The Regence Group

Medication Policies		
The Regence Group and its affiliated Plans use medication policies for coverage decisions within the member's written benefits. Below are summaries of recent changes to The Regence Group's medication policies. The detailed policies and complete Medication Policy Manual are available online at http://www.blue.regence.com/policy/medication/contents.html. We have included the policy number for your convenience.		
NEW POLICIES (PUBLISHED WITHIN THE LAST 6 MONTHS)		
Policy Name and Number **(Click on policy name for link to policy)**	**Summary of Policy**	**Approval Date**
Luvox® CR, fluvoxamine extended-release capsules Dru153	New policy allowing coverage of Luvox CR following inadequate treatment with immediate-release, generically available fluvoxamine.	5/9/2008
Pristiq™, desvenlafaxine Dru154	New policy allowing coverage of Pristiq following inadequate treatment with at least two generic or preferred brand antidepressants.	5/9/2008
Actonel®, risedronate-Containing Medications (Actonel, Actonel with Calcium) Dru155	New policy allowing coverage of Actonel-containing medications when a generic oral bisphosphonate, such as alendronate, was not tolerated or is contraindicated	7/18/2008
Boniva®, ibandronate injection Dru156	Policy effective December 1, 2008. New policy allowing coverage of IV Boniva when an oral bisphosphonate, such as alendronate, was not tolerated or is contraindicated.	7/18/2008
Boniva®, ibandronate oral Dru157	New policy allowing coverage of oral Boniva when a generic oral bisphosphonate, such as alendronate, and oral Actonel® has been ineffective or is contraindicated.	7/18/2008
Reclast®, zoledronic acid Dru158	Policy effective December 1, 2008. New policy allowing coverage of Reclast when an oral bisphosphonate, such as alendronate, was not tolerated or is contraindicated.	7/18/2008

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NEW POLICIES (PUBLISHED WITHIN THE LAST 6 MONTHS) - CONTINUED		
Policy Name and Number **(Click on policy name for link to policy)**	**Summary of Policy**	**Approval Date**
Arcalyst®, rilonacept Dru159	New policy allowing coverage of Arcalyst for cryopyrin-associated periodic syndromes (CAPS) when there is laboratory evidence of mutation in the CIAS1 gene, and there is documentation that the patient is experiencing classic CAPS symptoms resulting in significant functional impairment.	7/18/2008
Cimzia®, certolizumab pegol Dru160	New policy allowing coverage of Cimzia for the treatment of Crohn's disease following prior unsuccessful treatment with systemic corticosteroids or an oral immunomodulatory medication and either Humira® or Remicade®.	7/18/2008
Relistor®, methylnaltrexone Dru161	New policy allowing coverage of Relistor for opioid-induced constipation in terminally ill patients when treatment with a standard bowel regimen has been ineffective.	9/12/2008

Policy Updates as of September 12, 2008		
Policy Name **(Click on policy name for link to policy)**	**Summary of Changes**	**Policy No.**
Amevive®, alefacept Policy update – no criteria changes	Medication policy reviewed and approved without criteria changes.	Dru088
Anzemet®, dolasetron Policy update – criteria changes	• Policy criteria updated to include granisetron in the list of generically available antiemetic agents. • Policy clarified to state that quantities exceeding 30 tablets per month are considered investigational (as opposed to not medically necessary, as was stated in previous policy version). • Position statement updated.	Dru069

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Policy Updates as of September 12, 2008		
Policy Name **(Click on policy name for link to policy)**	**Summary of Changes**	**Policy No.**
Betaseron®, interferon beta-1b Policy update – formatting changes	Policy reviewed and approved with updates to the position statement.	Dru108
Cimzia®, certolizumab pegol Policy update – no criteria changes	Policy reviewed and approved without criteria changes.	Dru160
Emend®, aprepitant Policy update – formatting changes	Policy reviewed and approved with revisions to the position statement.	Dru091
Enbrel®, etanercept Policy update – formatting changes	Policy reviewed an approved with minor formatting changes.	Dru035
Humira®, adalimumab Policy update – formatting changes	• List of investigational conditions updated to include Blau's Syndrome (familial juvenile systemic granulomatosis). • Position statement updated with minor formatting changes.	Dru081
Kineret®, anakinra Policy update – formatting changes	• Position statement updated with minor formatting changes. • Cross references and medical billing codes updated.	Dru049
Kytril®, granisetron Policy update – formatting changes	• Updated policy criteria by removing thiethylperazine from list of generically available antiemetic agents. • Position statement updated.	Dru068

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Policy Updates as of September 12, 2008		
Policy Name **(Click on policy name for link to policy)**	**Summary of Changes**	**Policy No.**
Medication Policy Manual Introduction Content Changes	• Clarified "Purpose of Manual" section to specify that medication policies are not intended to guarantee treatment results or outcomes. • "Selection of Medications for Policy Development" section updated to include medications that might be used off-label and medications that are controversial in terms of their health outcomes as eligible for the development of a medication policy. • "Medication Policy Dissemination" section update to include current web site links.	Dru150
Nexavar®, sorafenib Policy update – formatting changes	Policy reviewed and approved with revisions to the position statement.	Dru134
Orencia®, abatacept Policy update – criteria changes	• Policy updated to include coverage criteria for juvenile idiopathic arthritis (JIA). • Coverage criteria simplified and made consistent with Humira®, Remicade® and Enbrel® policies by removing requirement of prior treatment with a tumor necrosis factor inhibitor and replacing it with the requirement of prior treatment with an adequate course of methotrexate unless contraindicated or not effective. • Cross references and medical billing codes updated.	Dru129
Raptiva®, efalizumab Policy update –criteria changes	Reauthorization criteria simplified and made consistent with other psoriasis medication policies by removing requirement of clinical documentation of symptom improvement.	Dru104
Remicade®, infliximab Policy update – formatting changes	• Policy reviewed and approved with minor formatting changes. • Cross references updated.	Dru036

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Policy Updates as of September 12, 2008		
Policy Name **(Click on policy name for link to policy)**	**Summary of Changes**	**Policy No.**
Synagis®, palivizumab Policy update – formatting changes	• List of not medically necessary conditions updated to include patients undergoing stem cell transplantation; children with cystic fibrosis; and children with Prader-Willi Syndrome. • List of investigational conditions updated to include only prevention of RSV in adults.	Dru029
Tasigna®, nilotonib Policy updated – criteria changes	• Policy updated to include a quantity limitation of 120 of the 200 mg capsules per month. • Position statement and medical billing codes updated.	Dru151
Tykerb®, lapatinib Policy update – formatting changes	Policy reviewed and approved with updates to the position statement.	Dru145
Xyrem®, sodium oxybate Policy update – formatting changes	Policy reviewed an approved with updates to the position statement.	Dru093
Zofran®, ondansetron Policy update – formatting changes	• Policy simplified by removing reauthorization criteria and references to specific approvable quantities. • Position statement updated.	Dru046

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