



Effective Date: 12/28/20



# Buckeye Health Plan

## Medicaid Criteria Updates –Q4 2020

**B**uckeye Health Plan (BHP) routinely reviews their Prior Authorization (PA) and Medical Necessity (MN) criteria. Decisions on PA and MN criteria content are coordinated with input from pharmacy and medical practitioners, Buckeye Health Plan representatives, and review of current available medical literature and professional standards of practice. Below is the list of changes to the Medicaid criteria this quarter.  
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Policy/ Coverage Criteria Guideline	Applicable Business	Revision Summary Description
<b>Clinically Significant Change(s)</b>		
CP.PHAR.05 Hyaluronate derivatives	Commercial, HIM, Medicaid	4Q 2020 annual review: added sports medicine physician as acceptable specialist; references reviewed and updated.
CP.PHAR.11 Burosumab-twza (Crysvita) ^	Commercial, HIM, Medicaid	RT2: Criteria added for new FDA indication: TIO; references reviewed and updated.
CP.PHAR.58 Denosumab (Prolia Xgeva)	Commercial, HIM, Medicaid	The MM/solid tumor common criteria line item, at risk for skeletal related event, is removed for solid tumor and for MM is replaced with receiving or initiating therapy for symptomatic disease per pivotal trials/NCCN; IV bisphosphonate trials are added per labels/NCCN to prostate/breast fracture prevention, MM/solid tumor (exception prostate/breast cancer), and systemic mastocytosis.
CP.PHAR.65 Imatinib (Gleevec)	Commercial, HIM, Medicaid	AIDS-related KS: updated criteria to require concurrent use with antiretroviral therapy and failure of first line agents per NCCN guidelines; added immunologist as a prescriber option per specialist feedback.
CP.PHAR.71 Lenalidomide (Revlimid)	Commercial, HIM, Medicaid	AIDS-related KS: updated criteria to require concurrent use with antiretroviral therapy and failure of first line agents per NCCN guidelines; added immunologist as a prescriber option per specialist feedback.
CP.PHAR.78 Thalidomide (Thalomid)	Commercial, HIM, Medicaid	AIDS-related KS: specified that the liposomal form of doxorubicin should be tried; added bypass of trial requirements if member is intolerant or contraindicated.



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CP.PHAR.79 Lapatinib (Tykerb)	Commercial, HIM, Medicaid	4Q 2020 annual review: updated the following off-label criteria per NCCN category 2A recommendations: chordoma- added that Tykerb must be prescribed as a single agent; colorectal cancer- added that disease must also be BRAF wild type; references reviewed and updated.
CP.PHAR.89 Peginterferon Alfa-2a,b (Pegasys, PegIntron, Sylatron)	Commercial, HIM, Medicaid	Added inadequate response or loss of response to hydroxyurea or interferon therapy if peginterferon alfa-2b or peginterferon alfa-2a naïve for polycythemia vera; added inadequate response or loss of response to hydroxyurea, anagrelide, or interferon therapy, if peginterferon alfa-2b or peginterferon alfa-2a naïve for essential thrombocytopenia; added NCCN-recommended (with Category 2A or above) off-label uses: primary cutaneous CD30+ T-cell lymphoproliferative disorder, adult T-cell leukemia or lymphoma; Mycosis fungoides or Sezary syndrome; NCCN references reviewed and updated.
CP.PHAR.93 Bevacizumab (Avastin, Mvasi, Zirabev)	Commercial, HIM, Medicaid	4Q 2020 annual review: removed AIDS-related Kaposi sarcoma as an off label use as it is no longer NCCN supported; added additional NCCN supported regimens for colorectal cancer, non-squamous non-small cell lung cancer, renal cell carcinoma, cervical cancer, and epithelial ovarian, fallopian tube, or primary peritoneal cancer; added to Section IB metastatic spine tumors or brain metastases and vulvar cancer diagnoses which are supported by NCCN; added appendix F: dose rounding guidelines; added reference to appendix F within criteria; references reviewed and updated.
CP.PHAR.97 Eculizumab (Soliris)	Commercial, HIM, Medicaid	For NMOSD: added requirement against concurrent use with rituximab, Enspryng, or Uplizna.
CP.PHAR.119 Ramucirumab (Cyramza)	HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added new indication NSCLC with EGFR mutations; added criteria for NSCLC for use in combo with Erlotinib; added criteria for advanced esophageal, EGJ or gastric cancer allowing combination with



