug), Skytrofa 9.1 mg subcutaneous cartridge (New Drug), Skytrofa 7.6 mg subcutaneous cartridge (New Drug), Skytrofa 3.6 mg subcutaneous cartridge (New Drug), Skytrofa 13.3 mg subcutaneous cartridge (New Drug), Skytrofa 6.3 mg subcutaneous cartridge (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Non-Preferred Brand		04.01.2022
Doxepin 3 mg tablet	Formulary Addition	Generic		04.01.2022
Cyclophosphamide 50 mg tablet, Cyclophosphamide 25 mg tablet	Formulary Addition; Specialty Addition	Generic		04.01.2022
Besremi 500 mcg/mL subcutaneous syringe (New Drug)	Formulary Addition; PA Addition	Non-Preferred Brand		04.01.2022
Eprontia 25 mg/mL oral solution (New Drug)	Formulary Addition	Non-Preferred Brand		04.01.2022
Clarinex 5 mg tablet	Formulary Deletion; PA Deletion; QL Deletion	NF	Azelastine 205.5 mcg (0.15 %) nasal spray	04.01.2022
Meloxicam 7.5 mg tablet, Meloxicam 15 mg tablet	QL Deletion	Generic		04.01.2022
Mobic 7.5 mg tablet, Mobic 15 mg tablet	QL Deletion	Non-Preferred Brand		04.01.2022
Penicillamine 250 mg oral capsule	PA Deletion	Generic		04.01.2022
Cuprimine 250 mg oral capsule	PA Deletion	Non-Preferred Brand		04.01.2022
Prepopik 10 mg-3.5 gram-12 gram oral powder packet	PA Deletion	Non-Preferred Brand		04.01.2022
Reyvow 50 mg tablet, Reyvow 100 mg tablet	PA Addition; ST Deletion	Preferred Brand		04.01.2022
Dayvigo 5 mg tablet, Dayvigo 10 mg tablet	PA Deletion	Non-Preferred Brand		04.01.2022
Meloxicam submicronized 5 mg capsule,	PA Deletion	Generic		04.01.2022

Meloxicam submicronized 10 mg capsule				
Nurtec ODT 75 mg disintegrating tablet	PA Addition; ST Deletion	Preferred Brand		04.01.2022
Ubrelvy 50 mg tablet, Ubrelvy 100 mg tablet	PA Addition; ST Deletion	Preferred Brand		04.01.2022
Ramelteon 8 mg tablet	ST Deletion	Generic		04.01.2022
Doxepin 6 mg tablet	ST Deletion	Generic		04.01.2022
Exforge 5 mg -160 mg tablet, Exforge 5 mg -320 mg tablet, Exforge 10 mg -320 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Edarbi 40 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Pramipexole ER 4.5 mg tablet ER 24 hr, Pramipexole ER 3.75 mg tablet ER 24 hr, Pramipexole ER 1.5 mg tablet ER 24 hr	QL Addition	Generic		04.01.2022
Mirapex ER 4.5 mg tablet ER, Mirapex ER 3.75 mg tablet ER, Mirapex ER 2.25 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022
Levocetirizine 2.5 mg/5 mL oral solution	QL Addition	Generic		04.01.2022
Desloratadine 5 mg disintegrating tablet, Desloratadine 2.5 mg disintegrating tablet	QL Addition	Generic		04.01.2022
Promacta 25 mg tablet, Promacta 50 mg tablet, Promacta 75 mg tablet, Promacta 12.5 mg tablet, Promacta 25 mg oral powder packet	QL Addition	Preferred Brand		04.01.2022
Promethazine VC- codeine 6.25 mg-5 mg-10 mg/5 mL oral syrup	QL Addition	Generic		04.01.2022
Promethazine-phenylephrine-codeine 6.25 mg-5 mg-10 mg/5 mL oral syrup	QL Addition	Generic		04.01.2022
Pioglitazone 15 mg tablet	QL Addition	Generic		04.01.2022
Brilinta 90 mg tablet	QL Addition	Preferred Brand		04.01.2022
Acyclovir 400 mg tablet, Acyclovir 200 mg capsule, Acyclovir 200 mg/5 mL oral suspension	QL Addition	Generic		04.01.2022
Zovirax 200 mg/5 mL oral suspension	QL Addition	Non-Preferred Brand		04.01.2022
Tivicay 25 mg tablet, Tivicay 10 mg tablet	QL Addition	Preferred Brand		04.01.2022
Acyclovir 200 mg/5 mL (5 mL) oral suspension	QL Addition	NF	Zovirax 200 mg/5 mL oral suspension	04.01.2022
Carisoprodol-aspirin 200 mg-325 mg tablet	QL Addition	Generic		04.01.2022
Metaxalone 400 mg tablet	QL Addition	Generic		04.01.2022

Atacand 8 mg tablet, Atacand 16 mg tablet, Atacand 4 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Candesartan 16 mg tablet, Candesartan 8 mg tablet, Candesartan 4 mg tablet	QL Addition	Generic		04.01.2022
Guanfacine 2 mg tablet, Guanfacine 1 mg tablet	QL Addition	Generic		04.01.2022
Benicar 5 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Olmesartan 5 mg tablet	QL Addition	Generic		04.01.2022
Revatio 10 mg/12.5 mL IV solution	QL Addition	Non-Preferred Brand		04.01.2022
Carvedilol 12.5 mg tablet	QL Addition	Generic		04.01.2022
Restoril 7.5 mg capsule	QL Addition	Non-Preferred Brand		04.01.2022
Vesicare 5 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Trospium ER 60 mg capsule ER 24 hr	QL Addition	Generic		04.01.2022
Oxybutynin chloride ER 15 mg tablet ER 24 hr, Oxybutynin chloride ER 10 mg tablet ER 24 hr, Oxybutynin chloride ER 5 mg tablet ER 24 hr	QL Addition	Generic		04.01.2022
Sensipar 30 mg tablet, Sensipar 60 mg tablet, Sensipar 90 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Orkambi 100 mg-125 mg oral granules in packet, Orkambi 150 mg-188 mg oral granules in packet	QL Addition	Preferred Brand		04.01.2022
Ditropan XL 5 mg tablet ER, Ditropan XL 10 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022
Alendronate 70 mg/75 mL oral solution	QL Addition	Generic		04.01.2022
Syprine 250 mg capsule	QL Addition	Non-Preferred Brand		04.01.2022
Trientine 250 mg capsule	QL Addition	Generic		04.01.2022
Rasuvo (PF) 7.5 mg/0.15 mL SC auto-injector	QL Addition	Preferred Brand		04.01.2022
Relafen 750 mg tablet, Relafen 500 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Sulindac 200 mg tablet	QL Addition	Generic		04.01.2022
Otezla Starter 10 mg (4)-20 mg (4)-30 mg(19) tablets in a dose pack, Otezla Starter 10 mg (4)-20 mg (4)-30 mg(47) tablets in a dose pack	QL Addition	Preferred Brand		04.01.2022

Etodolac 500 mg tablet, Etodolac 400 mg tablet, Etodolac 300 mg capsule, Etodolac 200 mg capsule	QL Addition	Generic		04.01.2022
Lodine 400 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Zortress 0.75 mg tablet, Zortress 1 mg tablet, Zortress 0.5 mg tablet, Zortress 0.25 mg tablet	QL Addition	Preferred Brand		04.01.2022
Everolimus (immunosuppressive) 0.5 mg tablet, Everolimus (immunosuppressive) 0.25 mg tablet, Everolimus (immunosuppressive) 0.75 mg tablet	QL Addition	Generic		04.01.2022
Leuprolide 1 mg/0.2 mL subcutaneous solution	QL Addition	Generic		04.01.2022
Revlimid 5 mg capsule, Revlimid 15 mg capsule, Revlimid 25 mg capsule, Revlimid 2.5 mg capsule, Revlimid 20 mg capsule	QL Addition	Preferred Brand		04.01.2022
Imbruvica 140 mg capsule, Imbruvica 70 mg capsule	QL Addition	Non-Preferred Brand		04.01.2022
Solaraze 3 % topical gel	QL Addition	Non-Preferred Brand		04.01.2022
Verzenio 200 mg tablet	QL Addition	Preferred Brand		04.01.2022
Ibrance 75 mg capsule, Ibrance 100 mg capsule	QL Addition	Preferred Brand		04.01.2022
Venclexta 50 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Fluorouracil 5 % topical cream	QL Addition	Generic		04.01.2022
Verzenio 50 mg tablet	QL Addition	Preferred Brand		04.01.2022
Braftovi 50 mg capsule	QL Addition	Preferred Brand		04.01.2022
Venclexta starting pack 10 mg-50 mg-100 mg tablets in a dose pack	QL Addition	Non-Preferred Brand		04.01.2022
Pennsaid 2 % topical solution in packet	QL Addition	Non-Preferred Brand		04.01.2022
Acitretin 17.5 mg capsule	QL Addition	Generic		04.01.2022
Sulfacetamide sodium 10 % shampoo, Sulfacetamide sodium 10 % topical cleanser gel, Sulfacetamide sodium 10 % topical cleanser	QL Addition	Generic		04.01.2022
Nifedipine ER 30 mg tablet ER	QL Addition	Generic		04.01.2022

Verapamil ER (PM) 300 mg capsule 24hr pellet CT ER	QL Addition	Generic		04.01.2022
Adalat CC 30 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022
Verelan PM 300 mg capsule ER	QL Addition	Non-Preferred Brand		04.01.2022
Torsemide 100 mg tablet	QL Deletion	Generic		04.01.2022
Tretinoin 0.05 % topical gel	QL Deletion	Generic		04.01.2022
Valsartan 160 mg tablet	QL Deletion	Generic		04.01.2022
Verelan 180 mg capsule ER	QL Update	Non-Preferred Brand		04.01.2022
Zestoretic 20 mg-25 mg tablet	QL Deletion	Non-Preferred Brand		04.01.2022
Zestril 40 mg tablet	QL Deletion	Non-Preferred Brand		04.01.2022
Piroxicam 10 mg capsule	QL Addition	Generic		04.01.2022
Feldene 10 mg capsule	QL Addition	Non-Preferred Brand		04.01.2022
Samsca 15 mg oral tablet	QL Update	Non-Preferred Brand		04.01.2022
Protopic 0.03 % topical ointment	QL Update	Non-Preferred Brand		04.01.2022
Sorilux 0.005 % topical foam	QL Deletion	Non-Preferred Brand		04.01.2022
Tacrolimus 0.03 % topical ointment, Tacrolimus 0.1 % topical ointment	QL Update	Generic		04.01.2022
Accuretic 20-25 mg oral tablet	QL Deletion	Non-Preferred Brand		04.01.2022
Acitretin 10 mg oral capsule	QL Addition	Generic		04.01.2022
Advair diskus 100-50 mcg/dose inhalation blister, Advair diskus 250-50 mcg/dose inhalation blister, Advair diskus 500-50 mcg/dose inhalation blister	QL Addition	Preferred Brand		04.01.2022
Afinitor 10 mg oral tablet	QL Update	Non-Preferred Brand		04.01.2022
Atralin 0.05 % topical gel	QL Deletion	Non-Preferred Brand		04.01.2022
Calcipotriene 0.005 % topical cream, Calcipotriene 0.005 % topical ointment	QL Deletion	Generic		04.01.2022
Calcitriol 0.5 mcg oral capsule	QL Deletion	Generic		04.01.2022
Cardizem CD 120 mg oral capsule ER 24 hr,	QL Update	Non-Preferred Brand		04.01.2022

Cardizem CD 180 mg oral capsule ER 24 hr, Cardizem CD 240 mg oral capsule ER 24 hr				
Carvedilol 3.125 mg oral tablet	QL Update	Generic		04.01.2022
Desloratadine 5 mg oral tablet	QL Addition	Generic		04.01.2022
Diltiazem HCl 120 mg oral capsule ER 24 hr, Diltiazem HCl 180 mg oral capsule ER 24 hr, Diltiazem HCl 240 mg oral capsule ER 24 hr	QL Update	Generic		04.01.2022
Diovan 160 mg oral tablet	QL Deletion	Non-Preferred Brand		04.01.2022
Diovan-HCTZ 160-25 mg oral tablet	QL Deletion	Non-Preferred Brand		04.01.2022
Dovonex 0.005 % topical cream	QL Deletion	Non-Preferred Brand		04.01.2022
Etodolac 400 mg oral tablet ER 24 hr, Etodolac 500 mg oral tablet ER 24 hr	QL Update	Generic		04.01.2022
Hydroxyzine HCl 25 mg/ml IM solution	QL Deletion	Generic		04.01.2022
Lisinopril 40 mg oral tablet	QL Deletion	Generic		04.01.2022
Methadone 5 mg oral tablet, Methadone 10 mg oral tablet	QL Deletion	Generic		04.01.2022
Ofloxacin 400 mg oral tablet	QL Deletion	Generic		04.01.2022
Promethazine 50 mg rectal suppository	QL Deletion	Generic		04.01.2022
Promethazine-DM 6.25-15 mg/5 ml oral syrup	QL Update	Generic		04.01.2022
Promethazine-phenylephrine 6.25-5 mg/5 ml oral syrup	QL Update	Generic		04.01.2022
Promethegan 50 mg rectal suppository	QL Deletion	Generic		04.01.2022
Protonix 20 mg oral tablet DR	QL Update	Non-Preferred Brand		04.01.2022
Quinapril 20 mg -Hydrochlorothiazide 25 mg oral tablet	QL Deletion	Generic		04.01.2022
Requip XL 12 mg oral tablet ER 24 hr	QL Deletion	Non-Preferred Brand		04.01.2022
Rocaltrol 0.5 mcg oral capsule	QL Deletion	Non-Preferred Brand		04.01.2022
Ropinirole 12 mg oral tablet ER 24 hr	QL Deletion	Generic		04.01.2022
Soriatane 10 mg oral capsule	QL Addition	Non-Preferred Brand		04.01.2022
Symbicort 80-4.5 mcg/actuation HFA aerosol inhalation,	QL Addition	Preferred Brand		04.01.2022

Symbicort 160-4.5 mcg/actuation HFA aerosol inhalation				
Terazosin 10 mg oral capsule	QL Deletion	Generic		04.01.2022
Timolol 5 mg oral tablet, Timolol 10 mg oral tablet, Timolol 20 mg oral tablet	QL Deletion	Generic		04.01.2022
Methotrexate sodium (PF) 1 gram injection	Specialty Deletion	Generic		04.01.2022
Hepsera 10 mg oral tablet	Specialty Addition	Non-Preferred Brand		04.01.2022
Epoprostenol 1.5 mg IV, Epoprostenol 0.5 mg IV	Specialty Addition	Generic		04.01.2022
Zoledronic acid 4 mg IV	Specialty Addition	Generic		04.01.2022
Cyclophosphamide 50 mg oral capsule	Specialty Addition	Generic		04.01.2022
Iclusig 10 mg oral tablet	Specialty Addition	Preferred Brand		04.01.2022
Fasenra pen 30 mg/ml subcutaneous auto-injector	QL Addition	Preferred Brand		04.01.2022
Ketoconazole 2 % topical foam	QL Addition	Generic		04.01.2022
Ketodan 2 % topical foam	QL Addition	Non-Preferred Brand		04.01.2022
Voriconazole 200 mg/5 ml (400 mg/ml) oral suspension	QL Addition	Generic		04.01.2022
Vfend 200 mg/5 mL (40 mg/mL) oral suspension	QL Addition	Non-Preferred Brand		04.01.2022
Voriconazole 200 mg IV solution	QL Addition	Generic		04.01.2022
Vfend IV 200 mg IV solution	QL Addition	Non-Preferred Brand		04.01.2022
Amlodipine 2.5 mg-benazepril 10 mg capsule	QL Addition	Generic		04.01.2022
Telmisartan 40 mg tablet, Telmisartan 20 mg tablet	QL Addition	Generic		04.01.2022
Micardis 40 mg tablet, Micardis 20 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Olmesartan 20 mg tablet	QL Addition	Generic		04.01.2022
Benicar 20 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Olmesartan 20 mg-hydrochlorothiazide 12.5 mg tablet	QL Addition	Generic		04.01.2022
Benicar-HCTZ 20 mg-12.5 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Carvedilol phosphate ER 10 mg capsule ER 24hr multiphase, Carvedilol phosphate ER 20 mg capsule ER 24hr multiphase,	QL Addition	Generic		04.01.2022

Carvedilol phosphate ER 40 mg capsule ER 24hr multiphase, Carvedilol phosphate ER 80 mg capsule ER 24hr multiphase				
Coreg CR 10 mg capsule ER, Coreg CR 20 mg capsule ER, Coreg CR 40 mg capsule ER, Coreg CR 80 mg capsule ER	QL Addition	Non-Preferred Brand		04.01.2022
Amlodipine 5 mg-valsartan 160 mg tablet, Amlodipine 5 mg-valsartan 320 mg tablet, Amlodipine 10 mg-valsartan 320 mg tablet	QL Addition	Generic		04.01.2022
Acetaminophen 120 mg-codeine 12 mg/5 mL oral solution, Acetaminophen 120 mg-codeine 12 mg/5 mL (5 mL) oral solution	QL Addition	Generic		04.01.2022
OneTouch Verio IQ meter kit, OneTouch Verio Flex meter, OneTouch Ultra2 kit, OneTouch Verio Reflect start kit, OneTouch Verio Reflect meter	QL Addition	Preferred Brand		04.01.2022
BD insulin syringe 1 mL 25 x 1", BD insulin syringe half unit ultra-fine 0.3 mL 31gauge x 5/16"	QL Addition	Preferred Brand		04.01.2022
Magellan insulin safety syringe 0.5 mL 29gauge x 1/2", Magellan insulin safety syringe 1 mL 29gauge x 1/2", Magellan syringe 0.3 mL 30 x 5/16", Magellan syringe 0.5 mL 30gauge x 5/16", Magellan Insulin safety syringe 0.3 mL 29 x 1/2", Magellan insulin safety syringe 1 mL 30gauge x 5/16"	QL Addition	Preferred Brand		04.01.2022
Assure ID insulin safety 0.5 mL 29gauge x 1/2" syringe, Assure ID insulin safety 1 mL 29gauge x 1/2" syringe	QL Addition	Preferred Brand		04.01.2022
Easy touch insulin safety syringe 1 ml 29gauge x 1/2", Easy touch insulin safety syringe 0.5 ml 29gauge x 1/2", Easy touch insulin safety syringe 0.5 ml 30gauge x 5/16",	QL Addition	Preferred Brand		04.01.2022

