Second Quarter 2021 Drug Formulary and Clinical Updates

Date of Notice: 07/09/2021

Formulary Updates

Drug Name, Strength(s), & Dosage Form(s)	Description of Change	Formulary Status	Alternative Drug(s) (if applicable)	Effective Date
Omeprazole 20 mg-sodium bicarbonate 1.1 gram capsule	Formulary Addition; Age Edit Addition	Generic		08/22/2021
Azopt 1 % eye drops suspension	Formulary Update	Non-Preferred brand		08/22/2021
Trijardy XR 10 mg-5 mg-1,000 mg tablet ER, Trijardy XR 12.5 mg-2.5 mg-1,000 mg tablet ER, Trijardy XR 25 mg-5 mg-1,000 mg tablet ER, Trijardy XR 5 mg-2.5 mg-1,000 mg tablet ER	Formulary Addition; QL Addition	Preferred brand		08/22/2021
Jardiance 10 mg tablet	QL Addition	Preferred brand		08/22/2021
Synjardy 12.5 mg-1,000 mg tablet, Synjardy 5 mg-500 mg tablet, Synjardy 5 mg-1000 mg tablet, Synjardy 12.5 mg-500 mg tablet, Synjardy XR 5 mg-1,000 mg tablet ER, Synjardy XR 10 mg-1,000 mg tablet ER, Synjardy XR 12.5 mg-1,000 mg tablet ER, Synjardy XR 25 mg-1,000 mg tablet ER	QL Addition	Preferred brand		08/22/2021
Jentadueto 2.5 mg-500 mg tablet, Jentadueto 2.5 mg-850 mg tablet, Jentadueto 2.5 mg-1000 mg tablet, Jentadueto XR 2.5 mg-1,000 mg tablet ER, Jentadueto XR 5 mg-1,000 mg tablet ER	QL Addition	Preferred brand		08/22/2021
Barhemsys 5 mg/2 mL (2.5 mg/mL) IV solution	Formulary Deletion	NF	Aprepitant 80 mg oral capsule, Ondansetron in	08/22/2021

			D5W 8 mg/50 mL IV solution	
Tramadol ER 300 mg tablet ER 24 hr, Tramadol ER 100 mg tablet, ER 24hr multiphase, Tramadol ER 200 mg tablet, ER 24hr multiphase, Tramadol ER 300 mg tablet, ER 24hr multiphase, Tramadol ER 100 mg capsule 24hr, ER (25-75), Tramadol ER 200 mg capsule 24hr, ER (25-75), Tramadol ER 300 mg capsule 24 hr ER, Tramadol ER 150 mg capsule, 24 hr ER (25-75)	QL Addition	Generic		08/22/2021
Fragmin 25,000 anti-Xa unit/mL subcutaneous solution	Formulary Deletion	NF	Lovenox 100 mg/mL subcutaneous syringe, Enoxaparin 100 mg/mL subcutaneous syringe	08/22/2021
Seroquel 25 mg tablet, Seroquel 100 mg tablet, Seroquel 50 mg tablet, Seroquel XR 200 mg tablet ER, Seroquel XR 300 mg tablet ER, Seroquel XR 400 mg tablet ER, Seroquel XR 50 mg tablet ER, Seroquel XR 150 mg tablet ER	QL Addition	Non-Preferred brand		08/22/2021
Quetiapine 25 mg tablet, Quetiapine 100 mg tablet, Quetiapine 50 mg tablet, Quetiapine ER 200 mg tablet ER 24 hr, Quetiapine ER 300 mg tablet ER 24 hr, Quetiapine ER 400 mg tablet ER 24 hr, Quetiapine ER 50 mg tablet ER 24 hr, Quetiapine ER 150 mg tablet ER 24 hr	QL Addition	Generic		08/22/2021