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		fluorouracil and irinotecan per NCCN; added disease characteristics criteria for all indications per NCCN; updated Appendix B; references reviewed and updated.
CP.PHAR.125 Palbociclib (Ibrance)	Commercial, HIM, Medicaid	4Q 2020 annual review: for breast cancer, modified to allow first-line use with fulvestrant per NCCN category 1 recommendation; for retroperitoneal liposarcoma, modified to allow only unresectable disease (removed metastatic and progressive options) per NCCN category 2A recommendation; references reviewed and updated.
CP.PHAR.129 Venetoclax (Venclexta)	Commercial, HIM, Medicaid	4Q 2020 annual review: HIM line of business added; references reviewed and updated.
CP.PHAR.131 Infertility and Fertility Preservation	Commercial, HIM, Medicaid	4Q 2020 annual review: step therapies added to OI and ART; 150 unit cartridge added to Follistim-AQ; exclusion added for use of policy drugs as treatment for obesity; general information appendix and references reviewed and updated.
CP.PHAR.132 Nitisinone (Orfadin, Nityr)	Commercial, HIM, Medicaid	4Q 2020 annual review: added requirement for adjunctive dietary restriction of tyrosine and phenylalanine, in line with the FDA-approved indication; removed references to HIM non-formulary policy for Nityr; references reviewed and updated.
CP.PHAR.136 Elagolix (Orilissa), elagolix-estradiol-norethindrone (Oriahnn) ^	Commercial, HIM, Medicaid	4Q 2020 annual review: for endometriosis, 3-month trial within the last year and non-contraceptive progestin added to reconcile with similar policies; RT2: Criteria added for new FDA-approved combination product and its indication: Oriahnn for management of heavy menstrual bleeding due to uterine fibroids; references reviewed and updated.
CP.PHAR.137 Ivosidenib (Tibsovo)	Commercial, HIM, Medicaid	4Q 2020 annual review: added criteria for biliary tract cancer per NCCN 2A off label indication; references reviewed and updated.



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CP.PHAR.138 Lenvatinib (Lenvima)	Commercial, HIM, Medicaid	4Q 2020 annual review: added off-label criteria for ATC per NCCN category 2A recommendation; references reviewed and updated.
CP.PHAR.140 Pegvaliase-pqpz (Palynziq)	Commercial, HIM, Medicaid	4Q 2020 annual review: added requirement for current and continued use of Phe-restricted diet; added requirement for a prior trial of Kuvan; referenced reviewed and updated.
CP.PHAR.151 Levoleucovorin (Fusilev, Khapzory)	Commercial, HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added Khapzory to policy; updated FDA approved indications for addition of pediatric use; references reviewed and updated.
CP.PHAR.201 Belatacept (Nulojix)	HIM, Medicaid	4Q 2020 annual review: revised HIM-Medical Benefit to HIM line of business; Cellcept dosing information adjusted per prescribing information; references reviewed and updated.
CP.PHAR.232 OnabotulinumtoxinA (Botox)	Commercial, HIM, Medicaid	For chronic migraine, clarified requirement for use of two oral migraine preventative therapies that are from different therapeutic classes. RT4: updated FDA approved indication for spasticity which now includes cerebral palsy for lower limb spasticity in pediatric patients.
CP.PHAR.246 Canakinumab (Ilaris ^)	Commercial, HIM, Medicaid	Criteria added for new FDA approved indication: AOSD; updated Appendix B; references reviewed and updated.
CP.PHAR.260 Rituximab (Rituxan, Ruxience, Truxima, Rituxan Hycela)	HIM, Medicaid	For NMOSD: added requirement against concurrent use with Soliris, Enspryng, or Uplizna; modified EDSS from $\leq 7$ to $\leq 8$ to align with Uplizna policy.
CP.PHAR.304 Irinotecan Liposome (Onivyde)	Commercial, HIM, Medicaid	4Q 2020 annual review: added oncologist prescriber requirement; references reviewed and updated.



