Kentucky Pharmacy and Therapeutics Advisory Committee Meeting Minutes

13550 Triton Park Blvd, Louisville, Ky 40223
2/28/17 1:00-3:00PM

Attendees:
Andrew Rudd
Victoria Meska
Steven Brody
Setifah Jordan
Nancy Redmon
Glenn Belemjian
Wendy Phillabaum
Daniel Calloway
Molly Wehrenberg
Susan Neff
Keith Huff

1. HEPATITIS C AGENTS

Review Date	4Q16
Clinical Review:	Hepatitis C Agents

RECOMMENDATION:

- Harvoni will move from Preferred to Non-Preferred (PA required)

2. ANTICONVULSANTS

Review Date	4Q16
Clinical Review:	Anticonvulsants

RECOMMENDATION:

- (Brand) Carbatrol ER capsule will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Depakene capsule will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Depakote Sprinkle capsule will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Depakote DR tablet will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Depakote EC tablet will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Depakote ER tablet will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Dilantin will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Gabitril 12mg and 16 mg will move from Preferred to Non-Preferred with Grandfathering

WEBPAKY-0089-17 March 2017

- (Brand) Lamotrigine ER will move from Non-Preferred to Preferred
- (Brand) Lamotrigine ODT will move from Non-Preferred to Preferred
- (Brand) Phenytek capsule will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Roweepra tablet will move from Non-Preferred to Preferred with Grandfathering

(Brand) Tegretol will move from Preferred to Non-Preferred with Grandfathering

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3. THYROID HORMONES

Review Date	4Q16
Clinical Review:	Thyroid Hormones

RECOMMENDATION:

- (Brand) Armour Thyroid will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Cytomel will move from Preferred to Non-Preferred with Grandfathering
- (Brand) Synthroid will move from Preferred to Non-Preferred with Grandfathering
- (Brand) WP Thyroid 65 mg will move from Preferred to Non-Preferred with Grandfathering
- (Brand) WP Thyroid 130 mg will move from Preferred to Non-Preferred with Grandfathering
- Unithroid 137 mg will move from Non-Preferred to Preferred
- (Brand) WP Thyroid 32.5 mg will move from Preferred to Non-Preferred with Grandfathering

4. DIGOXIN

Review Date	4Q16
Clinical Review:	Digoxin

RECOMMENDATION:

- (Brand) Lanoxin will move from Preferred to Non-Preferred with Grandfathering

5. GENERIC ORAL SKELETAL MUSCLE RELAXANTS

Review Date	4Q16
Clinical Review:	Oral Skeletal Muscle Relaxants

RECOMMENDATION:

• No changes

6. HEAD LICE

Review Date	4Q16
Clinical Review:	Head Lice
RECOMMENDATION: • Malathion will move from Preferred to Non-Preferred • RID Essential Lice Kit will move from Non-Preferred to Preferred • Spinosad will move from Non-Preferred to Preferred	

7. HYALURONIC ACIDS

Review Date	4Q16
Clinical Review:	Hyaluronic Acids
RECOMMENDATION: • Euflexxa will move from Non-Preferred to Preferred (PA required) • Gelsyn will move from Non-Preferred to Preferred (PA required) • Supartz will move from Non-Preferred to Preferred (PA required)	

8. ISOTRETINOINS

Review Date	4Q16
Clinical Review:	Isotretinoins
RECOMMENDATION: • Claravis will move from Non-Preferred to Preferred (PA required) • Mysorian will move from Non-Preferred to Preferred (PA required) • Zenatane will move from Non-Preferred to Preferred (PA required)	

9. IRON CHELATORS

Review Date	4Q16
Clinical Review:	Iron Chelators
RECOMMENDATION:	

- Exjade tablets will move from Preferred to Non-Preferred (PA required)

10. SPACERS

Review Date	4Q16
Clinical Review:	Spacers
RECOMMENDATION: • Compact Spacers will move from Non-Preferred to Preferred	

11. MISCELLANEOUS UTILIZATION MANAGEMENT EDITS

- **New Opportunities**

Self Injected Epinephrine	
Reason for Review	• Prevent waste. • QL alignment for Anthem Blue Cross and Blue Shield Medicaid (Anthem).
Edit Details	QL: 2 auto-injector pens per fill
Authorization Criteria	• Individuals replacing expired stock will be approved for 4 pens per fill (one time per calendar year). • Retail pharmacy may call and obtain override for 4 pens per fill once per calendar year. All other override requests must come from prescriber.
Current Status	2 per 30 days
Recommendation	**Revise the QL**

Lidocaine Patch Prior Authorization and Quantity Limit	
Reason for Review	• Potential inappropriate use when opioids are restricted. • Alignment for Anthem.

