

Quarterly pharmacy formulary change notice

Summary: The formulary changes listed in the table below were reviewed and approved at our third quarter 2020 Pharmacy and Therapeutics Committee meeting.

Effective February 1, 2021, the changes outlined below apply to all Amerigroup Community Care patients. Please remember to read the footnotes at the end of the table.

EFFECTIVE FOR ALL PATIENTS ON FEBRUARY 1, 2021			
Therapeutic class	Drug	Revised status	Potential alternatives
TOPICAL CORTICOSTEROIDS	FLUOCINONIDE CREAM 0.05% FLUOCINONIDE GEL 0.05% FLUOCINONIDE OINTMENT 0.05% FLUOCINONIDE SOLUTION 0.05% TRIAMCINOLONE LOTION 0.025% CORTISONE GEL 1% HYDROCORT LOTION 1% AND 2.5% TRIAMCINOLONE LOTION 0.1% AND 0.025% DESONATE GEL 0.05%	PREFERRED	N/A
	AMCINONIDE LOTION 0.1% DIFLORASONE CREAM 0.05% TRIAMCINOLON OINTMENT 0.05% TRIANEX OINTMENT 0.05% PREDNICARBAT OINTMENT 0.1%	NON-PREFERRED	FLUOCINONIDE CREAM 0.1% FLUOCINONIDE GEL 0.05% FLUOCINONIDE OINTMENT 0.05% FLUOCINONIDE SOLUTION 0.05% TRIAMCINOLONE OINTMENT 0.1% TRIAMCINOLON OINTMENT 0.025% FLUTICASONE CREAM 0.05% TRIAMCINOLONE LOTION 0.025% CORTISONE GEL 1% HYDROCORT LOTION 1% AND 2.5% TRIAMCINOLONE LOTION 0.1% AND 0.025% DESONATE GEL 0.05%
ANTISPASMODICS	GLYCOPYRROLATE TAB 1.5MG	NON-PREFERRED	GLYCOPYRROLATE TAB 1MG GLYCOPYRROLATE TAB 2MG
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	AIMOVIG INJ 140MG/ML AIMOVIG INJ 70MG/ML EMGALITY INJ 100MG/ML EMGALITY INJ 120MG/ML	PREFERRED WITH PA	N/A
	AJOVY INJ 225/1.5 VYEPTI INJ 100MG/ML	NON-PREFERRED WITH PA	AIMOVIG INJ 140MG/ML AIMOVIG INJ 70MG/ML EMGALITY INJ 100MG/ML EMGALITY INJ 120MG/ML

