



Effective Date: 9/29/20



Buckeye Health Plan

Medicaid Criteria Updates –Q3 2020

Buckeye 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
Clinically Significant Change(s)		
CP.PHAR.11 Burosumab-twza (Crysvita)	Commercial, HIM, Medicaid	3Q 2020 annual review: clarified weight-based dosing limits in initial and continued approval criteria; references reviewed and updated.
CP.PHAR.14 Hydroxyprogesterone caproate (Makena)	Commercial, HIM, Medicaid	Added requirement precluding concurrent therapy with Crinone or Endometrin.
CP.PHAR.16 Palivizumab (Synagis)	Commercial, HIM, Medicaid	Seasonal coverage criteria are added to all indications; related AAP/CDC guidance is added to Appendix D.
CP.PHAR.61 Cinacalcet (Sensipar)	Commercial, HIM, Medicaid	3Q 2020 annual review: added Commercial LOB; references reviewed and updated.
CP.PHAR.81 Pazopanib (Votrient)	Commercial, HIM, Medicaid	3Q 2020 annual review: For STS subtype GIST Ayvakit added per NCCN guidelines as a possible step through drug; for STS added criteria disease is stage IV, unresectable, advanced, or recurrent with metastases as per NCCN guidelines; for uterine carcinoma added criteria disease is recurrent or metastatic; for thyroid carcinoma added criteria disease is unresectable, advanced or metastatic; if papillary, follicular, or Hurthle cell carcinoma, disease is progressive and/or symptomatic iodine-refractory; off-label ovarian cancer added given 2A NCCN recommendation; references reviewed and updated.



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CP.PHAR.89 Peginterferon Alfa-2a,b (Pegasys, PegIntron, Sylatron)	Commercial, HIM, Medicaid	3Q 2020 annual review: added systemic mastocytosis with associated hematologic malignancy, aggressive systemic mastocytosis, osteopenia or osteoporosis with refractory bone pain and/or decreasing bone mineral density on bisphosphonate therapy as per NCCN compendium; specified myelofibrosis as low risk and symptomatic as per NCCN compendium; added specialist involvement for chronic hepatitis B infection; references reviewed and updated.
CP.PHAR.103 Immune Globulins	Commercial, HIM, Medicaid	3Q 2020 annual review: for dermatomyositis added a requirement for a prior trial of rituximab; added Indiana as another exception to the Section III exclusion for PANDAS; RT4: added new Hizentra prefilled syringe dosage form; references reviewed and updated.
CP.PHAR.130 Avatrombopag (Doptelet)	Commercial, HIM, Medicaid	For chronic immune thrombocytopenia: added requirement that Doptelet is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP; revised systemic corticosteroid and immune globulin trial to tiered re-direction with immune globulin trial only if corticosteroid cannot be used per ASH 2011 guideline and specialist feedback.
CP.PHAR.131 Infertility and Fertility Preservation	Commercial*, HIM*, Medicaid*	HIM line of business applied to all agents; infertility/fertility preservation benefit exclusion added for HIM line of business except for HIM Illinois; infertility/fertility preservation pharmacy benefit requirement added for all lines of business.
CP.PHAR.146 Deferoxamine (Desferal)	Commercial, HIM, Medicaid	3Q 2020 annual review: revised HIM-medical benefit to HIM line of business; references reviewed and updated.
CP.PHAR.150 Mecasermin (Increlex)	Commercial, HIM, Medicaid	3Q 2020 annual review: HIM non-formulary language removed; open epiphyses added; auxology updated for acquired GH insensitivity to reconcile with somatropin policy; malignancy contraindication added; positive response removed in deference to growth criteria; references reviewed and updated.