Easy touch insulin safety syringe 1 ml 30gauge x 1/2"				
Easy touch fliplock insulin syringe 1 ml 30gauge x 1/2", Easy touch fliplock insulin 1 ml 31gauge x 5/16" syringe, Easy touch fliplock insulin 1 ml 29 gauge x 1/2" syringe	QL Addition	Preferred Brand		04.01.2022
Easy touch sheathlock insulin 1 ml 29 gauge x 1/2" syringe, Easy touch sheathlock insulin 1 ml 30 gauge x 5/16" syringe, Easy touch sheathlock insulin syringe 1 ml 30 gauge x 1/2", Easy touch sheathlock insulin 1 ml 31 gauge x 5/16" syringe	QL Addition	Preferred Brand		04.01.2022
Inpen subcutaneous pen injector (for Humalog)	QL Addition	Non-Preferred Brand		04.01.2022
Droplet insulin syringe half unit 0.5 ml 30 gauge x 5/16", Droplet insulin syringe half unit 0.5 ml 30 gauge x 1/2", Droplet insulin syringe (half unit) 0.5 ml 29 gauge x ½	QL Addition	Preferred Brand		04.01.2022
Assure ID insulin safety 1 ml 31 gauge x 15/64" syringe, Assure ID insulin safety 0.5 ml 31 gauge x 15/64" syringe	QL Addition	Preferred Brand		04.01.2022
EZ-lets 26 gauge	QL Addition	Non-Preferred Brand		04.01.2022
Acetaminophen 300 mg-codeine 15 mg tablet, Acetaminophen 300 mg-codeine 30 mg/12.5 mL (12.5 mL) oral solution	QL Addition	Generic		04.01.2022
Acetazolamide 125 mg tablet	QL Addition	Generic		04.01.2022
Aciphex sprinkle 10 mg capsule DR	QL Addition	Non-Preferred Brand		04.01.2022
Adalat CC 60 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022
Aprepitant 125 mg (1)-80 mg (2) capsules in a dose pack	QL Addition	Generic		04.01.2022
Bumetanide 0.5 mg tablet, Bumetanide 1 mg tablet	QL Addition	Generic		04.01.2022
Butalbital compound with codeine 30 mg-50 mg-325 mg-40 mg capsule	QL Addition	Generic		04.01.2022

Butalbital-acetaminophen 50 mg-300 mg tablet, Butalbital-acetaminophen 50 mg-325 mg tablet	QL Addition	Generic		04.01.2022
Butalbital-acetaminophen-caffeine 50 mg-300 mg-40 mg capsule, Butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg capsule, Butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg tablet	QL Addition	Generic		04.01.2022
Calan SR 120 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022
Carafate 100 mg/mL oral suspension	QL Addition	Preferred Brand		04.01.2022
Cardizem 120 mg tablet, Cardizem 30 mg tablet, Cardizem 60 mg tablet, Cardizem LA 180 mg tablet ER, Cardizem LA 240 mg tablet ER, Cardizem LA 300 mg tablet ER, Cardizem LA 360 mg tablet ER, Cardizem LA 420 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022
Cimetidine 200 mg tablet, Cimetidine 300 mg tablet, Cimetidine 300 mg/5 mL oral solution, Cimetidine 800 mg tablet	QL Addition	Generic		04.01.2022
Cleansing wash 10 %-4 %-10 % topical cleanser	QL Addition	Generic		04.01.2022
Dapsone 25 mg tablet	QL Addition	Generic		04.01.2022
Dihydroergotamine 1 mg/mL injection solution	QL Addition	Generic		04.01.2022
Diltiazem 120 mg tablet, Diltiazem 30 mg tablet, Diltiazem 60 mg tablet, Diltiazem 90 mg tablet, Diltiazem ER (XR/XT) 120 mg capsule ER 24 hr controlled, Diltiazem ER (XR/XT) 180 mg capsule ER 24 hr controlled, Diltiazem ER (XR/XT) 240 mg capsule ER 24 hr controlled, Diltiazem ER 120 mg capsule ER 12 hr, Diltiazem ER 180 mg tablet ER 24 hr, Diltiazem ER 240 mg tablet ER 24 hr, Diltiazem ER 420 mg tablet ER 24 hr, Diltiazem ER 60 mg capsule ER 12 hr, Diltiazem ER 90 mg capsule ER 12 hr,	QL Addition	Generic		04.01.2022

Diltiazem ER 180 mg capsule 24 hr ER, Diltiazem ER 420 mg capsule 24 hr ER, Diltiazem ER 240 mg capsule 24 hr ER, Diltiazem ER 360 mg capsule 24 hr ER, Diltiazem ER 300 mg capsule 24 hr ER, Diltiazem ER 120 mg capsule 24 hr ER Diltiazem ER 300 mg tablet ER 24 hr				
Emend 125 mg (1)-80 mg (2) capsules in a dose pack	QL Addition	Non-Preferred Brand		04.01.2022
Esomeprazole magnesium 20 mg capsule ER, Esomeprazole magnesium 40 mg capsule ER	QL Addition	Generic		04.01.2022
Gavilyte-N 420 gram oral solution	QL Addition	Preferred Brand		04.01.2022
Hydrocodone 2.5 mg-acetaminophen 325 mg tablet, Hydrocodone 7.5 mg-acetaminophen 325 mg/15 mL oral solution	QL Addition	Generic		04.01.2022
Hydromorphone 2 mg tablet, Hydromorphone 4 mg tablet, Hydromorphone 8 mg tablet	QL Addition	Generic		04.01.2022
Levofloxacin 250 mg/10 mL oral solution	QL Addition	Generic		04.01.2022
Linezolid 100 mg/5 mL oral suspension	QL Addition	Generic		04.01.2022
Nifedipine ER 60 mg tablet ER	QL Addition	Generic		04.01.2022
Omeprazole 10 mg capsule ER	QL Addition	Generic		04.01.2022
Oxycodone 5 mg/5 mL oral solution, Oxycodone 20 mg/mL oral concentrate, Oxycodone ER 40 mg tablet crush resistant ER 12 hr, Oxycodone ER 80 mg tablet crush resistant ER 12 hr	QL Addition	Generic		04.01.2022
Oxymorphone 5 mg tablet	QL Addition	Generic		04.01.2022
PEG-3350 100 gram-sod sulf 7.5 gram-NaCl-KCl-ascorbate-C oral pwdr pack	QL Addition	Generic		04.01.2022
PEG-electrolyte solution 420 gram oral solution	QL Addition	Preventive Medications		04.01.2022
Pentasa 250 mg capsule CR	QL Addition	Non-Preferred Brand		04.01.2022
Propafenone ER 225 mg capsule ER 12 hr, Propafenone ER 325 mg capsule ER 12 hr, Propafenone ER 425 mg capsule ER 12 hr	QL Addition	Generic		04.01.2022
Rabeprazole 10 mg capsule DR sprinkle	QL Addition	Generic		04.01.2022
Ranexa 1,000 mg tablet ER	QL Addition	Non-Preferred Brand		04.01.2022

Ranolazine ER 1,000 mg tablet ER,12 hr	QL Addition	Generic		04.01.2022
Rosanil 10 %-5 % (w/w) topical cleanser	QL Addition	Non-Preferred Brand		04.01.2022
Samsca 30 mg tablet	QL Addition	Non-Preferred Brand		04.01.2022
Sfrowasa 4 gram/60 mL enema	QL Addition	Non-Preferred Brand		04.01.2022
Sivextro 200 mg IV solution	QL Addition	Non-Preferred Brand		04.01.2022
Sucralfate 100 mg/mL oral suspension	QL Addition	Generic		04.01.2022
Thalomid 100 mg capsule, Thalomid 150 mg capsule, Thalomid 200 mg capsule	QL Addition	Non-Preferred Brand		04.01.2022
Tiazac 120 mg capsule ER, Tiazac 180 mg capsule ER, Tiazac 240 mg capsule ER, Tiazac 420 mg capsule ER, Tiazac 300 mg capsule ER, Tiazac 360 mg capsule ER	QL Addition	Non-Preferred Brand		04.01.2022
Tobramycin with nebulizer 300 mg/5 mL solution for nebulization	QL Addition	Generic		04.01.2022
Tolvaptan 15 mg tablet, Tolvaptan 30 mg tablet	QL Addition	Generic		04.01.2022
Triamterene 37.5 mg-hydrochlorothiazide 25 mg capsule	QL Addition	Generic		04.01.2022
Trilyte with flavor packets 420 gram oral solution	QL Addition	Preferred Brand		04.01.2022
Veltassa 25.2 gram oral powder packet, Veltassa 8.4 gram oral powder packet	QL Addition	Non-Preferred Brand		04.01.2022
Verapamil 40 mg tablet, Verapamil 80 mg tablet, Verapamil ER (PM) 100 mg capsule 24hr pellet CT ER, Verapamil ER (PM) 200 mg capsule 24hr pellet CT ER, Verapamil ER (SR) 120 mg tablet ER, Verapamil ER 240 mg 24 hr capsule ER	QL Addition	Generic		04.01.2022
Verelan 120 mg capsule ER, Verelan 240 mg capsule ER, Verelan PM 100 mg capsule ER, Verelan PM 200 mg capsule ER	QL Addition	Non-Preferred Brand		04.01.2022
Zyvox 100 mg/5 mL oral suspension	QL Addition	Non-Preferred Brand		04.01.2022
Butterfly touch lancet 30 gauge	Formulary Update	Non-Preferred Brand		04.01.2022

Prezcobix 800 mg-150 mg tablet	Formulary Update	Preferred Brand		04.01.2022
Symfi lo 400 mg-300 mg- 300 mg tablet, Symfi 600 mg-300 mg- 300 mg tablet	Formulary Update	Preferred Brand		04.01.2022
Kaletra 200 mg-50 mg tablet, Kaletra 100 mg-25 mg tablet	Formulary Update	Non-Preferred Brand		04.01.2022
Lunesta 1 mg tablet, Lunesta 2 mg tablet, Lunesta 3 mg tablet	Formulary Deletion	NF	Eszopiclone 1 mg tablet, Eszopiclone 2 mg tablet, Eszopiclone 3 mg tablet	04.01.2022
Ambien CR 12.5 mg tablet ER, Ambien CR 6.25 mg tablet ER, Ambien 5 mg tablet, Ambien 10 mg tablet	Formulary Deletion	NF	Zolpidem 5 mg tablet, Zolpidem 10 mg tablet, Zolpidem ER 6.25 mg tablet extended release multiphase	04.01.2022
Bystolic 10 mg tablet, Bystolic 2.5 mg tablet, Bystolic 5 mg tablet, Bystolic 20 mg tablet	Formulary Update	Preferred Brand		04.01.2022
Halcion 0.25 mg tablet	Formulary Deletion	NF	Triazolam 0.125 mg tablet, Triazolam 0.25 mg tablet	04.01.2022
Cimduo 300 mg-300 mg tablet	Formulary Update	Preferred Brand		04.01.2022
Cartia XT 300 mg capsule ER	Formulary Update	Non-Preferred Brand		04.01.2022
Cardizem LA 120 mg tablet ER	Formulary Update	Non-Preferred Brand		04.01.2022
Rozerem 8 mg tablet	Formulary Deletion	NF	Ramelteon 8 mg tablet	04.01.2022
Prezista 600 mg tablet, Prezista 75 mg tablet, Prezista 150 mg tablet, Prezista 800 mg tablet	Formulary Update	Non-Preferred Brand		04.01.2022
Reyataz 50 mg oral powder packet	Formulary Update	Non-Preferred Brand		04.01.2022
Xultophy 100/3.6 100 unit-3.6 mg/ml (3 ml) SC insulin pen	Formulary Update	Preferred Brand		04.01.2022

Byetta 10 mcg/dose (250 mcg/ml) 2.4 ml SC pen injector, Byetta 5 mcg/dose (250 mcg/ml) 1.2 ml SC pen injector	Formulary Update	Preferred Brand		04.01.2022
Furosemide 40 mg/4 ml oral solution	Formulary Update	Generic		04.01.2022
Ferrlecit 62.5 mg/5 mL IV solution	PA Deletion	Non-Preferred Brand		04.01.2022
Hydrocodone-acetaminophen 10-325 mg/15 mL (15 mL) oral solution	PA Update	Generic		04.01.2022
Renagel 800 mg tablet	PA Deletion	Non-Preferred Brand		04.01.2022
Tazorac 0.1 % topical cream	PA Deletion	Non-Preferred Brand		04.01.2022
Sevelamer HCl 400 mg tablet	PA Deletion	Generic		04.01.2022
Amnesteem 10 mg capsule, Amnesteem 20 mg capsule, Amnesteem 40 mg capsule	PA Addition	Generic		04.01.2022
Zovirax 5 % topical cream	PA Deletion	Non-Preferred Brand		04.01.2022
Claravis 10 mg capsule, Claravis 20 mg capsule, Claravis 30 mg capsule, Claravis 40 mg capsule	PA Addition	Non-Preferred Brand		04.01.2022
Acetadote 200 mg/mL (20 %) IV solution	PA Deletion	Non-Preferred Brand		04.01.2022
Acetylcysteine 200 mg/mL (20 %) IV solution	PA Deletion	Generic		04.01.2022
Moxatag 775 mg ER tablet	PA Deletion	Non-Preferred Brand		04.01.2022
Feraheme 510 mg/17 mL (30 mg/mL) IV solution	PA Deletion	Non-Preferred Brand		04.01.2022
Venofer 50 mg iron/2.5 ml IV solution, Venofer 100 mg iron/5 mL IV solution, Venofer 200 mg iron/10 ml IV solution	PA Deletion	Preferred Brand		04.01.2022
Myorisan 10 mg capsule, Myorisan 20 mg capsule, Myorisan 30 mg capsule, Myorisan 40 mg capsule	PA Addition	Generic		04.01.2022
Zenatane 10 mg capsule, Zenatane 20 mg capsule, Zenatane 30 mg capsule, Zenatane 40 mg capsule	PA Addition	Non-Preferred Brand		04.01.2022
Injectafer 50 iron mg/ml IV solution	PA Deletion	Non-Preferred Brand		04.01.2022
Rukobia 600 mg tablet ER	PA Deletion	Preferred Brand		04.01.2022

Paricalcitol 5 mcg/mL solution for hemodialysis port injection, Paricalcitol 2 mcg/mL solution for hemodialysis port injection	PA Addition	Generic		04.01.2022
Cordran 0.05 % topical cream	PA Addition	Non-Preferred Brand		04.01.2022
Nolix 0.05 % topical cream	PA Addition	Generic		04.01.2022
Isotretinoin 20 mg capsule, Isotretinoin 40 mg capsule, Isotretinoin 10 mg capsule, Isotretinoin 25 mg capsule, Isotretinoin 35 mg capsule	PA Addition	Generic		04.01.2022
Dihydroergotamine 0.5 mg/pump act. (4 mg/mL) nasal spray	PA Addition	Generic		04.01.2022
Migranal 0.5 mg/pump act. (4 mg/mL) nasal spray	PA Addition	Non-Preferred Brand		04.01.2022

New Prior Authorization Policies

- RxA.704.Exkivity
- RxA.705.Tivdak
- RxA.707.Tyrvaya.docx
- RxA.708.Korsuva.docx
- RxA.709.Livmarli.docx
- RxA.710.LoreevXR.docx
- RxA.711.Nexviazyme.docx
- RxA.712.Opzelura.docx
- RxA.713.Qulipta.docx
- RxA.714.Trudhesa.docx
- RxA.715.Welireg.docx
- RxA.716.Brexafemme.docx
- RxA.717.Nurtec.ODT.docx
- RxA.718.Reyvow.docx
- RxA.719 Besremi
- RxA.720 Livtencity
- RxA.721 Voxzogo

Updated Prior Authorization Policies

Policy Name	Policy Changes	Effective Date
RxA.163.Ibrance	1. Initial Approval Criteria I.A.6 and I.B.5 were updated to include examples of CDK 4/6 inhibitors as Verzenio, Kisqali. 2. Appendix B was updated to include drug name, dosing regimen and max dose for Verzenio, Kisqali.	04.01.2022
RxA.071.Absorica_Absorica-LD.pdf	No Update	04.01.2022
RxA.207.Minastrin.24.Fe_Taytulla	No update	04.01.2022

RxA.304.Otrexup_Rasuvo_ Xatmep_Reditrex	1. Dosing information was updated for Otrexup™, Rasuvo®: maximum dose for pJIA updated from 20 mg/week to 30 mg/m2 /week. 2. Dosing information was updated to include renal and hepatic impairment dosing adjustment. 3. Initial Approval Criteria I.A.3.a was updated to include age ≤ 16 years; I.A.3.b was updated to include age ≥ 2.5 years for Xatmep® specifically. 4. Initial Approval Criteria I.B was updated to remove age criteria for psoriasis. 5. Appendix C was updated to remove contraindication regarding nursing mothers.	04.01.2022
RxA.032.Brand_Name_ Override	No Update	04.01.2022
RxA.334.Akynzeo	1. Dosing information was updated to include netupitant/ palonosetron, in order to separate capsule dosage form from injections, for better precision. 2. Dosing information was updated to include hepatic and renal impairment parameters. 3. Dosage form was updated to include solution for injection. 4. Appendix B Dosing regimen was updated to 125 mg orally 1 hour before chemotherapy for Emend. 5. Appendix B was updated to remove generic rolapitant as it is not available in market.	04.01.2022
RxA.369.Epclusa	1. Background was updated to change minimum age for pediatric patients from 6 years to 3 years. 2. Dosing information was updated to include Indication, Dosing regimen and Maximum dose information. 3. Dosage form was updated to include Oral pellets. 4. Initial Approval Criteria I.A.7 was updated from age is ≥ 6 years to ≥ 3 years. 5. Initial Approval Criteria I.A.12 was updated to include age criteria for Pediatric patients less than 17 kg. 6. Continued Therapy Criteria II.A.5 was updated to include age criteria for Pediatric patients less than 17 kg. 7. Initial and Continued Therapy Approval Criteria was updated to include Medicaid approval duration.	04.01.2022
RxA.037.Benlysta	1. Background was updated to include new indication adult patients with active lupus nephritis who are receiving standard therapy. 2. Dosing information was updated to include new indication (Lupus Nephritis), dosing regimen and max dose information. 3. Initial Approval Criteria I.B was updated to include a new indication, Lupus Nephritis. 4. Continued Therapy Criteria II.A.4 was updated to remove	04.01.2022