	NURTECTAB 75MG ODT	PREFERRED	N/A
	UBRELVY TAB 50MG UBRELVY TAB 100MG	NON-PREFERRED	NURTECTAB 75MG ODT
SEROTONIN AGONISTS	REYVOW TAB 50MG REYVOW TAB 100MG	NON-PREFERRED	NARATRIPTAN TAB SUMATRIPTAN TAB
MULTIPLE SCLEROSIS AGENTS	OCREVUS INJ 300/10ML KESIMPTA INJ 20/.4ML	NON-PREFERRED	DIMETHYL FUM CAP 120MG DR DIMETHYL FUM CAP 240MG DR DIMETHYL FUM MIS STARTER
	DIMETHYL FUM CAP 120MG DR DIMETHYL FUM CAP 240MG DR DIMETHYL FUM MIS STARTER	PREFERRED	N/A
ACNE PRODUCTS	RX ADAPALENE GEL 0.1% (DIFFERIN)	EXCLUDED	OTC ADAPALENE GEL 0.1%
	RX BENZACAC WASH 5%	EXCLUDED	OTC BENZOYL PEROXIDE WASH
ALLERGY PRODUCTS	RX CETIRIZINE SOLN 1MG/ML	EXCLUDED	OTC CETIRIZINE SOLN 1MG/ML (PA REQUIRED)
	RX DIPHENHYDRAMINE ELIXIR 12.5/5ML	EXCLUDED	OTC DIPHENHYDRAMINE ELIXIR 12.5/5ML
	RX FLUTICASONE NASAL SPRAY 50MCG (FLONASE) TRIAMCINOLONE NASAL 55MCG/AC	EXCLUDED	OTC FLUTICASONE NASAL SPRAY 50MCG OTC TRIAMCINOLONE NASAL 55MCG/ACB
	RX LEVOCETIRIZINE 5 MG TAB RX LEVOCETIRIZINE SOLN 2.5/5ML	EXCLUDED	OTC LEVOCETIRIZINE 5 MG TAB XYZAL 24HR SOL 2.5/5ML (PA REQUIRED)
	RX OLOPATADINE OPHTH SOLN 0.1% AND 0.2% (PATADAY)	EXCLUDED	OTC OLOPATADINE OPHTH SOLN 0.1% AND 0.2%
ANTI-INFLAMMATORY (TOPICAL)	RX DICLOFENAC GEL 1% (VOLTAREN)	EXCLUDED	OTC DICLOFENAC GEL 1%
ULCER DRUGS	RX CIMETIDINE TAB	EXCLUDED	OTC CIMETIDINE 200 MG TAB
	RX FAMOTIDINE 20MG TAB	EXCLUDED	OTC FAMOTIDINE 20MG TAB
	RX LANSOPRAZOLE 15MG CAP/ODT (PREVACID)	EXCLUDED	OTC LANSOPRAZOLE 15MG CAP/ODT
	RX ESOMEPRAZOLE MAG 20MG CAP (NEXIUM)	EXCLUDED	OTC ESOMEPRAZOLE MAG 20 MG CAP
	RX OMEPRAZOLE 20MG CAP FOR PATIENTS 6 YEARS OF AGE AND OLDER	EXCLUDED	OTC OMEPRAZOLE 20 MG CAP
	RX OMEPRAZOLE/BICARB CAP 20-1100MG (ZEGERID)	EXCLUDED	OTC ZEGERID 20-1100MG CAP

URINARY ANTISPASMODICS	OXYTROL PATCH (RX)	EXCLUDED	OTC OXYTROL/WOMN DIS 3.9MG/24
HEMATOPOIETIC GROWTH FACTORS	FULPHILA	NON-PREFERRED	NEULASTA NEULASTA ONPRO UDENYCA
	UDENYCA	PREFERRED	N/A
CONTRACEPTIVES	CAYA DIAPHRAGM OMNIFLEX DIAPHRAGM	PREFERRED	N/A
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN FEBRUARY 1, 2021 <i>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>			
ACNE AGENTS	WINLEVI 1% CREAM*		ADD PA ADD QL: 60 GM PER 30 DAYS
ADRENAL STEROID INHIBITORS	ISTURISA TAB 1MG ISTURISA TAB 5MG	1 MG, 5 MG TABS: 4 TABS PER DAY (2 CARTONS IN 30 DAYS)	ADD PA ADD QL:
	ISTURISA TAB 10MG		ADD PA ADD QL: 6 TABLETS PER DAY (3 CARTONS IN 30 DAYS)
ALKYLATING AGENTS	ZEPZELCA SOL 4MG		ADD PA
ANTI-CATALECTIC AGENTS	XYWAV SOL 0.5GM/ML		ADD PA ADD QL: 18 ML PER DAY
ANTICONVULSANTS	FINTEPLA SOL 2.2MG/ML		ADD PA ADD QL: 26 MG PER DAY
	VALTOCO SPR 5MG VALTOCO SPR 10MG VALTOCO LIQ 15MG VALTOCO LIQ 20MG		UPDATE QL: 10 BLISTER PACKS PER 30 DAYS*
	XCOPRI TITRATION PAK XCOPRI MAINTENANCE PAK		UPDATE QL: 1 BLISTER PACK FOR 28 DAYS
	XCOPRI TAB 50MG XCOPRI TAB 100MG XCOPRI TAB 150MG		UPDATE QL: 1 TABLET PER DAY
	XCOPRI TAB 200MG		UPDATE QL: 2 TABLETS PER DAY
	ZONEGRAN CAP 25MG ZONEGRAN CAP 100MG		UPDATE QL: 6 CAPSULES PER DAY
	LAMOTRIGINE KIT START 35 (BLUE) SUBVENITE KIT START 35 (BLUE)		UPDATE QL: 1 KIT PER 28 DAYS
	LAMOTRIGINE KIT START 49 (ORANGE) SUBVENITE KIT START 49 (ORANGE) LAMOTRIGINE KIT START 98 (GREEN) SUBVENITE KIT START 98 (GREEN)		UPDATE QL: 1 KIT PER 35 DAYS