Edit Details	PA: Individual is using for relief of pain associated with post-herpetic neuralgia. QL: 3 per day
Recommendation	**Adopt Anthem PA criteria.**

Non-Preferred Medications		
Current Status	Non-preferred with default NP criteria.	
Reason for Review	Drug specific criteria is preferred for 1 or more of the following reasons: • No viable preferred products to offer as alternative. • Clinical approved criteria limit number of preferred products to 1 rather than trial of 2 products. • Drug specific criteria more clearly defines preferred products. • Alignment with Anthem use of PA criteria.	
Class	**Drug**	**Drug Specific Edit**
SNRI antidepressants	Cymbalta, Fetzima, Pristiq, etc	I. Trial of and inadequate response or intolerance to two preferred agents; OR II. II. The preferred agent is not FDA-approved for the prescribed indication.
SSRI antidepressants	MSB Prozac, MSB Lexapro, MSB Paxil, etc.	I. The patient has failed an adequate trial of one chemically equivalent generic agent; AND a. Generic had inadequate response; OR b. Generic caused adverse outcome; OR c. The patient has a genuine documented allergic reaction.
Doxycycline	Avidoxy, Monodox, Morgidox, TargaDox, Vibramycin, Doryx MPC, TargaDox, etc	I. Trial of 1 generic minocycline IR agent; AND II. Trial of 1 generic doxycycline IR agent. Drug-specific criteria applied to Acticlate, Doryx: Revise with most recent criteria.
Doxycycline	Oracea	I. Trial of 1 preferred doxycycline Rosacea agent.
Topical Acne	Aczone	I. I. Individual has a diagnosis of acne; AND II. Trial of 2 preferred single ingredient topical acne agents; AND Documentation is provided for the clinical necessity of a NP agent.

Metformin	Riomet	I. Individual has the inability to swallow tablets.
	Fortamet Glucophage XR	I. Trial and inadequate response or intolerance to up to 3 preferred generically available metformin agents one of which must be an extended-release agent; AND II. Documentation has been provided. Drug-specific criteria applied to Glumetza
Rapid-Acting Insulins	Humalog, Novalog	I. Trial and inadequate response or intolerance to 1 preferred rapid-acting insulin agent Drug-specific criteria applied to Afrezza
Skin Ulcers	Santyl	I. Individual is using for debridement of necrotic tissue from chronic skin ulcers or severely burned areas. Not approved for therapy for an area with well-established granulation tissue.
Anti-emetic (5-HT3)	Anzemet, Granisetron, Sancuso, Zofran, Zuplenz,etc	I. Trial of and inadequate response or intolerance to one preferred 5-HT3 receptor antagonist agent; OR II. The preferred agent is not FDA-approved for the prescribed indication and the requested non-preferred agent is; OR III. The transdermal formulation (Sancuso) is non-preferred and the individual is unable to take oral medications.
Metabolism Disorder	Carbaglu	I. Individual has a diagnosis of acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS); AND II. Using as adjunctive therapy with other ammonia lowering therapies; OR III. Individual has a diagnosis of chronic hyperammonemia due to the deficiency of the hepatic enzyme NAGS; AND Using as maintenance therapy.
Hyponatremia	Samsca	I. Diagnosis of clinically significant hypervolemic or euvolemic hyponatremia; AND II. Being initiated or re-initiated on therapy in a hospital setting; AND III. Serum sodium of less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction. Exclusionary criteria applies when use is not clinically appropriate.

