Provider Update

Quarterly Pharmacy Formulary Change Notice

Summary of Change: The formulary changes listed in the table below were reviewed and approved at our December 18, 2014 Value Assessment Committee (VAC) meeting.

✦ **What this means to you:** Effective April 1, 2015 the changes outlined below apply to all Amerigroup† patients.

What is the impact of this change?

Effective for all patients on April 1, 2015			
Therapeutic Class	**Medication**	**Formulary Status Change**	**Alternatives**
ANTIEMETICS	ALOXI PALONOSETRON	REQUIRES PRIOR AUTHORIZATION (PA)	N/A
ANTI-DIABETIC AGENTS	INVOKAMET	ADD STEP THERAPY (ST) AND QUANTITY LIMIT (QL)	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR, ONGLYZA OR BYETTA AND VICTOZA
	XIGDUO XR	ADD ST AND QL	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR, ONGLYZA OR BYETTA AND VICTOZA
	JARDIANCE	ADD ST AND QL	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR, ONGLYZA OR BYETTA AND VICTOZA
	TRULICITY	ADD ST AND QL	BYETTA OR VICTOZA
ANTI-INFECTIVES	ACTICLATE	ST	GENERIC IR MINOCYCLINE OR DOXYCYCLINE MONOHYDRATE (CAPSULES)
ANTIEMETICS	ALOXI PALONOSETRON	REQUIRES PRIOR AUTHORIZATION (PA)	N/A
ANTI-DIABETIC AGENTS	INVOKAMET	ADD STEP THERAPY (ST) AND QUANTITY LIMIT (QL)	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR, ONGLYZA OR BYETTA AND VICTOZA

	XIGDUO XR	ADD ST AND QL	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR, ONGLYZA OR BYETTA AND VICTOZA
	JARDIANCE	ADD ST AND QL	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR, ONGLYZA OR BYETTA AND VICTOZA
	TRULICITY	ADD ST AND QL	BYETTA OR VICTOZA
ANTI-INFECTIVES	ACTICLATE	ST	GENERIC IR MINOCYCLINE OR DOXYCYCLINE MONOHYDRATE (CAPSULES)
	ATOVAQUONE 750MG/5ML SUSP	NON-PREFERRED WITH PA ALL CURRENT UTILIZERS TO BE GRANDFATHERED	N/A
	CEFDINIR CAPSULES AND SUSPENSION	QL	
	CIPROFLOXACIN ER TABS	QL	
	CIPROFLOXACIN ORAL SUSPUSPENSION	QL	
	FACTIVE	QL	
	NOROXIN	QL	
	XIFAXAN	QL	
	XYREM	QL	
	QUININE SULFATE	PA AND QL	N/A
ANTINEOPLASTICS	THALOMID	NON-PREFERRED WITH PA	N/A
	REVLIMID	NON-PREFERRED WITH PA	N/A
	OFEV	QL	
	ONCAPSAR	PA	N/A

	ERWINAZE	PA	N/A
	KEYTRUDA	PA	N/A
	ONCASPSAR	PA	N/A
	ERWINAZE	PA	N/A
	TAXOTERE (DOCETAXEL) PRIOR AUTHORIZATION	PA	N/A
	ALIMTA (PEMETREXED) PRIOR AUTHORIZATION	PA	N/A
	VELCADE (BORTEZOMIB) PRIOR AUTHORIZATION	PA	N/A
ANTIVIRAL COMBINATIONS	TRIUMEQ	PREFERRED	
CENTRAL NERVOUS SYSTEM AGENTS	AKYNZEO	QL	
	TARGINIQ	QL	
	BELSOMRA	QL	
CONTRACEPTIVES	ALL- ORAL, INJECTABLE AND TOPICAL	AGE LIMIT (AL)	
ELECTROLYTES	CERALYTE 50 LIQ/PEDIALYTE	QL	
IMMUNOLOGIC AGENTS	ESBRIET	QL	
METABOLIC AGENTS	FABRAZYME	QL REMOVED	
METABOLIC AGENTS	CERDELGA	PA	N/A
MISC COAGULATION MODIFIERS	ANTIHEMOPHILIC FACTOR VIIA RECOMBINANT	PA	N/A

	COAGULATION AGENTS-NOVOSEVEN RT		
	ANTIHEMOPHILIC FACTOR (FACTOR VIII) HUMAN PLASMA-DERIVED AGENTS-HEMOFIL M, KOĀTE-DVI, MONOCLATE-P	PA	N/A
	ANTIHEMOPHILIC FACTOR (FACTOR VIII) RECOMBINANT AGENTS-ADVATE, HELIXATE FS, KOGENATE FS, NOVOEIGHT, RECOMBINATE, XYNTHA	PA	N/A
	ANTIHEMOPHILIC FACTOR (RECOMBINANT), PORCINE SEQUENCE AGENTS -OBIZUR	PA	N/A
	ANTIHEMOPHILIC FACTOR VIII/VON WILLEBRAND FACTOR COMPLEX AGENTS-ALPHANATE, HUMATE-P, WILATE	PA	N/A
	COAGULATION FACTOR IX HUMAN PLASMA-DERIVED AGENTS-ALPHANINE SD, MONONINE	PA	N/A
	FACTOR IX COMPLEX, HUMAN PLASMA-DERIVED AGENTS-BEBULIN,	PA	N/A

	PROFILNINE SD		
	FACTOR XIII AGENTS-CORIFACT, TRETTEN	PA	N/A
	FIBRINOGEN CONCENTRATE HUMAN PLASMA-DERIVED AGENTS-RIASTAP	PA	N/A
	FIBRINOGEN CONCENTRATE HUMAN PLASMA-DERIVED AGENTS-RIASTAP	PA	N/A
	ELOCTATE [RECOMBINANT ANTIHEMOPHILIC FACTOR, FC FUSION PROTEIN (RFVIIIFC)	PA	N/A
	FACTOR IX RECOMBINANT AGENTS-BENEFIX, RIXUBIS	PA	N/A
NEUROLOGICAL AGENTS	RILUTEK	PA	N/A
OPHTHALMIC	NAPHAZOLINE SOL 0.1%	QL	
	TRAVATAN DROPS 0.004%	QL	
OVERACTIVE BLADDER AGENTS	TOLTERODINE TARTRATE	PREFERRED	
	TOLTERODINE TARTRATE ER	PREFERRED	
	TROSPIUM CHLORIDE	PREFERRED	
	TROSPIUM CHLORIDE ER	PREFERRED	
RESPIRATORY AGENT	SPIRIVA RESPIMAT	PREFERRED WITH QL	

	STRIVERDI RESPIMAT	QL	
	INCRUSE ELLIPTA	QL	
	ARNUITY ELLIPTA	QL	
	AEROSPAN 80MCG INHALER	PREFERRED	
SELECT ANDROGEN AGENTS	VOGELXO	PA AND QL	N/A
	TESTOSTERONE GEL/PUMP	PA AND QL	N/A
TOPICAL ANTIFUNGALS	JUBLIA	PA AND QL	ORAL ITRACONAZOLE AND TERBINAFINE
	KERYDIN 5%	PA AND QL	ORAL ITRACONAZOLE AND TERBINAFINE

What action do I need to take?
Please review these changes and work with your Amerigroup patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

What if I need assistance? We recognize the unique aspects of patients' cases. If for medical reasons your Amerigroup patient cannot be converted to a formulary alternative, call our Pharmacy department at 1-800-454-3730 and follow the voice prompts for pharmacy prior authorization. You can find the preferred drug list on our site.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

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†In Louisiana, Amerigroup Louisiana, Inc.; In Washington, Amerigroup Washington.