	"at 2-week intervals for the first 3 doses and at 4-week intervals thereafter". 5. Continued Therapy Criteria II.B was updated to include a new indication, Lupus Nephritis.	
RxA.411.Lyrica_Lyrica.CR	1. Appendix B: dosing regimen for anticonvulsants drugs was updated.	04.01.2022
RxA.432.Opioid_Analgesics	1. Initial Approval Criteria I.A.2.a-b: Updated a. To include the following amendment: If the incoming claim is after the 4th fill, then the 5-day supply limit does not apply. b. To include amendments that add clarifying language to include the incoming request in the calculation of cumulative days supply in the 60 day look back period, use short-term criteria if cumulative days supply is less than/equal to 20 days in past 60 day period, and use long-term criteria if cumulative day supply more than 20 days in the past 60-day period. 2. Initial Approval Criteria I.A.6: Updated to add If MME/day limit is exceeded: a. Prescriber should attest that member has a pain contract/treatment plan, AND that prescriber has assessed the appropriateness of naloxone in one of the following situations (i or ii): i. Opioid-naïve members whose total opioid dose is greater than 90 MME/day but less than 360 MME/day; ii. Members who are not opioid-naïve whose total opioid dose is greater than 120 MME/day but less than 360 MME/day; iii. Members who are not opioid-naïve whose total opioid dose is greater than 360 MME/day, prescriber should provide documentation of treatment plan/pain contract AND attest that prescriber has assessed the appropriateness of naloxone.	04.01.2022
RxA.461.Revlimid	1. Initial Approval Criteria I.F.c.iv, I.F.c.v, & I.F.c.vi were updated to include combination therapies for active/symptomatic multiple myeloma as per NCCN guidelines. 2. Initial Approval Criteria I.F.d.i, I.F.d.ii, I.F.d.iii, I.F.d.iv were updated to include combination therapies for relapse or progressive multiple myeloma as per NCCN guidelines. 3. Initial Approval Criteria I.F.g was updated to include combination with prednisone taper. 4. Initial Approval Criteria I.F.h.i, I.F.h.ii, I.F.h.iii & I.F.h.iv were updated to include treatment options for systemic light chain amyloidosis as per NCCN guidelines. 5. Initial Approval Criteria I.F.k was updated to include First-	04.01.2022

	line or subsequent therapy as a single agent off label indication as per NCCN guidelines. 6. Initial Approval Criteria I.F.I.iii was update to remove "AIDS related" and to include "given single agent (no HIV) or with antiretroviral therapy (ART) for people with HIV (PWH)". 7. Initial Approval Criteria I.F.I.x was updated to include or initial palliative intent therapy. 8. Initial Approval Criteria I.F.2 was updated to include REMS certification for prescriber. 9. Appendix B, Dosing regimen for melphalan/prednisone (MP) was updated from melphalan 8 mg/m^2 to melaphalan 9mg/m^2; Updated repeat cycle from every 28 days to every 6 weeks for a total of 9 cycles.	
RxA.467.Revatio	No Update	04.01.2022
RxA.468.Rexulti	1. Appendix D was updated to include Warning and Precautions.	04.01.2022
RxA.470.Sprycel	1. Initial Approval Criteria I.B.4 was updated to include Request would be used as a single agent. 2. Initial Approval Criteria I.B.4.a was updated to include new criteria Patient is with generalized (widespread, systemic) disease with progression on imatinib. 3. Initial Approval Criteria I.B.4.b was updated to include new criteria Patient has documented failure of response/progression on approved therapies. 4. Initial Approval Criteria I.C.4 was updated to include Request will be used as a single-agent therapy. 5. Initial Approval Criteria I.C.4.a was updated to include new indication Metastatic and widespread disease for patients. 6. Initial Approval Criteria I.C.4.b was updated to include new diagnostic criteria Recurrent conventional or chondroid chordoma.	04.01.2022
RxA.471.Stendra	1. Dosing information was updated to include that the dose may be increased up to 200 mg orally, approximately 15 minutes before sexual activity or decreased to 50 mg orally approximately 30 minutes before sexual activity. 2. Dosing information maximum dose updated to include dosing adjustment for moderate CYP3A4 inhibitors. 3. Dosing information was updated to include hepatic and renal impairment doses adjustment. 4. Appendix B was updated to include tadalafil (Cialis®) & vardenafil as therapeutic alternatives.	04.01.2022
RxA.472.Sunosi	1. Dosing information was updated to include hepatic and renal impairment doses adjustment. 2. Appendix B was updated to change Nuvigil®: Dosing regimen from 150 mg to 150 to 250 mg. 3. Appendix D was updated to include precautions during Sunosi™ use.	04.01.2022

RxA.473.Sylvant	1. Initial Approval Criteria I.B was updated to include a new off label indication, Immunotherapy related toxicities. 2. Continued Therapy Approval II.B was updated to include a new off label indication, Immunotherapy related toxicities.	04.01.2022
RxA.474.Symlin	1. Dosage form was updated to include (1000 mcg/ml) for 15 mcg, 30 mcg, 45 mcg, 60 mcg. 2. Appendix B Therapeutic Alternatives Dosing Regimen was updated from 0.5 to 1 U/kg SC daily to 0.4 to 1 U/kg subcutaneously daily for Humalog®, Humulin® R and Humulin® N. 3. Appendix C was updated to include Boxed Warnings.	04.01.2022
RxA.476.Saphris_Secuado	1. Dosing Information was updated to include Acute and maintenance monotherapy and as an adjunct to lithium or valproate.	04.01.2022
RxA.477.Sensipar	1. Appendix D, General Information: Updated to include clause recommending for patients with hepatic impairment to have regular serum calcium, serum phosphorus, and iPTH level monitoring.	04.01.2022
RxA.479.Silenor	1. Dosing information was updated from as needed at bedtime to once daily within 30 minutes of bedtime.	04.01.2022
RxA.482.Soolantra	1. Dosing information was updated to include Hepatic Impairment dosing regimen. 2. Dosage form was updated to remove 30 gm and 60 gm. 3. Appendix B dosing regimen and maximum dose was updated for drug Solody to Apply as a thin layer. 4. Appendix B dosing Regimen and maximum dose was updated for drug Oracea to discuss potential efficacy beyond 16 weeks.	04.01.2022
RxA.483.Sovaldi	No Update	04.01.2022
RxA.484.Spravato	1. Initial Approval Criteria I.B was updated to include indication Depressive symptoms in adults with major depressive disorder (MDD). 2. Continued Therapy Criteria II.B was updated to include indication Depressive symptoms in adults with major depressive disorder (MDD).	04.01.2022
RxA.485.Stivarga	1. Therapeutic Alternative Lonsurf maximum dose was updated from 70 mg/m^2/day to 80 mg/dose.	04.01.2022
RxA.486.Sutent	No Update	04.01.2022
RxA.487.Symdeko	No Update	04.01.2022
RxA.488.Savella	1. Dosing Information was updated to add dosing regimen for patients with severe renal impairment.	04.01.2022

	2. Therapeutic Alternative cyclobenzaprine dosing regimen was updated from 10 mg PO every morning & 20 mg at bedtime to 10-30 mg every night.	
RxA.489.Sernivo	1. Appendix B Dose Limit/Maximum Dose was updated to include 50 mg/week for augmented betamethasone dipropionate 0.05% (Diprolene®, Alphatrex®) ointment.	04.01.2022
RxA.491.Soliris	1. Initial approval criteria I.D.2 was updated to include patient relapse history criteria. 2. Initial Approval Criteria I.D.5 was updated to include new criteria Baseline expanded disability status score (EDSS) score of ≤ 7. 3. Appendix B updated for Dosing Regimen & Maximum Dose: a. For drug pyridostigmine (Mestinon®, Regonol®) Max dose for Oral immediate release updated to include 1,500 mg/day orally regular-release tablets; updated Oral sustained release to include 1,080 mg/day orally. b. For drug neostigmine (Bloxiverz®) Max dose for Oral updated to include 375 mg/day orally; updated Intra muscular or Subcutaneous to include 0.07 mg/kg or 5 mg total dose intravenous. c. For drug azathioprine (Imuran®) Max dose updated to include Base dosage on total body weight even in obese patients but do not exceed 250 mg/day. d. For drug mycophenolate mofetil (Cellcept®) updated to include Generalized myasthenia gravis: Oral: 500 mg twice daily; Max dose updated from 2 g/day to 3 g/day orally or intravenous. e. For drug rituximab (Rituxan® (rituximab), Ruxience™ (rituximab- pvvr), Truxima® (rituximab-abbs) for indication NMOSD dosing regimen updated from IV: 375 mg/m2 per week for 4 weeks as induction to 1,000 mg once every 2 weeks for 2 doses.	04.01.2022
RxA.492.SomatulineDepot	1. Dosing information was updated from 90-120 mg to Maintenance after 3 months: GH greater than 1 ng/mL to less than or equal to 2.5. 2. Dosing Information was updated to include hepatic and renal impairment dosing. 3. Initial Approval Criteria I.E. was added to include off label indication:	04.01.2022

	Neuroendocrine and Adrenal Tumors – Pheochromocytoma /Paraganglioma.	
RxA.494.Spinraza	1. Initial Approval Criteria I.A.7 was updated to include that Spinraza® is not prescribed concurrently with Evrysdi®. 2. Initial Approval Criteria I.A.8 was updated to include If the member is currently on Evrysdi®, documentation of prescriber attestation of Evrysdi® discontinuation. 3. Continued Therapy Approval II.A.4 was to include that Spinraza® is not prescribed concurrently with Evrysdi®.	04.01.2022
RxA.495.Spritam	1. Background was updated to include indications: a. Partial onset seizures was updated to remove age indicator children 1 month of age and older. b. Myoclonic seizures as adjunctive therapy in adults and adolescents was updated to include age criteria of 12 years. 2. Dosing information was updated to include dosing regimen for renal Impairment for in adult patients. 3. Initial Approval Criteria I.A.2 was added updated to include prescriber criteria. 4. Initial Approval Criteria I.A.3 was added updated to include age criteria. 5. Initial Approval Criteria I.A.5 was updated to include dosing criteria. 6. Initial Approval Criteria I.B was added for diagnosis Myoclonic seizures, and primary generalized tonic-clonic seizures. 7. Continued Therapy Criteria II.A.3 was updated to dosing criteria for Partial onset seizures, Myoclonic seizures and Primary generalized tonic-clonic seizures. 8. Appendix B therapeutic alternate Keppra Dosing Regimen & Maximum Dose for Partial onset seizures (Pediatric patients 1 month to < 16 years) was updated from age/weight-based dosing to Infants 1 to 5 months: Initially, 7 mg/kg/dose.	04.01.2022
RxA.498.Strensiq	No Update	04.01.2022
RxA.500.Synagis	No Update	04.01.2022
RxA.501.Syprine	1. Appendix B was updated from 750 mg/day if pregnant to 500-750 mg/day if pregnant.	04.01.2022
RxA.502.Tagrisso	1. Background was updated to include Tagrisso® can be used As adjuvant therapy after tumor resection in adult patients with non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations. 2. Dosing information was updated to include Adjuvant treatment of early stage NSCLC) in dosing regimen. Initial approval criteria I.A.4 was updated to include new	04.01.2022

	criteria Used as first-line therapy and used in adjuvant therapy after tumor resection. 3. Initial Approval Criteria I.C.4 was updated from EGFR T790M mutation-positive to Tagrisso® can be used as a single-agent treatment. 4. Initial Approval Criteria I.C.5 added to include limited brain metastasis.	
RxA.505.Tecfidera	No Update	04.01.2022
RxA.506.Tegsedi	1. Appendix D was updated to included perform laboratory tests before, during and for 8 weeks following discontinuation of treatment with Tegsedi.	04.01.2022
RxA.508.Tibsovo	1. Background was updated to include new indication Locally Advanced or Metastatic Cholangiocarcinoma. 2. Dosing Information was updated to include new indication Locally Advanced or Metastatic Cholangiocarcinoma. 3. Initial Approval Criteria I.B Biliary Tract Cancers (Intrahepatic and Extrahepatic Cholangiocarcinoma) was updated from off-label indication to FDA approved indication. 4. Initial Approval Criteria I.B.5 was updated from Disease has progressed on or after systemic treatment recommended by NCCN to Disease has progressed on or after treatment with at least 1 but not more than 2 prior regimens, including at least one gemcitabine- or 5-FU-containing regimen. 5. Initial Approval Criteria I.C was updated to include off-label indication, Bone Cancers (Chondrosarcoma and Osteosarcoma).	04.01.2022
RxA.509.Torisel	1. Dosing information was updated to include hepatic impairment doses adjustment, and to remove dosing adjustment with strong CYP3A4 inducer. 2. Dosing information was updated to change maximum dose from 50 mg/week to 25 mg/week.	04.01.2022
RxA.510.Trulance	1. Appendix B was updated to change dosing regimen and maximum dose for calcium polycarbophil from 1,000 mg 1 to 4 times per day or as needed to 1,250 mg 1 to 4 times per day or as needed; Max dose was updated from 6,000 mg/day to 5,000 mg/day. 2. Appendix D was updated to include Avoid use of Trulance® in patients 6 years to less than 18 years of age.	04.01.2022
RxA.511.Turalio	1. Dosing information was updated to include Dosing regimen for mild to severe renal impairment. 2. Initial Approval Approval I.B for off-label indication Histiocytic Neoplasms was added.	04.01.2022

RxA.513.Takhzyro	1. Initial Approval Criteria I.A. was updated from Hereditary Angioedema to Hereditary Angioedema attack prophylaxis. 2. Initial Approval Criteria I.A.2 prescriber criteria was updated to include dermatologist and immunologist.	04.01.2022
RxA.514.Talzenna	1. Dosing information was updated to include Dosing Regimen for moderate and severe renal impairment.	04.01.2022
RxA.515.Tasigna	1. Dosing information was updated to include Dosing Regimen for hepatic impairment. 2. Initial Approval Criteria I.A.1.diagnosis criteria was updated to include phase and accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML-CP).	04.01.2022
RxA.521.Tracleer	1. Appendix B Dosing Regimen for drug diltiazem was updated from 720-960 mg PO OD to 240-720 mg/day orally once daily.	04.01.2022
RxA.522.Trelstar_Triptodur	No Update	04.01.2022
RxA.524.Trogarzo	No Update	04.01.2022
RxA.587.Aimovig	1. Initial approval criteria I.A was updated to remove prescriber criteria corresponding to pain specialist. 2. Initial Approval Criteria I.A.7.a, and Continued Therapy Criteria II.A.4.a were updated to remove, “70 mg (1 injection) once monthly”. 3. Initial Approval Criteria I.A.7.b, and Continued Therapy Criteria II.A.4.b was updated to remove “if medical justification is provided”. 4. Appendix B Therapeutic Alternative table was updated to include dosing regimen and maximum dose for divalproex (Depakote®), topiramate (Topamax®), propranolol (Inderal®), metoprolol (Lopressor®), timolol, amitriptyline (Elavil®), venlafaxine (Effexor®).	04.01.2022
RxA.588.Ajovy	1. Appendix B was updated to include dosing regimen and maximum doses for “Depakote, Topamax, propranolol, Lopressor, timolol, amitriptyline, and venlafaxine.”	04.01.2022
RxA.592.Biologic_DMARDs	1. Background was updated to include indication SSC-ILD for Actemra and indication DIRA for Kineret. 2. Dosing information for Humira was updated for indication UC from 160 mg subcutaneous on Day 1 to 160 mg subcutaneous on Day 1 (given in one day or split over two consecutive days); adult dosing added for its indication HS. 3. Dosing Information, Dosing Regimen, Humira: Updated to include a. New dosing guideline allowing for 80mg every other	04.01.2022

week for indication RA
   b. Pediatric dosing information for indication UC
   c. Adult dosing information for indication UV.
4. Dosing Information, Dosing Regimen, Kineret: Updated to include weight-based dosing guidelines.
5. Dosing Information, Dosing Regimen, Tremfya: Updated to include guideline stating that medication can be used alone or in combination with conventional DMARD e.g. methotrexate
6. Dosing Information, Dosing Regimen, Cosentyx: Updated to include pediatric dosing regimen.
7. Dosing Information: Updated to include dosing regimen and maximum dose for Entyvio.
8. Dosing information was updated to include new indication DIRA for Kineret, its dosing regimen and max dose information.
9. Dosing information was updated for indication PsO (with or without coexistent PsA) for drug Taltz by separating dosing for Adult and Pediatric Plaque Psoriasis.
10. Dosing information was updated to include new indication SSC-ILD for Actemra, its dosing regimen and max dose information.
11. Initial Approval Criteria I.C.4.d: Updated to include requirement for member to be currently using a corticosteroid.
12. Initial Approval Criteria, I.C.4.c, I.H.5.c, I.K.5.c, and I.M.4.b: Updated to include clause requiring member to try and fail at least one DMARD.
13. Initial approval criteria I.H.4 age criteria updated for Cosentyx from 18 years and older to 6 years and older.
14. Initial approval criteria I.M.4 age criteria updated for Humira from 18 years and older to 5 years and older.
15. Initial approval criteria I.E.4 updated to remove, “in conjugation with methotrexate or Azathioprine”.
16. Initial approval criteria I.P. added to include indication- Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) for Actemra.
17. Initial approval criteria I.Q. added to include indication- Deficiency of Interleukin-1 Receptor Antagonist (DIRA) for Kineret.
18. Appendix B: Dosage regimen for cyclophosphamide was updated from 1-2 mg/kg/day orally to 1-3 mg/kg/day orally.
19. Appendix B: Dosage regimen updated for cyclosporine (Sandimmune®, Neoral®) indication PsO from 2.5 - 4 mg/kg/day to 1- 4 mg/kg/day.
20. Appendix B: Dosage regimen updated for methotrexate indication GCA from 20-25 mg/week orally to 10- 15 mg/week orally; Indication SJIA from 0.5-1 mg/kg/week to 10 mg/m2/dose orally once weekly initially. Individualize

	dosage and titrate gradually to achieve optimal clinical response. 21. Appendix B: Dosage regimen updated for mycophenolate mofetil (Cellcept) indication UA from 500 – 1,000 mg PO BID to Oral: Initial: 500 mg twice daily for 2 weeks; increase to a maintenance dose of 1 to 1.5 g twice daily as tolerated.	
RxA.594.Dupixent	1. Initial Approval Criteria I.B.3 was updated from age 12 years of age or older to age 6 years of age or older. 2. Initial Approval Criteria I.B.4 was updated to remove the statement "requiring any of the following despite adherent use of controller therapy…if LABA contraindication/intolerance)". 3. Initial Approval Criteria I.B.5 was moved to I.B.6; new criteria for I.B.5 requires that member has been adherent to ICS therapy plus either a LABA or LTRA (i.e chart notes, fill history) for at least 3 months. 4. Initial Approval Criteria I.B.6 was inserted requiring concomitant prescribing with with a medium- to high-dose inhaled corticosteroid (ICS) plus either a long-acting beta-2 agonist (LABA) or leukotriene modifier (LTRA). 5. Therapeutic alternative dosing regimen updated for dexamethasone (Decadron®).	04.01.2022
RxA.595.Emgality	1. Initial Approval Criteria I.B.1.b was updated from ≥ 2 cluster periods lasting ≤ 1 year each and separated by ≥ 3 months to Total of ≥ 5 previous attacks. 2. Initial Approval Criteria I.B.1 was updated to include criteria c (I.B.1.c) indicating ≥ 2 cluster periods lasting from 7 days to 1 year each and separated by ≥ 3 months. 3. Appendix B therapeutic Alternative table was updated to include dosing regimen and maximum doses for Depakote, Topamax, propranolol, Lopressor, timolol, amitriptyline, and venlafaxine. 4. Appendix B dosing regimen for verapamil was updated from 120 mg to 360 - 480 mg; Max. Dose was updated from 360 to 480 mg.	04.01.2022
RxA.597.Growth_Hormones	1. Background information was updated to include Skytrofa. 2. Dosing information was updated to include Skytrofa, its indication and dosage regimen. 3. Initial Approval Criteria I.A.1.b ISS SD value was changed from 2.25 to 2. 4. Initial Approval Criteria I.A.8 was updated to include Unless treating CKD at the beginning of the clause. 5. Initial Approval Criteria I.B.1.a.1 was updated to remove "retarded bone age".	04.01.2022