Pregabalin ER 82.5 mg tablet ER 24 hr, Pregabalin ER 165 mg tablet ER 24 hr, Pregabalin ER 330 mg tablet ER 24 hr	Formulary Addition; QL Addition	Generic		08/22/2021
Lyrica CR 82.5 mg tablet ER, Lyrica CR 165 mg tablet ER, Lyrica CR 330 mg tablet ER	Formulary Addition; QL Addition	Non-Preferred brand		08/22/2021
Tepmetko 225 mg tablet (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred brand		08/22/2021
Ukoniq 200 mg tablet (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred brand		08/22/2021
Evkeeza 150 mg/mL IV solution (New Drug)	Formulary Addition; PA Addition	Preferred brand		08/22/2021
Cosela 300 mg IV solution (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Non-Preferred brand		08/22/2021
Amondys-45 50 mg/mL IV solution (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Preferred brand		08/22/2021
Nulibry 9.5 mg IV solution (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Preferred brand		08/22/2021
Pepaxto 20 mg IV solution (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Preferred brand		08/22/2021
Fotivda 0.89 mg capsule (New Drug), Fotivda 1.34 mg capsule (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred brand		08/22/2021
Ponvory 14-Day Starter Pack 2-3-4-5-6-7-8-9-10 mg tablets (New Drug), Ponvory 20 mg tablet (New Drug)	Formulary Addition; PA Addition; QL Addition; Specialty Addition	Non-Preferred brand		08/22/2021
Zegalogue 0.6 mg/0.6 mL subcutaneous auto-injector (New Drug), Zegalogue 0.6 mg/0.6 mL subcutaneous syringe (New Drug)	Formulary Addition; QL Addition	Non-Preferred brand		08/22/2021
Qelbree 100 mg capsule ER (New Drug), Qelbree 150 mg capsule ER (New Drug), Qelbree 200 mg capsule ER (New Drug)	Formulary Addition; QL Addition	Preferred brand		08/22/2021

Nextstellis 3 mg-14.2 mg (28) tablet (New Drug)	Formulary Addition; QL Addition	Preferred brand		08/22/2021
Jemperli 50 mg/mL IV solution (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Non-Preferred brand		08/22/2021
Zynlonta 10 mg IV solution (New Drug)	Formulary Addition; PA Addition; Specialty Addition	Preferred brand		08/22/2021

Legend: AL=Age Limit; OTC=Over-The-Counter; PA=Prior Authorization; SP=Specialty; ST=Step Therapy; QL=Quantity Limit; NF=Non-Formulary

New Prior Authorization Policies

- RxA. 677.Amondys 45
- RxA. 678.Evkeeza
- RxA. 680.Ukoniq
- RxA. 681.Tepmetko
- RxA. 682.Cosela
- RxA. 683.Fotivda
- RxA. 684.Nulibry
- RxA. 685.Jemperli
- RxA. 686.Ponvory
- RxA. 687.Zynlonta

Updated Prior Authorization Policies

Policy Name	Policy Changes	Effective Date
RxA. 145.Gilenya	Criteria for approval updated	06.10.2021
RxA. 146.Copaxone_Glatopa	Initial approval therapy criteria I.A.4 has been updated to show Trial and failure of at least two (2) preferred agents: Aubagio, Avonex, Betaseron, Copaxone, Glatopa, Kesimpta, Ocrevus, Plegridy, or Zeposia.	06.10.2021
RxA. 147.Gralise	Appendix C: Contraindication updated to "Gralise® is contraindicated in patients who have demonstrated hypersensitivity to the drug or its ingredients." References were reviewed and updated. Dosing regimen updated to include: If dose is reduced, discontinued, or substituted with an alternative medication, this should be done gradually over a minimum of 1 week or longer (at the discretion of the prescriber). Renal impairment: Dose should be adjusted in patients with reduced renal function. Gralise® should not	06.10.2021