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CP.PHAR.168 Corticotropin (H.P. Acthar)	Commercial, HIM, Medicaid	Revised multiple sclerosis approval duration from 4 weeks to 3 weeks and added max vial quantity of 6 vials total; revised Appendix D; references reviewed and updated.
CP.PHAR.173 Leuprolide Acetate (Lupron, Lupron Depot, Eligard, Lupaneta Pack, Fensolvi)	Commercial, HIM, Medicaid	3Q 2020 annual review: revised HIM-Medical Benefit to HIM line of business; added Fensolvi (new dosage form) to the policy for Central Precocious Puberty; added off-label NCCN indication and criteria for salivary gland tumor; references reviewed and updated.
CP.PHAR.179 Romiplostim (Nplate)	Commercial, HIM, Medicaid	For immune thrombocytopenia: added requirement that Nplate is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP.
CP.PHAR.180 Eltrombopag (Promacta)	Commercial, HIM, Medicaid	For chronic immune thrombocytopenia: added requirement that Promacta is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP.
CP.PHAR.212 Dornase alfa (Pulmozyme)	HIM, Medicaid	Added pulmonologist prescriber requirement; added requirement of therapeutic plan including concomitant use of standard CF therapies as indicated in PI.
CP.PHAR.243 Alemtuzumab (Lemtrada)	Commercial, HIM, Medicaid	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; references reviewed and updated.
CP.PHAR.258 Mitoxantrone (Novantrone)	Commercial, HIM, Medicaid	MS: added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; references reviewed and updated.
CP.PHAR.259 Natalizumab (Tysabri)	Medicaid	MS: added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.



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CP.PHAR.260 Rituximab (Rituxan, Ruxience, Truxima, Rituxan Hycela)	HIM, Medicaid	Added criteria for off-label indication of ITP; for RA, added specific diagnostic criteria for definite RA, baseline CDAI score requirement, and decrease in CDAI score as positive response to therapy.
CP.PHAR.270 Paricalcitol Injection (Zemlar)	Commercial, HIM, Medicaid	3Q 2020 annual review: added Commercial line of business, modified HIM-Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.285 Nintedanib (Ofev)	Commercial, HIM, Medicaid	3Q 2020 annual review: criteria added for new FDA indication: chronic fibrosing ILD with a progressive phenotype; references reviewed and updated.
CP.PHAR.286 Pirfenidone (Esbriet)	Commercial, HIM, Medicaid	3Q 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PHAR.302 Ixazomib (Ninlaro)	Commercial, HIM, Medicaid	3Q 2020 annual review: NCCN recommended uses for MM and Waldenstrom added; references reviewed and updated.
CP.PHAR.303 Brentuximab (Adcetris)	Commercial, HIM, Medicaid	Q3 2020 annual review: HIM line of business added; per NCCN, breast-implant associated ALCL stage restriction removed, primary mediastinal large B-cell lymphoma added, post-transplant lymphoproliferative disorder limited to monomorphic PTLD (T-cell type) inclusive of primary therapy; references reviewed and updated.
CP.PHAR.310 Daratumumab, Daratumumab-Hyaluronidase-fihj (Darzalex, Darzalex Faspro)	Medicaid, HIM	3Q 2020 annual review: Darzalex Faspro added; references reviewed and updated.
CP.PHAR.322 Pembrolizumab (Keytruda)	Commercial, HIM, Medicaid	3Q 2020 annual review: new FDA approved dosing of 400 mg every 6 weeks added to all labeled adult indications; NSCLC: first-line removed from combination with chemotherapy per NCCN; brain metastasis moved under PD-L1 positive disease per NCCN; SCLC: relapsed disease added per



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		NCCN; cHL: Keytruda as single-agent therapy added per NCCN; HNSCC: first-line therapy requirement removed from combination platinum/FU therapy per NCCN; MSI-H/dMMR tumors: first-line therapy for occult primary tumor and small bowel added per NCCN; HCC: Child-Pugh Class A added per NCCN/pivotal trial with no prior checkpoint inhibitor therapy caveat per NCCN; references reviewed and updated.
CP.PHAR.335 Ocrelizumab (Ocrevus)	Commercial, HIM, Medicaid	Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified Medicaid/HIM continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.
CP.PHAR.360 Olaparib (Lynparza)	Commercial, HIM, Medicaid	Criteria added for two newly FDA-approved indications: 1) HRD-positive ovarian cancers in combination with bevacizumab after bevacizumab primary therapy, and 2) HRR-mutated mCRPC.
CP.PHAR.365 Neratinib (Nerlynx)	Commercial, HIM, Medicaid	Added NCCN Compendium supported use in combination with capecitabine for CNS metastases; references reviewed and updated.
CP.PHAR.379 Etelcalcetide (Parsabiv)	HIM, Medicaid	3Q 2020 annual review: added to Section I requirement that member does not have serum calcium less than the lower limit of the normal to align with prescribing information and similar Sensipar criteria requirements; modified HIM-Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.381 Mechlorethamine (Valchlor)	Commercial, HIM, Medicaid	3Q 2020 annual review: added to Section I requirement that member does not have serum calcium less than the lower limit of the normal to align with prescribing information and similar Sensipar criteria requirements; modified HIM-Medical Benefit to HIM line of business; references reviewed and updated.