Recommendation	**Apply drug specific criteria to NP brands and generics.**

- **UM Removals**

Herceptin Prior Authorization Removal	
Reason for Review	• Anthem Medical Policy is being discontinued due to high overturn rate from appeals.
Current Status	• NP with drug-specific criteria for clinically appropriate treatment for breast cancer and GI cancers.
Recommendation	**Remove PA to align with medical benefit.** **Change status from NP to Non-PDL.**

Cerezyme, Elelyso Quantity Limit Removal	
Reason for Review	• Dosing is based on individual's weight which is not available through pharmacy claims data.
Recommendation	**Remove QL.**

- **New UM Edits on New Drugs**

Class	**Drug**	**Recommended Edit**
Duchenne Muscular Dystrophy	Deflazacort	Prior Authorizations I. Individual has a diagnosis of Duchenne Muscular Dystrophy (DMD); AND II. Individual has had a trial of oral prednisone.
Atopic Dermatitis	Crisaborole	Prior Authorization I. Individual is 2 years of age or older; AND II. Individual has a diagnosis of mild to moderate atopic dermatitis; AND III. Individual has had a trial of 1 topical corticosteroid unless use is not acceptable due to the specific concomitant clinical conditions. Not be approved for the following: I. Individual has an active skin infection.

GLP-1/ LA Insulin Combination	Soliqua, Xultophy	I. Trial of metformin; AND II. Trial of 1 preferred GLP-1; AND III. Trial of 1 preferred LA insulin; AND IV. Documentation has been provided for why the combination agent is clinically necessary and not for convenience. QL: 5 pens (1 pack) per 25 days
Contraceptives	Amethia Lo/Amethia, Camrese Lo/Camrese, Daysee, etc	QL: 1 per day
Methotrexate	Otrexup	New strengths: 7.5 mg/0.4 mL, 12.5 mg/0.4 mL, 17.5 mg/0.4 mL, 22.5 mg/0.4 mL PA: Appropriate age and diagnosis. Step: Trial of 1 generic oral MTX and 1 generic inj. QL: 4 auto-injectors per 28 days
Antihypertensive	Byvalson	QL: 1 tablet per day
	Qbrelis	QL: 40mL per day
NSAID	Fenortho	Step Therapy: Individual has had a trial and inadequate response or intolerance to 2 preferred single agent oral. QL: 200mg 6 capsules per day QL: 400mg 4 capsules per day
COPD	Bevespi Aerosphere	Step: Trial and inadequate response or intolerance to 1 preferred agent QL: 1 inhaler per 30 days.
Long-Acting Opioid Agents Step Therapy	Troxyca ER	Step: Trial and inadequate response or intolerance to 2 preferred long-acting agents Prior Authorization: Consistent with other LA opioids QL: 2 capsules per day
Anti-emetic	Syndros	Prior Authorization I. Diagnosis of AIDs-related weight-loss. II. Using for chemotherapy-induced nausea and vomiting with trial of 2 conventional drug.
SGLT-2 (Diabetes)	Invokamet XR	Step: I. Trial and inadequate response or intolerance to metformin; OR II. Has a contraindication to metformin; AND III. Individual has had a trial with the following: a. 1 preferred DPP-4; OR

		b. 1 preferred GLP-1; OR c. 1 sulfonylurea QL: 2 tablets per day
GLP-1 (Diabetes)	Adlyxin	Step Edit I. Trial of metformin; AND II. Trial of 1 preferred GLP-1 receptor agonist. QL for starter pak: 1 pack (2 pens) per one time fill (28 day supply) QL for Maintenance Pack: 1 pack (2 pens) per 28 days
Antibiotic Ear Drop	Otovel	Step: Consistent with Cetraxal, Ciprodex, Cipro HC QL: 28 single dose vials per fill; 1 fill per 30 days
Targeted Immune Modulators	Brodalumab Sarilumab	Prior Authorization: pending final Anthem Medical Policy for clinically appropriate criteria. Step: Nonpreferred until final review by CRC and VAC. QL: 2 injections per 28 days Override criteria available for initiation (Brodalumab only)
Biosimilars	Amjevita Erelzi Inflectra	PA: Anthem Medical Policy clinical criteria currently applied to originator products Humira, Enbrel, Remicade. Step: Nonpreferred until reviewed by VAC. QL with override criteria: Consistent with originator product.
Targeted Immune Modulators	Orencia 250 mg/vial (for IV use)	PA: Anthem Medical Policy clinical criteria currently applied to original dosage forms of Orencia. Step: Consistent with original dosage forms of Orencia. QL: 4 vials per 28 days Override criteria for initiation.
Targeted Immune Modulators	Kineret	• Update to include approved compendia recommended off-label uses for refractory NOMID (DrugPoints) and Castleman's Disease (NCCN). • Update to include treatment guideline (ACR 2013) recommended off-label use for Systemic Juvenile Idiopathic Arthritis.
Targeted Immune Modulators	Stelara 90 mg/ 1mL	• Update to include new indication for Crohn's disease and weight-related recommendations for plaque psoriasis and psoriatic arthritis.
Targeted Immune Modulators	Xeljanz, Xeljanz XR	• Update to include an excluded use for Xeljanz XR with concomitant moderate hepatic impairment per labeled recommended dosing for only Xeljanz in this population
Recommendation	**Add PA, ST and/or QL.**	

