Capital BlueCross Open/Closed Formulary Update

(2nd Quarter 2017)

The Capital BlueCross formulary is a reference list of prescription drugs that contains a wide range of generic and brand drugs that have been approved by the U.S. Food and Drug Administration (FDA). The formulary is updated on a quarterly basis or when new generic or brand-name medications become available and as discontinued drugs are removed from the marketplace.

Several new drugs have come to market and are now included in our formulary.

Capital BlueCross Formulary Update KEY: **lowercase bold print = generic**; UPPERCASE PRINT = BRAND; (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply			
Newly Marketed Drugs Effective Immediately			
Brand Name	**Tier Status**	**Indication**	**Preferred Alternatives**
DUPIXENT* (PAR)	BNP	Moderate to severe atopic dermatitis	**hydrocortisone, tacrolimus,** ELIDEL
EMFLAZA* (PAR)	BNP	Duchenne Muscular Dystrophy (DMD)	**prednisone and prednisolone**
EUCRISA (PAR)	BNP	Mild to moderate atopic dermatitis	**hydrocortisone, tacrolimus,** ELIDEL
RHOFADE (PAR)	BNP	Persistent facial erythema associated with rosacea	topical **metronidazole**, FINACEA, SOOLANTRA
RUBRACA* (PAR)	BNP	Monotherapy for breast cancer n mutation associated w/advanced ovarian cancer who have been treated with ≥ 2 chemotherapies	LYNPARZA
TRULANCE (PAR)	BNP	Chronic idiopathic constipation	LINZESS
XERMELO (PAR)	BNP	Carcinoid syndrome diarrhea	**octreotide**

KEY: Generic Preferred (GP), Generic Non-Preferred (GNP), Brand Preferred (BP), Brand Non-Preferred (BNP)
***** Indicates specialty medication

The Capital BlueCross formulary serves as a reference for all prescription drug benefit designs ranging from an *open* formulary to a *closed* formulary.

- An *open* formulary provides access to generic preferred, generic non-preferred, brand preferred brand and brand non-preferred medications.
- A *closed* formulary provides access to generic preferred, generic non-preferred and brand preferred medications. Brand non-preferred medications are not covered under a closed formulary. You or your physician may request coverage for medically necessary brand non-preferred drugs through the Non-formulary Consideration Process.

Certain medications are subject to *Enhanced Prior Authorization* (EPA) due to health care concerns and/or safety reasons. In order to have these medications covered under your prescription drug benefit, you may be required to try a formulary alternative first or to complete the Prior Authorization process.

To obtain Prior Authorization, your physician or pharmacist should call or fax a request with supporting clinical information to the CVS/caremark™ Prior Authorization Department at 800.294.5979 (Fax: 888.836.0730). Members may initiate a Prior Authorization request by calling CVS/caremark at 800.585.5794 or by visiting the website at capbluecross.com.

The following medications have been **removed** from the Enhanced Prior Authorization (EPA) program.

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Removal from Enhanced Prior Authorization (EPA) Program **Effective January 1, 2018**	
Drug Class/Drug	**Purpose/Guidelines**
LYRICA (PAR)	Management of fibromyalgia, management of neuropathic pain associated with diabetic peripheral neuropathy, or management of neuropathic pain associated with spinal cord injury
SAVELLA (PAR)	Management of fibromyalgia

The following medications have been **added** to the Prior Authorization (PAR) program.

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Prior Authorization (PAR) Program **Effective Immediately**	
Drug Class/Drug	**Purpose/Guidelines**
DUPIXENT* (PAR)	Member is greater than 18 years of age and has a diagnosis of moderate to severe atopic dermatitis; Prescribed by specialist; Documented failure, contraindication, or inadequate response to preferred agents
EMFLAZA* (PAR)	Member is 5 years of age or older w/diagnosis of Duchenne Muscular Dystrophy (DMD); Documented trial/failure of preferred agents
EUCRISA (PAR)	Member has mild to moderate atopic dermatitis; Documented failure, contraindication, or inadequate response to preferred agents

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On behalf of Capital BlueCross, CVS/caremark™ assists in the administration of our prescription drug program. CVS/caremark is an independent pharmacy benefit manager.

