Capital BlueCross Selectively 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.

The Capital BlueCross Selectively Closed formulary serves as a reference for Exchange/Marketplace prescription drug benefit designs.

- A *Selectively Closed* formulary provides access to generic, brand preferred and select brand non-preferred medications. Under a Selectively Closed formulary, only select brand non-preferred drugs (non-formulary drugs) are covered unless approved via a Non-Formulary Consideration Process. The provider may request that coverage be granted when medically necessary. The Non-Formulary Consideration Process may require the trial and failure of 2 formulary alternatives (if 2 are available) prior to approval of the non-formulary medication. Approvals will be member-and drug-specific. Each unique non-formulary drug exception must be reviewed and approved separately.The following chart indicates medications that have changed formulary status.

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.

F1/2569B. 2nd Quarter

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

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND	
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.

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND	
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
CARBAGLU* (PAR) #	Diagnosis of actinic keratosis or external genital warts
CAYSTON* (PAR) #	Diagnosis of NAGS deficiency confirmed by enzymatic or genetic testing, diagnosis of methylmalonic academia, and a diagnosis of propionic acidemia
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

Impacted members will be notified prior to change
***** Indicates specialty medication

The information contained in this document is current at the time of printing, is not all encompassing, and is subject to change. Please refer to your Certificate of Coverage for specific terms, conditions, exclusions, and limitations relating to your coverage.

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

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company®, and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

Pharmacy Management Program Update

KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply
lowercase bold print = generic; UPPERCASE PRINT = BRAND

Prior Authorization (PAR) Program
Effective January 1, 2018

Drug Class/Drug	Purpose/Guidelines
fluticasone-salmeterol- (GENERIC ADVAIR) (PAR, QLL)#	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
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
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

Impacted members will be notified prior to change
***** Indicates specialty medication

The information contained in this document is current at the time of printing, is not all encompassing, and is subject to change. Please refer to your Certificate of Coverage for specific terms, conditions, exclusions, and limitations relating to your coverage.

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

F1/2569B. 2nd Quarter

Pharmacy Management Program Update

KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply
lowercase bold print = generic; UPPERCASE PRINT = BRAND

Prior Authorization (PAR) Program
Effective January 1, 2018

Drug Class/Drug	Purpose/Guidelines
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
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)

Impacted members will be notified prior to change
***** Indicates specialty medication