- **Revisions to Existing UM Edits**

PA Criteria Revisions		
Class	**Drug**	**Recommended Edit**
Pegylated Interferons	Pegasys, PegIntron	• Update PA criteria, step criteria, and approval duration with most recent label changes and AASLD guidelines.
Bile Acid Synthesis Disorders	Cholbam	• Add criteria for maintenance therapy requests requiring an improvement in liver function and/or cholestasis and absence of complete biliary obstruction. • Add initial approval duration of 3 months and maintenance approval duration of 12 months. • Add exclusionary criteria per label when requested for extrahepatic manifestations in single enzyme defect associated-bile acid synthesis or peroxisomal disorders.
Smoking Cessation Agents	Chantix, Nicotrol (inhaler, NS), Zyban	• Remove requirement for enrollment in a smoking cessation program. • Update criteria to allow for use of non-preferred agent in specific clinical situations.
Cysteine-Depleting Agents	Thiola	• Update criteria based on treatment guidelines to clarify the non-pharmacologic therapies are included within the conservative treatment standard of care program recommendations from both AUA and ACP. • Update criteria to include minimum age requirement and clarification that utilization is to prevent cystine stone formation.
Hypoparathyroidism	Natpara	• Include requirements for minimum age and use as adjunct therapy to calcium supplementation and active vitamin D

		agents. • Add exclusionary criteria for limitations of use and not recommended for use based on label and/or clinical trial. • Include additional black box warning information.
Short-Acting Opioid Analgesics	APAP/codeine	• Allow approval for continued use for diagnosis of sickle cell anemia.
Long-Acting Opioid Agents	Oxycontin, Zohydro ER, Hysingla, Avinza	• Added age related and opioid tolerant criteria for fentanyl patch authorization per label • Update criteria to simplify for continued therapy.
	Zohydro ER	• Removed reference as an abuse deterrent agent as it is not an FDA recognized abuse deterrent agent.
Transmucosal Immediate Release Fentanyl (TIRF) Agents	Actiq, Abstral, Fentora, Onsolis, etc	• Clarified cancer pain as "active" and provided descriptor of active cancer diagnoses • Add exclusionary criteria to define inappropriate use.
Idiopathic Pulmonary Fibrosis	Ofev	• Update exclusionary criteria to be consistent with label.
Acne/ Rosacea	Adapalene/ Benzoyl Peroxide Agents and Clindamycin-Tretinoin Combination Agents	• Update to allow adapalene as an option in addition to tretinoin as a required prior topical retinoid-based therapy
	Azelex	• May be approved if the individual is pregnant and requires a topical non-retinoid agent.

	Finacea, Soolantra	• Removed general language concerning metronidazole contraindication.
Menopausal Therapy	Osphena	• Removed Femring as a vaginal preparation for use before Osphena due to additional use for Femring to treat vasomotor symptoms. • Updated override criteria for use in circumstances where low dose vaginal estrogen cannot be used
Immune Thrombocytopenia	Promacta	• Add maintenance therapy request approval criteria requiring a demonstrated response to therapy and continued therapy are to maintain an adequate platelet count for bleeding risk reduction. • Remove criteria allowing approval for chronic hepatitis C-associated thrombocytopenia. • Add criteria requiring a platelet count of less than 30 X 10^9/L or active bleeding prior to approval for ITP. • Add requirement for a platelet count of less than or equal to 30 X 10^9/L for approval in aplastic anemia. • Remove age requirement. • Update to provide examples of first-line treatment options of immunoglobulins for ITP and immunosuppressive agents for aplastic anemia. • Remove the exclusion for use related to myelodysplastic syndrome. • Add exclusion for use when peginterferon/ribavirin therapy has been discontinued. • Modify note based on update to the black box

			warning.
Cancer	Cabometyx	Stivarga	Update with most recent FDA-approved and medically accepted criteria.
	Cometriq	Tafinlar	
	Imbruvica	Valchlor	
	Istodax	Zelboraf	
	Nexavar		
Recommendation	**Apply PA revisions.**		

