“What’s New” Medical Pharmaceutical Policy Updates September 2016

MBP 144.0 Tecentriq (atezolizumab)- NEW POLICY

Tecentriq (atezolizumab) is a humanized monoclonal antibody immune checkpoint inhibitor that binds to programmed death ligand 1 (PD-L1) to selectively prevent the interaction between the programmed cell death 1 (PD-1) and B7.1 (also known as CD80) receptors, while still allowing interaction between PD-L2 and PD-1. PD-L1 is an immune check point protein expressed on tumor cells and tumor infiltrating cells and down regulates anti-tumor T-cell function by binding to PD-1 and B7.1; blocking PD-1 and B7.1 interactions restores antitumor T-cell function.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Tecentriq (atezolizumab) will be considered medically necessary when all of the following criteria are met:

1. **Locally Advanced or Metastatic Urothelial Carcinoma:**
- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of locally advanced or metastatic urothelial carcinoma **AND**
- Medical record documentation that the patient has had either:
    - Disease progression during or following platinum-containing chemotherapy OR
    - Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

7/19/16

MBP 13.0 Viscosupplementation using hyaluronan injections (Hyalgan, Orthovisc, Supartz, Monovisc, Gel-One)- REVISED (Criteria)

NOTE: Euflexxa, Synvisc, and Synvisc One are preferred agents and DO NOT Require Prior Authorization

~~**Orthovisc, Supartz, Hyalgan, Monovisc & Gel-One Require Prior Authorization by a Plan Medical Director or Designee* and require failure on, intolerance to or contraindication to Euflexxa, *Synvisc, and Synvisc One***~~

Hyalgan, **Orthovisc**, **Supartz**, **Monovisc**, and **Gel-One** Require Prior Authorization and will be considered medically necessary when all of the following criteria are met:

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of “bone-on-bone”, morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; AND
- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; AND
- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; AND
- Physician documentation that there has been no significant improvement following pharmacologic

therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if NSAID's are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; AND

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; AND

- Physican documentation of failure on, intolerance to or contraindication to Euflexxa, Synvisc, and Synvisc One

7/19/16

MBP 24.0 Aloxi (Palonosetron)- REVISED (Criteria)

Aloxi (Palonosetron) will be considered medically necessary when all of the following criteria are met:

1. **PREVENTION OF ACUTE NAUSEA AND VOMITING**
   - Medical record documentation that Aloxi is being used for prevention of chemotherapy induced nausea or vomiting from low, or minimally, ~~or moderately~~ emetogenic cancer chemotherapy for members who have a treatment failure or contraindication to Granisetron (Kytril) or Ondansetron (Zofran). Treatment failure is defined as an allergy, intolerable side effects, significant drug-drug interactions, or lack of efficacy; **OR**
   - Medical record documentation that Aloxi is being used for prevention of acute nausea or vomiting associated with initial and repeat courses of moderately or highly emetogenic cancer chemotherapy.

The following antineoplatic agents are considered MODERATELY emetogenic (not a complete list):

- Aldesleukin >12-15 million IU/m^2
- Amifostine >300 mg/m^2
- Arsenic trioxide
- Azacitidine
- Bendamustine
- Busulfan
- Carboplatin
- Carmustine ≤ 250 mg/m^2
- Clofarabine
- Cyclophosphamide ≤ 1500mg/m^2
- Cytarabine >200mg/m^2
- Dactinomycin
- Daunorubicin
- Dinutuximab
- Doxorubicin <60 mg/m^2
- Epirubicin ≤ 90 mg/m^2
- Idarubicin
- Ifosfamide <2 g/m^2 per dose
- Interferon alfa ≥ 10 million IU/m^2
- Irinotecan
- Melphalan
- Methotrexate ≥250 mg/m^2
- Oxaliplatin
- Temozolomide
- Trabectedin

The following antineoplastic agents are considered highly emetogenic (not a complete list):

