January 2022

Cigna pharmacy clinical update

Plan affordability is a strategic imperative for Cigna – which means a hyper-focus on specialty drug utilization under both medical and pharmacy benefits. This also includes using our low net drug cost approach to remove or manage certain high-priced, low-value drugs where clinically appropriate alternatives are available – regardless of drug company incentives or rebates. For January 2022, we have made a number of changes to achieve better drug affordability and improved pharmacy plan performance for clients.

January 2022 clinical drug changes[1]

Our latest comprehensive drug review and actions span across medical and pharmacy drug utilization to promote appropriate and cost-effective medication use and expanded choice that encourages preferred alternatives. They include:

Specialty drugs – medical benefit

Encouraging use of preferred agents, biosimilars and site-of-care management for conditions such as immunodeficiency and pulmonary hypertension, in addition to supportive treatments for cancer patients and transplant recipients

Specialty drugs – pharmacy benefit

Promoting lower costs and better adherence to drive improved health for conditions including HIV, multiple sclerosis (MS) and cancer

Non-specialty drugs

Encouraging appropriate use and lower-cost alternatives for conditions including hypothyroidism, ADHD, asthma/COPD and diabetes

Egregiously priced drugs

Removing 33 high-cost, low-value drugs where clinically appropriate alternatives are available

Non-FDA-approved drugs

Excluding 72 drugs that are not approved by the U.S. Food and Drug Administration

Preventive drugs

For clients that adopt Cigna's Preventive Drug List, removing 106 drugs to promote lower-cost options (e.g., generics)

Positive changes

Improving access to and affordability of drugs for conditions such as high cholesterol, asthma and obesity

Continuous glucose monitor (CGM) change

Ending program that offers Dexcom G6® transmitter at no cost ($0); customers will pay pharmacy plan's preferred-brand copay or coinsurance, and/or customers will pay pharmacy plan's preferred-brand copay, coinsurance and/or deductible

Together, these actions impact less than 1% of membership and achieve an average savings of...[2]

$2.83 PMPM[3]

> $2.28 PMPM pharmacy benefit

> $0.55 PMPM medical benefit

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Summary of January 1, 2022, formulary changes

Below are examples of drug classes targeted as part of our clinical review changes process for January 2022.

Changes apply to Cigna's Standard, Performance, Value and Advantage formularies and span across medical and pharmacy benefits, as noted. These highlights do not reflect the entire list of Cigna's January 2022 drug changes. For drug-specific changes, please request a customer formulary change flyer.

Specialty drugs – medical benefit

- **Immunoglobulins** – Primary immunodeficiency
  Goal: Drive affordability in this drug class
  - Precertification criteria will require trial of preferred products, Gamunex-C, Gammaked, Gammaplex, Flebogamma, Octagam, Privigen, or Hizentra, before non-preferred products are approved for coverage
  - Allowing current authorizations to expire for current users of non-preferred agents to limit disruption

- **Pegfilgrastim** – Neutropenia (during cancer treatment)
  Goal: Management of biosimilar options to drive greater affordability
  - Udenyca moving to non-preferred status; Ziextenzo moving to preferred-brand status
  - Both medical and pharmacy benefits require use of preferred agents first
  - Allowing current prior authorizations (PA) to expire; those with three-tier pharmacy benefits may have cost-share change

- **Remodulin** – Pulmonary arterial hypertension
  Goal: Affordability through use of generics
  - Approval will require use of generic equivalent treprostinil
  - We will be limiting the impact to customers by creating proactive authorization of generic for current users of Remodulin

- **Belatacept** – Transplant therapy
  Goal: Affordability through site-of-care guidance
  - Guidance to clinically appropriate, cost-effective site of care
  - Pharmacy: adding specialty PA for Performance and Advantage formularies

- **Monoferric, Injectafer, Feraheme** – Iron replacement
  Goal: Affordability through utilization management
  - Coverage approval will require embedded step through Venofer (does not apply to dialysis-dependent chronic kidney disease)
  - Pharmacy: adding specialty prior authorization with embedded step for Performance and Advantage formularies

Specialty drugs – pharmacy benefit

- **Symfi, Symfi Lo, Kaletra, Atripla, Emtriva, Intelence** – HIV treatment
  Goal: Continuing to leverage generics in HIV drug class to lower cost and promote adherence
  - Moving these multisource brands to non-covered status[4] – preferring generics