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CP.PHAR.307 Bendamustine (Bendeke, Treanda)	Commercial, HIM, Medicaid	4Q 2020 annual review: HIM-Medical Benefit line of business removed; off-label criteria sets combined into one - additional criteria limited to subsequent therapy requirement; appendix B prior therapy examples truncated; references reviewed and updated.
CP.PHAR.308 Elotuzumab (Empliciti)	Commercial, HIM, Medicaid	4Q 2020 annual review: added Commercial line of business, modified HIM-Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.309 Carfilzomib (Kyprolis)	Commercial, HIM, Medicaid	4Q 2020 annual review: MM - FDA approved regimen added: in combination with Darzalex and dexamethasone, and NCCN recommended regimen added: in combination with dexamethasone and cyclophosphamide ± Thalomid; references reviewed and updated.
CP.PHAR.311 Belinostat (Beleodaq)	HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added additional off-label indication cutaneous CD30+ T-cell lymphoma as per NCCN 2A or above off label indication; added Appendix D: PTCL subtypes per NCCN; references reviewed and updated.
CP.PHAR.313 Pralatrexate (Folotyn)	Commercial, HIM, Medicaid	4Q 2020 annual review: added Commercial line of business; added additional PTCL subtypes per NCCN; added Appendix D; updated HGTL use after 2 prior therapy regimens per NCCN; references reviewed and updated.
CP.PHAR.314 Romidepsin (Istodax)	Commercial, HIM, Medicaid	4Q 2020 annual review: added Commercial line of business to policy; updated Appendix B; updated Appendix E with additional PTCL subtypes per NCCN; references reviewed and updated.
CP.PHAR.317 Cetuximab (Erbix)	Commercial, HIM, Medicaid	4Q 2020 annual review: added criteria to HNSCC indication for use as single agent or in combination with platinum based therapy with 5-FU; added BRAF disease wild-type and for treatment in combination with Braftovi if BRAF V600E mutation positive to colorectal indication as per NCCN 2A or above off label indication; references reviewed and updated.



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CP.PHAR.318 Eribulin mesylate (Halaven)	Commercial, HIM, Medicaid	4Q 2020 annual review: for STS per NCCN recommendations – added “advanced” designation to extremity/body wall and head/neck STS; removed “progressive” and added “recurrent or stage IV” designation to retroperitoneal/intra-abdominal STS; added “advanced or metastatic” designation to pleomorphic rhabdomyosarcoma; added additional STS subtype options: solitary fibrous tumor and UPS; added that Halaven should be used as subsequent therapy for all STS subtypes except angiosarcoma, solitary fibrous tumor, and UPS; references reviewed and updated.
CP.PHAR.321 Panitumumab (Vectibix)	Commercial, HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added BRAF disease wild-type and for treatment in combination with Braftovi if BRAF V600E mutation position to colorectal indication as per NCCN 2A off label indication; references reviewed and updated.
CP.PHAR.325 Ziv-aflibercept (Zaltrap)	Commercial, HIM, Medicaid	4Q 2020 annual review: removed HIM-Medical Benefit line of business and associated references to non-formulary requests; references reviewed and updated.
CP.PHAR.332 Pasireotide (Signifor, Signifor LAR)	Commercial, HIM, Medicaid	4Q 2020 annual review: removed HIM-Medical Benefit line of business; references reviewed and updated.
CP.PHAR.334 Ribociclib (Kisqali, Kisqali Femara)	Commercial, HIM, Medicaid	4Q 2020 annual review: added HIM line of business; removed option for combination use with tamoxifen as this is no longer NCCN supported; added that member has not previously failed another CDK 4/6 inhibitor therapy; references reviewed and updated.
CP.PHAR.352 Daunorubicin-cytarabine (Vyxeos)	HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; AML criteria collapsed in recognition of the interrelated transformative nature of the three disease states and to encompass new subtypes and treatment algorithms; references reviewed and updated.



