

This is an update about information in the provider manual. For access to the latest provider manual, go online to <https://providers.amerigroup.com/MD>.

## Quarterly pharmacy formulary change notice

**Summary of change:** The formulary changes listed in the table below were reviewed and approved at our June 27, 2016, Pharmacy and Therapeutics Committee (P&T) meeting.

**What this means to you:** Effective November 1, 2016, the changes outlined below apply to all Amerigroup Community Care patients.

### What is the impact of this change?

Effective for all patients on November 1, 2016			
THERAPEUTIC CLASS	MEDICATION	REVISED STATUS	POTENTIAL ALTERNATIVES
RESPIRATORY SPACERS	<b>SPACERS:</b> AEROCHAMBER AEROCHAMBER Z-STAT PLUS AEROCHAMBER PLUS EASIVENT E-Z SPACER FLEXICHAMBER INSPIRACHAMBER	NON-PREFERRED	OPTICHAMBER DIAMOND POCKET CHAMBER VORTEX LITEAIRE MICROSPACER MICROCHAMBER BREATHERITE
PROTON PUMP INHIBITORS	PANTOPRAZOLE SOD DR 20 MG TAB PANTOPRAZOLE SOD DR 40 MG TAB	NON-PREFERRED	NEXIUM 24HR 20 MG TABLET (OTC) NEXIUM 24HR 22.3 MG CAPSULE (OTC) OMEPRAZOLE MAG DR 20.6 MG CAP (OTC) OMEPRAZOLE DR 20 MG TABLET (OTC) PREVACID 24HR DR 15 MG CAPSULE(OTC) HEARTBURN TREATMNT 24HR 15 MG (OTC)
ALCOHOL PREP PADS	ONE PHARMACEUTICAL PHOENIX HEALTHCARE SPECIALTY MED HOME AID DIAGNOSTICS SIMPLE DIAGNOSTICS	NON-PREFERRED	MCKESSON DRUG TARGET CORP. RITE AID CORP. WALGREEN CO. LEADER CVS WAL-MART STORES BD DIABETES
ALKYLATING AGENTS	CYCLOPHOSPHAMIDE CAPS	PREFERRED	N/A

<b>ALPHA PROTEINASE INHIBITOR</b>	PROLASTIN C 1;000 MG VIAL	NON-PREFERRED	N/A
<b>ANTIDIURETIC AND VASOPRESSOR HORMONES</b>	DDAVP 0.2 MG TABLET	QL REVISION	N/A
<b>ANTIFUNGAL AGENTS</b>	MYCELEX TROCHE NOXAFIL 40 MG/ML SUSPENSION	QL REVISION	N/A
<b>ANTIHYPERTENSIVE AGENTS</b>	TARKA ER 2-180 MG TABLET NICARDIPINE 30 MG CAPSULE PRINIVIL 5 MG TABLET PRINIVIL 10 MG TABLET PRINIVIL 20 MG TABLET ZESTORETIC 10-12.5 MG	QL REVISION	N/A
<b>ANTIMETABOLITES</b>	METHOTREXATE INJ TABLOID TABLET Trexall TABLET	PREFERRED	N/A
<b>ANTIMETABOLITES</b>	ADRUCIL VIAL FLUOROURACIL VIAL GEMCITABINE VIAL	NON-PREFERRED	N/A
<b>ANTIMIGRAINE PREPARATIONS</b>	ZEMBRACE SYMTOUCH ONZETRA XSAIL NASAL SPRAY	STEP THERAPY (ST) REQUIRED ADD QL	N/A
<b>ANTIMIGRAINE PREPARATIONS</b>	IMITREX 6 MG/0.5 ML VIAL	QL REVISION	N/A
<b>ANTINEOPLASTIC INJECTIONS</b>	AVASTIN 100 MG/4 ML VIAL AVASTIN 400 MG/16 ML VIAL LEUPROLIDE 2WK 1 MG/0.2 ML KIT HERCEPTIN 440 MG VIAL INTRON VIALS LEUPROLIDE 2WK 1 MG/0.2 ML KIT LUPRON DEPOT KITS SYNRIBO 3.5 MG/ML VIAL TORISEL 25 MG KIT TRELSTAR SYRINGE VECTIBIX VIAL ZALTRAP VIAL ZOLADEX IMPLANT SYRN	NON-PREFERRED	N/A
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	SIGNIFOR LAR VIAL SOMATULINE DEPOT	ADD PA AND QL	N/A
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	FIRMAGON KIT SANDOSTATIN AMPULS/VIALS SANDOSTATIN LAR DEPOT VIALS	ADD QL	N/A
<b>ANTIPSORIATIC/ ANTISEBORRHEIC</b>	TALTZ 80 MG/ML AUTOINJECTOR TALTZ 80 MG/ML SYRINGE	ADD PA AND QL	N/A
<b>ANTIVERTIGO &amp; ANTIEMETIC AGENTS</b>	EMEND CAPSULE EMEND TRIPACK EMEND 150 MG VIAL	ADD QL	N/A

