PROVIDER *Update*

CalViva HEALTH

Health Net COMMUNITY SOLUTIONS

CONTRACTUAL | FEBRUARY 14, 2018 | UPDATE 18-123 | 5 PAGES

Medication Trend Updates and Formulary Changes – 1st Quarter 2018

This update includes information regarding the use of codeine and tramadol in children and nursing mothers, an opioid prescribing update for CalViva Health members, the Prescription Drug Prior Authorization or Step Therapy Exception Request Form, and changes to the *CalViva Health Recommended Drug List* (*RDL*) for the first quarter of 2018.

CODEINE AND TRAMADOL SHOULD NOT BE PRESCRIBED FOR CHILDREN AND NURSING MOTHERS

On April 20, 2017, the U.S. Food and Drug Administration (FDA) issued an announcement restricting the use of codeine and tramadol (generic for Ultram®) in children and nursing mothers. The updated changes include:

- A contraindication to the codeine and tramadol labels alerting users that codeine should not be used to treat pain or cough, and tramadol should not be used to treat pain in children younger than age 12.
- A new contraindication to the tramadol label warning against its use in children younger than age 18 to treat pain after surgery to remove the tonsils and/or adenoids.
- A new warning to codeine and tramadol labels recommending against their use in adolescents between ages 12–18 who are obese and have conditions such as obstructive sleep apnea or severe lung disease.
- A warning that breastfeeding is not recommended when taking codeine or tramadol due to the risk of serious adverse reactions in breastfed infants, which can include excess sleepiness, difficulty breastfeeding, or serious breathing problems that could result in death.

This advice is also consistent with the September 2016 Policy Statement from the American Academy of Pediatrics titled *Codeine: Time To Say "No."*

For more information, visit the following websites:

- www.fda.gov/Drugs/DrugSafety/ucm549679.htm
- http://pediatrics.aappublications.org/content/early/2016/09/15/peds.2016-2396

OPIOID PRESCRIBING UPDATE FOR CALVIVA HEALTH MEMBERS

In response to the national opioid epidemic and recommendations from the Centers for Disease Control and Prevention (CDC), and to ensure proper use of opioid medications and safety of our members, the health plan will be implementing changes in opioid utilization. Starting in April 2018, prescribers may be required to submit a prior authorization and a signed pain contract for CalViva Health members when opioid

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- ● Physicians
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prescriptions exceed plan quantity or frequency limits. For more information, review the following resources:

- CDC Opioid Prescribing Guidelines: www.cdc.gov/drugoverdose/prescribing/guideline.html.
- CDC's *Guideline for Prescribing Opioids for Chronic Pain* factsheet: www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf.
- Prescription Drug Monitoring Program [Controlled Substance Utilization Review and Evaluation System (CURES) 2.0]. All prescribers are required to enroll in and access CURES reports to establish whether or not a member is receiving controlled substances from other providers. For further information, visit https://oag.ca.gov/cures.

NEW PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Effective January 1, 2018, providers must use the updated Prescription Drug Prior Authorization or Step Therapy Exception Request Form for members with prescription medication benefits enrolled in Medi-Cal plans. The form must be completed and submitted for all prior authorization prescription requests. A copy of the updated form is attached to this update for reference, and is also available on the provider website at provider.healthnet.com under *Pharmacy Information* and in the Provider Library under *Forms*. Medication authorization requests for CalViva Health members continue to be processed within 24 hours.

Beginning January 1, 2018, providers must submit prior authorization prescription requests on the updated form, or the request will be rejected. Also, effective January 1, 2018, the previous version of the Prescription Drug Prior Authorization Request Form (also referred to as the SB866 form) is no longer accepted.

CHANGES TO THE *CALVIVA HEALTH RDL*

The Pharmacy and Therapeutics Committee, which comprises practicing physicians, pharmacists and other health care professionals, reviews the medications on the *CalViva Health RDL* each quarter to determine which medications should remain on the *RDL* and which should be moved to a different status. A list of some recent changes is provided beginning on page 3 of this update. The list contains prescription medications, their status, alternatives, and comments for the first quarter of 2018. The complete *CalViva Health RDL* and other pharmacy-related provider updates, revised prior authorization criteria and pharmacy forms are available at provider.healthnet.com under *Pharmacy Information*.

If you need additional information regarding the *CalViva Health RDL*, contact CalViva Health at 1-888-893-1569 or the pharmacy department by telephone at 1-800-867-6564, press #, or by fax at 1-800-977-8226.

CALVIVA HEALTH RDL CHANGES

Medication	Status	Formulary Alternative(s)	Comments
ORAL MEDICATIONS			
Idhifa® (enasidenib) tablet	F*, **		Treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with an IDH2 mutation as detected by an FDA-approved test
Nerlynx® (neratinib) tablet	F*, **	Herceptin® (under medical benefit)*	Extended adjuvant treatment of adult patients with early stage human epidermal growth factor receptor 2 (HER2)-overexpressed/amplified breast cancer, to follow adjuvant trastuzumab based therapy
Symproic® (naldemedine) tablet	NF**	docusate sodium (Colace®), lactulose, polyethylene glycol 3350 (Miralax®), bisacodyl (Dulcolax®)	Treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain
INJECTABLE PREPARATIONS			
Kevzara® (sarilumab) prefilled syringe	NF**	Disease-modifying antirheumatic drugs (DMARDs): methotrexate**, sulfasalazine, leflunomide**, hydroxychloroquine Biologic DMARDS: Humira® *, **, Simponi Aria® *, **, Remicade® *, **	Treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more DMARDs
Tremfya® (guselkumab) prefilled syringe	NF**	methotrexate**, cyclosporine ** Biologic DMARDS: Humira*, **, Stelara® *, **, Remicade*, **	Treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy

*Prior authorization (PA) is required to verify member eligibility and that the member satisfies clinical protocols to ensure appropriate use of the medication.

**CCS = California Children's Services – Refer to www.dhcs.ca.gov for the local telephone number to determine a member's coverage eligibility.

- F indicates formulary.
- NF indicates nonformulary.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)_____**

Plan/Medical Group Fax#: (_____)_____ **Non-Urgent** ☐ **Exigent Circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:	☐ Patient's Home	☐ Long Term Care
☐ Physician's Office	☐ Home Care Agency	☐ Other (explain):_____
☐ Ambulatory Infusion Center	☐ Outpatient Hospital Care	_____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

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Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number (_____)_____

☐ Approved ☐ Denied Comments/Information Requested: _____

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CONTRACTUAL | FEBRUARY 14, 2018 | UPDATE 18-123sum | 2 PAGES

Summary Update: Medication Trend Updates and Formulary Changes – 1st Quarter 2018

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ADDITIONAL INFORMATION

To obtain a comprehensive description of the above topics, the complete update, 18-123, *Medication Trend Updates and Formulary Changes – 1st Quarter 2018,* is available on the provider website at provider.healthnet.com in the Provider Library under *Updates and Letters > 2018;* search for provider update 18-123. Providers who do not have access to the Internet may request a print copy of update 18-123 by contacting the Provider Communications Department by fax at 1-800-937-6086 or by email at provider.communications@healthnet.com.

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For the most current version of the *RDL*, visit the provider website at provider.healthnet.com > *Pharmacy Information* > *Drug Lists*.