- AC combination defined as either doxorubicin or epirubicin with cyclophosphamide
- Carmustine at doses >250mg/m^2
- Cisplatin
- Cyclophosphamide at doses >1500 mg/m^2
- Dacarbazine
- Doxorubicin at doses ≥ 60mg/m^2
- Epirubicin at doses >90mg/m^2
- Ifosfamide at doses ≥2g/m^2
- Mechlorethamine
- Streptozotocin

7/19/16

MBP 75.0 Stelara (ustekinumab)- REVISED (Criteria)

Stelara (ustekinumab) will be considered medically necessary when all of the following criteria are met:

1. For plaque psoriasis
   - Prescription must be written by a dermatologist **AND**
   - Member must be at least 18 years of age **AND**
   - Medical record documentation that the prescribed dosing is appropriate for patient's weight **AND**
   - Medical record documentation of moderate to severe plaque psoriasis characterized by ≥5% of body surface area involved or disease affecting crucial body areas such as the hands, feet, face, or genitals **AND**
   - Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* **AND** Enbrel*

   *Requires Prior Authorization

2. For psoriatic arthritis
   - Prescription must be written by a rheumatologist or a dermatologist **AND**
   - Member must be at least 18 years of age **AND**
   - Medical record documentation that the patient is going to receive a dose of 45 mg every 12 weeks OR medical record documentation that the patient has a co-existing diagnosis of moderate-to-severe plaque psoriasis and weighs > 100 kg. **AND**
   - Medical record documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include the following:
     - Documentation of either active psoriatic lesions or a documented history of psoriasis **AND**
   - Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* **AND** Enbrel*

   *Requires Prior Authorization

7/19/16

MBP 106.0 Injectable Antipsychotic Medications - REVISED (Quantity Limits)

LIMITATIONS:

The following quantity limits should apply (please enter claims payment note, when entering authorization)

- Abilify Maintena – One syringe or vial per 28 days
- Aristada – One syringe per 28 days
- Invega Sustenna – ~~One syringe per 28 days~~ two syringes per 1 week, then one syringe per 28 days thereafter

  Enter claims payment note as follows to account for loading dose in the first week:

  - Rx Count of 1 approved by GPID for 234 mg, quantity limit 1
  - Rx Count of 1 approved by GPID for 156 mg, quantity limit 1
  - Open-ended authorization for quantity limit 1 syringe per month, request to be approved by GPID for the prescribed strength.

- Invega Trinza – One syringe per 84 days (3 months)
- Risperdal Consta – Two vials per 28 days
- Zyprexa Relprevv – Two vials per 28 days

7/19/16

MBP 126.0 Opdivo (nivolumab)- REVISED (New Indication)

4. *Classical Hodgkin Lymphoma (CHL)*

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 18 years of age **AND**
- Medical record documentation of a diagnosis of classical Hodgkin lymphoma (CHL) that has relapsed or progressed after autologous hematopoietic stem cell transplantation and post-transplantation brentuximab vedotin (Adcetris).

7/19/16

MBP 131.0 Cosentyx (secukinumab) vials - REVISED (New Indication's)

1. **Psoriatic Arthritis:**
   - Medical record documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include the following:
     - Documentation of either active psoriatic lesions or a documented history of psoriasis **AND**
   - Prescription must be written by a rheumatologist or dermatologist **AND**
   - Member must be at least 18 years of age **AND**
   - Medical record documentation of intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* AND Enbrel*

2. **Ankylosing Spondylitis:**
   - Medical record documentation of a diagnosis of ankylosing spondylitis **AND**
   - Prescription must be written by a rheumatologist **AND**
   - Member must be at least 18 years of age **AND**
   - Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial of Humira* AND Enbrel* **AND**
   - Medical record documentation that the medication is being dosed as 150 mg every 4 weeks with or without a loading dose of 150 mg at Weeks 0, 1, 2, 3, and 4.

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