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CP.PHAR.353 Pegaspargase (Oncaspar), Calaspargase pegol-mknl (Asparlas)	Commercial, HIM, Medicaid	4Q 2020 annual review: extranasal and aggressive NK/T-cell subtypes and DDGP regimen added to NK/T-cell off-label criteria set - limited to Oncaspar per NCCN; references reviewed and updated.
CP.PHAR.354 Testosterone (Testopel, Jatenzo)	HIM*, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; delayed puberty dosing added to appendix B; contraindications added to appendix C; references reviewed and updated.
CP.PHAR.355 Abemaciclib (Verzenio)	Commercial, HIM, Medicaid	4Q 2020 annual review: added HIM line of business; modified to allow first-line use with fulvestrant per NCCN category 1 recommendation; added that member has not previously failed another CDK 4/6 inhibitor therapy; references reviewed and updated.
CP.PHAR.358 Gemtuzumab (Mylotarg)	Commercial, HIM, Medicaid	4Q 2020 annual review: revised HIM-Medical Benefit to HIM line of business; updated age limit to 1 month from 18 years for new diagnosed AML as per FDA label; references reviewed and updated.
CP.PHAR.359 Inotuzumab Ozogamicin (Besponsa)	Commercial, HIM, Medicaid	4Q 2020 annual review: added Commercial LOB; modified HIM-Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.385 Corticosteroid Intravitreal Implants (Iluvien, Ozurdex, Retisert, Yutiq)	Commercial, HIM, Medicaid	Revised dosing frequency for Ozurdex from q6 months to q4 months per literature review, guideline recommendations, market analysis, and specialist feedback.
CP.PHAR.387 Azacitidine (Vidaza)	Commercial, HIM, Medicaid	4Q 2020 annual review: MDS, MF, AML criteria collapsed in recognition of the interrelated transformative nature of the three disease states and to encompass new subtypes and treatment algorithms; references reviewed and updated.



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CP.PHAR.390 Cholic Acid (Cholbam)	Commercial, HIM, Medicaid	4Q 2020 annual review: updated criteria to require diagnosis confirmation, allow metabolic disease specialist, and require evidence of improvement in LFTs for continued therapy; shortened initial approval duration to 3 months from 6 months for Medicaid and HIM/Length of Benefit for Commercial per PI stating that therapy should be discontinued if insufficient response or complete biliary obstruction occurs at 3 months; references reviewed and updated.
CP.PHAR.391 Lanreotide (Somatuline Depot)	Commercial, HIM, Medicaid	4Q 2020 annual review: NET criteria consolidated into one section - off-label pheochromocytoma added; somatostatin receptor positive imaging and/or hormonal symptoms removed to include other uses per NCCN; examples of tumor types added to criteria and appendix D; references reviewed and updated.
CP.PHAR.395 Patisiran (Onpattro)	Commercial, HIM Medical Benefits, Medicaid	4Q 2020 annual review: genetic testing methodology examples removed from criteria with deference to appendix; references reviewed and updated.
CP.PHAR.437 Thioguanine (Tabloid)	HIM, Medicaid	4Q 2020 annual review: AML dosing information limited to package insert information or directive for providers to forward protocol dosing information (there is no NCCN guidance here); the off-label ALL criteria is presented separately with standard off-label dosing language; references reviewed and updated.
CP.PHAR.439 Valrubicin (Valstar)	HIM, Medicaid	4Q 2020 annual review: revised criteria to include adjuvant intravesical chemotherapy for non-muscle invasive bladder cancer in the event of a BCG shortage as per NCCN 2A or above off label indication; updated Appendix D with information on BCG shortage; references reviewed and updated.