	6. Initial approval criteria I.A.4. was updated to include weight criteria for Skytrofa. 7. Initial Approval Criteria I.B.6 & I.C.8 was updated to include maximum dose. 8. Initial Approval Criteria I.C.7 was changed from failure of preferred products to Request must be for Serostim. 9. Continued Approval Criteria II.A.2.b was updated to change SD value from 2.25 to 2.	
RxA.600.Nucala	1. Background was updated to include new indications CRSwNP and HES. 2. Dosing information was updated to include new indications (CRSwNP, HES), dosing regimen and max dose information. 3. Dosing information was updated to include Max. dose for indication Severe asthma. 4. Initial Approval Criteria I.A.2 was updated from Member has an absolute blood eosinophil count to Member has a baseline blood eosinophil count. 5. Initial and continued approval criteria were updated to include approval criteria for CRSwNP and HES. 6. Continued Therapy Approval II.B.4 was updated to change dose limit for EGPA from 100 mg every 4 weeks to 300 mg every 4 weeks. 7. Appendix B was updated to remove ciclesonide, fluticasone furoate, salmeterol, mometasone/ formoterol, and fluticasone/ vilanterol generics as these were not available in US. 8. Appendix B was updated to change dosing regimen for zyflo from 1200 mg orally twice daily to 600 mg orally four times daily. 9. Appendix C was updated to rephrase contraindication as History of hypersensitivity to mepolizumab or excipients in the formulation.	04.01.2022
RxA.601.Off-label_Use	No Update	04.01.2022
RxA.601.Off-label	No Update	04.01.2022
RxA.603.Glucose_Meter_Test_Strip_Exception_Policy	1. Dosage forms was updated to include Preferred Meter and Test Strip Manufacturer: LifeScan, which was moved here from clinical policy section.	04.01.2022
RxA.604.Juxtapid	1. Dosing Information, Dosing Regimen: was updated to include maximum dosing, hepatic impairment, and renal impairment dosing information. 2. Appendix B, Dosing Regimen, Lipitor: Updated from 40 mg orally once daily to Initially, 10 to 20 mg orally once daily. May start at 40 mg orally once daily in patients requiring greater than 45% LDL-reduction. The dosage range is 10 to 80 mg orally once daily (mean LDL reduction range: 43% to	04.01.2022

	60% LDL).	
RxA.605.Exondys51	1. Initial Approval Criteria I.A.3 age criteria was changed from at least 13 years of age to at least 7 years. 2. Appendix B was updated to include max dose for Emflaza™ 0.9 mg/kg/dose. 3. Appendix B dosing regimen for prednisone was updated from 0.3-0.75 mg/kg/day or 10 mg/kg/weekend orally to 0.75 mg/kg/day orally. If side effects (e.g., weight gain and Cushingoid facial appearance) outweigh benefits on muscle strength and function, gradual dose reduction to as low as 0.3 mg/kg/day orally can still be beneficial.	04.01.2022
RxA.606.Jevtana	1. Dosing information was updated to include hepatic impairment doses adjustment.	04.01.2022
RxA.607.Jublia	1. Initial and Continued approval duration was updated from 48 weeks to 12 months. 2. Initial Approval Criteria I.A.2 age criteria was updated from ≥ 18 years of age to ≥ 6 years of age.	04.01.2022
RxA.608.Lumizyme	No Update	04.01.2022
RxA.610.Luzu	1. Initial Approval Criteria I.A.2 was updated to include age criteria as per indications Tinea pedis, Tinea cruris and tinea corporis. 2. Appendix B was updated to remove sertaconazole cream, clotrimazole athletes Foot generics as these were not available in US.	04.01.2022
RxA.613.Oralair	1. Appendix B Therapeutic Alternatives dosing regimen was updated for Claritin-D® 12 and 24 hour, Allegra Allergy®, Flonase®, Nasacort AQ ® and Nasonex®. 2. Appendix C was updated to include Boxed Warnings.	04.01.2022
RxA.615.Synribo	No Update	04.01.2022
RxA.616.Tarceva	1. Initial approval criteria I.E. updated to include off-label indication Central nervous system cancers. 2. Appendix D was updated to include Renal and Hepatic toxicity warning and precautions.	04.01.2022
RxA.617.Venclexta	1. Dosing information was updated by including dosing schedule of Venclexta® for CLL and SLL in combination with rituximab. 2. Dosing information was updated to include dosing schedule of Venclexta® for AML to indicate each 28- day cycle. 3. Initial Approval Critiera I.C.4 was updated to include Must be prescribed as (a or b): as a single agent or; in combination with rituximab. 4. Initial Approval Criteria I.D.4 was clarified to Must be prescribed in combination with azacitidine, decitabine, or low-dose cytarabine for patients with (a or b).	04.01.2022

	5. Dosing information was updated to include dosing regimen for hepatic impairment. 6. Initial Approval Criteria I.A.2 was updated to remove "Request is for one of the following (a or b); Without del(17p)/TP53 mutation in frail patients with significant comorbidity (not able to tolerate purine analogs) or age ≥ 65 years and younger patients with or without significant comorbidities; With del(17)p/TP53 mutation;" 7. Initial Approval criteria I.E was updated to include off label indication Multiple Myeloma. 8. Initial Approval criteria I.F was updated to include off label indication Systemic Light Chain Amyloidosis. 9. Appendix B was updated to remove alemtuzumab, duvelisib, acalabrutinib, ofatumumab generics as they were not available in US.	
RxA.618.Vyndamax_Vyndaqel	1. Dosing information was updated for Vyndaqel® from 20 mg to 80 mg orally once daily.	04.01.2022
RxA.619.Onpattro	1. Dosing Information table was updated to include Maximum Dose Adults weighing < 100 kg. 2. Initial Approval Criteria I.A.5 was updated to include new criteria Patient is not currently taking diflunisal. 3. Initial Approval Criteria I.A.7 was updated to include new criteria Neuropathy Impairment Score requirement of 5-130.	04.01.2022
RxA.630.Ubrelvy	1. Initial Approval Criteria I.A.6: quantity limit was updated from 16 over 30 days to 200 mg orally once daily. 2. Initial approval criteria I.A.4 was inserted requiring member to currently be treated with one of the following preventative treatments, unless previously ineffective, contraindicated, or clinically significant adverse effects are experienced (a, b, or c): a. antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate); b. beta-blockers (e.g., metoprolol, propranolol, timolol); c. antidepressants (e.g., amitriptyline, venlafaxine).	04.01.2022
RxA.657.Gavreto	1. Background was updated to include population parameters adult and pediatric patients 12 years and older. 2. Dosing information was updated for NSCLC to include with concomitant use of CYP3A inducer. 3. Dosing information was updated to include new indication Thyroid Cancer, dosing regimen 400 mg orally, and max dose 400 mg PO once daily. 4. Initial Approval Criteria I.B. was updated to include a new indication Thyroid Cancer. Continued Approval Criteria for thyroid cancer was also added. 5. Appendix D was updated to include information about CYP enzyme interactions.	04.01.2022

RxA.660.Blenrep	1. Dosing information was updated for maximum dose to 2.5 mg/kg (actual body weight) intravenous every 3 weeks.	04.01.2022
RxA.662.Enspryng	1. Initial Approval Criteria I.A.7 was updated to Dosing does not exceed 120 mg/dose subcutaneously every 4 weeks. 2. Continued Therapy Approval II.A.3 was updated to Dosing does not exceed 120 mg/dose subcutaneously every 4 weeks. 3. Appendix B was updated to include Riabni, Rituxan, Ruxience and Truxima as therapeutic alternatives because generic rituximab is not available. 4. Appendix B Therapeutic Alternatives: Dosing Regimen and Maximum dose was updated from 100 mg/day to 2-3 mg/kg/day for azathioprine. 5. Appendix B Therapeutic Alternatives: Dosing Regimen and Maximum dose was updated from 1000 mg/dayto 1000-2000 mg/day for mycophenolate.	04.01.2022
RxA.663.Evrysdi	1. Appendix B was updated to remove nusinersen, onasemnogene abeparvovec-xioi generics as they were DSC. 2. Appendix B was updated to update dosing regimen of Spinraza from 7.5 mg -15 mg PO once daily to 12 mg intrathecally. 3. Appendix B was updated to update max dose of Spinraza from 15 mg/day to 12 mg/dose intrathecally. 4. Appendix B was updated to update dosing regimen of Zolgensma from 50 mg PO TID to 1 x 1014 vector genomes. 5. Appendix B was updated to update max dose of Zolgensma from 150 mg/day to 1.1 x 1014 vector.	04.01.2022
RxA.664.Vyepti	1. Initial Approval Criteria I.A.8 was updated to include that Member shouldn't have any history of cardiovascular disease (hypertension, ischemic heart disease), neurological disease, or cerebrovascular disease. 2. Appendix B was updated to include CGRP inhibitors (Aimovig®, Ajovy®). 3. Appendix B was updated to include Dosing regimen and maximum dose for divalproex, topiramate, propranolol, metoprolol, timolol, amitriptyline, venlafaxine.	04.01.2022
RxA.524.Trogarzo	No Update	04.01.2022
RxA.525.Tykerb	1. Initial Approval Criteria I.D was updated to include a new off label indication Central Nervous System Cancers.	04.01.2022
RxA.526.Tafinlar	1. Initial Approval Criteria I.D was updated to include off label indication, Central Nervous System Cancers. 2. Initial Approval Criteria I.E was updated to include off label indication, Biliary Tract Cancers. 3. Initial Approval Criteria I.F was updated to include off label indication, Histiocytic Neoplasms.	04.01.2022

	4. Initial Approval Criteria I.G was updated to include off label indication, Thyroid Carcinoma.	
RxA.527.Tavalisse	1. Appendix B was updated to include dosing regimen for drug methylprednisolone.	04.01.2022
RxA.528.Tecentriq	1. Dosing Information for indication NSCLC was updated from 1200mg every three weeks prior to chemotherapy to 840 mg intravenous every 2 weeks, 1,200 mg intravenous every 3 weeks, or 1,680 mg intravenous every 4 weeks. 2. Dosing Information for indication NSCLC was updated from Following completion of 4-6 cycles of chemotherapy to administer prior to chemotherapy and bevacizumab when given on the same day. 3. Dosing Information for indication SCLC was updated to remove “When administering with carboplatin and etoposide…” and to include administer prior to chemotherapy when given on the same day. 4. Dosing Information for indication TNBC was updated from 840mg IV on days 1 and 15 to 840 mg intravenous every 2 weeks, 1,200 mg intravenous every 3 weeks, or 1,680 mg intravenous every 4 weeks. 5. Dosing Information for indication TNBC was updated to include Administer prior to paclitaxel protein- bound when given on the same day. 6. Doing Information for indication HCC was updated to remove “1,200mg IV every 3 weeks plus bevacizumab 15mg/kg IV on the same day. If bevacizumab is discontinued for toxicity…” and to include administer prior to bevacizumab when given on the same day. Bevacizumab is administered at 15 mg/kg every 3 weeks. 7. Dosing Information for indication Melanoma was updated to remove “Administering with cobimetinib and vemurafenib…” and to include patients should receive a 28 day treatment cycle of cobimetinib 60 mg orally once daily. 8. Initial Approval Criteria I.A was updated from Breast Cancer to Triple Negative Breast Cancer. 9. Initial Approval Criteria I.A.7.a was updated from Dose does not exceed 840 mg every 2 weeks to Dose does not exceed 840 mg every 2 weeks, 1200 mg every 3 weeks, or 1680 mg every 4 weeks. 10. Initial Approval Criteria I.B.4.c was updated from "…expression for any of the following...." to "… regardless of PD-L1 expression...". 11. Continued Therapy Approval Criteria II.A.3.a was updated to include additional indication, TNBC. 12. Continued Therapy Approval Criteria II.A.3.b was updated to remove “For TNBC: New dose does not exceed 840 mg every 2 weeks.”. 13. Continued Therapy Approval Criteria II.A.3.b was updated	04.01.2022

	to include 1200 mg every 3 weeks, or 1680 mg every 4 weeks. 14. Appendix B was updated to remove currently unavailable generic drugs crizotinib, alectinib, ceritinib, erlotinib, afatinib & gefitinib.	
RxA.530.Thyrogen	1. Dosing information was updated to 0.9 mg/day intramuscular for 2 doses.	04.01.2022
RxA.534.Valchlor	1. Initial Approval Criteria I.B.1.d & I.B.1.e added to include off label indication Unifocal Langerhans Cell Histiocytosis.	04.01.2022
RxA.536.Valstar	1. Appendix C was updated to include Contraindication Perforated bladder or compromised bladder mucosa.	04.01.2022
RxA.54.Calquence	1. Dosing information Max Dose was updated from 400 mg/day to 200 mg/day. 2. Dosing information was updated to include dosing regimen for hepatic impairment. 3. Initial Approval Criteria I.A.5.a and I.B.6.a was updated from 400 mg (4 capsules) to 200 mg (2 capsules). 4. Initial Approval Criteria I.D was updated to include a new off label indication B-Cell Lymphomas. 5. Continued Therapy Approval II.3.a was updated from 400 mg (4 capsules) to 200 mg (2 capsules). 6. Appendix B was updated to include: a. Aggresive therapy: CALGB (treatment 1, 2, 2.5: rituximab, methotrexate with augmented CHOP, treatment 3: etoposide,cytarabine, rituximab...; b. NORDIC dose-intensified induction immunochemotherapy; c. [maxi-CHOP] alternating; d. RDHAP (oxaliplatin or carboplatin can be used instead of cisplatin e. Less Aggressive therapy: Modified rituximab-HyperCVAD in patients > 65 years (rituximab + ibrutinib can be used. f. First-line consolidation candidate for HDT/ASCR. g. First-line consolidation not a candidate for HDT/ASCR. h. Second line therapy. i. Second-line consolidation. 7. Appendix B was updated to remove: a. Aggressive therapy: “CALGB (rituximab + methotrexate + cyclophosphosphamide, doxorubicin, vincristine..”; b. RDHAP: "(rituximab, dexamethasone, cisplatin, cytarabine)"	04.01.2022
RxA.540.Vecamyl	No Update	04.01.2022
RxA.541.Vectibix	No Update	04.01.2022

RxA.542.Velcade	1. Dosing Information was updated to include hepatic impairment dosing. 2. Initial Approval Criteria I.B was updated to include new off label indications Kaposi Sarcoma, Acute Lymphoblastic Leukemia, Pediatric Acute Lymphoblastic Leukemia, and Pediatric Hodgkin Lymphoma.	04.01.2022
RxA.545.Ventavis	1. Dosing information was updated to include regimen for Hepatic Impairment: In patients with Child-Pugh Class B or C. 2. Appendix B Dosing Regimen and Maximum Dose were updated for: a. diltiazem dosing regimen from 720-960 mg to 120-540 mg & Max dose from 960mg/day to 540mg. b. amlodipine Dosing regimen from 20-30 mg to 5-10 mg & Max dose from 30 mg/day to 10 mg/day.	04.01.2022
RxA.546.Verzenio	1. Initial approval criteria I.A.6.a.i and II.A.4.a.i was updated to remove “two 150 mg tablets per day”. 2. Initial approval criteria I.A.6.a.ii and II.A.4.a.ii was updated to remove “two 200 mg tablets per day”.	04.01.2022
RxA.548.Viberzi	No Update	04.01.2022
RxA.549.Vidaza_Onureg	1. Background was updated to include indication for Onureg. 2. Dosing Information was updated to include dosing regimen and maximum dose for Onureg. 3. Dosing information was updated to include dosing adjustment for renal impairment. 4. Dosage Forms was updated to include azacytidine (Onureg®): Tablets: 200 mg, 300 mg. 5. Initial Approval Criteria I.B & I.B.1 was updated to include off-label diagnoses Myelofibrosis & Advanced phase (i.e., accelerated- or blast-phase) respectively. 6. Initial Approval Criteria I.B.4.b.iii & I.B.4.d was updated to include In combination with Venclexta®. 7. Initial Approval Criteria I.B.4.d was updated to include Treatment of Blastic Plasmacytoid Dendritic Cell Neoplasm. 8. Initial Approval Criteria I.C was updated to include off-label indications Myelodysplastic syndrome (MDS)/Myeloprolif erative Neoplasms (MPN) Overlap Neoplasms.	04.01.2022
RxA.550.ViekiraPak	1. Dosing information was updated to include new indication Genotype 1a, with compensated cirrhosis. 2. Dosing information was updated to include Hepatic impairment dosing. 3. Approval durations were updated from 12 weeks to 3 months. 4. Appendix B was updated to remove generics grazoprevir/ elbasvir, and glecaprevir/ pibrentasvir, as these were not	04.01.2022