ANTIMETABOLITES	ONUREG TAB 200MG ONUREG TAB 300MG	ADD PA ADD QL: 14 TABLETS PER 28 DAYS
ANTINEOPLASTIC	KEYTRUDA INJ 100MG/4M	ADD QL: 4 VIALS PER 6 WEEKS
	BLENREP INJ 100MG	ADD PA
	MONJUVI INJ 200MG	ADD PA
	XPOVIO PAK 40MG ONCE WEEKLY XPOVIO PAK 40MG TWICE WEEKLY XPOVIO PAK 60MG TWICE WEEKLY	ADD QL: 1 CARTON PER 28 DAYS OR 1 BLISTER PACK PER 7 DAYS
	PHESGO SOL 80 MG-40 MG-2000 UNT/ML PHESGO SOL 60 MG-60 MG-2000 UNT/ML	ADD PA ADD QL: 80MG-40MG-2000UNIT/ML: 1 VIAL PER 42 DAYS 60MG-60MG-2000UNIT/ML: 1 VIAL PER 21 DAYS
	INQOVI TAB 35-100MG	ADD PA ADD QL: 1 CARTON/BLISTER (5 TABLETS) PER 28 DAYS
	GAVRETO CAP 100MG	ADD PA ADD QL: 4 CAPSULES PER DAY
ANTIPARKINSON	ONGENTYS CAP 50MG	ADD PA ADD QL: 1 CAPSULE PER DAY
	OSMOLEX ER TAB 322 MG DOSING KIT	ADD QL: 2 TABLETS PER DAY
	KYNMOBI MIS 10MG KYNMOBI MIS 15MG KYNMOBI MIS 20MG KYNMOBI MIS 25MG KYNMOBI MIS 30MG	ADD PA ADD QL: 5 FILMS PER DAY
	AMANTADINE SYP 50MG/5ML	ADD QL: 40ML PER DAY
ANTIRETROVIRALS	RUKOBIA TAB 600MG ER	ADD PA ADD QL: 2 TABLETS PER DAY
	TIVICAY PD TAB 5MG	ADD QL: 12 TABLETS PER DAY
	TIVICAY TAB	UPDATE QL: 4 TABLETS PER DAY
	DOVATO TAB 50-300MG	REMOVE PA
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	AJOVY INJ 225/1.5	ADD ST
	VYEPTI INJ 100MG/ML	ADD ST
	UBRELVY TAB 50MG	ADD ST