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CP.PHAR.383 Trifluridine-tipiracil (Lonsurf)	Commercial, HIM, Medicaid	3Q 2020 annual review: added HIM line of business; added advanced CRC, GC, and GEJ per NCCN guidelines; changed T/F of Herceptin to trastuzuamb allowing usage of biosimilars as supported by NCCN guidelines; updated Appendix B; references reviewed and updated.
CP.PHAR.384 Lutetium Lu 177 dotatate (Lutathera)	Commercial, HIM, Medicaid	3Q 2020 annual review: revised HIM-Medical Benefit line of business to HIM; added Commercial line of business; revised criteria requiring disease progression while on a long-acting somatostatin analog to allow short and long acting somatostatin analogs; updated Appendix B and D; references reviewed and updated.
CP.PHAR.385 Corticosteroid Intravitreal Implants (Iluvien, Ozurdex, Retisert, Yutiq)	Commercial, HIM, Medicaid	3Q 2020 annual review: added HIM line of business, removed HIM-Medical Benefit; references reviewed and updated.
CP.PHAR.408 Niraparib (Zejula)	Commercial, Medicaid	Criteria added for expanded FDA-indication as maintenance treatment in advanced ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to first-line platinum-based chemotherapy; added that Zejula must be used as a single agent or in combination with bevacizumab per NCCN recommendations.
CP.PHAR.423 Erdafitinib (Balversa)	Commercial, HIM, Medicaid	3Q 2020 annual review: recurrent disease and checkpoint inhibitor prior therapy option added per NCCN; references reviewed and updated.
CP.PHAR.424 Fulvestrant (Faslodex Injection)	Commercial, HIM, Medicaid	3Q2020 annual review: for endometrial carcinoma, added option for us in stage II disease, in combination with sequential external beam radiation therapy; references reviewed and updated.
CP.PHAR.433 Polatuzumab vedotin-piiq (Polivy)	Commercial, HIM, Medicaid	3Q 2020 annual review: HIM and Commercial lines of business added; NCCN off-label uses added for HGBL, follicular and mantle cell lymphomas, post-transplant lymphoproliferative disorder, AIDS-related B-cell lymphoma, histologic transformation of nodal marginal lymphoma to DLBCL; 6 cycles total highlighted in approval section; more than 6 cycles added if supported by NCCN compendium in continuation section; references reviewed and updated.



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CP.PHAR.450 Luspatercept-aamt (Reblozyl)	Commercial, HIM, Medicaid	Criteria added for new FDA indication: MDS; references reviewed and updated.
CP.PHAR.460 Monomethyl fumarate (Bafiertam)	Commercial, HIM, Medicaid	Drug is now FDA approved - criteria updated per FDA labeling; modified CIS re-direction to include glatiramer per SDC; added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; added primary progressive MS as a diagnosis not covered; references reviewed and updated.
CP.PHAR.462 Ozanimod (Zeposia)	Commercial, HIM, Medicaid	Drug is now FDA approved - criteria updated per FDA labeling; modified CIS re-direction to include glatiramer per SDC; added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; added primary progressive MS as a diagnosis not covered; references reviewed and updated.
CP.PHAR.465 Teprotumumab (Tepezza)	Commercial, HIM, Medicaid	Added requirement that member has not had previous surgical intervention for TED consistent with clinical trial exclusion criteria.
CP.PHAR.475 Sacituzumab govitecan-hziy (Trodelvy)	Commercial, HIM, Medicaid	Drug is now FDA-approved - criteria updated per FDA-labeling: removed requirement for previous taxane-based regimen as this is neither in the PI nor required by NCCN.
CP.PHAR.476 Ubrogepant (Ubrovelvy)	Commercial, HIM, Medicaid	Revised requirement 'for monthly quantities > 1 box of 6 tablets per month' to 10 tablets per month as this is the smallest available package size. Updated Section VI to remove the 6 and 8 tablet package sizes.
CP.PHAR.478 Selpercatinib (Retevmo)	Commercial, HIM, Medicaid	Drug is now FDA approved - criteria updated per FDA labeling: For NSCLC, failure of platinum-based chemotherapy and PD-1/PD-L1 therapy removed per FDA; recurrent, advanced or metastatic replaces advanced per FDA and NCCN; dosing added; for thyroid cancer, MTC restricted to mutant-positive rather