	available.	
RxA.551.Vimizim	No Update	04.01.2022
RxA.552.Vimovo	1. Appendix D updated to include Warnings and precautions.	04.01.2022
RxA.554.Visudyne	No Update	04.01.2022
RxA.555.Vitrakvi	1. Continued Therapy Approval II.B. created. 2. Appendix D is updated to include Central Nervous System (CNS) Effects.	04.01.2022
RxA.556.Vivlodex	1. Dosing information was updated to exclude Rheumatoid arthritis (off label indication).	04.01.2022
RxA.557.Vizimpro	No Update	04.01.2022
RxA.558.Vosevi	1. Dosing information was updated to remove genotype 3 treatment naive off label indication.	04.01.2022
RxA.559.Votrien	1. Dosing information table was updated by adding that Votrient® is not recommended in patients with severe hepatic impairment & by adding dose for hepatic impairment. 2. Initial approval criteria 1.E, Ovarian cancer off label use, removed as it is 2B recommendation per NCCN and not FDA-approved. 3. Initial Approval criteria I.B.4 updated to include Member has advanced or metastatic disease. 4. Initial Approval Criteria. I.D.2 updated to include criteria for differentiated thyroid carcinoma. 5. Initial approval criteria 1.D.4 updated to remove Capresla from prior authorization required. 6. Initial Approval criteria I.E.4 updated to include Used as single-agent therapy for persistent disease or with recurrence. 7. Initial Approval criteria I.F added to include off label indication Bone Cancer.	04.01.2022
RxA.560.VPRIV	1. Initial approval criteria I.A.1 was updated to remove “Type 3 Gaucher disease”.	04.01.2022
RxA.562.Vyleesi	1. Initial Approval Criteria I.A.1 was updated to include symptoms have persisted for a minimum of 6 months.	04.01.2022
RxA.564.Vyxeos	1. Background information was updated to expand patient population to pediatric patients 1 year and older. 2. Initial Approval criteria I.A.3 age criteria updated from Age ≥ 18 years to Age ≥ 1 years.	04.01.2022
RxA.567.Xhance	No Update	04.01.2022
RxA.568.Xpovio	1. Background was updated to include new combination	04.01.2022

	therapy In combination with bortezomib and dexamethasone. 2. Dosing Information was updated to include new dosing regimen 100 mg in combination with bortezomib and dexamethasone orally on day 1 of each week for RRMM. 3. Dosage Forms was updated to include 40 mg, 50 mg, 60 mg tablets. 4. Initial Approval Criteria I.A.4.a, I.A.4.b and I.A.4.c were updated to include combination therapies. 5. Initial Approval Criteria I.A.5.a was updated to include maximum dose criteria. 6. Continued Therapy Approval II.A.3.a was updated to include maximum dose criteria. 7. Appendix B was updated to replace generic drugs pomalidomide and panobinostat with brand drugs Pomalyst and Farydak respectively as generic not available for both.	
RxA.569.Iluvien_Ozurdex_Retisert_Yutiq	1. Dosing information was updated for Iluvien® max dose duration from 12 to 36 months. 2. Initial and Continued Therapy Approval Criteria approval duration was updated from 4 weeks to 28 days. 3. Continued Therapy Criteria II.A.3.b Iluvien® max dose duration criteria was updated from 12 to 36 months. 4. Appendix B was updated to include Dosing regimens for Azasan® & Imuran®, 1.5-2 mg/kg/day & 2-3 mg/kg/day orally, respectively. 5. Appendix B was updated to update maximum dose for Leukeran® from 0.2 mg/kg/day to Max. dosage is dependent on indication, response, and toxicity. 6. Appendix B was updated to include Dosing regimen for Prograf®.	04.01.2022
RxA.570.Zavesca	1. Dosing Information updated to include the dosing regimen for patients with renal impairment. 2. Therapeutic Alternative table was updated to include Dose Limit/Maximum Dose for Cerezyme®, Elelyso® and VPRIV®.	04.01.2022
RxA.571.Zelboraf	1. Initial Approval Criteria I.A.6 was updated to include Preferred systemic therapy* option in combination with cobimetinib. 2. Initial Approval Criteria I.A.7 was updated to include Systemic therapy* option in combination with cobimetinib and atezolizumab. 3. Initial Approval Criteria I.C.5 was updated to include new criteria Failure of Tafinlar® and Mekinist. 4. Initial Approval Criteria I.D.5 was updated to include new criteria Request to be used as a preferred therapy with or without rituximab. 5. Initial Approval Criteria I.E.5 was updated to include new criteria Consider if clinical trials or other systemic therapies are not available.	04.01.2022

	6. Initial Approval Criteria I.G was added to include new indication Langerhans Cell Histiocytosis. 5. Appendix B was updated to remove dabrafenib, trametinib, cetuximab & panitumumab generics as not available on ESM.	
RxA.572.Zepatier	1. Appendix C was updated to include Contraindications.	04.01.2022
RxA.573.Zejula	1. Dosing information is updated to include moderate hepatic impairment dosing. 2. Appendix D was updated to include Warnings and precautions.	04.01.2022
RxA.575.Zemplar	1. Dosing Information Maximum dose was updated from Adults:0.24 mcg/kg to Adults:0.24 mcg/kg every other day. 2. Dosage Forms was updated to include 10 mcg/2 mL (5 mcg/mL) multiple-dose vial.	04.01.2022
RxA.577.Zolgensma	1. Generic name for the drug was updated from onasemnogene abeparvovec to onasemnogene abeparvovec-xioi. 2. Dosing information was updated from once to 1.1 x 10^{14} vg/kg as a single intravenous dose. 3. Appendix C was updated to include Boxed Warnings.	04.01.2022
RxA.578.Zolinza	1. Dosing information table was updated to add dosing regimen for hepatic impairment.	04.01.2022
RxA.579.Zulresso	1. Dosing information was updated to include renal impairment doses adjustment. 2. Appendix B was updated to change clomipramine Dosing regimen from 12.5-150 mg/day orally once daily to 25-100 mg/day orally once daily. 3. Appendix B was updated to remove levomilnacipran generic as it was not available in US.	04.01.2022
RxA.581.Zydelig	1. Appendix B was updated to remove ibrutinib, venetoclax, obinutuzumab, alemtuzumab, duvelisib, acalabrutinib, lenalidomide, ofatumumab, chlorambucil, copanlisib generics as these were not available in US. 2. Appendix D was updated to include Severe Cutaneous Reactions.	04.01.2022
RxA.582.Zykadia	1. Dosing information was updated to add dosing regimen for severe hepatic impairment. 2. Initial Approval criteria I.C added to include off label indication criteria for Central Nervous System Cancers.	04.01.2022
RXA.585.Arzerra	No Update	04.01.2022
RxA.586.Adakveo	No Update	04.01.2022
RxA.003 Proton Pump Inhibitors	1. Dosing Information, Maximum Dose, rabeprazole (Aciphex®): Updated maximum dosing information from 20 mg/day to 40 mg/day for indications Duodenal ulcers,	04.01.2022

	Erosive esophagitis, H. pylori triple therapy, & Symptomatic GERD (erosive/ulcerative), healing and maintenance. 2. Dosing Information, Dosing Regimen, rabeprazole sodium delayed-release (Aciphex® sprinkle): Updated dosing information for Pediatric Ages 1 to 11 years from Weight <15 kg: 5 to 10 mg PO once daily & Weight ≥15 kg: 10 mg PO once daily to Less than 15 kg: 5 mg once daily with the option to increase to 10 mg once daily, if inadequate response for up to 12 weeks & 15 kg or more: 10 mg once daily for up to 12 weeks. 3. Dosing Information, Drug Name: Updated to include new drug Prilosec®. 4. Drug(s) Applied, Background, Dosing Information, Dosage forms, Clinical Policy, Appendix C and Appendix D were updated to remove information about Dexilant®, Nexium®, Nexium® 24HR, Nexium® 24HR ClearMinis™, Zegerid®, Zegerid® OTC as they no longer require Prior Authorization. 5. Initial Approval Criteria, I.A.3.a: Updated to remove prior age criteria for Prilosec® packets "Age less than 12 years and request is for lansoprazole disintegrating tablets, AcipHex Sprinkle, or Prilosec® packets". 6. Initial Approval Criteria 1.A.3 was updated to add I.A.3. a, I.3.A.b and I.A.3.c which includes: a. Age less than 12 years and request is for AcipHex Sprinkle; b. Age 1 year and older, if request is for Prilosec Packets for indications (i and ii): i. Maintenance of healing of Erosive Esophagitis (EE) due to acid-mediated GERD; ii. Symptomatic GERD; c. Age 1 month and older for Erosive Esophagitis (EE) due to acid-mediated GERD for Prilosec® Packets	
RxA.007 Adempas	1. Dosing Information, Dosing Regimen, Adempas: Updated to include dosing information for indication Pulmonary arterial hypertension/chronic thromboembolic pulmonary hypertension. 2. Appendix B updated: a. Dosing Regimen, Procardia XL: Updated dosing information from 60 mg orally once daily; may increase to 120 to 240 mg/day to Initial, 30 or 60 mg orally once daily; generally, titrate over 7 to 14 days for indication Hypertension. b. Maximum Dose, Procardia XL: Updated maximum dose information from 240 mg/day to 120 mg/day for indication Hypertension. c. Dosing Regimen, Norvasc: Updated dosing information from 20 to 30 mg orally Once daily to Initial, 2.5 mg orally once daily; increase cautiously	04.01.2022

	and progressively up to the maximum tolerated dose (up to 20 mg/day was used in studies) for indication Pulmonary hypertension. d. Maximum Dose Norvasc: Updated maximum dose information from 30 mg/day to 10 mg/day for indication Pulmonary hypertension. e. Dosing Regimen, Dilt-XR®, Cardizem® CD, Cartia XT®, Tiazac®, Taztia XT®, Cardizem® LA, Matzim® LA: Updated dosing information from 720 to 960 mg orally Once daily to Initially, 180 to 240 mg PO once daily. Adjust dosage to individual patient needs up to a maximum of 540 mg/day for indication Hypertension. f. Appendix B, Maximum Dose, Dilt-XR®, Cardizem® CD, Cartia XT®, Tiazac®, Taztia XT®, Cardizem® LA, Matzim® LA: Updated maximum dose information from 960 mg/day to 540 mg/day for indication Hypertension. 3. Appendix C, Contraindications: Updated to include new contraindication Patients with concomitant use of other soluble guanylate cyclase (sGC) stimulators.	
RxA.008 Afinitor, Afinitor Disperz, Zortress	1. Dosing Information, Maximum Dose, Afinitor®: Updated maximum dosing information from 20 mg/day to 10 mg/day for indications Breast cancer, PNET (pancreas), NET (GI, lung), RCC, TSC-AML (renal). 2. Dosing Information, Dosing Regimen, Afinitor®: Updated to include hepatic impairment dosing information for indications Breast cancer, PNET (pancreas), NET (GI, lung), RCC, TSC-AML (renal), TSA-SEGA. 3. Dosing Information, Dosing Regimen, Afinitor Disperz®: Updated to include hepatic impairment dosing information for TSA-SEGA and TSC-associated partial-onset seizures. 4. Dosing Information, Dosing Regimen Zortress®: Updated to include hepatic impairment dosing information for Liver transplant rejection prophylaxis. 5. Initial Approval Criteria; a. I.E.3: Updated to include new age criteria Age ≥ 1 years. b. I.F.2: Updated to include new age criteria Age ≥ 2 years 6. Initial Approval Criteria, IH1: Updated to include new indication a. Histiocytic Neoplasms (Langerhans Cell Histiocytosis, Rosai-Dorfman Disease, a Erdheim-Chester Disease b. Uterine Neoplasms - Endometrial Carcinoma c. Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma - Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma 7. Appendix B, Maximum Dose,	04.01.2022

	a. sunitinib (Sutent®): Updated maximum dose information from 50 mg/day to 87.5 mg/day for indication GIST. b. Nexavar: Updated maximum dose information from 400 mg/day to 800 mg/day for indication DTC.	
RxA.10 Aldurazyme	No update	04.01.2022
RxA.011 Aliqopa	1. Dosing Information: Updated a. Dosing Regimen, Aliqopa®: Updated dosing information from 60 mg IV to 60 mg administered as a 1-hour intravenous infusion for indication follicular lymphoma. b. Dosing Regimen, Aliqopa®: Updated to include hepatic impairment dosing information for indication follicular lymphoma.	04.01.2022
RxA.012 Alunbrig	1. Dosing Information, Dosing Regimen, Alunbrig: Updated to include hepatic impairment dosing information for indication ALK-positive metastatic non-small cell lung cancer (NSCLC). 2. Dosing Information, Dosing Regimen, Alunbrig: Updated to include renal impairment dosing information for indication ALK-positive metastatic non-small cell lung cancer (NSCLC). 3. Initial Approval Criteria I.B: Updated to include approval criteria for indication Central Nervous System Cancer. 4. Initial Approval Criteria I.C: Updated to include approval criteria for indication Soft Tissue Sarcoma. 5. Appendix D, General Information: Updated to include new information regarding Drug Interactions.	04.01.2022
RxA.014 Apokyn	1. Dosing Information, Dosing Regimen, Apokyn® : Updated to include renal impairment dosing information for indication Parkinson's disease. 2. Background was updated to remove, 'with carbidopa and levodopa therapy'. 3. Initial approval criteria I.A.4 and I.A.6 were updated to add drug names to pharmacological class. (e.g. pramipexole, ropinirole were added as dopamine agonist examples)	04.01.2022
RxA.015 Aralast NP, Glassia, Prolastin-C, Zemaira	No update	04.01.2022
RxA.016 Arcalyst	1. Background: Updated to include new indication recurrent pericarditis. 2. Dosing Information, Indication: Updated to include new indication recurrent pericarditis 3. Initial Approval Criteria: Updated a. I.B.3 and I.B.4: Age criteria rephrased to be clear on age requirements b. I.C: Updated to include approval criteria for indication, recurrent pericarditis. 4. Continued Therapy Approval Criteria: Updated II.C: Updated to include approval criteria for indication,	04.01.2022

	recurrent pericarditis. 5. Appendix A: Updated a. To include abbreviations CINCA, NOMID, RP b. To remove abbreviation SC. 6. Appendix B: Updated Maximum Dose, Kineret: Updated maximum dose information from 100 mg/day SC to 8 mg/kg/day for indication CAPS.	
RxA.017 Arikayce	1. Dosing Information, Dosing Regimen, Arikayce®: Updated dosing information to include use with Lamira Nebulizer System for indication MAC. 2. Initial Approval Criteria, I.A.4:, Updated to include requirement for combination therapy with antibiotic	04.01.2022
RxA.019 Auvi-Q	1. Dosing Information, Maximum Dose, Auvi-Q®: Updated maximum dosing information to add that More than 2 sequential doses should only be administered under direct medical supervision and indication for therapy for indication allergic reactions (Type I) including anaphylaxis. 2. Updated the policy title background, dosing information, dosage forms, clinical policy to remove information about EpiPen and EpiPen Jr as they currently do not need prior authorization	04.01.2022
RxA.021 Accrufer	1. Dosage Forms: Updated dosage form to include package size of 60.	04.01.2022
RxA.022 Actimmune	1. Initial Approval Criteria, I.C.3 and I.C.4: updated to include diagnostic criteria IA-IIA, IVA1, and IVA2.	04.01.2022
RxA.023 Balversa	1. Initial Approval Criteria, I.A.1: Updated diagnostic criteria from Diagnosis of locally advanced or metastatic urothelial carcinoma to Diagnosis of at least one of the following: Locally advanced or metastatic urothelial carcinoma, Bladder Cancer, Upper GU Tract Tumors and Primary Carcinoma of the Urethra. 2. Appendix A was updated to include abbreviations for Genital Urinary Tract.	04.01.2022
RxA.025 Beleodaq	No update	04.01.2022
RxA.028 Step_Therapy_Exception	No update	04.01.2022
RxA.031 Bosulif	1. Initial Approval Criteria, I.C: Updated to include approval criteria for indication Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes (off-label).	04.01.2022
RxA.033 Brovana	1. Initial Approval Criteria, I.A.2: Updated to include new prescriber criteria mandating pulmonologist or respiratory therapist.	04.01.2022

RxA.038 Binosto_Fosamax.Plus.D	1. Dosing Information, Maximum Dose, Fosamax®: Updated to include maximum dosing information for indication PMO prevention. 2. Appendix A: Updated to remove abbreviation PO. 3. Appendix D, General Information: Updated to include new information regarding Drug Interactions.	04.01.2022
RxA.041 Bryhali_Lexette_Ultravate	1. Background: Updated patient population from 18 years or older to 12 years or older for Lexette. 2. Initial Approval Criteria, IA.2: Updated age criteria from 18 to 12 for Lexette®.	04.01.2022
RxA.049 Brineura	No Update	04.01.2022
RxA.051 Cablivi	No Update	04.01.2022
RxA.052 Cabometyx_Cometriq	1. Background: Updated to include new indication Differentiated thyroid cancer for Cabometyx®. 2. Dosing Information, Indication: Updated to include new indication Differentiated thyroid cancer for Cabometyx®. 3. Dosing Information, Dosing Regimen, Cabometyx®: Updated to include hepatic impairment dosing information for indication RCC, HCC, DTC. 4. Dosing Information, Dosing Regimen, Cometriq®: Updated to include hepatic impairment dosing information for indication MTC. 5. Initial Approval Criteria, I.A.5.a, 1.A.5.b, I.A.5.c were removed. I.A.5.a included low-risk group, I.A.5.b included intermediate risk group and I.A.5.c included poor risk group. 6. Initial Approval Criteria, I.B.1.b: Updated indication from Differentiated thyroid carcinoma (DTC; i.e., follicular, Hurthle cell, or papillary thyroid carcinoma) to Locally advanced or metastatic differentiated thyroid carcinoma (DTC; i.e., follicular, Hurthle cell, or papillary thyroid carcinoma); 7. Initial Approval Criteria, I.B.3: Updated to include new criteria pertaining to indication DTC, If DTC; disease has progressed following both (a and b): a. Prior VEGFR-targeted therapy; b. Who are radioactive iodine-refractory or ineligible 8. Initial approval criteria I.B.4: Updated age criteria from Age ≥ 18 years to: a. Age ≥ 18 years for Cometriq®; b. Age ≥ 12 years for Cabometyx®. 9. Initial Approval Criteria, I.B.5: Updated drug request criteria from Request is for Cometriq to Request is for one of the following (a or b): a. Cometriq® for MTC; b. Cabometyx® for DTC 10. Initial Approval Criteria, I.B.6: Updated dose criteria to include dose limit for Cabometyx.	04.01.2022