CENTRAL MUSCLE RELAXANTS	CHLORZOXAZONE TAB	ADD QL: 4 TABLETS PER DAY
	METAXALONE TAB	ADD QL: 4 TABLETS PER DAY
	OZOBAX SOL 5MG/5ML	ADD QL: 80ML PER DAY
	CYCLOBENZAPR TAB 5MG	ADD QL: 3 TABLETS PER DAY
	FEXMID TAB 7.5MG	ADD QL: 3 TABLETS PER DAY
CONTRACEPTIVES	DEPO-PROVERA INJ 150MG/ML	ADD QL: 1 INJECTION (1 ML) PER 3 MONTHS
	TWIRLA DIS 120-30	3 PATCHES PER 28 DAYS
DIABETICSUPPLIES	MINIMED 630G KIT INSULIN	ADD QL: 1 PUMP PER YEAR
	MINIMED 670G MIS INS PUMP	ADD QL: 1 PUMP EVERY 4 YEARS
	OMNIPOD PDM OMNIPOD DASH PDM	ADD QL: 1 PDM EVERY 4 YEARS
	OMNIPOD POD OMNIPOD DASH POD	ADD QL: 15 PODS PER 30 DAYS
	T:SLIM X2 MIS	ADD QL: 1 PUMP EVERY 4 YEAEERS
	INSULIN INFUSION PUMP SUPPLIES	ADD QL: 15 INFUSION SETS/RESERVOIRS PER 30 DAYS
	DEXCOM G5 MIS RECEIVER DEXCOM G6 MIS RECEIVER	ADD QL: 1 PER YEAR
	DEXCOM G5 MIS TRANSMIT DEXCOM G6 MIS TRANSMIT	ADD QL: 1 PER 90 DAYS
	DEXCOM G5 MIS SENSOR	ADD QL: 5 PER 30 DAYS
	DEXCOM G6 MIS SENSOR	ADD QL: 3 PER 30 DAYS
	FREESTY LIBR MIS 2 READER	ADD QL: 1 PER YEAR
	FREESTY LIBR KIT 2 SENSOR	ADD QL: 2 PER 28 DAYS
	GUARDIAN CON MIS TRANSMIT	ADD QL: 2 PER YEAR
	GUARDIAN MIS SENSOR 3	ADD QL: 5 PER 30 DAYS
	EVERSENSE MIS TRANSMTR	ADD QL: 1 PER YEAR
	DERMATOLOGICALS	COSENTYX PEN INJ 300 DOSE COSENTYX INJ 300 DOSE

	COSENTYX PEN INJ 150MG/ML COSENTYX INJ 150MG/ML	1 PEN/SYRINGE PER 28 DAYS
ECZEMA AGENT	DUPIXENT INJ 300/2ML	ADD QL: 2 PENS PER 28 DAYS
GLUCOCORTICOSTEROIDS	ZILRETTA INJ 32MG	ADD PA ADD QL: 1 INJECTION PER LIFETIME
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ	ADD QL: 4 SYRINGES/VIALS PER 28 DAYS
	EPOGEN INJ 2000/ML EPOGEN INJ 3000/ML EPOGEN INJ 4000/ML EPOGEN INJ 10000/ML	ADD QL: 12 VIALS PER 28 DAYS
	EPOGEN INJ 20000/ML	ADD QL: 24 VIALS PER 28 DAYS
	EPOGEN INJ 20000/2 ML MULTI-DOSE VIAL	ADD QL: 6 VIALS PER 28 DAYS
	MIRCERA INJ/SOL	ADD QL: 2 SYRINGES PER 28 DAYS
	PROCRIT INJ 2000/ML PROCRIT INJ 3000/ML PROCRIT INJ 4000/ML PROCRIT INJ 10000/ML PROCRIT INJ 20000/ML PROCRIT INJ 40000/ML	ADD QL: 12 VIALS PER 28 DAYS
	PROCRIT INJ 20000/2 ML MULTI DOSE VIAL	ADD QL: 6 VIALS PER 28 DAYS
	RETACRIT INJ 2000UNIT RETACRIT INJ 3000UNIT RETACRIT INJ 4000UNIT RETACRIT INJ 10000UNT RETACRIT INJ 20000UNT RETACRIT INJ 40000UNT	ADD QL: 12 VIALS PER 28 DAYS
	RETACRIT INJ 20000UNT/2 ML MULTI-DOSE VIAL	ADD QL: 6 VIALS PER 28 DAYS
	NYVEPRIA 6 MG/0.6 ML PREFILLED SYRINGE*	ADD PA ADD QL: 2 SYRINGES
IMMUNOSUPPRESSIVE AGENTS	ENSPRYNG INJ	ADD PA ADD QL: 1 SYRINGE PER 28 DAYS
INTERLEUKIN-1BETA BLOCKERS	ILARIS INJ 150MG/ML	UPDATE QL: 2 VIALS PER 28 DAYS
METABOLIC MODIFIERS	PALYNZIQ INJ 2.5/0.5 PALYNZIQ INJ 10/0.5ML PALYNZIQ INJ 20MG/ML	UPDATE QL: 1 SYRINGE PER DAY

