PHARMACY NEWS

PASSPORT HEALTH PLAN

SUPPORTING OUR PROVIDER PARTNERS THROUGH COMMUNICATION AND COLLABORATION.

DATE JUNE 2017
ISSUE 3

HELPFUL NUMBERS FOR PROVIDERS
CVS: 1-888-512-8935
Primary: 004336
Secondary Commercial: 013089
Secondary Part D: 012114

Passport Advantage
BIN: 004336
PCN: MEDDAVDV

HELPFUL NUMBERS FOR MEMBERS
Passport Health Plan
1-800-578-0603

WEBSITE
www.passporthealthplan.com

NEW IN THIS ISSUE

- Generic Metformin Products – May 2017 Update
- Basal Insulin Changes
- Suboxone® Formulary Changes
- Controlled Substance Edits
- New Generics
- P & T Committee Review

Generic Metformin Products May 2017 Update

Metformin is available under three different brand names: Glucophage®, Fortamet®, and Glumetza®. Please note that the corresponding generic products to each brand product may have different coverage and is outlined below:

Preferred Products: These medications are covered

- Metformin 500mg, 850mg, 1000mg tablets (generic for Glucophage®)
- Metformin 500mg, 750mg ER tablets (generic for Glucophage® XR)

Non-Preferred Products: These medication requires step therapy or prior authorization

- Metformin 500mg, 1000mg ER tablet (generic for Fortamet®)
- Metformin 500mg, 1000mg ER tablets (generic for Glumetza®)
- Brand-name products: Glucophage®, Glucophage® XR, Fortamet®, Glumetza®

Basal Insulin Changes

As a reminder, Passport Health Plan's preferred basal insulin products have changed as of June 1, 2017. Please review the new preferred formulary agents and consider transitioning members to one of the preferred products. All members will be required to have their provider submit a prior authorization request to continue use of a non-preferred product after June 1, 2017.

Preferred Products: These medications are covered with a quantity limit

- Basaglar KwikPen®: 45mL per 30 days
- Tresiba® FlexTouch®: 45mL per 30 days

Non-Preferred Products: These medications require prior authorization and are subject to a quantity limit

- Lantus® (vial): 50mL per 30 days
- Lantus® SoloStar®: 45mL per 30 days
- Levemir® (vial): 50mL per 30 days
- Levemir® FlexTouch®: 45mL per 30 days
- Toujeo® SoloStar®: 45mL per 30 days

Suboxone® Formulary Changes

Effective July 17, 2017, Suboxone® (buprenorphine-naloxone sublingual film) will move to a non-preferred status on the formulary. All members, even those with a currently effective prior authorizations for Suboxone® film, will need to be changed to buprenorphine-naloxone sublingual tablet. All buprenorphine products will continue to require prior authorization. However, any new authorizations or reauthorizations for non-preferred products will require documentation of an allergy to the preferred buprenorphine-naloxone sublingual tablets through MedWatch and a trial and failure of the preferred products. Please review the new preferred formulary agents and consider transitioning members to the preferred products.

Preferred Products: These medications require prior authorization and are subject to a quantity limit

- Buprenorphine-naloxone sublingual tablets: 60 tablets per 30 days
- Buprenorphine sublingual tablets (when used during pregnancy or in the presence of a naloxone allergy documented through MedWatch): 60 tablets per 30 days

Non-Preferred Products: These medications require prior authorization, step therapy, and are subject to quantity limit

- Suboxone® sublingual films: 60 tablets per 30 days
- Zubsolv® sublingual tablets: 60 tablets per 30 days
- Bunavail® sublingual tablets: 60 tablets per 30 days

Controlled Substance Edits

As a reminder, Passport Health Plan has implemented safety edits for controlled substances. Members who exceed any of the below safety edits will require a prior authorization. Please review the currently active controlled substance edits for your reference.

- Exceed 120 Morphine Equivalent Dose (MED)
- Greater or equal to 9 controlled substances
- Greater or equal to 3 pharmacies utilized to fill controlled substances
- Received controlled substances prescriptions from greater or equal to 3 prescribers
- Exceed 90 day supply of short-acting opioids
- Concurrent use of a opioid with a benzodiazepines/carisoprodol
- Concurrent use of more than one short-acting stimulant

New Generics

BRAND NAME	GENERIC NAME	BRAND NAME	GENERIC NAME
Cordran®	Flurandrenolide	Zyflo®	Zileuton
Pristiq®	Desvenlafaxine ER	Tazorac®	Tazarotene

**Generic drugs will have a $0 co-pay. However, some generic drugs may still be subject to prior authorization or step therapy requirements, and certain quantity limits. For details, please refer to the drug formulary on Passport Health Plan website www.passporthealthplan.com*

The Passport Health Plan Pharmacy and Therapeutics Committee Reviewed the Following Medications in May 2017*