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Prior Authorization (PAR) Program Effective Immediately	
Drug Class/Drug	**Purpose/Guidelines**
RHOFADE (PAR)	Member is greater than 18 years of age and has a diagnosis of persistent facial erythema associated with rosacea ; Prescribed by specialist; Documented failure, contraindication, or inadequate response to preferred agents
RUBRACA* (PAR)	Member has advanced ovarian cancer w/breast cancer (BRCA) mutation who have been treated with ≥ 2 chemotherapies; BRCA mutation-detected by FDA diagnostic test
TRULANCE (PAR)	Member is greater than 18 years of age and has a diagnosis of Chronic idiopathic constipation; Prescribed by specialist; Documented failure, contraindication, or inadequate response to preferred agents
XERMELO (PAR)	Member is greater than 18 years of age and has a diagnosis of on Carcinoid syndrome diarrhea; Prescribed by specialist; Xermelo is used in combination w/a somatostatin analog (SSA)

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The following medications have been **added** to the Prior Authorization (PAR) program.

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Prior Authorization (PAR) Program Effective January 1, 2018	
Drug Class/Drug	**Purpose/Guidelines**
APTIOM (PAR)#	Partial-onset seizures as monotherapy or adjunctive therapy
BANZEL (PAR)#	Adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome in a patient one year of age or older and; The patient does not have Familial Short QT Syndrome
CARAC (PAR)#	Diagnosis of actinic keratosis or external genital warts
CARBAGLU* (PAR)#	Diagnosis of NAGS deficiency confirmed by enzymatic or genetic testing, diagnosis of methylmalonic academia, and a diagnosis of propionic acidemia

Impacted members will be notified prior to change

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Prior Authorization (PAR) Program
Effective January 1, 2018

Drug Class/Drug	Purpose/Guidelines
CAYSTON* (PAR)#	Diagnosis was confirmed by appropriate diagnostic or genetic testing w/pseudomonas aeruginosa is present in airway culture
CYSTARAN* (PAR)#	Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing; Member has corneal cystine crystal accumulation
DIFICID (PAR)#	Diagnosis of clostridium difficile-associated diarrhea (CDAD) confirmed by a positive stool assay and; a recurrent infection w/ clostridium difficile after previous antibiotic therapy
FLUOROPLEX (PAR)#	Diagnosis of actinic keratosis or external genital warts
fluticasone-salmeterol- (GENERIC ADVAIR) (PAR)#	Member has asthma or COPD and has a clinical condition for which the preferred formulary alternative Advair Diskus is not recommended based on published guidelines or clinical literature; Member had at least 30 days of therapy with preferred brand Advair Diskus; Member experienced a documented contraindication to preferred formulary brand Advair that can be attributed to the inactive ingredients and is not a known contraindication of Advair Diskus; Member demonstrated a failure of, or intolerance to, or have an adverse reaction to or would be reasonably expected to have an adverse reaction to preferred formulary brand Advair Diskus that can be attributed to the inactive ingredients and is not a known side effect/adverse reaction of Advair Diskus
AIRDUO BRAND AND GENERIC fluticasone-salmeterol (PAR)#	Diagnosis of asthma/COPD; Member has a clinical condition for which the preferred formulary alternative Advair Diskus is not recommended and had at least 30 days of therapy with preferred brand Advair Diskus or member experienced a documented contraindication, failure or intolerance to preferred formulary brand Advair