	be used in patients with CrCl less than 30 or in patients on hemodialysis. Take with evening meal.	
RxA. 149.Galafold	Dosing frequency abbreviations expanded	06.10.2021
RxA. 150.Gattex	Initial criteria for approval and duration updated	06.10.2021
RxA. 153.Gocovri_Osmolex_ER	Background was updated to the indication of "as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing 'off' episodes" for Gocovri	06.10.2021
RxA. 156.GoNitro	No update	06.10.2021
RxA. 157.Neupogen_ Zarxio_ Nivestym_ Granix	Updated dosing information: Separated "acutely exposed to myelosuppressive doses of radiation" from other drugs as it is only applicable for Neupogen. Initial approval criteria I.E.,1 was added "Request is for Neupogen®." Appendix C was updated: added "filgrastim products or pegfilgrastim products" to Contraindications.	06.10.2021
RxA. 158.H.P. ActharGel	Criteria for other FDA approved indications updated.	06.10.2021
RxA. 159.Hemlibra	Updated format of Approval Duration for initial therapy and continued therapy	06.10.2021
RxA. 163.Ibrance	Dosing frequency abbreviations were expanded.	06.10.2021
RxA. 167.Inlyta	Updated dosing criteria based on NCCN evidence under section I.B.6.	06.10.2021
RxA. 169.Iclusig	Background was updated. Initial Approval Criteria I.A.b was updated. Initial Criteria I.C was included.	06.10.2021
RxA. 170.Imbruvica	No update	06.10.2021
RxA. 171.Increlex	Dosing frequency abbreviations were expanded.	06.10.2021
RxA. 175.Istodax	No update	06.10.2021
RxA. 176.Idhifa	Initial approval criteria have been updated per NCCN AML guideline recommendation under section I.A.4. Updated Appendix D.	06.10.2021
RxA. 177.Exjade_Jadenu	No update	06.10.2021
RxA. 179.Kadcyla	Initial approval criteria updated for new off-label indication "Head and Neck Cancers - Salivary Gland Tumors". Continued Therapy approval criteria II.A.3.b updated for indication "Salivary Gland Tumors".	06.10.2021

	Appendix C: box warning was updated to "Hepatotoxicity, liver failure and death have occurred and Embryo-Fetal Toxicity…". Appendix D added to policy.	
RxA. 181.Kisqali_Kisqali_Femara	No update	06.10.2021
RxA. 183.Kymriah	Initial approval criteria I.B.1 updated to include the indication of "Histologic transformation of nodal marginal zone lymphoma to DLBCL". Initial approval criteria I.B.2 was updated to include off label indications.	06.10.2021
RxA. 184.Sancuso_Sustol	No update	06.10.2021
RxA. 185.Kalbitor	APPENDIX B: Therapeutic Alternatives was added	06.10.2021
RxA. 186.Kanuma	No update	06.10.2021
RxA. 187.Kerydin	No update	06.10.2021
RxA. 190.Kalydeco	Background was updated to change the patients minimum age from 6 months to 4 months. Dosing information was updated for pediatric patients 4 months to less than 6 months. Initial approval criteria was updated for minimum age of 4 months. Initial and continuation criteria were updated to include maximum dose for patients age 4 months to less than 6 months. Dosage regimen updated to include: Not recommended in patients less than 4 months of age. • Reduce dose in patients 6 months and older with moderate or severe hepatic impairment. • Not recommended in patients 4 months to less than 6 months of age with hepatic impairment.	06.10.2021
RxA. 191.Keveyis	Initial criteria for approval and duration updated. Contraindications were updated.	06.10.2021
RxA. 192.Keytruda	Background was updated. Dosing information was updated. Initial Approval Criteria was updated. Duration of approved continued therapy was updated	06.10.2021
RxA. 193.Bethkis_Kitabis Pak_ TOBI_ TOBI Podhaler	Approval duration section was updated to remove HIM from initial and continued therapy approval. Appendix B for therapeutic alternatives was updated to add information.	06.10.2021