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CP.PHAR.458 Inebilizumab-cdon (Uplizna) ^	Commercial, HIM, Medicaid	Drug is now FDA approved - criteria updated per FDA labeling: added requirement that member does not have active HBV or TB since both are contraindications; added requirement against concurrent use with rituximab, Soliris, or Enspryng; modified approval durations from 26 weeks to 6 months; modified continued dose requirement from every 26 weeks to 6 months; references reviewed and updated.
CP.PHAR.469 Belantamab mafodotin (Blenrep)	Commercial, HIM, Medicaid	Drug is now FDA approved - criteria updated per FDA labeling: revised from 3 to 4 prior lines of therapy; modified to the actual FDA max dose; on re-auth, added requirement that dose is at least 1.9 mg/kg; references reviewed and updated.
CP.PHAR.479 Decitabine-Cedazuridine (Inqovi) ^	Commercial, HIM, Medicaid	Drug is now FDA approved - criteria updated per FDA labeling: MDS criteria collapsed given complexity of disease state/treatment guidelines and expert feedback; AML and MF criteria deleted pending NCCN Inqovi recommendations; references reviewed and updated.
CP.PMN.35 Armodafinil (Nuvigil)	Commercial, HIM, Medicaid	For narcolepsy indication added sleep medicine specialist as optional prescriber.
CP.PMN.39 Modafinil (Provigil)	HIM, Medicaid	For narcolepsy indication added sleep medicine specialist as optional prescriber.
CP.PMN.42 Sodium Oxybate (Xyrem)	Commercial, HIM, Medicaid	Updated policy to only require 1 month T/F of armodafinil/modafinil for narcolepsy with EDS if member is $\geq 17$ years given lack of evidence supporting use of armodafinil/modafinil in pediatric populations; references reviewed and updated.
CP.PMN.53 Off-Label Use	HIM-Benefits, Medicaid	4Q 2020 annual review: removed criteria for drugs without existing coverage criteria and moved to separate policy per PA Ops request; added NCCN 2B as an acceptable level of evidence per Compliance; references reviewed and updated.



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CP.PMN.86 Oxymetazoline (Rhofade, Upneeq) ^	Commercial, HIM, Medicaid	RT2: added Upneeq to policy with new criteria set for blepharoptosis; added HIM line of business.
CP.PMN.90 Benznidazole	Commercial, HIM, Medicaid	Age removed to allow use at any age; 60 days of therapy limitation added to initial criteria; clarification added to initial and continuation criteria that the 60-day limitation refers to the current infection; Appendix D and references reviewed and updated.
CP.PMN.116 L-glutamine (Endari)	Commercial, HIM, Medicaid	4Q 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PMN.181 Calcipotriene-Betamethasone Dipropionate Foam (Enstilar)	Commercial, HIM, Medicaid	4Q 2020 annual review: HIM line of business added; references reviewed and updated.
CP.PMN.199 Esketamine (Spravato) ^	Commercial, HIM, Medicaid	Criteria added for new FDA-approved indication: MDD with acute suicidality; for TRD indication initial review: added a time frame to the PHQ-9 score of 4 weeks to ensure assessment is current, added criteria for either no previous use of Spravato or prior positive response to ensure appropriate use, and added requirement for psychiatrist prescriber; references reviewed and updated.
CP.PMN.209 Solriamfetol (Sunosi)	Commercial, HIM, Medicaid	For narcolepsy indication added sleep medicine specialist as optional prescriber.
CP.PMN.221 Pitolisant (Wakix)	Commercial, HIM, Medicaid	Add sleep medicine specialist as optional prescriber.
<b>New</b>		