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		than also fusion-positive; failure of systemic therapy removed per FDA; dosing added; references reviewed and updated.
CP.PMN.40 Acitretin (Soriatane)	Medicaid	3Q 2020 annual review: added rheumatologist as a prescriber option; references reviewed and updated.
CP.PMN.44 Pyrimethamine (Daraprim)	Commercial, HIM, Medicaid	3Q 2020 annual review: added requirement for use of generic products before brand product; references reviewed and updated. 3Q 2020 annual review: added requirement for use of generic products before brand product; references reviewed and updated
CP.PMN.76 Calcifediol (Rayaldee)	Commercial, HIM, Medicaid	3Q 2020 annual review: added HIM line of business; references reviewed and updated.
CP.PMN.163 Sodium zirconium cyclosilicate (Lokelma)	Commercial, Medicaid	3Q 2020 annual review: clarified redirection to preferred sodium polystyrene sulfonate; added to Section III exclusion for emergency treatment of hyperkalemia to align with prescribing information limitation of use and Veltassa; references reviewed and updated.
CP.PMN.199 Esketamine (Spravato)	Commercial, HIM, Medicaid	Added requirements for PHQ-9 score of at least 15 for initial approval with a decrease of at least 50% from baseline for continued approval.
CP.PMN.208 Halobetasol-Tazarotene (Duobrii)	Commercial, HIM, Medicaid	3Q 2020 annual review: added HIM line of business; added rheumatologist as prescriber involvement for plaque psoriasis; references reviewed and updated.
New		
CP.PHAR.487 Osilodrostat (Isturisa)*	Commercial, HIM, Medicaid	Policy created.



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CP.PHAR.489 Eptinezumab (Vyepi)*	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.490 Rimegepant (Nurtec ODT)*	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.491 Setmelanotide (RM-493)	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.492 Teplizumab	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.493 Infusion Therapy Site of Care Optimization	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.494 Capmatinib (Tabrecta)*	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.495 Mitomycin for Pyelocalyceal Solution (Jelmyto)*	Commercial, HIM, Medicaid	Policy created.
CP.PHAR.496 Pemigatinib (Pemazyre)*	Commercial, HIM, Medicaid	Policy created.



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CP.PHAR.497 Tucatinib (Tukysa)*	Commercial, HIM, Medicaid	Policy created.
CP.PMN.236 Amisulpride (Barhemsys)	Commercial, HIM, Medicaid	Policy created.
CP.PMN.239 Chenodiol (Chenodal)	Commercial, HIM, Medicaid	Policy created.
CP.PMN.240 Gabapentin ER (Gralise, Horizant)	Commercial, HIM, Medicaid	Policy created.
CP.PMN.241 Lactitol (Pizensy)*	Commercial, HIM, Medicaid	Policy created.
CP.PMN.243 Progesterone (Crinone, Endometrin, Milprosa)	Commercial, HIM, Medicaid	Policy created.
CP.PMN.245 Opicapone (Ongentys)*	Commercial, HIM, Medicaid	Policy created.
No Significant Change(s)		