Quantity Limit Revisions		
Class	**Drug**	**Recommended Edit**
Acne/ Rosacea	Acne medication (benzoyl peroxide) 5%,10% lotion	QL change from 180 to 177 mL to align with package size.
Immune Thrombocytopenia	Promacta 50mg	Increase from 2 tablets per day to 3 per day.
Anti-emetics	Ondansetron, Granistron, etc.	Add authorization criteria for palliative care.
Recommendation	**Apply QL revisions and approval criteria**	

Step Therapy Revisions

Class	Drug	Recommended Edit
Acne/ Rosacea	Doxycycline Agents for Acne, Brand Minocin for Acne, and Minocycline Extended-Release Agents	• approval duration of 3 months
	Doxycycline Agents for Acne	• Remove Oracea (brand and generic) as potential preferred because it is not indicated for acne
Menopausal Therapy	Alora, Climara, Elestrin, etc	• Removed requirement for individual to be female • Re-classified clinical edit as a step therapy
Antibiotic Ear Drop	Cetraxal, Ciprodex, Cipro HC	• Include wording which allows approval of a non-preferred agent when the preferred agent(s) does not have an acceptable off-label indication, in addition to FDA-approved indication, for the requested use
Ophthalmic Antihistamine and Mast-Cell Stabilizer Agents	Alocril, Pataday, Patanol, Pazeo, etc	• Remove general criteria allowing a non-preferred agent when preferred agents have contraindications to use and not associated with the non-preferred agent.
Acne/Rosacea	Azelex Finacea	
SGLT2, SGLT2 combo, TZD, DPP4, GLP1, Meglitinide, Cycloset	Januvia, Invokana, Byetta, Pioglitazone, etc	• Update metformin contraindication language in all step therapies to define renal

		insufficiency in terms of eGFR.
GLP1	Byetta, Bydureon, etc	• Remove criteria as not applicable since Victoza will always be a preferred agent and it does not carry warnings for renal insufficiency
Recommendations:	• **Apply step therapy revisions**	

- **Medical Policy and Clinical Guidelines**

Policy Number	**Policy Name**	**Key Revisions**
DRUG.00048	Eribulin Mesylate (Halaven®)	Removed requirement for prior taxane or anthracycline treatment for breast cancer
DRUG.00068	Vedolizumab (Entyvio®)	Changed minimum age requirement from 18 to 6 years-old
DRUG.00075	Nivolumab (Opdivo®)	Added indication for head and neck cancer
DRUG.00081	Eteplirsen (Exondys 51™)	Investigational and not medically necessary criteria for all indications
DRUG.00085	Ixabepilone (Ixempra®)	Removed requirement for prior taxane or anthracycline treatment for breast cancer
DRUG.00088	Atezolizumab (Tecentriq™)	Added indication for non-small cell lung cancer
DRUG.00090	Bezlotoxumab (ZINPLAVA™)	Criteria to reduce recurrence of C-diff in high risk individuals receiving antibiotics
CG-DRUG-54	Agalsidase beta (Fabrazyme®)	Criteria for symptomatic, confirmed Fabry disease