	Appendix D for general information was updated to add “Due to risks as well as clinical efficacy…”	
RxA. 194.Korlym	Initial Approval Criteria: 1.A.5.c. was added. Appendix D: General Information was added.	06.10.2021
RxA. 197.Lamictal XR, Lamictal ODT	Appendix D was added	06.10.2021
RxA. 198.Lenvima	Dosing information updated for indication EC & HCC. Clinical policy Initial Approval Criteria (2) off-label indications added for Thymomas and Thymic Carcinomas & Thyroid Carcinoma - Anaplastic Carcinoma. Updated initial criteria in section I.B to include criteria for anaplastic carcinoma (NCCN 2A recommendation). Updated section I.C initial approval criteria for RCC for non-clear cell histology. Updated section I.D.4 initial approval criteria for HCC to elaborate on who is eligible for therapy. Added criteria I.D.5. Added initial approval criteria for NCCN 2A recommendation – thymomas and thymic carcinomas in section I.F.	06.10.2021
RxA.199. Leukine	Dosage forms was updated: [DSC] was updated for Solution: 500 mcg/mL. APPENDIX B: Therapeutic Alternatives was added.	06.10.2021
RxA. 200.Levitra_Staxyn	No update	06.10.2021
RxA. 201.LindaneShampoo	APPENDIX C: Contraindication was updated to include “contraindicated for individuals with a known sensitivity to the product or any of its components.”	06.10.2021
RxA. 203.Letairis	Age criteria was added to Initial approval criteria I.A.3. Safety criteria about hepatic impairment was added to initial approval criteria I.A.4.	06.10.2021
RxA. 205.Marqibo	Background was updated	06.10.2021
RxA. 209.Ribavirin	Dosing Information was updated. Initial criteria I.A. 5, 6 and 7 were updated. Continued therapy criteria II.A. 7 is updated	06.10.2021
RxA. 213.Mavenclad	Dosing regimen was updated. APPENDIX B was updated: Included therapeutic alternatives Aubagio®, Tecfidera®, Mayzent®.	06.10.2021
RxA. 214.Mavyret	No update	06.10.2021
RxA. 215.Mayzent	Approval duration for Continued Therapy Approval criteria has been changed from 1 year to 12 months.	06.10.2021

	Appendix D: General Information was updated.	
RxA.216 Mekinist	Background was updated. Initial Approval Criteria was updated to reflect current off-label indications. Initial duration of approval updated. Appendix A and Appendix D were updated. Appendix B information regarding colorectal cancer removed.	06.10.2021
RxA. 217.Mepsevii	No update	06.10.2021
RxA. 218.Solodyn_ Ximino_ Minolira_ Arestin	Solodyn 45mg, 90 mg, 135 mg were discontinued strengths thus they were removed from the policy. Initial Approval criteria I.A.6 and Continued Therapy Approval criteria II.B.4: Maximum dose for Solodyn was updated. Periostat was discontinued thus it was removed from Appendix. "The use of drugs of the tetracycline class during tooth development…" was added to Appendix.	06.10.2021
RxA. 221.Mozobil	Dosing regimen updated for simplification	06.10.2021
RxA. 225.Marinol_Syndros	Appendix A: Abbreviation/Acronym Key added for CINV	06.10.2021
RxA. 226.Mektovi	Dosing information was updated. Colon cancer, rectal cancer (off-label) were removed from Initial Approval Criteria.	06.10.2021
RxA. 229.Mulpleta	HIM approval duration was removed from initial approval criteria and continued Therapy Approval criteria.	06.10.2021
RxA. 230.Myalept	Background updated to: "Myalept® is a leptin analog indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy." Dosing updated to specify Body Weight.	06.10.2021
RxA. 232.Mytesi	No update	06.10.2021
RxA. 233.Naglazyme	Dosing regimen, maximum dose, initial and continued criteria updated to specify: 1 mg/kg of body weight IV once weekly.	06.10.2021
RxA. 235.Jatenzo_ Testin_ Vogelxo_ Natesto_ Testopel_ Xyosted	APPENDIX C updated to include contraindications for Jatenzo®, Xyosted® and a boxed warning for Testim®.	06.10.2021
RxA. 238.Nityr_Orfadin	Updated initial criteria for approval and duration of approval. Appendix D was added.	06.10.2021
RxA. 239.Nplate	Indications were updated. Dosing regimen was updated.	06.10.2021