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CP.PHAR.27 Tolvaptan (Jynarque, Samsca)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; updated product availability; updated Jynarque boxed warnings as per updated prescribing information; references reviewed and updated.
CP.PHAR.28 Immunization coverage	Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.82 Collagenase (Xiaflex)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; revised HIM-Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.83 Vorinostat (Zolinza)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; Appendix D subtype classification updated per NCCN/WHO-EORTC 2018; references reviewed and updated.
CP.PHAR.88 Belimumab (Benlysta)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; revised from HIM-Medical Benefit to HIM line of business; references reviewed and updated.
CP.PHAR.95 Thyrotropin alfa (Thyrogen)	HIM, Medicaid	3Q 2020 annual review: revised HIM-Medical Benefit line of business to HIM; no significant changes; references reviewed and updated.
CP.PHAR.109 Tesamorelin (Egrifta SV)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; replaced old formulation Egrifta with new formulation Egrifta SV; references reviewed and updated.
CP.PHAR.145 Deferasirox (Exjade, Jadenu)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.147 Deferiprone (Ferriprox)	Commercial, Medicaid	3Q 2020 annual review: no significant changes; added new tri-scored 1,000 mg tab formulation; references reviewed and updated.



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CP.PHAR.169 Vigabatrin (Sabril)	HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.277 Cytomegalovirus Immune Globulin (Cytogam)	Commercial, HIM, Medicaid	3Q 2020 annual review: changed HIM-Medical Benefit to HIM line of business; no significant changes; references reviewed and updated.
CP.PHAR.287 Obeticholic acid (Ocaliva)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.312 Blinatumomab (Blinicyto)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; HIM line of business added; references reviewed and updated.
CP.PHAR.323 Plerixafor (Mozobil)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.338 Cerliponase alfa (Brineura)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.351 Daptomycin (Cubicin, Cubicin RF)	Commercial, HIM, Medicaid	3Q 2020 annual review: revised HIM-Medical Benefit line of business to HIM; no significant changes; references reviewed and updated.
CP.PHAR.382 Panobinostat (Farydak)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; HIM line of business added; references reviewed and updated.



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CP.PHAR.425 Metreleptin (Myalept)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PHAR.429 Valproate (Depacon)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated
CP.PHAR.430 Alpelisib (Piqray)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated
CP.PHAR.431 Selinexor (Xpovio)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated
CP.PHAR.432 Tafamidis (Vyndaqel, Vyndamax)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated
CP.PMN.09 Lindane shampoo	Medicaid	3Q2020 annual review; no significant changes; references reviewed and updated
CP.PMN.60 SSRI SNRI Duplicate Therapy	Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.83 Short ragweed pollen allergen extract (Ragwitek)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.
CP.PMN.84 Timothy grass pollen allergen extract (Grastek)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.



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CP.PMN.85 Mixed pollens allergen extract (Oralair)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.
CP.PMN.111 House dust mite allergen extract (Odactra)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.
CP.PMN.139 Naloxone (Evzio)	Commercial, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.144 Epinephrine (Auvi-Q, Epipen, Epipen Jr) Quantity Limit	Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.152 Lofexidine (Lucemyra)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.202 Benzyl alcohol (Ulesfia)	Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.205 Patiromer (Veltassa)	Commercial, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.207 Triclabendazole (Egaten)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.211 Midazolam (Nayzilam)	Commercial, HIM, Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.
CP.PMN.230 Mometasone-formoterol (Dulera)	Medicaid	3Q 2020 annual review: no significant changes; references reviewed and updated.



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OH.PHAR.PPA.02 Opioid Rx Limits	Medicaid	3Q 2020 annual review: no significant changes
OH.PHAR.PPA.03 Pharmacy Compounds	Medicaid	3Q 2020 annual review: no significant changes
Policies to retire		
CP.PHAR.276 Ombitasvir/Paritaprevir/Ritonavir (Technivie)	Commercial, HIM, Medicaid	Retire, since drug is off the market and drug will be obsolete by 8/2020
CP.PHAR.280 Simeprevir (Olysio)	Medicaid	Retire, since drug is off the market and drug will be obsolete by 8/2020
CP.PMN.75 Age Limit for Tazarotene (Tazorac, Arazlo)	Medicaid	Retire, replaced by CP.PMN.244 Tazarotene (Arazlo, Fabior, Tazorac) to accommodate for SDC recommendation to add Arazlo and Fabior

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