	11. Initial Approval Criteria, 1.C.6: Updated dosing criteria to include dose limit of 80 mg per day. 12. Initial Approval Criteria, I.E.1: Updated indication to also include Uterine Neoplasms - Endometrial Carcinoma.	
RxA.055 Cambia_Zipsor_Pennsaid_Solaraze_Zorvolex	1. Background was updated to include information regarding age criteria for brand Zipsor® pediatric patients 12 years of age and older. 2. Initial Approval Criteria, I.A.2: Updated to remove prior drug specific criteria "Request is for Zipsor® or Zorvolex®". 3. Initial Approval Criteria, I.A.2, I.A.3: Updated to include new drug/age specific criteria a. Request is for Zipsor® and age ≥ 12 years b. Request is for Zorvolex® and age ≥ 18 years	04.01.2022
RxA.061 Ceprotin	1. Background: Updated information regarding indication severe congenital Protein C deficiency to expand patient population to neonates.	04.01.2022
RxA.062 Cerdelga	1. Dosing Information, Dosing Regimen, Cerdelga®: Updated to include hepatic and renal impairment dosing information for indication Type 1 Gaucher Disease. 2. Initial Approval Criteria, I.A.2: Updated to include new prescriber criteria mandating hematologist.	04.01.2022
RxA.065 Chenodal	No Update	04.01.2022
RxA.066 Chloramphenicol sodium succinate	1. Initial Approval Criteria, I.A.4: Updated to include new criteria Member has serious infections caused by organisms that are resistant to other therapeutic agents or contraindicated. 2. Continued Therapy Approval II.A Updated to All FDA-Approved Indications.	04.01.2022
RxA.067 Cholbam	1. Dosing Information, Maximum Dose, Cholbam®: Updated to include maximum dosing information for indication Bile acid synthesis disorders due to SEDs, PDs including Zellweger spectrum disorders. 2. Appendix D, General Information: Updated to remove information regarding limitation(s) of use.	04.01.2022
RxA.069 Cinqair	1. Background updated to remove, “it should be administered in an health care setting by a healthcare professional prepared to manage anaphylaxis.” 2. Appendix B, Drug Name: Updated to include brand-name therapeutic alternatives a. Qvar RediHaler b. Flovent diskus® c. Flovent HFA	04.01.2022

RxA.070 Berinert_ Cinryze_ Haegarda_ Ruconest	1. Dosing Information, Maximum Dose, Berinert®: Updated to include maximum dosing information for indication Treatment of acute HAE attacks. 2. Dosing Information, Maximum Dose, Haegarda®: Updated to include maximum dosing information for indication Prophylaxis against acute HAE attacks. 3. Initial Approval Criteria I.A.4.c was removed. 4. I.a.6.a,I.A.6.c , II.B.4.a and II.B.4.c was updated to remove "up to 2 administered in a 24-hour period". 5. Initial and continued therapy approval duration updated to remove short term prophylaxis	04.01.2022
RxA.071 Absorica_Absorica.LD	1. Drugs applied, Background, Dosing information, Dosage forms, Clinical Policy was updated to remove Claravis®, Myorisan®, Zenatane®, Amnesteem® as these drugs no longer require prior authorization. 2. Appendix B: Updated 3. Dosing Regimen, Cleocin T, Clindagel: Updated dosing information to specify indication acne vulgaris. 4. Appendix B, Maximum Dose, tetracycline: Updated maximum dose information from 4 mg per day to 4 gm per day for indication acne vulgaris. 5. Drug Name: Updated to include new therapeutic alternative Sulfacetamide (Klaron®).	04.01.2022
RxA.071 Claravis Absorica Myorisan Zenatane Amnesteem	1. Appendix B Updated: a. Dosing Regimen, Cleocin T, Clindagel: Updated dosing information to specify indication acne vulgaris b. Appendix B, Maximum Dose, tetracycline : Updated maximum dose information from 4 mg per day to 4 gm per day for indication acne vulgaris. c. Drug Name: Updated to include new therapeutic alternative Sulfacetamide (Klaron®).	04.01.2022
RxA.072 Clarinex	1. Clinical policy title updated to remove desloratadine/pseudoephedrine. 2. Drug(s) applied updated to remove Clarinex-D® 12 Hour as it does not require prior authorization. 3. Background, Dosing information, Dosage forms, Clinical policy, Appendix C and Appendix D updated to remove information about Clarinex-D® 12 Hour as it does not require prior authorization. 4. Dosing Information, Updated: a. Dosing Regimen, Clarinex®: Updated dosing information to remove "12 months-5 years: ½ tsp oral solution orally once daily". b. Dosing Regimen, Clarinex®: Updated dosing information for patients aged 6-11 months from 2 mL oral solution orally once daily to 2.5 mg once daily for indication Seasonal and perennial allergic rhinitis and chronic idiopathic urticaria.	04.01.2022

	c. Dosing Regimen, Clarinex®: Updated to include hepatic and renal impairment dosing information for indication Seasonal and perennial allergic rhinitis and chronic idiopathic urticaria. 5. Initial Approval Criteria, I.A.2: Updated to include new prescriber criteria mandating otolaryngologist or dermatologist. 6. Appendix B, Drug Name: Updated to include new therapeutic alternative levocetirizine dihydrochloride (Xyzal®).	
RxA.076 Cortrosyn	1. Dosage Forms: Updated dosage form from "Vial of sterile lyophilized powder for injection: 0.25 mg" to "Injection: 0.25 mg/mL in 1 mL single-dose vial (Box of 10 vials)". 2. Appendix A: Updated to include abbreviations ACTH.	04.01.2022
RxA.077 Dose_Optimazation	No update	04.01.2022
RxA.080 Crysvita	No update	04.01.2022
RxA.082 Cuprimine	1. Appendix B, Dosing Regimen, potassium citrate: Updated dosing information from 60-80 mEq/day divided into 3-4 doses (15–20 mL/day); titrate to achieve a urine pH within target range 7-7.5 to 60 to 90 mEq total in 3 or 4 divided doses, titrated as needed to optimize the pH at 7.5 for indication Cystinuria. 2. Appendix B, Maximum Dose, potassium citrate: Updated maximum dose information from See regimen to 90 mEq for indication Cystinuria. 3. Appendix C, Boxed Warnings: Updated boxed warning to include should be administered under the close supervision of a physician familiar with the toxicity and dosage considerations.	04.01.2022
RxA.083 Cyramza	1. Initial Approval Criteria, 1.A.4: Updated combination therapy options to include irinotecan with or without fluorouracil.	04.01.2022
RxA.084 Cystagon_Procysbi	1. Dosing information, Procysbi: updated to include delayed release.	04.01.2022
RxA.085 Cystaran	1. Clinical Policy Title: Updated from cysteamine ophthalmic to cysteamine hydrochloride. 2. Dosing Information, Indication: Updated from Corneal cystine crystal accumulation to Corneal cystine crystal accumulation in patients with cystinosis.	04.01.2022

RxA.086 Compounded_Medications	No update	04.01.2022
RxA.087 Cystadane	No update	04.01.2022
RxA.088 Daraprim	1. Dosing Information, Maximum Dose, Daraprim®: Updated maximum dosing information from 300 mg/day to 75 mg/day orally for indication toxoplasmosis. 2. Dosing information, Dosing regimen, Daraprim®: Updated to remove dosing regimen for ocular taxoplamosis. 3. Dosing information, Dosing regimen, Daraprim®: Updated to remove "50-75 mg/week PO in combination with a sulfonamide" for indication of primary prophylaxis of taxoplasmosis. 4. Initial Approval Criteria 1.A.5.b updated from initial loading dose of 100 mg followed by ≤ 50 mg per day for treatment duration to 75 mg/day.	04.01.2022
RxA.089 CNS_Stimulants	1. Initial Approval Criteria, I.A.2: Updated age criteria from age is ≥ 6 years to age is ≥ 13 years for Mydayis, for all other brands member age is ≥ 6 years. 2. Continued Therapy Approval Criteria II.A.3.i: Updated to include pediatric dose limit for Mydayis® of 25 mg per day.	04.01.2022
RxA.090 Total_Parenteral_Nutrition_and_Intradialytic_Parenteral_Nutrition	No Update	04.01.2022
RxA.094 Nocdurna_Noctiva	1. Drugs applied, Background, Dosing Information, Dosage forms, Clinical Policy, Appendix A, Appendix C updated to remove information about DDAVP® and Stimate® as they no longer require prior authorization. 2. Initial Approval Criteria, I.A.3: Updated age criteria from ≥ 18 years to: a. If the request is for Noctiva™ patient is > 50 years; b. If the request is for Nocdurna patient is ≥ 18 years; 3. Initial Approval Criteria I.A.2 was updated to include prescriber criteria. 4. Initial Approval Criteria I.A 5 was updated to include Member awakens at least two times per night to void. 5. Initial Approval Criteria I.A.6 was updated to include Prescriber has verified that the individual does not have the following conditions/circumstances in which use of Noctiva is not recommended (a, b, c, d or e): a. Currently receiving loop diuretics (e.g., furosemide, torsemide, bumetanide); b. Currently receiving systemic or inhaled glucocorticoids;	04.01.2022

	c. Renal impairment with an estimated glomerular filtration rate < 50 mL/min/1.73 m2; OR iv. New York Heart Association class II to IV congestive heart failure; d. Polydipsia; e. Known or suspected syndrome of inappropriate antidiuretic hormone	
RxA.096 Desoxyn	1. Initial Approval Criteria, I.A.2: Updated to include new prescriber criteria requiring a psychiatrist or psychologist.	04.01.2022
RxA.097 Blood_glucose_test_strip_quantity_limit - Not_Receiving_Insulin	No update	04.01.2022
RxA.099 Duexis	1. Appendix B, Maximum Dose, Protonix®: Updated maximum dose information from 40 mg/day to 80 mg/day (for most GERD indications) for indication NSAID-induced ulcer prophylaxis. 2. Appendix B, Maximum Dose, Pepcid® : Updated maximum dose information from Varies based on indication to 40 mg/day for indication NSAID-induced ulcer prophylaxis.	04.01.2022
RxA.100 Dysport	1. Dosing Information: Updated a. Indication: Updated to include new indication Glabellar Lines. b. Maximum Dose, Dysport®: Updated to maximum dosing information from 1000 Units/12 weeks to 15 Units/kg for unilateral lower limb injections, 30 Units/kg for bilateral injections, or 1000 Units, whichever is lower for indication Pediatrics lower limb spasticity 2. Initial Approval Criteria: Updated a. I.B: Updated to include approval criteria for indication, Glabellar Lines. b. I.C.5.a: Updated dosing criteria from Dose does not exceed 1,000 units and 1,500 units per treatment session to Dose does not exceed 1,000 units for upper limb spasticity and 1,500 units for lower limb spasticity per treatment session. 3. Continued Therapy Approval, II.A.5.a: Updated to include new dosing criteria Glabellar Lines: 50 units.	04.01.2022
RxA.102.Daurismo	1. Background: Updated to remove limitation(s) of use, "Limitation(s) of use: Glasdegib has not been studied in patients with the comorbidities of severe renal impairment or moderate-to-severe hepatic impairment".	04.01.2022
RxA.104.Diacomit	1. Dosing Information, Indication: Updated from Dravet syndrome to Seizures associated with Dravet syndrome. 2. Initial Approval Criteria, I.A, I.A.1: Updated indication from Dravet syndrome to Seizures associated with Dravet	04.01.2022

	syndrome. 3. Continued Therapy Approval Criteria, II.A: Updated indication from Dravet syndrome to Seizures associated with Dravet syndrome. 4. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 5. Appendix B, Epidiolex®: Updated to remove unavailable generic therapeutic alternative cannabidiol. 6. Appendix B, Dosing Regimen, Onfi®, Sympazan®: Updated dosing information from Initial: 0.2-0.3 mg/kg/day PO to Initial: 0.2-0.3 mg/kg/day orally divided twice daily.	
RxA.109.Edluar_Intermezzo_Zolpimist	1. Dosing Information, Updated a. Dosing Regimen, Intermezzo®: Updated dosing information from sublingual HS as needed to sublingual as needed for indication middle-of-the-night awakening followed by difficulty returning to sleep. b. Dosing Regimen, Edluar®: Updated to include hepatic impairment dosing information for indication short-term treatment of insomnia characterized by difficulties with sleep initiation. c. Dosing Regimen, Zolpimist®: Updated to include hepatic impairment dosing information for indication short-term treatment of insomnia characterized by difficulties with sleep initiation. d. Dosing Regimen, Intermezzo®: Updated to include hepatic impairment dosing information for indication middle-of-the-night awakening followed by difficulty returning to sleep.	04.01.2022
RxA.111.Egrifta_SV	1. Initial approval criteria I.A.5 and continued therapy approval II.A.3 updated from 2 mg/day to 1.4 mg/day.	04.01.2022
RxA.112.Elaprase	No Update	04.01.2022
RxA.113.Elelyso	1. Initial approval criteria I.A.3 was updated to add prescriber criteria.	04.01.2022
RxA.116.Enstilar	1. Appendix B, Dosing Regimen, Updated. a. diflorasone 0.05% (Apexicon E®) cream: Updated from Apply topically to the affected area(s) twice daily to Apply sparingly 1 to 3 times daily for indication dermatoses. b. fluocinolone acetonide 0.025% (Synalar®) cream, ointment: Updated from Apply topically to the affected area(s) twice daily to Apply a thin layer to affected area 2 to 4 times daily for indication	04.01.2022

	dermatoses. c. mometasone furoate 0.1% cream, lotion, ointment: Updated from Apply topically to the affected area(s) twice daily to Apply a thin film to affected area once daily for indication dermatoses.	
RxA.117.Fabrazyme	1. Background: Updated to include new patient population/age criteria pediatric patients 2 years of age and older with confirmed Fabry disease. 2. Initial Approval Criteria, I.A.2: Updated age criteria from Age 8 years of age or older to Age 2 years of age or older.	04.01.2022
RxA.118.Faslodex	1. Dosing Information, Dosing Regimen, Faslodex®: Updated to include hepatic impairment dosing information for indication Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)- negative advanced breast cancer. 2. Initial Approval Criteria I.A..4 a,b,c,d,e,f were included. 3. Initial Approval Criteria I.A.5 was updated to include, used as a single agent or in combination with Herceptin® if disease is HR-Positive, HER2- positive; 4. Initial approval criteria I.C.4 updated to remove: a. For recurrent or metastatic disease; b. For stage IIIA or higher disease; c. For disease not suitable for primary surgery; 5. Initial approval criteria I.C.4 updated to include: a. Primary treatment in patients undergoing both brachytherapy and external beam radiation therapy (EBRT) with cervical involvement that is not suitable for surgery; b. Primary treatment in patients with disease limited to the uterus or extrauterine disease that is not suitable for primary surgery; c. Primary treatment in patients with distant metastatic disease; d. Adjuvant treatment for locally advanced or metastatic (stage III-IV) disease; e. Treatment for disseminated metastases or locoregional recurrence;	04.01.2022
RxA.120.Firdapse_Ruzurgi	1. Dosing Information, Dosing Regimen, Firdapse®: Updated to include hepatic impairment/renal impairment dosing information. 2. Dosing Information, Dosing Regimen, Ruzurgi®: Updated to include hepatic impairment/renal impairment dosing information. 3. Initial approval criteria I.A.3 was updated to modify age criteria for Firdapse®, it was 6 years of age previously and was updated to ≥ 18 years of age.	04.01.2022

	4. Continued Therapy Approval Criteria, II.A.4: Updated to include new seizures criteria Member does not have history seizures.	
RxA.121.Folotyn	1. Background was updated to include statement about accelerated approval. 2. Dosing Information, Dosing Regimen, Folotyn®: Updated to include renal impairment dosing information for indication PTCL. 3. Initial Approval Criteria, I.A.1: Updated indication from Diagnosis of PTCL to Diagnosis of relapsed or refractory PTCL. 4. Initial Approval Criteria, I.A.4: Updated trial and failure criteria from Failed prior therapy (see Appendix B for examples) to Failure of at least one (1) prior therapy (see Appendix B for examples) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced. 5. Initial Approval Criteria, I.B.1.b.iv.: Updated to include approval criteria for indication, Breast Implant-Associated ALCL, as a second line therapy. 6. Appendix B, first line therapy added for indication Breast implant ALCL.	04.01.2022
RxA.122.Fortamet_ Glumetza	1. Dosing Information, Dosing Regimen, Glumetza: Updated to include renal impairment dosing information for indication Type 2 Diabetes mellitus (DM). 2. Appendix B, Drug Name: Updated to remove discontinued brand-name therapeutic alternative Glucophage, Glucophage XR. 3. Appendix D, General Information: Updated to include new information regarding Glumetza® may need to be discontinued at time of, or prior to, iodinated contrast imaging procedures.	04.01.2022
RxA.125.Fuzeon	1. Appendix B, Truvada®: Updated to include generic therapeutic alternative (emtricitabine-tenofovir) Truvada®.	04.01.2022
RxA.126.Fanapt	No Update	04.01.2022
RxA.129.Firmagon	1. Dosing Information, Maximum Dose, Firmagon®: Updated to include maximum dosing information for indication Advanced prostate cancer.	04.01.2022
RxA.130.Auryxia_Renagel_ Velphoro	1. Clinical policy sections: Drug(s) Applied, Background, Dosing Information, Dosage forms, Initial and Continued Approval Criteria (I.A. and II.A) , Appendix C, were updated to remove information about Fosrenol®, Renvela® as they no longer require Prior Authorization. 2. Background: Updated information regarding indication chronic kidney disease (CKD) to remove patient population	04.01.2022

	with end stage renal disease (ESRD). 3. Dosing Information, Dosing Regimen, Velphoro®: Updated to include maintenance dosing information for indication Hyperphosphatemia. 4. Initial Approval Criteria, 1.B.3: Updated trial and failure criteria to specify that member must try at least one (1) of the alternative therapies previously listed. 5. Appendix B, Dosing Regimen, calcium acetate: Updated dosing information to 1334 mg (2 tablets or capsules) orally with each meal initially. The dosage may be gradually increased every 2 to 3 weeks to lower serum phosphate concentrations within the desired range for indication Hyperphosphatemia. 6. Appendix B, Maximum Dose, calcium acetate: Updated maximum dose information from 1,500 mg/day total elemental calcium to 2000 mg/day total elemental calcium for indication Hyperphosphatemia. 7. Appendix B, Dosing Regimen, ferrous sulfate, ferrous fumarate, ferrous gluconate: Updated dosing information from 100 to 200 mg elemental iron PO daily in 2 to 3 divided doses (or daily with extended release tablets) to 60 mg elemental iron orally 1 to 3 times daily for 4 week for indication Iron Deficiency Anemia.	
RxA.131.Neulasta_Fulphila_Udenyca_Ziextenzo	1. Appendix B, Drug Name: Updated to remove unavailable generic therapeutic alternative filgrastim, filgrastim sndz, tbo filgrastim, filgrastim aafi and sargramostim.	04.01.2022
RxA.135.Feraheme	No Update	04.01.2022
RxA.136.Firazyr	No Update	04.01.2022
RxA.137.Formulary Exceptions	No Update	04.01.2022
RxA.138.Forteo	1. Dosage Forms: Updated dosage form from 620 mcg/2.48 mL to 600 mcg/2.4 mL. 2. Initial Approval Criteria, I.A.4: Updated diagnostic criteria to include b. regardinguse of medication for more than 2 years. 3. Continued Therapy Approval Crtieria, II.A.3: Updated diagnostic criteria to include b. regardinguse of medication for more than 2 years.	04.01.2022
RxA.140.Fusilev	1. Background: Updated indication to remove “For the palliative treatment”. 2. Dosing Information, Dosing Regimen: Updated serum threshold from serum MTX is < 10^{-8}M to serum MTX is < 5 × 10^{-8}M. Also added instructions to increase Fusilev® to 50 mg/m^2 intravenous every 3 hours until serum MTX is < 5 ×	04.01.2022