	Initial Approval Criteria and Continued Therapy Approval was updated with new indications.	
RxA. 240.Nuedexta	Dosing frequency abbreviations expanded.	06.10.2021
RxA. 241.Nuvessa	No update	06.10.2021
RxA. 242.NamendaXR_Namzaric	No update	06.10.2021
RxA. 244.Natpara	No update	06.10.2021
RxA. 245.Nerlynx	Initial and continued therapy approval criteria was created for Central Nervous System Cancers (off-label use). Approval duration for Initial Approval Criteria was updated to 12 months from 6 months.	06.10.2021
RxA. 246.Ocaliva	No update	06.10.2021
RxA. 248.Pegasys_PegIntron	Dosing Information was updated. Initial Approval Criteria for approval updated along with the addition of other off-label indications. Initial duration of approval updated.	06.10.2021
RxA. 249.Perjeta	Dosing information was updated. Initial approval criteria were updated with off-label indication. Appendix A and C were updated. Appendix D was added.	06.10.2021
RxA. 250.Piqray	Appendix B: Discontinued brand Nolvadex® was removed. Appendix D: General Information was added.	06.10.2021
RxA. 251.Polivy	Dosage form section was updated to include 30mg vial. Initial and continuation approval criteria: off-label indication criteria were added. HIM approval duration was removed from Initial and continued approval criteria. Appendix A: Updated for HHVB8 and NCCN.	06.10.2021
RxA. 254.Qualaquin	Appendix B: Drug Aralen® removed.	06.10.2021
RxA. 257.QudexyXR_ TrokendiXR	Dosing Information abbreviated form “PO” changed to "by mouth." Updated the language of I.A.4.b and II.A.3.b to specific age criteria for Trokendi XR and Qudexy XR.	06.10.2021
RxA. 258.Orenitram_Remodulin_Tyvaso	APPENDIX B: Therapeutic Alternatives were updated.	06.10.2021
RxA. 260.Radicava	Initial therapy criteria I.A.8 was updated to reference Appendix D. Appendix C was updated from “general information” to “contraindications/boxed	06.10.2021

	warnings" and updated. Information previously here moved to newly created. Appendix D for general information and updated for clarity	
RxA. 261.Ravicti	No update	06.10.2021
RxA. 263.Reclast	Zometa removed from policy because it was discontinued from the market. HIM approval duration is removed from the policy.	06.10.2021
RxA. 264.Repatha	Background was updated. Dosing Information was updated. Initial approval criteria 1.A.1.a verbiage was updated.	06.10.2021
RxA. 266.Revcovi	No update	06.10.2021
RxA. 267.Rhofade	Background was updated.	06.10.2021
RxA. 269.Rocklatan_Rhopressa	Appendix A Abbreviation/Acronym Key added for IOP.	06.10.2021
RxA. 270.Rozlytrek	Appendix B: Therapeutic Alternatives added. Updated Appendix D to include NCCN 1 and 2A recommended uses.	06.10.2021
RxA. 271.Rydapt	Dosing regimen updated to include route of administration.	06.10.2021
RxA. 272.Ragwitek	APPENDIX C: Boxed Warnings were updated.	06.10.2021
RxA. 274.AvonexRebif	Dosing regimens updated for clarity. Dosing frequency abbreviations expanded.	06.10.2021
RxA. 275.Relistor	Approval Duration for Initial and continuation updated. Dosing criteria for initial and continued therapy criteria was updated. Updated initial approval criteria to include specific use under I.A.2.	06.10.2021
RxA. 277.JynarqueSamsca	HIM approval duration was removed from Initial and continued approval criteria. Hypersensitivity to tolvaptan was added to Appendix C: Contraindication.	06.10.2021
RxA. 278.Sandostatin_Sandostatin_LAR_Depot	Background was updated.	06.10.2021
RxA. 280.Seysara	No update	06.10.2021
RxA. 281.Siklos	Initial approval criteria was updated: Off-label indication "Histiocytic neoplasms (Langerhans Cell Histiocytosis)" was added to I.B.1. Appendix D was updated.	06.10.2021
RxA. 283.Somavert	Route of administration updated to abbreviations. Dosing regimen updated to include dose titration details.	06.10.2021