MOVEMENT DISORDER DRUG THERAPY	XENAZINE TAB 12.5MG	ADD QL: 8 TABLETS PER DAY
	XENAZINE TAB 25MG	ADD QL: 4 TABLETS PER DAY
MULTIPLE SCLEROSIS AGENTS	KESIMPTA INJ 20/.4ML	ADD PA ADD QL: 1 SYRINGE PER 28 DAYS
	BAFIERTAM CAP 95MG	ADD PA ADD QL: 4 CAPSULES PER DAY
	COPAXONE INJ 40MG/ML PF SYR GLATOPA INJ 40MG/ML PF SYR	ADD QL: 12 SYRINGES PER 28 DAYS
	PLEGRIDY PEN INJ STARTER PLEGRIDY INJ STARTER	ADD QL: 1 PACK (1 ML) PER FILL, ONE TIME FILL (28 DAY SUPPLY)
	PLEGRIDY INJ PEN PLEGRIDY INJ	ADD QL: 2 PENS/SYRINGES PER 28 DAYS
	REBIF INJ 22/0.5 REBIF INJ 44/0.5 REBIF REBIDO INJ 22/0.5 REBIF REBIDO INJ 44/0.5	ADD QL: 12 SYRINGES/AUTOINJECTORS PER 28 DAYS
	REBITITRTN INJ PACK REBIF REBIDO INJ TITRATN	ADD QL: 1 PACK (4.2 ML) PER FILL, ONE TIME FILL (28 DAY SUPPLY)
OPHTHALMICS - MISC.	CYSTARAN SOL 0.44%	ADD QL: 60 ML PER 28 DAYS
	PATADAY SOL (OTC)	ADD QL: 1 BOTTLE (5 ML, 2.5 ML) PER 30 DAYS
	BEPREVE DRO 1.5%	ADD QL: 5 ML BOTTLE: 1 BOTTLE PER 30 DAYS
	KETOTIFEN FUM DRO 0.025%OP	ADD QL: 10 ML BOTTLE: 1 BOTTLE PER 30 DAYS
	ZERVIATE DRO 0.24%	ADD QL: 2 BOXES (60 SINGLE-USE CONTAINERS) PER 30 DAYS
	UPNEEQ SOL 0.1%	ADD PA ADD QL: 30 SINGLE USE CONTAINERS PER 30 DAYS
OPIOID AGONISTS	HYDROMORPHONE INJ 0.2MG/ML MORPHINE SULFATE INJ 1MG/ML	ADD QL: 6 ML PER DAY
ROSACEA AGENTS	ZILXI AER 1.5%	ADD PA ADD QL: 30 GM TUBE: 30 GM PER 30 DAYS 45 GM TUBE: 45 GM PER 30 DAYS 60 GM TUBE: 60 GM PER 30 DAYS
	SOOLANTRA CRE 1%	UPDATE QL: 30 GM TUBE: 30 GRAMS PER 30 DAYS