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CP.PHAR.506 Antithymocyte Globulin (Atgam, Thymoglobulin)	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.507 Lomustine (Gleostine)	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.508 Tafasitamab-cxix (Monjuvi)	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.509 Triheptanoin (Dojolvi) ^	Commercial, HIM, Medicaid	Policy created.
CP.PMN.248 Ciprofloxacin-Dexamethasone (Ciprodex)	HIM, Medicaid	Policy created.
CP.PMN.251 Lactic acid-citric acid-potassium bitartrate (Phexxi) ^	Commercial, HIM, Medicaid	Policy created.
CP.PMN.252 Metoclopramide (Gimoti)	Commercial, HIM, Medicaid	Policy created.
CP.PMN.253 Abametapir (Xeglyze)	Commercial, HIM, Medicaid	Policy created.



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CP.PMN.254 Budesonide-glycopyrrolate-formoterol fumarate (Breztri Aerosphere)	Commercial, Medicaid	Policy created.
CP.PMN.255 No Coverage Criteria	Medicaid, HIM-Medical Benefit	Policy created.
CP.PMN.256 Nifurtimox (Lampit) ^	Commercial, HIM, Medicaid	Policy created.
<b>No Significant Change(s)</b>		
CP.PHAR.130 Avatrombopag (Doptelet)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.133 Idelalisib (Zydelig)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.134 Methotrexate (Otrexup, Rasuvo, Xatmep, Reditrex)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.139 Mogamulizumab-kpkc (Poteligeo)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.



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CP.PHAR.142 Adefovir (Hepsera)	HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.143 Betaine (Cystadane)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.149 Baclofen (Gablofen, Lioresal, Ozobax)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.170 Degarelix (Firmagon)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; in continuation criteria clarified quantity limit of one injection; references reviewed and updated.
CP.PHAR.171 Goserelin Acetate (Zoladex)	HIM, Medicaid	4Q 2020 annual review: no significant changes; revised notation on endometriosis to state total duration of therapy should not exceed 6 months (previously stated 12 months) per the prescribing information; references reviewed and updated.
CP.PHAR.172 Histrelin (Vantas, Supprelin LA)	HIM- Medical Benefits, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.174 Nafarelin (Synarel)	HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.175 Triptorelin pamoate (Trelstar, Triptodur)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; removed HIM-Medical Benefit and references to non-formulary policy; references reviewed and updated.



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CP.PHAR.305 Obinutuzumab (Gazyva)	HIM-Medical Benefits, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.306 Ofatumumab (Arzerra)	HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.315 Vincristine Liposome (Marqibo)	Commercial, HIM-Medical Benefits, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.320 Necitumumab (Portrazza)	HIM, Medicaid	4Q 2020 annual review: no significant changes; modified HIM Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.324 Temsirolimus (Torisel)	HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.326 Olaratumab (Lartruvo)	HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; no significant changes; references reviewed and updated.
CP.PHAR.328 Asfotase Alfa (Strensiq)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; for Commercial line of business revised approval duration to “6 months or to member’s renewal date, whichever is longer”; references reviewed and updated.
CP.PHAR.357 Copanlisib (Aliqopa)	Commercial, HIM-Medical	4Q 2020 annual review: added Commercial line of business; no significant changes; references reviewed and updated.



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**B**uckeye Health Plan (BHP) routinely reviews their Prior Authorization (PA) and Medical Necessity (MN) criteria. Decisions on PA and MN criteria content are coordinated with input from pharmacy and medical practitioners, Buckeye Health Plan representatives, and review of current available medical literature and professional standards of practice. Below is the list of changes to the Medicaid criteria this quarter.