RxA. 284.SporanoxOnmelTolsura	Approval durations for HIM were removed. Appendix B (Therapeutic Alternatives): Fixed header verbiage was updated as “Below are suggested therapeutic alternatives.” Discontinued brands Lamisil®, and Mycelex® were removed. Appendix C: Contraindication(s) was updated. Appendix D: General Information was added.	06.10.2021
RxA. 286.Uceris_ Entocort_ Ortikos	Dosing Information abbreviated forms changed to full form.	06.10.2021
RxA. 287.Ulesfia	No update	06.10.2021
RxA. 290.Uptravi	Initial approval criteria I.A.3 was added to consider patient age. Initial approval criteria I.A.4a was updated to change term “vasodilator” to “vasoreactivity” for accuracy. Appendix B for therapeutic alternatives standard verbiage updated. Also brand Afeditab® CR was removed due to discontinuation.	06.10.2021
RxA. 296.Vantas_Supprelin_LA	Appendix D for general information was added.	06.10.2021
RxA. 302.Flolan_Veletri	Appendix C for contraindications updated to include pulmonary edema.	06.10.2021
RxA. 306.Xiaflex	Initial criteria for approval and number of injections updated. Appendix D was added.	06.10.2021
RxA. 310.Xalkori	Background was updated: Indication for ALCL was added. Dosing Information was updated: ALCL dosing was added. Initial approval criteria were updated: I.B. ALCL (off-label) was updated to ALCL. I.B.3 was updated to “Age 1 to =21 years.” I.B.4 was updated to “Dose is within FDA maximum limit (see dosing regimen)” Initial approval criteria were created for Histiocytic Neoplasms (off label use). Approval duration for HIM was removed. Appendix D: General Information was updated.	06.10.2021
RxA. 314.Xifaxan	Dosing Information for off label indications removed. HIM deleted as per update. Updated initial approval criteria under I.A.3, and I.B.3.	06.10.2021
RxA. 316.Xolair	Background, dosing regimen, initial and continuation therapy criteria updated for new indication “Nasal polyp”. Appendix B: Allegra®, Deltasone®, Zyflo® CR, Flovent®, Aerospan®, Qvar® brand names were removed.	06.10.2021

	Appendix C: updated Contraindication and box warning phrasing to “Severe hypersensitivity reaction…” and “Anaphylaxis, presenting as bronchospasm, hypotension, syncope…”. Appendix G added for new indication dosing regimen “Nasal polyp”.	
RxA. 317.Xospata	Initial and continued therapy approval criteria was created for ‘’Myeloid/Lymphoid Neoplasms with Eosinophilia and TK Fusion Genes’’ (off label use). Approval duration for HIM was removed.	06.10.2021
RxA. 318.Xtandi	Updated off-label dosing criteria under I.A.5 and II.A.3.	06.10.2021
RxA. 321.Xepi	Appendix D: updated to “Prolonged use of Xepi® may result in overgrowth of nonsusceptible bacteria and fungi. If such infections occur, discontinue use and institute alternative therapy.” Dosage form updated to Cream: Each gram contains 10 mg of ozenoxacin (1%). Dosage Regimen rephrased to: “Topical application (thin layer) twice daily for 5 days (for up to 100 cm2 in patients ≥ 12 years or 2% of the total body surface area and not exceeding 100 cm2 if age < 12 years.”	06.10.2021
RxA. 322.Yervoy	Dosing information table updated: a. For clarity. b. To add off-label dosing for indication cutaneous melanoma. Dosage forms section updated to add vial strength, 5 mg/mL. Age criteria language for all indications updated for simplification. Dosing criteria updated to add verbiage “*Prescribed regimen must be FDA-approved or recommended by NCCN.”. Initial approval criteria I.A.4 was added and I.A.5 updated based on updated guidelines. Initial approval criteria I.C.6 added for consistency with indication. Initial approval criteria for small cell lung cancer removed based on updated guidelines. All approval durations with 3-week doses with 4-dose maximum updated from 112 days to 3 months for accuracy. Appendix A for abbreviations was updated for accuracy. Appendix C for boxed warnings was updated to remove boxed warning.	06.10.2021
RxA. 323.Yescarta	Dosing information updated. FL indication and criteria added. Appendices updated.	06.10.2021