		45 GM TUBE: 45 GRAMS PER 30 DAYS 60 GM TUBE: 60 GRAMS PER 30 DAYS
SOMATOSTATIC AGENTS	MYCAPSSA CAP 20MG	ADD PA ADD QL: 1 BLISTER PACK PER 7 DAYS (4 BLISTER PACKS PER 28 DAYS)
SPINAL MUSCULAR ATROPHY AGENTS (SMA)	EVRYSDI SOL	ADD PA ADD QL: 5 MG PER DAY
STIMULANTS - MISC.	METHYLPHENIDATE CHEW 10MG	UPDATE QL: 6 TABLETS PER DAY
TOPICAL CORTICOSTEROIDS	AMCINONIDE LOT 0.1%	ADD PA ADD QL: 60 ML PER 30 DAYS
	AMCINONIDE OIN 0.1%	ADD PA ADD QL: 60 GM PER 30 DAYS
	DIFLORASONE CRE 0.05%	ADD PA
	FLUOCINONIDE CRE 0.05% FLUOCINONIDE GEL 0.05% FLUOCINONIDE OIN 0.05% FLUOCINONIDE SOL 0.05% TRIAMCINOLON LOT 0.1% TRIAMCINOLON LOT 0.025% DESONATE GEL 0.05% HYDROCORT LOT 2.5% HYDROCORT LOT 1% CORTISONE GEL 1%	REMOVE PA
	TRIAMCINOLON OIN 0.05% TRIANEX OIN 0.05% PREDNICARBAT OIN 0.1%	ADD PA
	AMCINONIDE CRE 0.1% CLOBETASOL CRE 0.05% CLOBETASOL E CRE 0.05% CLOBETASOL GEL 0.05% CLOBETASOL OIN 0.05% DESONIDE CRE 0.05% DESONIDE GEL 0.05% DESONIDE OIN 0.05% DESOXIMETAS GEL 0.05% FLUTICASONE OIN 0.005% FLUTICASONE CRE 0.05% CORTISONE GEL 1% HC BUTYRATE CRE 0.1% HC BUTYRATE OIN 0.1% HC VALERATE CRE 0.2% HC VALERATE OIN 0.2%	ADD QL: 60 GM PER 30 DAYS

TOPICAL CORTICOSTEROIDS	AUG BETAMET CRE 0.05% AUG BETAMET OIN 0.05% AUG BETAMET GEL 0.05%	ADD QL: 50 GM PER 30 DAYS
	AUG BETAMET LOT 0.05% BETAMETH DIP LOT 0.05% ULTRAVATE LOT 0.05% HC BUTYRATE SOL 0.1% TRIAMCINOLON LOT 0.025% TRIAMCINOLON LOT 0.1%	ADD QL: 60 ML PER 30 DAYS
	BETAMETH DIP CRE 0.05% BETAMETH DIP OIN 0.05%	ADD QL: 45 GM PER 30 DAYS
	SERNIVO SPR 0.05%	ADD QL: 120 ML PER 30 DAYS
	IMPOYZ CRE 0.025%	ADD QL: 112 GM PER 30 DAYS
	CLOBETASOL LOT 0.05% CLOBETASOL SHA 0.05%	ADD QL: 118 ML PER 30 DAYS
	CLOBETASOL SOL 0.05%	ADD QL: 50 ML PER 30 DAYS
	CLOBEX SPR 0.05%	ADD QL: 125 ML PER 30 DAYS
	DESONIDE LOT 0.05% HYDROCORTISONE LOTION 0.1% HYDROCORTISONE LOTION 2.5%	ADD QL: 118 ML PER 30 DAYS
	DESOXIMETAS CRE 0.05% DESOXIMETAS OIN 0.05% DESOXIMETAS CRE 0.25% DESOXIMETAS OIN 0.25% VERDESO AER 0.05% CLOBETASOL AER 0.05% BRYHALI LOT 0.01% TRIAMCINOLON AER SPRAY BETAMETH VAL AER 0.12%	ADD QL: 100 GM PER 30 DAYS
	TOPICORT SPR 0.25%	ADD QL: 100 ML PER 30 DAYS
	FLURANDRENOL CRE 0.05% FLURANDRENOL OIN 0.05% CORDRAN CRE 0.025%	ADD QL: 120 GM PER 30 DAYS
	CORDRAN 80X3 TAP 4MCG/CM	ADD QL: 80 INCH (1 BOX) PER 30 DAYS
	FLUTICASONE LOT 0.05% CORTISONE LOT 1% SCALPICIN SOL 1% FLURANDRENOL LOT 0.05%	ADD QL: 120 ML PER 30 DAYS

