BlueCross BlueShield of Alabama
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Pharmacy News

October 2024

Drug Guide and Clinical Program Updates

The Prime Therapeutics® Pharmacy and Therapeutics Committee, in association with Blue Cross and Blue Shield of Alabama's Formulary Business Committee, recently approved updates to the Drug Guides and made clinical program changes to select medications. Members will receive a letter from Blue Cross if they are negatively affected by a formulary change that is not a result of a new generic being available.

Formulary and Clinical Programs – Effective October 1, 2024

Click the links below to view updated formularies and clinical programs. If members have questions about their benefits, they should call the Customer Service number on the back of their Blue Cross member ID card.

- Standard Prescription Drug Guide Updates
- Generics Plus Drug Guide Updates
- High-Cost Exclusion Updates
- Source Rx Formulary Updates
- Source+Rx 1.0 Prescription Drug List
- Source+Rx 2.0 Prescription Drug List
- NetResults Formulary Updates
- **Clinical Programs**
  - Prior Authorization
  - Step Therapy
  - Quantity Limit

PEEHIP Update: Preferred Trastuzumab Products – Effective October 1, 2024

Kanjinti (trastuzumab-anns) will be added to list of preferred trastuzumab products including Trazimera (trastuzumab-qyyp) and Ogivri (trastuzumab-dkst) for Public Education Employees' Health Insurance Plan (PEEHIP) patients.

Prior to consideration of a non-preferred trastuzumab product:

- Patients must have tried and had an inadequate response or intolerance to, or a contraindication to Kanjinti, Trazimera and Ogivri, attributable to the biosimilar formulation; **OR**,
- Patient must be continuing treatment with a non-preferred trastuzumab product.

Blue Cross (Excluding PEEHIP) Updates – Effective January 1, 2025

The following updates will affect Blue Cross patients excluding PEEHIP:

Preferred trastuzumab products: Kanjinti (trastuzumab-anns) will be added to list of preferred trastuzumab products including Trazimera (trastuzumab-qyyp) and Ogivri (trastuzumab-dkst).

Prior to consideration of a non-preferred trastuzumab product:

- Patient must have tried and had an inadequate response or intolerance to, or a contraindication to Kanjinti, Trazimera and Ogivri, attributable to the biosimilar formulation; **OR**,
- Patient must be continuing treatment with a non-preferred trastuzumab product.

Preferred intravenous immune globulin products: Gammagard, Gammaked, Gamunex-C, Privigen and Octagam will be the preferred intravenous immune globulin products.

Treatment with non-preferred products (Alyglo, Gammagard SD, Gammaplex, Panzyga, Bivigam, Flebogamma or Yimmugo) may be considered when the following criteria is met:

- Patient is receiving and is stable on treatment with a non-preferred agent; **OR**,
- Patient has had a trial and inadequate response or intolerance to two preferred agents; **OR**,
- Patient has severe immunoglobulin A (IgA) deficiency (< 7 mg/dl of IgA) or IgA deficiency with antibodies against IgA, requiring an agent with low IgA content (Gammagard SD and Gammaplex only).

Treatment with non-covered products (Asceniv) will be considered excluded from coverage unless the patient is continuing therapy.

Preferred subcutaneous immune globulin or chronic inflammatory demyelinating polyneuropathy products: Hyqvia and Xembify will be the preferred subcutaneous immune globulin products. Hizentra will be preferred for chronic inflammatory demyelinating polyneuropathy (CIDP) only.

Treatment with non-preferred products may be considered when the following criteria is met:

- Patient is receiving and is stable on treatment with a non-preferred agent; **OR**,
- Patient has had a trial and inadequate response or intolerance to one preferred intravenous agent and one preferred subcutaneous agent.

New or Revised Provider-Administered (Medical) Drug Policies

Policy Name	Type of Policy	Coverage Criteria and Changes
Beqvez (fidanacogene elaparvovec-dzkt)	Medical PA	**New – Effective 9/1/24 –** New gene therapy policy for hemophilia B.
Imdelltra (tarlatamab-dlle)	Medical PA	**New – Effective 9/1/24 –** New policy for small cell lung cancer.
Rytelo® (imetelstat)	Medical PA	**New – Effective 10/1/24 –** New policy for myelodysplastic syndrome.

Note: Prior Authorization is abbreviated as PA.