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	Benefit, Medicaid	
CP.PHAR.363 Enasidenib (Idhifa)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; updated Appendix C; references reviewed and updated.
CP.PHAR.365 Neratinib (Nerlynx)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.389 Pegvisomant (Somavert)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; appendix D updated with 2018 consensus recommendations; references reviewed and updated.
CP.PHAR.392 Pegademase Bovine (Adagen)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.393 Leucovorin Injection	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; revised HIM-Medical Benefit to HIM line of business; updated Appendix D per NCCN Compendium; references reviewed and updated.
CP.PHAR.394 Migalastat (Galafold)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; added requirement for enzyme or genetic testing to confirm Fabry disease diagnosis, consistent with the previously P&T-approved approach for Fabry disease diagnosis confirmation for Fabrazyme; revised link to GLA mutation search tool; references reviewed and updated.



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CP.PHAR.397 Cemiplimab-rwlc (Libtayo)	Commercial, HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; no significant changes; references reviewed and updated.
CP.PHAR.398 Moxetumomab pasudotox-tdfk (Lumoxiti)	Commercial, HIM, Medicaid	4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; no significant changes; references reviewed and updated.
CP.PHAR.399 Dacomitinib (Vizimpro)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.400 Duvelisib (Copiktra)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.434 Bremelanotide (Vyleesi)	Commercial, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.435 Darolutamide (Nubeqa)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.436 Pexidartinib (Turalio)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.438 Trientine (Syprine)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.





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CP.PHAR.441 Entrectinib (Rozlytrek)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; finalized HIM line of business per August SDC and prior clinical guidance; updated Appendix D with additional examples of solid tumors per NCCN Compendium; references reviewed and updated.
CP.PHAR.442 Fedratinib (Inrebic)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.13 Dose optimization	Medicaid	4Q 2020 annual review: no significant changes.
CP.PMN.16 Med Neces for Drug not PDL	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; added bypass of required preferred agent trials if clinically significant adverse effects are experienced or all are contraindicated; clarified claims history for non-PDL drug requests must support requirements for failure of preferred agents; references reviewed and updated.
CP.PMN.17 Droxidopa (Northera)	Commercial, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.59 Quantity Limit Override	Medicaid	4Q 2020 annual review: no significant changes; removed cross reference to the off-label use policy per PA Ops request; references reviewed and updated.
CP.PMN.143 Isotretinoin (Claravis, Absorica, Absorica LD, Myorisan, Zenatane, Amnesteem)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.165 Fluorouracil Cream (Tolak)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.



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CP.PMN.167 Neomycin-fluocinolone cream (Neo-Synalar)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.168 Ospemifene (Osphena)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.177 Glycopyrronium (Qbrexza)	Commercial, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.179 Megestrol Acetate Oral Suspension (Megace ES)	HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.185 Baloxavir Marboxil (Xofluza)	Commercial, Medicaid	4Q 2020 annual review: no significant changes; updated FDA Approved Indication section with revised indication to specify use in healthy or high risk patients; references reviewed and updated.
CP.PMN.213 Ferric maltol (Accrufer)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; removed references to HIM non-formulary policy and finalized HIM line of business; references reviewed and updated.
CP.PMN.215 Non-preferred blood glucose monitors and test strips	Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.216 Diazepam nasal spray (Valtoco)	Commercial, HIM, Medicaid	4Q 2020 annual review: no significant changes; references reviewed and updated.
OH.PHAR.PPA.20 Continuous Glucose Monitors	Medicaid	4Q 2020 annual review: no changes

**Retired**



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CP.PMN.30 paliperidone ER (Invega)	Medicaid	Retire, replaced by CP.PMN.16
CP.PMN.114 betrixaban (Bevyxxa)	Medicaid	Retire, use general prior auth criteria.
CP.PMN.162 Moxidectin	Commercial, Medicaid	Retire, no need for criteria.
OH.PHAR.PPA.17 Buprenorphine/Naloxone (Bunavail, Suboxone, Zubsolv)	Medicaid	Retire: replaced by OH.PHAR.PPA.40
OH.PHAR.PPA.18 Buprenorphine (Subutex)	Medicaid	Retire: replaced by OH.PHAR.PPA.40

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