RxA. 371.Epiduo-Forte	Dosing Information “QD” changed to “once daily.” Updated dosing criteria to include 60 g gel pump. Updated trial and fail criteria under I.A.3.	06.10.2021
RxA. 393.Imfinzi	Background was updated. Dosing Information was updated. Initial Approval criteria was updated. Continued Therapy approval criteria was updated. Appendix A and D were updated.	06.10.2021
RxA. 413.Mitoxantrone	Continued therapy approval criteria II.A.4 indicating , ”Trial and failure of at…….or Zeposia” was removed.	06.10.2021
RxA. 587.Aimovig	Dosing information was updated. Continued approval duration updated. Appendix D was updated.	06.10.2021
RxA. 591.Botox	Background was updated: new indication added. Dosing information updated for indication Neurogenic detrusor overactivity. Initial Approval Criteria added. Continued Therapy Approval updated in all other indications. Appendix A: Abbreviation/Acronym Key added for NDO & OZ. Updated initial approval criteria under I.A.7, I.H.1, I.D.1, I.D.5, I.E.,4, I.B.6, I.C. Removed initial approval criteria section for “spasticity associated with cerebral palsy” as the same criteria is already laid out under section I.D. Added separate initial approval criteria for strabismus under section I.M. Updated appropriate dosing criteria under continuation of therapy. Updated the Dosing information table with appropriate regimen for each indication.	06.10.2021
RxA. 611.Libtayo	Criteria I.B and I.C were added. Added Appendix D general information.	06.10.2021
RxA.637. Fasenra	Dosing information was updated for maximum dose as 30 mg/dose. Dosing regimen and maximum dose were updated for therapeutic alternatives (inhaled corticosteroids). Aerospan®, Zyflo® CR, Deltasone® were removed from therapeutic alternatives table because of discontinuation.	06.10.2021
RxA. 638.Darzalex_Faspro	Background, Dosing information, Initial approval and continued therapy approval criteria updated for new indication “Light chain (AL) amyloidosis”.	06.10.2021

	Appendix C: Contraindication was updated to "Patients with a history of severe hypersensitivity ….". Appendix D: updated to "Monitor patients with cardiac involvement of light chain (AL)…"	
RxA. 648.Uplinza	Initial approval criteria was updated: added criteria I.A.3 and changed EDSS score from 7 to 7.5 as per the PI of criteria I.A.4. Appendix D updated. Updated initial approval criteria with additional criteria based on clinical trial information. Updated therapeutic alternatives to include Enspryng.	06.10.2021
RxA. 649.Zeposia	Continued therapy approval criteria II.A.3 indicating , "Trial and failure of at…….or Zeposia" was removed.	06.10.2021
RxA. 661.Bafiertam	No update	06.10.2021

New Step Therapy

- Pregabalin ER 82.5 mg tablet ER 24 hr, Pregabalin ER 165 mg tablet ER 24 hr, Pregabalin ER 330 mg tablet ER 24 hr
- Lyrica CR 82.5 mg tablet ER, Lyrica CR 165 mg tablet ER, Lyrica CR 330 mg tablet ER
- Qelbree 100 mg capsule ER, Qelbree 150 mg capsule ER, Qelbree 200 mg capsule ER

Updated Step Therapy

Drug Name; Strength(s); & Dosage Form(s)	Step Edit Details	Effective Date
NA	NA	NA