

Medication Policies		
<p>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 <a href="http://www.regence.com/policy/medication/contents.html">http://www.regence.com/policy/medication/contents.html</a>. We have included the policy number for your convenience.</p>		
NEW POLICIES (PUBLISHED WITHIN THE LAST 6 MONTHS)		
Policy Name and Number  (Click on policy name for link to policy)	Summary of Policy	Effective Date
Aciphex <sup>®</sup> , rabeprazole (Medicare Part D Only)  Dru101_MedPtD	New policy maintaining previous coverage criteria of Aciphex. <u>Applies to Medicare Part D members only.</u>	3/18/2008
Kuvan <sup>™</sup> , sapropterin dihydrochloride  Dru152	New policy allowing coverage of Kuvan for treatment of phenylketonuria (PKU) when blood phenylalanine levels are not adequately controlled through diet alone.	3/18/2008
Luvox <sup>®</sup> 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 <sup>™</sup> , desvenlafaxine  Dru154	New policy allowing coverage of Pristiq following inadequate treatment with at least two generic or preferred brand antidepressants.	5/9/2008

**Policy Updates as of May 9, 2008**

<b>Policy Name</b> (Click on policy name for link to policy)	<b>Summary of Changes</b>	<b>Policy No.</b>
Actos <sup>®</sup> , pioglitazone-containing medications (Actos, ACTOplus Met <sup>®</sup> , Duetact <sup>™</sup> )  Policy update – formatting changes	Updated list of investigational conditions and position summary.	Dru131
Ambien <sup>®</sup> , zolpidem  Policy update – criteria changes	<ul style="list-style-type: none"> <li>• Due to availability of generic zolpidem, policy updated to remove criterion requiring prior therapy with one other insomnia treatment.</li> <li>• Position summary updated.</li> </ul>	Dru062
Ambien CR <sup>®</sup> , zolpidem MR  Policy update – formatting changes	Simplified reauthorization criteria and updated position summary.	Dru130
Aranesp <sup>®</sup> , darbepoetin  Policy update – criteria changes	<ul style="list-style-type: none"> <li>• Policy updated to include coverage criteria for myelodysplastic syndrome (consistent with coverage criteria for Epogen<sup>®</sup> and Procrit<sup>®</sup>, dru012).</li> <li>• Clarified criteria for coverage of Aranesp for chronic kidney disease.</li> <li>• Updated hematocrit levels for AZT-related anemia.</li> <li>• <u>Effective September 15, 2008</u>: Updated criteria for AZT-related anemia to require hematocrit less than 30%. Reauthorization criteria updated to require that the patient’s hemoglobin is less than 12 g/dL. (Click <a href="#">HERE</a> to view policy effective September 2008.)</li> </ul>	Dru076
Avandia <sup>®</sup> , rosiglitazone-containing medications (Avandia, Avandamet <sup>®</sup> , Avandaryl <sup>®</sup> )  Policy update – formatting changes	Updated list of investigational conditions and position summary.	Dru132