CG-DRUG-55	Elosulfase alfa (Vimizim®)	Criteria for symptomatic, confirmed mucopolysaccharidosis type IVA (Morquio A syndrome)
CG-DRUG-56	Galsulfase (Naglazyme®)	Criteria for confirmed mucopolysaccharidosis VI (Maroteaux-Lamy Syndrome)
CG-DRUG-57	Idursulfase (Elaprase®)	Criteria for symptomatic, confirmed mucopolysaccharidosis II (Hunter syndrome)
CG-DRUG-58	Laronidase (Aldurazyme®)	Criteria for forms of mucopolysaccharidosis I – Hurler and Hurler-Scheie syndrome; symptomatic Scheie syndrome
DRUG.00094	Dupilumab (Dupixent®)	Pending FDA approval – criteria for treatment of severe atopic dermatitis
DRUG.00095	Ocrelizumab (Ocrevus™)	Pending FDA approval - treatment of relapsing MS or primary progressive MS
DRUG.00096	Ibalizumab (TMB-355)	Pending FDA approval - criteria for treatment experienced, multi-drug resistant HIV-1
DRUG.00097	Olaratumab	Criteria for advanced soft tissue sarcoma
DRUG.00098	Octreotate Lu-177 DOTA Tyr-3 (Lutathera®)	Pending FDA approval – criteria for treatment of advanced inoperable midgut neuroendocrine carcinoid tumors
DRUG.00101	Sarilumab	Pending FDA approval - criteria for 2nd-line treatment of rheumatoid arthritis
DRUG.00102	Cabazitaxel (Jevtana®)	Criteria for hormone-refractory metastatic prostate cancer
CG-DRUG-60	Gonadotropin Releasing Hormone Analogs for Oncologic Indications	Oncologic indications from newly archived CG-DRUG-15
CG-DRUG-61	Gonadotropin Releasing Hormone Analogs for Non- Oncologic Indications	Non-oncologic indications from newly archived CG-DRUG-15
CG-DRUG-62	Fulvestrant (FASLODEX®)	Criteria for hormone-receptor positive metastatic breast cancer

CG-DRUG-63	Levoleucovorin Calcium (Fusilev®)	Criteria for rescue following high dose folic acid antagonist therapy; preferred drug criteria to be reviewed at future VAC
CG-DRUG-64	FDA-Approved Biosimilar Products	Criteria for review of biosimilars to be consistent with originator product. Preferred drug criteria to be reviewed by VAC separately.
DRUG.00002	Tumor Necrosis Factor Antagonists	Removal of biosimilar products
DRUG.00006	Botulinum Toxin	Preferred drug language; replaces pharmacy step criteria
DRUG.00038	Bevacizumab for Non-Ophthalmologic Indications (Avastin®)	New criteria for unresectable malignant mesothelioma
DRUG.00041	Rituximab (Rituxan®) Proposed New Title: Rituximab (Rituxan®) for Non-Oncologic Indications	Removed oncologic indications; clarified diagnostic criteria for thrombotic thrombocytopenia
DRUG.00042	Ustekinumab (Stelara®)	New criteria for 2nd-line treatment of Crohn's disease
DRUG.00051	Ziv-aflibercept (Zaltrap®)	Minor revision: added "metastatic" to gastrointestinal tumors
DRUG.00055	Denosumab (Prolia®, Xgeva®)	Minor revision: added aromatase inhibitors as risk factor for osteoporosis
DRUG.00057	Canakinumab (Ilaris®)	New criteria for tumor necrosis factor receptor associated periodic syndrome, hyperimmunoglobulin D syndrome, and Familial Mediterranean Fever
DRUG.00066	Antihemophilic Factors and Clotting Factors	Criteria for recombinant factor VIII (Afstyla)
DRUG.00071	Pembrolizumab (Keytruda®)	Criteria for advanced squamous cell head and neck cancer; 1st-line therapy for metastatic non-small cell lung cancer; advanced Merkel-cell carcinoma
DRUG.00077	Monoclonal Antibodies to Interleukin-17A	Pending FDA approval – Brodalumab - criteria for plaque psoriasis

DRUG.00082	Daratumumab (DARZALEX™)	New criteria for combination bortezomib/dexamethasone and lenalidomide/dexamethasone
CG-DRUG-09	Immune Globulin (Ig) Therapy	Added new SQ formulation Cuvitru
CG-DRUG-29	Hyaluronan Injections in the Knee	Preferred drug language; refer to category
CG-DRUG-38	Pemetrexed Disodium (Alimta®)	New indications for 1st-line treatment of malignant mesothelioma, 2nd-line treatment of thymic carcinoma and thymoma
CG-DRUG-52	Temsirolimus (Torisel®)	Clarification of ECOG criteria for advanced renal cell carcinoma.
CG-DRUG-30	Oprelvekin (Neumega®)	Drug was discontinued by manufacturer.
CG-DRUG-15	Gonadotropin Releasing Hormone Analogs	Replaced by “new” separated policies, CG-DRUG-60 and CG-DRUG-61