TOPICAL CORTICOSTEROIDS	HALOBETASOL CRE 0.05% HALOBETASOLOIN 0.05% HALOBETASOL AER 0.05%	ADD QL: 50 GM PER 30 DAYS
	HYDROCORT CRE 0.5% HYDROCORT OIN 0.5%	ADD QL: 30 GM PER 30 DAYS
	HYDROCORT CRE 1% HYDROCORT OIN 1% HYDROCORT CRE 2.5% HYDROCORT OIN 2.5% TRIAMCINOLON OIN 0.025% TRIAMCINOLON OIN 0.1% TRIAMCINOLON CRE 0.025% TRIAMCINOLON CRE 0.1% TRIAMCINOLON CRE 0.5%	ADD QL: 454 GM PER 30 DAYS
	ALA SCALP LOT 2%	ADD QL: 60 GM/ML PER 30 DAYS
	TEXACORT SOL 2.5%	ADD QL: 30 ML PER 30 DAYS
	PANDEL CRE 0.1%	ADD QL: 80 GM PER 30 DAYS
	TRIAMCINOLON OIN 0.5%	ADD QL: 30 GM PER 30 DAYS
	TRIAMCINOLON OIN 0.05%	ADD QL: 430 GM PER 30 DAYS
	HALOG SOL 0.1%	ADD PA ADD QL: 120ML PER 30 DAYS
	IMPEKLO 0.05% LOTION*	ADD PA ADD QL: 68 GM PER 30 DAYS
	WYNZORA 0.005%/0.064% CREAM*	ADD QL: 420 GM PER 28 DAYS
	URINARY ANTISPASMODICS	DETROL TAB 1MG DETROL TAB 2MG
DETROL LA CAP 2MG DETROL LA CAP 4MG TROSPIUM CHL CAP 60MG ER		ADD QL: 1 CAPSULE PER DAY
OXYBUTYNIN TAB 5MG		ADD QL: 4 TABLETS PER DAY

	ENABLEXTAB 7.5MG ENABLEXTAB 15MG MYRBETRIQ TAB 25MG MYRBETRIQ TAB 50MG TOVIAZ TAB 4MG TOVIAZ TAB 8MG VESICARE TAB 5MG VESICARE TAB 10MG	ADD QL: 1 TABLET PER DAY
	OXYTROL/WOMN DIS 3.9MG/24 OXYTROL DIS 3.9MG/24	ADD QL: 8 PATCHES PER 28 DAYS
	TROSPIUM CL TAB 20MG	ADD QL: 2 TABLETS PER DAY
	VESICARE LS SOLN*	ADD PA
VASOPRESSIN RECEPTOR ANTAGONISTS	JYNARQUE PAK	ADD QL: 1 CARTON PER 28 DAYS
INFLUENZA VACCINES	FLUZONE HD INJ PF 20-21	ADD QL: 0.7 ML PER FILL
IMMUNOSUPPRESSIVE AGENTS	UPLIZNA SOL 100MG	ADD PA ADD QL: 3 VIALS (300 MG) EVERY 6 MONTHS
NON-STEROIDAL ANTIINFLAMMATORY DRUGS	ELYXYB SOLN 25MG/ML*	ADD PA ADD QL: 9 BOTTLES PER 30 DAYS

These edits will be applied once the medication is available on the market

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 (PA) 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 PA. You can find the *Preferred Drug List* on our provider website at <https://providers.amerigroup.com/GA>.

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