**Policy Updates as of May 9, 2008**

<b>Policy Name</b> (Click on policy name for link to policy)	<b>Summary of Changes</b>	<b>Policy No.</b>
Botox <sup>®</sup> , botulinum toxin type A  Policy update – criteria changes	<u>Effective October 1, 2008</u> : coverage criteria for migraine headaches removed. Botox will no longer be covered for treatment of migraine headaches. (Click <a href="#">HERE</a> to view policy effective October 2008.)	Dru006
Byetta <sup>®</sup> , exenatide  Policy update – criteria changes	Updated criteria to cover Byetta when metformin and one other preferred medication has been ineffective in controlling A1c.	Dru120
Cymbalta <sup>®</sup> , duloxetine  Policy update – formatting changes	Updated positions summary, cross references, and Appendix 2 listing the FDA approved indications for available antidepressants.	Dru147
Effexor XR <sup>®</sup> , venlafaxine extended-release capsules  Policy update – formatting changes	Updated positions summary, cross references, and Appendix 2 listing the FDA approved indications for available antidepressants.	Dru146
Epogen <sup>®</sup> , Procrit <sup>®</sup> , epoetin alfa  Policy update – criteria changes	<ul style="list-style-type: none"> <li>• Clarified criteria for coverage of Epogen/Procrit for chronic kidney disease.</li> <li>• Updated hematocrit levels for AZT-related anemia.</li> <li>• <u>Effective September 15, 2008</u>: Updated criteria for AZT-related anemia to require hematocrit less than 30%. Reauthorization criteria updated to require that the patient’s hemoglobin is less than 12 g/dL. (Click <a href="#">HERE</a> to view policy effective September 2008.)</li> </ul>	Dru012
Infergen <sup>®</sup> , interferon alfacon-1  Policy update – no criteria changes	Policy approved without revisions.	Dru115

**Policy Updates as of May 9, 2008**

<b>Policy Name</b> (Click on policy name for link to policy)	<b>Summary of Changes</b>	<b>Policy No.</b>
IVIG, intravenous immunoglobulins (Carimune NF <sup>®</sup> , Gammagard S/D <sup>®</sup> , Gamunex <sup>®</sup> , Provigen <sup>®</sup> , Flebogamma <sup>®</sup> , Gamastan <sup>®</sup> , Iveegam <sup>®</sup> , Polygam S/D <sup>®</sup> , Baygam <sup>®</sup> , Octagam <sup>®</sup> , Vivaglobin <sup>®</sup> )  Policy update – criteria changes	<ul style="list-style-type: none"> <li>• Policy title updated to include both intravenous and subcutaneous immune globulin replacement products.</li> <li>• Simplified coverage criteria for multifocal motor neuropathy by removing requirement of prior conventional treatment.</li> </ul>	Dru020
Januvia <sup>®</sup> , sitagliptin  Policy update – formatting changes	<ul style="list-style-type: none"> <li>• Policy name updated to apply to both Januvia and Janumet<sup>®</sup>.</li> <li>• Updated list of investigational conditions and position summary.</li> </ul>	Dru140
Lexapro <sup>®</sup> , escitalopram  Policy update – formatting changes	Updated positions summary, cross references, and Appendix 2 listing the FDA approved indications for available antidepressants.	Dru148
Lunesta <sup>®</sup> , eszopiclone  Policy update – formatting changes	Simplified reauthorization criteria.	Dru114
Paxil CR <sup>®</sup> , paroxetine  Policy update – formatting changes	Updated positions summary, cross references, and Appendix 2 listing the FDA approved indications for available antidepressants.	Dru149
Pegasys <sup>®</sup> , peginterferon alfa-2a  Policy update – formatting changes	Updated list of investigational conditions and position summary.	Dru044
PEG-Intron <sup>®</sup> , peginterferon alfa-2b  Policy update – formatting changes	Updated list of investigational conditions and position summary.	Dru144

**Policy Updates as of May 9, 2008**

<b>Policy Name</b> (Click on policy name for link to policy)	<b>Summary of Changes</b>	<b>Policy No.</b>
Rozerem™, ramelteon  Policy update – formatting changes	<ul style="list-style-type: none"> <li>• Simplified reauthorization criteria.</li> <li>• Updated position summary.</li> </ul>	Dru124
Sonata®, zaleplon  Policy update – formatting changes	<ul style="list-style-type: none"> <li>• Due to availability of generic zaleplon, removed criteria requiring prior treatment with one other insomnia medication.</li> <li>• Updated position summary.</li> </ul>	Dru061
Symlin®, pramlintide  Policy update – criteria changes	<ul style="list-style-type: none"> <li>• Policy updated to require concomitant treatment with insulin.</li> <li>• Quantity limitations updated to reflect new dosage forms.</li> </ul>	Dru121