	10^{-8} M if one of the following for indication Inadvertent MTX overdose. 3. Dosing Information, Dosing Regimen: Updated dosing information from Fusilev® 100 mg/m^2 followed by 5-FU 370 mg/m^2 to Fusilev® 100 mg/m^2 intravenous over a minimum of 3 minutes followed by 5-FU 370 mg/m^2 intravenous injection, once daily for 5 consecutive days for indication Colorectal cancer. 4. Dosing Information, Dosing Regimen: Updated dosing information from Fusilev® 10 mg/m^2 intravenous followed by 5-FU 425 mg/m^2 to Fusilev® 10 mg/m^2 intravenous followed by 5-FU 425 mg/m^2 intravenous injection, once daily for 5 consecutive days for indication Colorectal cancer. 5. Appendix C, Contraindications: Updated contraindication regarding severe hypersensitivity reactions to also include leucovorin products. 6. Appendix D: Updated to include NCCN recommended combination use of levoleucovorin with methotrexate as a rescue for the following cancers (2A recommendation) when leucovorin is not available: a. Acute Myeloid Leukemia; b. Pediatric Aggressive Mature B-Cell Lymphomas. c. Updated from T-cell lymphomas (including peripheral T-cell lymphomas, adult T-cell leukemia/lymphoma, extranodal NK/T-cell lymphoma [nasal type]) to T-cell lymphomas (including peripheral T-cell lymphomas, adult T-cell leukemia/lymphoma, extranodal NK/T-cell lymphoma [nasal type]), Hepatosplenic T-Cell Lymphoma. 7. Appendix D: Updated to include NCCN recommended combination use of levoleucovorin with fluorouracil-based regimens for the following cancers (2A recommendation) when leucovorin is not available: a. Small Bowel Adenocarcinoma - Small Bowel Adenocarcinoma, Advanced Ampullary Cancer b. Updated from Poorly differentiated (high grade)/large or small cell neuroendocrine and adrenal tumors to Poorly differentiated (high grade)/large or small cell neuroendocrine and adrenal tumors, Well Differentiated Grade 3 Neuroendocrine Tumors, Neuroendocrine Tumors of the Pancreas (Well Differentiated Grade 1/2), Well Differentiated Grade 3 Neuroendocrine Tumors	

	c. Updated from Hepatobiliary carcinoma to Hepatobiliary carcinoma (Biliary Tract Cancers: Intrahepatic Cholangiocarcinoma, Gallbladder Cancer.	
RxA.141.Gablofen_Lioresal_Ozobax	1. Clinical Policy Title, Drug(s) Applied: Updated to remove suffix Intrathecal from Lioresal® Intrathecal to Lioresal®. 2. Dosing Information, Dosing Regimen, Gablofen®, Lioresal®: Updated from 90 mcg/day - 700 mcg/day to 90 mcg/day to 703 mcg/day for spasticity of cerebral origin. 3. Dosing Information, Dosing Regimen, Gablofen®, Lioresal® Intrathecal, Ozobax®: Updated to include renal impairment dosing information for indications Severe spasticity of cerebral or spinal cord origin & Spasticity resulting from multiple sclerosis.	04.01.2022
RxA.142.Gamifant	1. Dosage Forms: Updated to include new dosage form, 100 mg/20 mL. 2. Initial approval therapy criteria I.A.1 was updated to add sub-criteria a, b, c, d, e, f, and g in their entirety.	04.01.2022
RxA.143.Immune_Globulin	1. Background: Updated to include new indication Dermatomyositis. 2. Policy updated to remove unavailable drug Carimune NF. 3. Dosing Information, Dosing Regimen: a. Gammagard® Liquid: Updated maintenance dosing information to indicate that maintenance dose is based on clinical response and target IgG trough level b. Hizentra®: Updated to include Start Hizentra® 1 or 2 weeks after the last IGIV infusion or 1 week after the last weekly IGSC infusion. Administer twice the calculated weekly dose. Frequent dosing (2 to 7 times per week): Start Hizentra® 1 week after the last IGIV or IGSC infusion. Divide the calculated weekly dose by the desired number of times per week. Adjust the dose based on clinical response and serum IgG trough levels. c. Cuvitru®: Updated to include Switching from Immune Globulin Subcutaneous (Human) treatment (IGSC): Weekly dose (in grams) should be the same as the weekly dose of prior IGSC treatment (in gm). Frequent dosing (2-7 times per week): Divide the calculated weekly dose by the desired number of times per week. Biweekly dosing: Multiply the calculated weekly dose by 2. Infusion sites: up to 4 infusion sites simultaneously, with at least 4 inches between sites avoiding bony prominences. Rotate sites with each administration.	04.01.2022

	d. Xembify®: Updated to include Switching from immune globulin subcutaneous (human) treatment (IGSC): Weekly dose (grams) should be the same as the weekly dose of prior IGSC treatment (grams). e. Octagam® 10%: Updated to include dosing information for indication Dermatomyositis. f. Gammagard S/D: Updated to remove dosing information for Subcutaneous dosage. g. Panzyga®: Updated to include dosing information for indication CIDP. h. Gammaked® Liquid: Updated dosing information from 1 g/kg IV once daily given on 2 consecutive days or 0.4 g/kg IV once daily given on 5 consecutive days to 2 g/kg for indication ITP. 3. Initial Approval Criteria, a. I.E.1: Updated indication from Diagnosis of acute or chronic ITP to Diagnosis of ITP. b. I.E.2: Updated to include new indication criteria Member meets one of the following (a-b): a. Chronic ITP: If request is for Flebogamma® 10%, Gammagard S/D®, Gammaked™, Gammaplex®, Gamunex C®, Octagam 10%, Panzyga®, Privigen b. Acute ITP: Gammaked™, Gamunex C® c. I.D.5.b: Updated Dose criteria to specify drugs Gammaked™ and Gamunex®-C. d. I.B.2: Updated to include Request for Octagam 10%; e. Initial Approval Criteria, I.E.3: Updated to include new age criteria Member meets one of the following (a or b or c): a. Octagam 10% , Gammaked®, Gammagard S/D®, Gamunex C®: Age at least 18 years or older b. Privigen®: Age at least 15 years or older c. Flebogamma®, Gammaplex®: 10%: 2 years of age and older f. I.P.3: Updated to include new age criteria a-c. g. I.S: Updated to include approval criteria for indication Management of Immunotherapy-Related Toxicities (CAR T-Cell-Related Toxicities) h. I.T: Updated to include approval criteria for indication, Management of Immunotherapy-Related Toxicities (Immune Checkpoint Inhibitor-Related Toxicities) i. I.E.6: Updated to add a. Acute bleeding due to severe thrombocytopenia (platelet count less than 30,000/ µL), b. In patients with severe thrombocytopenia(platelet counts less than 20,000/ µL) considered to be	

	at risk for intracerebral hemorrhage; c. Platelets counts persistently at or below 20,000/ µL(for CITP); j. I.I.5:Updated to add documented failure or inability to tolerate chemotherapy or radiation therapy. k. I.K.3.C.i and K.3.C.ii updated to add for LEMS and for MG respectively. l. I.N.3 updated serum IgG concentration to less than 250 mg/dl from 400 mg/dl. 4. All Initial Approval Criteria were updated to remove requirement: Member meets one of the following (a or b): a. Request is for Gammagard unless there is a specific health plan-preferred* immune globulin product; b. Failure of Gammagard (or health plan-preferred* immune globulin product) unless contraindicated or clinically significant adverse effects are experienced; *Immune globulin products are generally interchangeable, and it is at the health plan's discretion to prefer a clinically appropriate alternative product based on the time of request. 5. Continued Therapy Approval Criteria, II.A updated from Kawasaki Syndrome/Incomplete (Atypical) Kawasaki Disease, Viral Prophylaxis (Hep A, Measles, Varicella, Rubella) to Kawasaki Syndrome/Incomplete (Atypical) Kawasaki Disease, Viral Prophylaxis (Hep A, Measles, Varicella, Rubella), Management of Immunotherapy-Related Toxicities (Immune Checkpoint Inhibitor-Related Toxicities), Management of Immunotherapy-Related Toxicities (CAR T-Cell-Related Toxicities).	
RxA.159.Hemlibra	1. Appendix D was updated to include warning about thrombotic microangiopathy and thromboembolism.	04.01.2022
RxA.198.Lenvima	No Update	04.01.2022
RxA.207.Minastrin.24.Fe_ Taytulla_Gemmily	1. Dosage Forms: Updated to include new brand drug Gemmily™. 2. Initial Approval Criteria, 1.A.1: Updated trial and failure criteria to specify that the drugh options for norethindrone acetate/ethinyl estradiol/ferrous fumarate containing products are: a. Loestrin® Fe b. Junel® Fe 24 c. Tarina 24 Fe® 3. Initial Approval Criteria, I.A.3: Updated to include new menopausal criteria Request is not to be used before menarche and in postmenopausal member.	04.01.2022

	4. Appendix C, Boxed Warnings: Updated boxed warning from Cigarette smoking and serious cardiovascular events to (a and b): a. Women over 35 years old who smoke should not use b. Cigarette smoking increases the risk of serious cardiovascular events from combination oral contraceptive (COC) use. 5. Appendix D has been updated to remove discontinued Lomedia.	
RxA.256.Quantity_Limit_ Override	No Update	04.01.2022
RxA.264.Repatha	1. Background was updated to include new indication As an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 10 years and older with HeFH, to reduce LDL-C. 2. Background was updated to include new patient population pediatric patients aged 10 years and older. 3. Dosing information was updated to include pediatric dosing for Primary hyperlipidemia (including HeFH). 4. Initial Approval Criteria I.A.4: age criteria was updated from 18 years of age or older to 10 years of age or older. 5. Initial Approval Criteria I.B.3.a & I.B.3.b: age criteria were updated from less than 18 years of age to less than 10 years of age. 6. Initial Approval Criteria I.B.4: age criteria was updated from 18 years of age or older to 10 years of age or older.	04.01.2022
RxA.273.Rayaldee_retired	1. Dosing Information, Dosing Regimen, Rayaldee®: Updated maintenance dosing information from Increase the dose to 60 mcg once daily after 3 months if intact PTH is above the treatment goal to Monitor serum calcium, phosphorus, 25-hydroxyvitamin D and intact parathyroid hormone (PTH) 3 months after starting therapy or changing dose for indication Secondary hyperparathyroidism. 2. Appendix D, General Information: Updated to include new information Calcifediol is not indicated for patients with Stage 5 chronic kidney disease or end-stage renal disease on dialysis.	04.01.2022
RxA.286.Uceris_Entocort_ Ortikos	1. Initial Approval Criteria I.B.4 was updated to specify that tablets are extended-release. 2. Initial Approval Criteria I.B.5 and I.C.5 were updated to specify that the capsules must be extended-release. 3. Continued Approval Criteria II.A.3 was updated to specify extended-release tablets.	04.01.2022
RxA.309.Xyrem_Xywav	1. Background: Updated to include new indication Xywav® is also indicated for Idiopathic Hypersomnia (IH) in adults. 2. Dosing Information, Drug Name: Updated from sodium oxybate (Xyrem®); Ca, Mg, K & Na oxybates (XYWAV™) to	04.01.2022

	sodium oxybate (Xyrem®); Ca, Mg, K & calcium, magnesium, potassium, and sodium oxybates (Xywav®) due to improper name. 3. Dosing Information, Dosing Regimen, calcium, magnesium, potassium, and sodium oxybates (Xywav®): Updated to include: a. New dosing information for Idiopathic Hypersomnia (IH) in adults. b. Maximum Dose for Idiopathic Hypersomnia (IH) in adults. c. Hepatic impairment dosing for Cataplexy and/or EDS in narcolepsy & Idiopathic Hypersomnia (IH) in adults. 4. Dosage Forms: Updated dosage form from 0.5 gm per mL (both products) to Oral solution: 0.5 gm per mL total salts (equivalent to 0.413 g/mL of oxybate (both products). 5. Initial approval criteria I.B.7 was updated to remove, "For members 18 years of age or older, the member has tried and failed at least a one-month trial of solriamfetol (Sunosi™) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;" 6. Initial Approval Criteria, 1.C: Updated to include approval criteria for indication Idiopathic Hypersomnia. 7. Appendix C, Boxed Warnings: Updated boxed warning to include statement about Central Nervous System (CNS) depressant.	
RxA.313.Prolia_Xgeva	1. Dosing Information, Maximum Dose, Xgeva®: Updated maximum dosing information from 20 mg/dose to 120 mg/dose for indication Multiple myeloma and bone metastasis from solid tumors. 2. Initial Approval Criteria I.A 2.a.ii: Updated from BMD T-score at hip or spine ≤ -3.5 to BMD T-score at hip or spine ≤ -3.0. 3. Initial Approval Criteria: Updated a. I.B.2.b: Updated trial and failure criteria from Nilandron® to nilutamide (Nilandron®). b. I.D.4: Updated to include new trial and failure criteria Member not responding to bisphosphonates or for patients who are not candidates for bisphosphonates because of renal insufficiency.	04.01.2022
RxA.344.Annovera_retired	No Update	04.01.2022
RxA.368.Entresto	1. Initial approval criteria I.A.1 updated to include b. Diagnosis of pediatric heart failure with systemic left ventricular systolic dysfunction with is symptomatic; 2. Initial Approval Criteria, I.A.5.c: Updated to include new	04.01.2022

	contraindication History of angioedema related to previous ACE inhibitor or ARB therapy.	
RxA.374.Erbitux	1. Background was updated to include new indication BRAF V600E Mutation-Positive Metastatic Colorectal Cancer (CRC). 2. Dosing information was updated to include combination with encorafenib. 3. Initial approval criteria I.B.4.b was updated to include Disease is positive for BRAF V600E mutation and prescribed in combination with encorafenib. 4. Initial approval criteria I.B.6 was added. 5. Initial approval criteria I.C.1 was updated to include recurrent, advanced, or metastatic disease. 6. Initial approval criteria I.C.4.a, b, and c were added per NCCN guidelines . 7. Initial approval criteria I.C.5 was updated to remove "Disease has progressed on or after an EGFR tyrosine kinase inhibitor". 8. Initial approval criteria I.C.6 was updated to remove "Prescribed in combination with Gilotrif® as subsequent therapy".	04.01.2022
RxA.376.Erleada	1. Appendix B, Dosing Regimen & Maximum Dose: Updated to include drugs Xtandi®,Nubeqa®,Zytiga® & Yonsa® as therapeutic alternatives. 2. Appendix D was updated to include warning and precautions for drug use.	04.01.2022
RxA.4.Acticlate	1. Drug(s) Applied, Background, Dosing Information, Dosage forms, Clinical Policy , Appendix C: Updated to remove Doryx®, Doryx® MPC, Oracea® as they no longer require Prior Authorization. 2. Initial Approval Criteria, I.B.5.a, I.C.4.a, I.D.5.a: Updated dosing criteria from Acticlate®230 mg/day to Acticlate®200 mg/day. 3. Continued Therapy Approval, II.B.4.a: Updated dosing criteria from Acticlate® 300 mg/day to Acticlate® 200 mg/day.	04.01.2022
RxA.411.Lyrica_Lyrica.CR_ retired	1. Policy was retired.	04.01.2022
RxA.431.Opdivo	1. Background was updated to include: a. For indication Melanoma: Patients with unresectable or metastatic melanoma, or in combination with ipilimumab to Patients with unresectable or metastatic melanoma, as a single agent or in combination.	04.01.2022

	b. For indication Urothelial Carcinoma: adjuvant treatment of patients with urothelial carcinoma (UC). 2. Background was updated to remove: "Patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib, as a single agent..". 3. Dosage form was updated to include Single-dose vial: 120 mg/12 mL. 4. Initial Approval Criteria I.G.6.a was updated to include pediatric dosing. 5. Initial approval criteria I.H.5.a was removed. 6. Initial approval criteria I.H.4 was updated to add Opdivo is used in combination with Yervoy.	
RxA.478.Signifor_Signifor.LAR	1. Dosing Information, Dosing Regimen, Signifor®: Updated to include hepatic impairment dosing information for indication Cushing's disease. 2. Dosing Information, Dosing Regimen, Signifor® LAR: Updated to include hepatic impairment dosing information for indications Cushing's disease and Acromegaly.	04.01.2022
RxA.5.Atelvia	1. Drugs Applied, Background, Dosing Information, Dosage Forms, Clinical Policy, Appendix A: Updated to remove information about Actonel® as it no longer requires PA. 2. Dosage Forms: Updated to remove discontinued dosage forms 30 mg, 75 mg.	04.01.2022
RxA.531.Tymlos	1. Appendix C, Boxed Warnings: Updated to include new boxed warning Cumulative use of Tymlos® and parathyroid hormone analogs (e.g., teriparatide) for more than 2 years during a patient's lifetime is not recommended.	04.01.2022
RxA.561.Vraylar	No Update	04.01.2022