BRAND NAME	GENERIC NAME	INDICATIONS	FORMULARY ALTERNATIVES	PASSPORT HEALTH PLAN STATUS
Trulance™	Plecanatide	Chronic Idiopathic Constipation (CIC)	Linzess®, Amitiza®	Non-Preferred, PA, QL 30 tablets/month
Rhofade™	Oxymetazoline	Persistent facial erythema associated with rosacea	Mirvaso®, Finacea®, Metronidazole	Non-Preferred, PA
Xermelo™	Telotristat	treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) in adults inadequately controlled by SSA therapy	Antidiarrheal agents, 5-HT3 receptor agonists, long-acting somatostatin analogues	Non-Preferred, PA, QL 90 tablets/month
Symproic®	Naldemedine	Opioid-induced Constipation (OIC)	Movantik®, Relistor®, Amitiza®	Non-Preferred, PA, QL 30 tablets/month
Xadago®	Safinamide	Parkinson's disease (off episode) in combination with levodopa/carbidopa	Rasagiline, Selegiline	Non-Preferred, PA, 30 tablets/month
Qtern®	Dapagliflozin/Saxagliptin	Type 2 diabetes inadequately controlled with dapagliflozin	Glyxambi®, SGLT-2 inhibitors, DPP-4 agonists	Non-Preferred, ST, QL 30 tablets/month
Emflaza™	Deflazacort	Duchenne muscular dystrophy (DMD)	Prednisone	Non-Preferred, PA
Siliq™	Brodalumab	Moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies	Stelara®, Talz®, Cosentyx®	Non-Preferred, PA, QL 2 syringes/28 days
Dupixent®	Dupilumab	Moderate to severe atopic dermatitis inadequately controlled by topical therapies	N/A	Non-Preferred, PA, QL 2 syringes/28 days

DRUG CLASS REVIEW
Hepatitis C • Preferred Product: Zepatier® • Non-Preferred Products: Harvoni®, Epclusa®, Viekira Pak/XR™, Sovaldi®, Olysio®, Daklinza™, Technivie™
ADHD • Preferred Products: generic stimulants, Vyvanse® • Non-Preferred Products: brand stimulants, Strattera®
Buprenorphine Products • Preferred Products: buprenorphine/naloxone SL tablets, buprenorphine SL tablets • Non-Preferred Products: Suboxone®, Bunavail®, Zubsolv®

DRUG CLASS REVIEW (CONTINUED)
Hypnotics • Preferred Products: eszopiclone, zaleplon, zolpidem/ER • Non-Preferred Products: Rozerem® (prior authorization criteria will continue to address abuse concerns), Belsomra®, Silenor®, Ambien/CR®, Edluar™, Intermezzo®, Lunesta®, Sonata®, Zolpimist™
Androgens • Preferred Products: testosterone topical gel • Non-Preferred Products: Androgel®, Testim®, Androderm®, Axiron®, Fortesta®, Natesto®
Inflammatory Bowel Disease – Oral Agents • Preferred Products: balsalazide disodium, sulfasalazine/DR, sulfazine/EC, budesonide EC, Apriso, Lialda • Non-Preferred Products: Pentasa®, Uceris®, Asacol® HD, Delzicol, Dipentum®, Giazo®, Entocort EC, Azulfidine®/EN, Colazal
Opioid Induced Constipation • Preferred Products: Movantik® • Non-Preferred Products: Relistor®, Symproic®, Amitiza®
Long-Acting Anticholinergic Inhalers • Preferred Products: Spiriva®, Respimat®, Incruse®, Ellipta® • Non-Preferred Products: Spiriva®, Handihaler®, Tudorza®, Pressair®, Seebri™, Neohaler®
Inhaled Corticosteroids • Preferred Products: Aerospan®, Arnuity®, Ellipta®, Asmanex®, Twisthaler®/HFA, Flovent®, Diskus®/HFA • Non-Preferred Products: Pulmicort Flexhaler®, QVAR®, Alvesco®
Anticonvulsants • Preferred Products: generic products, Banzel®, Onfi®, Celontin®, Peganone®, Vimpat®, Potiga®, Sabril®, Gabitril® (12mg, 16mg), Lyrica® • Non-Preferred Products: Aptiom®, Briviact®, Fycompa®, Gabitril® (2mg, 4mg), Oxtellar XR®
Atypical Antipsychotics – Oral Agents • Preferred Products: generic products, Latuda® • Non-Preferred Products: Fanapt®, Rexulti®, Saphris®, Seroquel/XR®, Vraylar®
Multiple Sclerosis • Preferred Products: Aubagio®, Avonex®, Copaxone®, Extavia®, Gilenya®, Rebif®/Rebidose®, Tecfidera® • Non-Preferred Products: Betaseron®, Plegridy®/Pen
Pancreatic Enzymes • Preferred Products: Creon®, Viokace™, Zenpep® • Non-Preferred Products: Pancreaze®, Pertyze®
Long-Acting Beta-Agonist/Long-Acting Anticholinergic Inhalers • Preferred Products: Stiolto®, Respimat®, Anoro® Ellipta® • Non-Preferred Products: Bevespi®, Utibron™ Neohaler®

**The Pharmacy and Therapeutics committee also reviewed updates to quantity limits, prior-authorization durations, and other clinical criteria requirements. For specific questions about the clinical criteria please visit www.passporthealthplan.com or call the CVS Help Desk at 1-888-512-8935.*