- **Tasigna, Bosulif and Iclusig** – Chronic myeloid leukemia (CML) treatment
  Goal: Driving affordability through oncology pathways for CML
  - Tasigna moving to non-preferred brand with specialty prior authorization, with embedded step through imatinib or Sprycel for new starts only
  - Bosulif and Iclusig coverage to require step through imatinib or Sprycel for new starts only

- **22 single-source branded drugs** – MS treatment
  Goal: Continue to leverage generics for MS to lower cost and promote adherence
  - Oral, injectable and infused MS products will include a specialty PA that will require use of generic Tecfidera before being considered for coverage
  - For new starts only

Non-specialty drugs – pharmacy benefit

- **Synthroid** – hypothyroidism
  Goal: Encourage use of generics to drive affordability
  - Moving to non-covered status[4]

- **Mydayis** – ADHD treatment
  Goal: Positive change to offer additional access to treatment with appropriate use by age
  - Moving to preferred-brand tier with quantity limit for Standard and Performance formularies
  - Age prior authorization for clients that adopted Cigna Complete UM package

- **Perforomist, Brovana[4]** – Asthma/COPD
  Goal: Promote newly preferred agents to drive lower cost
  - Moving to non-covered status
  - Spiriva and Stiolto moved to preferred brand to allow better drug access

Diabetes drugs

Goal: Repositioned our preferred products and narrowed class to drive affordability – Metformin prerequisite still applies where applicable

- **Insulin Lispro, Novolog, Fiasp[4]**
  - These non-covered insulins will now also have non-preferred cost-share when approved for medical necessity, when applicable[1]

- **Trulicity, Rybelsus, Ozempic, Victoza, Byetta, Bydureon**
  - Implementing PA with confirmation of type 2 diabetes diagnosis to prevent off-label use for weight loss

- **Invokana, Invokamet XR, Steglatro, Segluromet[4]**
  - Moving to non-covered status (Invokana, Invokamet – Standard and Performance formularies only)[1]

Egregiously priced drugs

Goal: Lower overall claims costs by removing drugs with hyperinflated costs from our formularies, regardless of drug company incentives

- 33 drugs including Edarbi, Edarbyclor and Multaq

Positive additions and criteria changes

Goal: Greater access and affordability for a variety of conditions

- Saxenda (obesity), Dupixent (eosinophilic asthma, eczema), Aubagio (MS), Repatha (cholesterol), Ingrezza (tardive dyskinesia), Linzess (chronic constipation)

Customer communications

Less than 1% of customers will be affected by these changes.[1]

We will send letters and emails to impacted customers in early October 2021. Reminder notifications will release in early November and again in January 2022. Other materials are available at client request, such as formulary-specific flyers for customers and formulary PDFs.

Health care provider communications

To build awareness and help providers talk with their patients, we will:

- Send patient-specific letters to affected providers that outline key formulary changes and covered drug alternatives.
- Post information on our provider portal.
- Article in provider newsletter.

Our priority is to maintain affordability for our clients and customers now and in the future. We will continue to make clinical drug enhancements across medical and pharmacy benefits to help drive sustainable cost savings and improve medication adherence and health outcomes.

1. Utilization management changes are for clients that have adopted Essential, Complete or Limited UM package. State laws in Texas and Louisiana may require your plan to cover your medication at your current benefit level until your plan renews. This means that if your medication is taken off the drug list, is moved to a higher cost-share tier or needs approval from Cigna before your plan will cover it, these changes may not begin until your plan's renewal date. State law in Illinois may require your plan to cover your medications at your current benefit level until your plan renews. This means that if you currently have approval through a review process for your plan to cover your medication, the drug list change(s) listed here may not affect you until your plan renewal date. If you don't currently have approval through a coverage review process, you may continue to receive coverage at your current benefit level if your doctor requests it.
2. Cigna's National Book of Business estimate of customers disrupted by 1/1/22 formulary changes.
3. For clients using Standard, Performance, Value or Advantage formularies. Cigna National Book of Business pricing analysis estimating value of January 2022 drugs under medical benefit, under pharmacy benefit (formulary) and UM changes (for clients that adopt Cigna's UM packages or Cigna specialty UM). Results may vary.
4. If a customer and/or prescriber believes any of the products that will no longer be covered as preferred options are medically necessary, then Cigna will review requests for a medical necessity exception.

This document is intended to provide current information as of the time it was published. It does not supersede contractual obligations and other detailed plan documents or contracts. This information is subject to change.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, the customer may be required to use an in-network pharmacy to fill the prescription or the prescription may not be covered or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements.

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