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F1/2569A. 2nd Quarter

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Drug Class/Drug	Purpose/Guidelines
FORTAMET **, metformin ER osmotic release,** GLUMETZA**, metformin ER modified release** (PAR)#	Diagnosis of type 2 diabetes mellitus **AND** member used BOTH generic metformin immediate release AND generic Glucophage XR (metformin ER) for a minimum of 3 months **AND** member had an inadequate treatment response and the prescriber is able to provide published peer-reviewed medical literature demonstrating that the requested drug is likely to be more efficacious for the patient than BOTH generic metformin immediate release AND generic Glucophage XR (metformin ER) **OR** the patient is unable to take BOTH generic metformin immediate release AND generic Glucophage XR (metformin ER) due to intolerance or contraindication
INTRON A* (PAR)#	Treatment of acute and chronic hepatitis C virus infection; AIDs-related Kaposi's sarcoma, chronic hepatitis B (including hepatitis D virus co-infection) virus infection; Syndrome (SS); Follicular Lymphoma (clinically aggressive); Treatment of polycythemia vera; Treatment of systemic light chain amyloidosis
LYRICA (PAR)#	Management of fibromyalgia, neuropathic pain associated with diabetic peripheral neuropathy, or pain associated with spinal cord injury or; management of postherpetic neuralgia, cancer-related neuropathic pain, or as adjunctive therapy for partial onset seizures; and the patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin
MARINOL (PAR)#	Diagnosis of anorexia associated with weight loss in a patient with AIDS or; The patient is receiving the requested drug for nausea and vomiting associated with cancer chemotherapy and; The patient has experienced an inadequate treatment response, intolerance, or contraindication to an anti-emetic agents
MIRCERA* (PAR)#	Diagnosis of anemia due to chronic kidney disease (CKD) w/pre-treatment hemoglobin < 10 g/dL

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Drug Class/Drug	Purpose/Guidelines
MULTAQ (PAR)#	Member has a history of paroxysmal or persistent atrial fibrillation (AF), (non-permanent AF) AND the patient does not have any of the following: Symptomatic heart failure with recent decompensation requiring hospitalization or New York Heart Association (NYHA) Class IV symptoms, Second- or third-degree atrioventricular (AV) block or sick sinus syndrome except when used in conjunction with a functioning pacemaker, Bradycardia, Liver or lung toxicity related to the previous use of amiodarone, QTc Bazett interval ≥ 500 milliseconds (500 ms) or PR interval greater than 280 milliseconds (280 ms), Severe hepatic impairment, or Patient is nursing AND the patient will not be taking Class I or III antiarrhythmics or strong cytochrome P450 3A (CYP3A) inhibitors AND the pregnancy status of the patient has been evaluated
PICATO (PAR)#	Diagnosis of actinic keratosis or external genital warts
RESTASIS (PAR)#	Diagnosis of dry eye disease and member has tried/ failed or been intolerant to artificial tears products and; Patient will not be using ophthalmic anti-inflammatory drugs concurrently with the requested drug or; Patient will be using ophthalmic anti-inflammatory drugs concurrently with the requested drug and; The ophthalmic anti-inflammatory drugs will be used concurrently for a short period (2 to 4 weeks) while transitioning to monotherapy with the requested drug
REVLIMID* (PAR)#	Diagnosis of multiple myelomas and treatment of non-Hodkgins Lymphoma (NHL) w/subtypes related to NHL
SAVELLA (PAR)#	Management of fibromyalgia in a patient 18 years of age or older
SENSIPAR* (PAR)#	Treatment of primary, secondary, and tertiary hyperparathyroidism based on serum calcium levels and kidney disease function or transplant
STIMATE* (PAR)#	Members who are carriers of hemophilia A with factor VIII level >5% or qualitative platelet disorder or members w/menorrhagia associated with bleeding disorder or members w/mild to moderate type 1 Vwd or Type 2A, 2M, 2N vWD

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SYNDROS (PAR)#	Diagnosis of anorexia associated with weight loss in a patient with AIDS or for members receiving the requested drug for nausea and vomiting associated with cancer chemotherapy and; The patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one of the following anti-emetic agents: metoclopramide IV, promethazine, prochlorperazine, meclizine, or oral 5-HT3 receptor antagonists
TOLAK (PAR)#	Diagnosis of actinic keratosis or external genital warts
VIMPAT (PAR)#	Monotherapy or adjunctive therapy in the treatment of partial-onset seizures in a patient 17 years of age or older
ZAVESCA* (PAR)#	Diagnosis of mild- Gaucher disease type 1 confirmed by enzyme assay demonstrating a deficiency of betaglucocerebrosidase (glucosidase) enzyme activity or by genetic testing and is ≥ 18 years of age; Member has mild to moderate disease; Member has a clinical reason for not using enzyme replacement therapy (eg, allergy, hypersensitivity, poor venous access)
ZYCLARA (PAR)#	Diagnosis of Actinic Keratosis, External Genital Warts

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