"What's New" Medical Pharmaceutical Policy April 2024 Updates

The following policy updates and reviews apply to all GHP members (Commercial, Marketplace, TPA, Medicare and Medicaid):

MBP 4.0 Intravenous Immune Globulin (IVIG) – Updated Policy

This policy refers to the following intravenous immune globulin drug products:

Asceniv
Bivigam
Carimune NF
Cutaquig
Cuvitru
Flebogamma
Flebogamma DIF
Gammagard Liquid
Gammagard S/D
Gammaked
Gammaplex
Gamunex
Gamunex-C
Hizentra
Hyqvia ~~(Primary Humoral Immunodeficiencies indications only)~~
Octagam
Panzyga
Privigen
Xembify

MBP 23.0 Velcade (bortezomib) – Updated Policy

AND

- If a brand drug is being requested when a therapeutically equivalent generic drug exists:
  - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
  - Medical record documentation of an intolerance to or contraindication to the inactive ingredients of the generic formulary agent(s)

MBP 36.0 Abraxane (paclitaxel protein bound particles)

1. **Breast Cancer when the following criteria is met:**
   - Treatment of breast cancer after failure of combination chemotherapy which should have included an anthracycline (unless clinically contraindicated) for metastatic disease or relapse within 6 months of adjuvant chemotherapy **AND**
   - Physician provided documentation of breast cancer after failure of combination chemotherapy for metastatic disease or relapse within 6 months of adjuvant chemotherapy **AND**
   - Physician provided documentation of prior therapy with an anthracycline, or documentation of clinical contraindication to its use **AND**
   - Physician provided documentation of intolerance to or contraindication to standard paclitaxel therapy **AND**
   - Medical record documentation that the member has a baseline neutrophil count greater than or equal to 1,500 cells/mm^3 **AND**
   - If a brand drug is being requested when a therapeutically equivalent generic drug exists:
     - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
     - Medical record documentation of an intolerance to or contraindication to the inactive ingredients of the generic formulary agent(s) **AND**
   - Prescribed by a hematologist/oncologist **OR**
2. **Locally advanced or metastatic non-small cell lung cancer (NSCLC) when the following criteria is met:**

- First–line treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC), in combination with carboplatin in insured individuals who are not candidates for curative surgery or radiation therapy **AND**
- Physician provided documentation of intolerance to or contraindication to standard paclitaxel therapy **AND**
- Medical record documentation that the member has a baseline neutrophil count greater than or equal to 1,500 cells/mm^3 **AND**
- If a brand drug is being requested when a therapeutically equivalent generic drug exists:
  - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
  - Medical record documentation of an intolerance to or contraindication to the inactive ingredients of the generic formulary agent(s) **AND**
- Prescribed by a hematologist/oncologist **OR**

3. **Metastatic adenocarcinoma of the pancreas when the following criteria is met:**
   - First-line treatment of metastatic adenocarcinoma of the pancreas when used in combination with gemcitabine with a good performance status (ECOG score 0-2 or Karnofsky score greater than or equal to 60%) **AND**
   - Medical record documentation that the member has a baseline neutrophil count greater than or equal to 1,500 cells/mm^3 **AND**
   - If a brand drug is being requested when a therapeutically equivalent generic drug exists:
     - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
     - Medical record documentation of an intolerance to or contraindication to the inactive ingredients of the generic formulary agent(s) **AND**
   - Prescribed by a hematologist/oncologist

MBP 38.0 Clolar (clofarabine) – Updated Policy

AND

- If a brand drug is being requested when a therapeutically equivalent generic drug exists:
  - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
  - Medical record documentation of an intolerance to or contraindication to the inactive ingredients of the generic formulary agent(s)

MBP 62.0 Remodulin IV (treprostinil) – Updated Policy

AND

- If a brand drug is being requested when a therapeutically equivalent generic drug exists:
  - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
  - Medical record documentation of an intolerance to or contraindication to the inactive ingredients of the generic formulary agent(s)

MBP 158.0 Tepadina (thiotepa) – Updated Policy

AND

For all indications:

- If a brand drug is being requested when a therapeutically equivalent generic drug exists):
  - Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s) **OR**
  - Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to the inactive ingredients of the generic formulary agent(s)

The following policies were reviewed with no changes:

- MBP 15.0 Zevalin (Ibritumomab)
- MBP 53.0 Eraxis (anidulafungin)
- MBP 82.0 Jevtana (cabazitaxel)
- MBP 135.0 Unituxin (dinutuximab)
- MBP 154.0 Radicava (edaravone)
- MBP 156.0 Imfinzi (durvalumab)
- MBP 169.0 Baxdela IV (delafloxacin)
- MBP 185.0 Poteligeo (mogamulizumab-kpkc)
- MBP 188.0 Onpattro (patisiran)
- MBP 193.0 Revcovi (elapegademase-lvlr)
- MBP 197.0 Elzonris (Tagraxofusp-erzs)
- MBP 198.0 Gamifant (emapalumab-lzsg)
- MBP 225.0 Uplizna (inebilizumab-cdon)
- MBP 230.0 Darzalex Faspro (daratumumab-hyaluronidase)
- MBP 248.0 Nexviazyme (avalglucosidase alfa-ngpt)
- MBP 249.0 Saphnelo (anifrolumab-fnia)
- MBP 270.0 Imjudo (tremelimumab-actl)
- MBP 271.0 Terlivaz (terlipressin)
- MBP 273.0 Tecvayli (teclistamab-cqyv)

The following policy updates and reviews apply to Commercial, Marketplace, TPA, and Medicare GHP members only:

MBP 77.0 Ilaris (canakinumab) – Updated Policy

1. Acute Gout Flare

Ilaris® (canakinumab) may be considered to be medically necessary in individuals 18 years of age and older with an acute gout flare when the following criteria are met:

- Medical record documentation of a diagnosis of acute gout flare **AND**
- Medical record documentation that the member is age 18 or older **AND**
- Medical record documentation that Ilaris is being prescribed by a rheumatologist **AND**
- Medical record documentation of therapeutic failure on, intolerance to or contraindication to two (2) formulary NSAID's **AND**
- Medical record documentation of therapeutic failure on, intolerance to or contraindication to colchicine **AND**
- Medical record documentation of therapeutic failure on, intolerance to or contraindication to one (1) formulary corticosteroid.

AUTHORIZATION DURATION (for acute gout flares): One-Time Authorization of one (1) Ilaris dose (Facets RX count: 150 (J0638) units, NCRx QL of 1 vial (150mg) per 12 weeks with an RX count of 1) over a duration of 3 months