RxA.592.Biologic_DMARDs	1. Dosing Information for (Orencia®) was updated to include indication and dosing information for Acute Graft Vs Host Disease prophylaxis (aGVHD). 2. Dosing information for Cosentyx® was updated to include pediatric dosing for PsA. 3. Dosing information for Xeljanz® XR and Xeljanz® updated to add indication AS. 4. Dosing information for Rinvoq™ updated to include indication PsA. 5. Dosing information for Cosentyx® updated to include indication and dosing information for Enthesitis-related Arthritis (ERA). 6. Initial approval criteria I.A.2, I.A.6: Updated to include Xeljanz® XR and Xeljanz® . 7. Initial Approval Criteria I.J.2 , I.J.4.a, I.J.5: Updated to include Rinvoq™. 8. Initial Approval Criteria I.J.4.b: Updated to add Cosentyx®. 9. Initial Approval Criteria I.R was added for Acute Graft Vs Host Disease prophylaxis (aGVHD). 10. Initial Approval Criteria I.S was added for Enthesitis-related Arthritis (ERA). 11. Boxed warning for Xeljanz® ,Xeljanz® XR/ Xeljanz® oral Solution update to include MACE.	04.01.2022
RxA.620.Brukinsa	1. Background: Updated to include a. Waldenström's Macroglobulinemia b. Marginal Zone Lymphoma 2. Dosing Information, Indication: Updated to include a. New Indication Waldenström's Macroglobulinemia b. New Indication Marginal Zone Lymphoma 3. Initial Approval Criteria I.A.1.c and I.A.1.d: Updated to remove Nodal marginal zone lymphoma & Splenic marginal zone lymphoma. 4. Initial Approval Criteria I.B: Updated to include approval criteria for Waldenström's macroglobulinemia (WM). 5. Initial Approval Criteria I.C Updated to include approval criteria for marginal zone lymphoma (MZL). 6. Appendix B, Drug Name: Updated to remove unavailable generic therapeutic alternative lenalidomide and rituximab.	04.01.2022
RxA.621.Caplyta	1. Dosing Information, Dosing Regimen, Caplyta™ Updated to include hepatic impairment dosing information for indication Schizophrenia.	04.01.2022
RxA.622.Dayvigo	1. Dosing Information, Dosing Regimen, Dayvigo®: Updated	04.01.2022

	to include hepatic impairment dosing information for indication insomnia.	
RxA.623.Givlaari	1. Dosing Information, Maximum Dose, Givlaari®: Updated maximum dosing information from 250mg per month (1.3ml) to 2.5 mg/kg once monthly for indication Acute hepatic porphyria. 2. Initial approval criteria I.A.3 and I.A.4 were updated to add Patient has not had or is not anticipating a liver transplant and Patient will not receive concomitant prophylactic hemin treatment while on Givlaari. 3. Initial Approval Criteria, I.A.5: Updated dosing criteria from 250mg/month (1.3ml) to 2.5 mg/kg once monthly. 4. Continued Therapy Criteria II.A.2 was updated to add examples of positive response to therapy. 5. Continued Therapy Criteria II.A.3 and II.A.4 updated to add Patient has not had or is not anticipating a liver transplant and Patient will not receive concomitant prophylactic hemin treatment while on Givlaari. 6. Continued Therapy Approval II.A.5: Updated to include new dosing criteria If request is for a dose increase, new does not exceed 2.5 mg/kg once monthly.	04.01.2022
RxA.624.Oxbryta	1. Dosing Information, Dosing Regimen: updated to include hepatic impairment dosing information. 2. Appendix B, Maximum Dose, hydroxyurea (Droxia®): Updated maximum dose from 35 mg/kg/day to 80 mg/kg orally for indication Sickle cell anemia. 3. Appendix B, Dosing Regimen, hydroxyurea (Siklos®): Updated age-specific dosing information for ages 2 years of age and older to include 20 mg/kg once daily. Monitor blood counts every two weeks. The dose may be increased by 5 mg/kg/day every 8 weeks, or sooner if a severe painful crisis occurs, until a maximum tolerated dose or 35 mg/kg/day is reached if blood counts are in an acceptable range.	04.01.2022
RxA.625.Aklief	1. Dosing Information, Maximum Dose, Aklief®: Updated maximum dosing information from once daily dosing to Not applicable for indication Acne vulgaris. 2. Dosage Forms: Updated dosage form to include 45-gm pump.	04.01.2022
RxA.626.Ayvakit	1. Background: Updated to include: a. New indication: Advanced Systemic Mastocytosis (AdvSM). b. Limitations of Use: Ayvakit™ is not recommended for the treatment of patients with AdvSM with platelet counts of less than 50×10^9/L.	04.01.2022

	2. Dosing Information, Indication: Updated to include new indication AdvSM. 3. Dosage Forms: Updated dosage form from Tablets: 100 mg, 200 mg and 300 mg to Tablets: 25 mg, 50 mg, 100 mg, 200 mg and 300 mg. 4. Initial Approval Criteria, 1.B: Updated to include approval criteria for indication AdvSM. 5. Continued Therapy Approval, II.A.3.b: Updated to include new dosing criteria AdvSM: Dose does not exceed 200 mg orally once daily.	
RxA.627.Arazlo	1. Appendix B, Dosing Regimen, Epiduo: Updated dosing information from Not applicable to 1 application per day topically for indication acne vulgaris. 2. Appendix B, Dosing Regimen, Epiduo Forte: Updated dosing information from Not applicable to 1 application per day topically for indication acne vulgaris. 3. Appendix B, Dosing Regimen, Tazorac: Updated dosing information from Not applicable to 1 application per day topically for indication acne vulgaris.	04.01.2022
Rxa.628.Reblozyl	1. Appendix B, Dosing Regimen: a. Procrit®: Updated to include dosing information for indication For Anemia - Myelodysplastic syndrome b. Epogen®: Updated to include dosing information for indication For Anemia - Myelodysplastic syndrome c. Retacrit®: Updated to include dosing information for indication For Anemia - Myelodysplastic syndrome d. Aranesp®: Updated to include dosing information for indication For Anemia - Myelodysplastic syndrome 2. Appendix B, Maximum Dose: a. Procrit®: Updated to include maximum dose information for indication For Anemia - Myelodysplastic syndrome b. Epogen®: Updated to include maximum dose information for indication For Anemia - Myelodysplastic syndrome c. Retacrit®: Updated to include maximum dose information for indication For Anemia - Myelodysplastic syndrome d. Aranesp®: Updated to include maximum dose information for indication For Anemia - Myelodysplastic syndrome	04.01.2022
RxA.629.Tazverik	1. Updated to remove discontinued brand-name therapeutic alternative Lartruvo®	04.01.2022
RxA.63.Cerezyme	1. Dosage forms updated to remove 200 Units.	04.01.2022

	2. Initial Approval Criteria was I.A.3 updated to include new prescriber criteria mandating geneticist, endocrinologist, a metabolic disorder sub specialist, or a physician who specializes in the treatment of lysosomal storage disorders. 3. Initial approval criteria I.A.1 updated to remove Type 2 Gaucher disease. 4. Initial approval Criteria I.A.5 was updated to remove generic names of Vpriv and Elelyso.	
RxA.631.Xcopri	1. Dosing Information, Drug Name: Updated to include new drug cenobamate (Xcopri®). 2. Dosage Forms: Updated dosage form to include 12.5 mg and 25 mg. 3. Initial Approval Criteria, I.A.1: Updated to include new diagnosis Partial onset seizures. 4. Initial Approval Criteria, I.A.6: Updated trial and failure criteria to give examples of appropriate drugs, gabapentin, lamotrigine, levetiracetam, oxcarbazepine. 5. Appendix D, General Information: Updated to include new information regarding The 2018 Joint American Academy of Neurology/American Epilepsy Society guideline update to provide specific recommendations regarding antiepileptics that can be considered for treatment-resistant adult focal epilepsy (TRAFE).	04.01.2022
RxA.649.Zeposia	1. Initial Approval Criteria I.B.4.a was updated to add failure of a trial of azathioprine, 6-mercaptopurine, or aminosalicylate (e.g.,sulfasalazine) or corticosteroid (e.g., prednisone, methylprednisolone, etc), at up to maximally indicated doses, unless contraindicated or clinically significant adverse events are experienced . 2. Initial Approval Criteria 1.B.4.b was updated in include patient has been previously treated with at least one other biologic DMARD that is FDA approved for the treatment of ulcerative colitis. 3. Initial Approval Criteria I.B.5 was updated to include failure of two (2) of the following: Inflectra®, Renflexis™, , Stelara®, Humira® or Xeljanz®/Xeljanz XR®, each used for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced.	04.01.2022
RxA.655.LA_Injectable_Antipsychotics_Policy	1. Dosing information was updated: a. For drug Aristada: 4 weeks was updated to 1 month. b. For drug Invega Trinza: 12 weeks was updated to 3 months. c. For drug Perseris: 4 weeks was updated to 1 month.	04.01.2022

RxA.659.Kynmobi	1. Appendix D, General Information: Updated to include new information regarding renal impairment and hepatic impairment.	04.01.2022
RxA.665.Bevacizumab	1. Background: Updated indication: a. From Non-Squamous Non–Small Cell Lung Cancer to Unresectable, locally advanced, recurrent or metastatic Non-Squamous Non–Small Cell Lung Cancer. b. From Renal Cell Carcinoma to Metastatic Renal Cell Carcinoma. c. From Cervical Cancer to Persistent, recurrent, or metastatic cervical Cancer. 2. Dosage Forms: Updated dosage form: a. From Avastin ®:Single-dose vial 100mg/4mL (4 mL), 400mg/16mL (16mL) to Avastin ®:Single-dose vial 100mg/4mL (25 mg/mL), 400mg/16mL (25 mg/mL). b. From Zirabev ®:Single-dose vial 100mg/4mL (4mL), 400mg/16mL (16mL) to Zirabev ®:Single-dose vial 100mg/4mL (25 mg/mL), 400mg/16mL (25 mg/mL). c. From Mvasi ®:Single-dose vial 100mg/4mL (4mL), 400mg/16mL (16mL) to Mvasi ®: Single-dose vial 100mg/4mL (25 mg/mL), 400mg/16mL (25 mg/mL). 3. Initial Approval Criteria, I.D: Updated to include approval criteria for indication, Metastatic renal cell carcinoma. 4. Initial Approval Criteria, I.F.1: Updated to remove prior drug request criteria “Request is for Avastin®”. 5. Initial Approval Criteria, I.F.4.b: Updated combination therapy criteria to specify that it is for members who have received no more than 2 prior chemotherapy regimens. 6. Initial Approval Criteria, I.H: Updated to remove approval criteria for Breast cancer (off-label) changed to CNS cancers. a. Added prescribing requirements, single agent and as combination 7. Initial Approval Criteria, I.K: Updated to remove approval criteria for Diabetic macular edema (off-label).	04.01.2022
RxA.666.Danyelza	No Update	04.01.2022
RxA.667.Klisyri	No Update	04.01.2022
RxA.669.Tiglutik	1. Appendix D, Warnings and Precautions: Updated to include a. Use is not recommended in patients with baseline elevation of serum transaminases more than 5 times the upper limit of normal (ULN) or evidence of liver dysfunction (e.g., elevated bilirubin). b. Discontinue Tiglutik® if interstitial lung disease	04.01.2022

	develops.	
RxA.670.Zokinvy	No Update	04.01.2022
RxA.671.Chemotherapy NOS	No Update	04.01.2022
RxA.672.Margenza	1. Appendix B, Drug Name: Updated to remove unavailable generic therapeutic alternative ado-trastuzumab emtansine, fam-trastuzumab deruxtecan-nxki, neratinib, pertuzumab, trastuzumab, tucatinib.	04.01.2022
RxA.673.Rituximab	1. Background: Updated to include new indication a. Mature B-cell NHL and mature B-cell acute leukemia in paediatric patients b. Rheumatoid Arthritis (RA) 2. Dosing Information, Dosing Regimen, Rituxan®: Updated to include dosing information for indication Pediatric NHL/B-AL. 3. Initial Approval Criteria, I.B.3: Updated age criteria from Member is 2 years of age or older to For Rituxan® age ≥ 2 years or, For Ruxience®, Truxima®, Riabni™ age ≥ 18 years. 4. Appendix A: Updated to include abbreviations B-AL, BL, BLL.	04.01.2022
RxA.674.Trastuzumab	1. Dosage Forms: Updated a. Herceptin®: Updated dosage form to remove multiple-dose vial, 420 mg. b. Trazimera™: Updated dosage form to include Single-dose vial, 150 mg. 2. Initial Approval Criteria, I.D.4: Updated to include drugs trastuzumab must be prescribed with for endometrial carcinoma. 3. Initial Approval Criteria, I.F: Updated to include approval criteria for indication, Central Nervous System Cancer.	04.01.2022
RxA.675.Orgovyx	1. Dosing Information, Maximum Dose, Orgovyx™: Updated to include maximum dosing information for indication advanced prostate cancer. 2. Appendix B, Drug Name: Updated to remove unavailable generic therapeutic alternative degarelix. 3. Appendix D, Warnings and Precautions: Updated to include new warning and precaution regarding Embryo-Fetal toxicity.	04.01.2022
RxA.676.Oxlumo	No Update	04.01.2022
RxA.68.Cialis	1. Clinical Policy Title: Updated from tadalafil BPH - ED to tadalafil.	04.01.2022

	2. Dosing Information, Dosing Regimen, Cialis®: Updated to include may decrease to 5 mg based upon efficacy/tolerability for indication ED. 3. Appendix B, Drug Name: Updated to remove discontinued brand-name therapeutic alternative Hytrin®. 4. Appendix D, General Information: Updated to include new information regarding dose adjustment for renal and hepatic impairment.	
RxA.685.Jemperli	1. Background was updated to include indication Solid tumors. 2. Dosage information was updated to include new indication: solid tumors, along with its dosage regimen. 3. Initial approval criteria I.B. was updated to include new indication Solid tumors. 4. Appendix D was updated to include Warning and precautions.	04.01.2022
RxA.74.Colonoscopy_Preparation_Products	1. Drug(s) applied, Background, Dosing Information, Dosage forms, Clinical Policy, Appendix C was updated to remove information about Colyte®, GoLYTELY®, MoviPrep®, Plenvu® as they no longer need PA .	04.01.2022

New Step Therapy

- Acticlate 150 mg tablet
- Avidoxy 100 mg tablet
- Clenpiq 10 mg-3.5 gram-12 gram/160 mL oral solution
- Cuprimine 250 mg capsule
- Dayvigo 10 mg tablet, Dayvigo 5 mg tablet
- Doxepin 3 mg tablet, Doxepin 6 mg tablet
- Doxy-100 100 mg IV solution
- Doxycycline hyclate 100 mg tablet DR, Doxycycline hyclate 150 mg tablet DR, Doxycycline hyclate 200 mg tablet DR, Doxycycline hyclate 50 mg tablet DR, Doxycycline hyclate 75 mg tablet DR, Doxycycline hyclate 80 mg tablet DR
- Eprontia 25 mg/mL Oral Solution (New Drug)
- Eszopiclone 1 mg tablet, Eszopiclone 2 mg tablet, Eszopiclone 3 mg tablet
- Imitrex 20 mg/actuation nasal spray
- Linzess 145 mcg capsules, Linzess 290 mcg capsules, Linzess 72 mcg capsules
- Meloxicam 15 mg tablet, Meloxicam 7.5 mg tablet, Meloxicam submicronized 10 mg capsule, Meloxicam submicronized 5 mg capsule
- Minocycline 100 mg tablet, Minocycline 50 mg tablet, Minocycline 75 mg capsule, Minocycline 100 mg capsule, Minocycline 75 mg tablet, Minocycline 50 mg capsule
- Mobic 15 mg tablet, Mobic 7.5 mg tablet
- Mondoxyne NL 75 mg capsule
- Monodox 100 mg capsule, Monodox 75 mg capsule
- Morgidox 100 mg capsule, Morgidox 50 mg capsule
- Moviprep 100 gram-7.5 gram-2.691 gram oral powder packet
- Naproxen sodium ER (CR) 750 mg tablet, ER 24 hr multiphase

- Oracea 40 mg capsule, immediate DR
- Penicillamine 250 mg capsule, Penicillamine 250 mg tablet
- Plenvu 140 gram-9 gram-5.2 gram powder packs
- Prepopik 10 mg-3.5 gram-12 gram oral powder packet
- Qudexy XR 100 mg capsule sprinkle ER (New Drug), Qudexy XR 150 mg capsule sprinkle ER (New Drug), Qudexy XR 200 mg capsule sprinkle ER (New Drug), Qudexy XR 25 mg capsule sprinkle ER (New Drug), Qudexy XR 50 mg capsule sprinkle ER (New Drug)
- Ramelteon 8 mg tablet
- Sumatriptan 20 mg/actuation nasal spray
- Suprep bowel prep kit 17.5 gram-3.13 gram-1.6 gram oral solution
- Temazepam 15 mg capsule, Temazepam 22.5 mg capsule, Temazepam 30 mg capsule, Temazepam 7.5 mg capsule
- Topiramate 15 mg sprinkle capsule (New Drug), Topiramate 200 mg tablet (New Drug), Topiramate 25 mg sprinkle capsule (New Drug), Topiramate 25 mg tablet (New Drug), Topiramate 50 mg tablet (New Drug)
- Triazolam 0.125 mg tablet, Triazolam 0.25 mg tablet
- Trijardy XR 10 mg-5 mg-1,000 mg tablet ER, Trijardy XR 12.5 mg-2.5 mg-1,000 mg tablet ER, Trijardy XR 25 mg-5 mg-1,000 mg tablet ER, Trijardy XR 5 mg-2.5 mg-1,000 mg tablet ER
- Trokendi XR 100 mg capsule ER (New Drug), Trokendi XR 200 mg capsule ER (New Drug), Trokendi XR 25 mg capsule ER (New Drug), Trokendi XR 50 mg capsule ER (New Drug)
- Vibramycin 100 mg capsule, Vibramycin 25 mg/5 mL oral suspension
- Zaleplon 10 mg capsule, Zaleplon 5 mg capsule
- Zelnorm 6 mg tablets
- Zolpidem 1.75 mg sublingual tablet, Zolpidem 10 mg tablet, Zolpidem 3.5 mg sublingual tablet, Zolpidem 5 mg tablet, Zolpidem ER 12.5 mg tablet, ER multiphase, Zolpidem ER 6.25 mg tablet ER multiphase

Updated Step Therapy

Drug Name; Strength(s); & Dosage Form(s)	Step Edit Details	Effective Date
Belsomra 5 mg tablet, Belsomra 10 mg tablet, Belsomra 15 mg tablet, Belsomra 20 mg tablet	ST update from retired ST2335 AMZ Belsomra to AMZ Sleep Aides, step 2 drug, with at least 30 days supply within 120 days	04.01.2022
Qtern 10 mg-5 mg tablet, Qtern 5 mg-5 mg tablet	Update from Step 1 to Step 2 AMZ SGLT2, ST setup to required 2 alternatives products (Farxiga, Glyxambi, Jardiance, Synjardy, Synjardy XR, Xigduo XR) with at least 28 days supply within last 1 year	04.01.2022