To: **Jai Medical Providers**
From: **ProCare Rx**
Date: **June 30, 2022**
Subject: **June 2022 Formulary Updates**

Effective 7/1/2022, the following products have been added to the formulary:

- **Xarelto 2.5mg, 10mg, 15mg, and 20mg tablet, and Treatment Pack 15mg-20mg**
- **Entecavir 0.5mg and 1mg** have been added with a quantity limit of #30/30 days

Effective 7/1/2022, the following products were added to the formulary with a prior authorization requirement:

- **Xifaxan 550mg** – Only the 550mg will be added to the formulary**,** with the PA criteria below**:**
  INDICATION:
  (1) Reduction in risk of overt hepatic encephalopathy (HE) Recurrence in Adults
  (2) Treatment of Irritable Bowel Syndrome with Diarrhea (IBS-D) in adults
  Criteria:
  (a) For Hepatic Encephalopathy:
    - Failure of, intolerance to, contraindication to, or previous use of Lactulose at maximally tolerated doses

  (b) For IBS-D:
    - Failure of, intolerance to, contraindication to, or previous use of Loperamide
    - For renewals: the patient has a 10 week or more treatment-free period

- **Restasis 0.05%** will be added to the formulary**,** with the PA criteria below**:**
  INDICATION:
  (1) Increase tear production in patients whose tear productions is presumed to be suppressed due to ocular inflammation associated with Keratoconjunctivitis Sicca.
  Criteria:
  (a) Failure of, intolerance to, contraindication to, or previous use of artificial tears or equivalent.

- **Testosterone Cypionate 100mg/mL and 200mg/mL** – will be added to the formulary with the same PA criteria as other Testosterone products on the formulary:
  INDICATION:
  (1) Hypogonadism
  Criteria for Hypogonadism:
  (a) Must be prescribed by an Endocrinologist or Urologist
  (b) Initial therapy: The patient has documented low testosterone concentration
  (c) Renewal: The patient has documented therapeutic concentration to confirm response
  Criteria for transgender members:
  (a) Referral from mental health professional; and

(b) Persistent, well-documented gender dysphoria; and
(c) Capacity to make fully informed decision and to consent for treatment; and
(d) 18 years of age or older

Other coverage status updates:
PA Criteria has been updated for the following medications:

- **Jardiance** - PA criteria and indication for heart failure were updated
  INDICATION:
  (1) Type II Diabetes Mellitus
  (2) To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure
  (3) To reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease.
  Criteria for Type 2 diabetes mellitus:
  (a) Failure of metformin, a sulfonylurea, or pioglitazone
  Criteria for heart failure:
  (a) Diagnosis of heart failure
  (b) Has not achieved adequate symptom control with the following:
  (1) ACE/ARB or ARNI, and
  (2) Beta Blocker

- **Trulicity** - Indication for heart failure was added
  INDICATION:
  (1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes Mellitus
  (2) To reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus who have established cardiovascular disease or multiple cardiovascular risk factors
  Criteria:
  (a) Diagnosis of type II diabetes mellitus; and
  (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by diabetes educator
  (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinediones, or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications

- **Victoza** – PA criteria was updated
  (1) Adjunct to diet and exercise to improve glycemic control in patients 10 years and older with type II diabetes mellitus
  (2) To reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease.
  Criteria:
  (a) Diagnosis of type II diabetes mellitus; and
  (b) Must be under the care of a healthcare provider skilled with the use of insulin and Supported by a diabetes educator; and

(c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione, or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; and
(d) Must have tried and failed or intolerant to treatment with Bydureon or Byetta; and
(e) NO personal or family history of medullary thyroid carcinoma

Effective 8/1/2022, formulary medication Valsartan-Hydrochlorothiazide (Brand Name Diovan HCT) will now have a prior authorization requirement for members who are new to treatment – members currently receiving the medication will have prior authorization already in place:

GENERIC: VALSARTAN-HCTZ
INDICATION:
(1) Hypertension
Criteria:
(a) Failure or contraindication of 2 formulary ARB-HCTZ combinations (Irbesartan-HCTZ, Losartan-HCTZ)

Providers can contact ProCare's Prior-Authorization Department at 800-555-8513 for assistance with PA requests or questions regarding clinical guidelines. Our PA Department is available Monday through Friday from 8:30 am-5:30 pm EST. For assistance with PA requests during non-business hours please contact our 24 hour customer service department at 800-213-5640.