<p><b>BARBITURATE COMBINATION AGENTS</b></p>	<p>BUTALBITAL-ACETAMINOPHEN 25-325 MG  BUTALBITAL-ACETAMINOPHEN 50 MG-300 MG TABLET  BUTALBITAL-ACETAMINOPHEN 50 MG-325 MG TABLET  BUTALBITAL-ACETAMINOPHEN 50 MG-650 MG  BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50 MG-325 MG-40 MG/15 ML SOLUTION  BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50 MG-300 MG-40 MG CAPSULE  BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50 MG-325 MG-40 MG CAPSULE  BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50 MG-325 MG-40 MG TABLET  BUTALBITAL-ASPIRIN-CAFFEINE 50 MG-325 MG-40 MG CAPSULE  BUTALBITAL-ASPIRIN-CAFFEINE-CODEINE 50 MG-325 MG-40 MG-30 MG CAPSULE</p>	<p>ADD QL</p>	<p>N/A</p>
<p><b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b></p>	<p>VISTOGARD 10 GRAM PACKET</p>	<p>ADD QL</p>	<p>N/A</p>
<p><b>MISCELLANEOUS DERMATOLOGICALS</b></p>	<p>CARAC 0.5% CREAM  EFUDEX 5% CREAM  TOLAK 4% CREAM  FLUOROURACIL 5% TOP SOLUTION  FLUOROURACIL 2% TOPICAL SOLN  FLUOROPLEX 1% CREAM  ALDARA 5% CREAM  PICATO 0.015% GEL  PICATO 0.05% GEL  SOLARAZE 3% GEL</p>	<p>ADD QL</p>	<p>N/A</p>
<p><b>GNRH AGENTS</b></p>	<p>LUPANETA PACK 3.75/5 MG  LUPANETA PACK 11.25/5 MG  LUPRON DEPOT PED 30 MG  LUPRON DEPOT PED 11.25 OR 15 MG  LUPRON DEPOT 7.5 MG  LUPRON DEPOT 11.25 MG, 22.5 MG  LUPRON DEPOT 30 MG  SUPPRELIN LA  SYNAREL</p>	<p>ADD QL</p>	<p>N/A</p>
<p><b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b></p>	<p>SOMAVERT 10MG, 15MG, 20MG, 25MG, 30MG</p>	<p>ADD QL</p>	<p>N/A</p>

<b>LAXATIVES AND CATHARTICS</b>	MIRALAX	ADD QL	N/A
<b>MISCELLANEOUS AGENTS</b>	CHEMET DEFERAL	PA REQUIRED	N/A
<b>MITOTIC INHIBITORS</b>	IXEMPRA 15 MG KIT IXEMPRA 45 MG KIT	NON-PREFERRED	N/A
<b>NASAL STEROIDS</b>	RHINOCORT ALLERGY (OTC) NASONEX/ MOMETASONE	ADD QL	N/A
<b>NON-SEDATING ANTIHISTAMINES (NSA)</b>	CLARINEX 0.5 MG/ML (2.5 MG/5) CHILD'S CLARITIN 5 MG TAB CHEW CLARITIN 5 MG REDITABS	NON-PREFERRED	FEXOFENADINE HCL 60 MG TABLET (OTC) FEXOFENADINE HCL 180 MG TABLET (OTC) LORATADINE ALLERGY 5 MG/5 ML (OTC) LORATADINE 10 MG ODT (OTC)
<b>NSAIDS</b>	VIVLODEX CAPSULE	ADD QL	N/A
<b>OPHTHALMIC ANGIOGENESIS INHIBITORS</b>	LUCENTIS 0.5 MG VIAL LUCENTIS 0.3 MG VIAL	NON-PREFERRED	N/A
<b>OSTEOPOROSIS THERAPY</b>	ALENDRONATE SOD 70 MG/75 ML	PREFERRED	N/A
<b>OSTEOPOROSIS THERAPY</b>	FORTEO 600 MCG/2.4 ML PEN INJ	NON-PREFERRED	N/A
<b>SKELETAL MUSCLE RELAXANTS</b>	AMRIX 30MG METHOCARBAMOL 750 MG	ADD QL	N/A
<b>TOPICAL ANTI-INFLAMMATORY-NSAIDS</b>	FLECTOR PATCH PENNSAID 1.5% PENNSAID 2% VOLTAREN GEL	ADD QL	N/A
<b>PAH AGENTS</b>	TYVASO INHALATION	NON-PREFERRED	LETAIRIS 5 MG TABLET LETAIRIS 10 MG TABLET
<b>PAH AGENTS</b>	ATROVENT HFA ATROVENT SOLUTION	QL REVISION	N/A
<b>PRENATAL VITAMINS</b>	ENBRACE HR FOCALGIN 90 DHA COMBO PACK; FOCALGIN CA COMBO PACK NIVA-PLUS OB COMPLETE GOLD PREFERA-OB PLUS DHA COMBO PACK PROVIDA DHA TRISTART DHA VITAFOL FE + DOCUSATE COMBO PACK	ADD QL	N/A
<b>PROTON PUMP INHIBITORS</b>	DEXILANT SOLUTAB	ADD QL	N/A

<b>RH IMMUNE GLOBULIN</b>	MICRHOGAM ULTRA-FILTD PLUS SYR RHOGAM ULTRA-FILTERED WINRHO SDF HYPERRHO S-D RHOPHYLAC 300 MCG/2 ML SYRINGE	NON-PREFERRED	N/A
<b>MISCELLANEOUS RHEUMATOLOGICAL AGENTS</b>	KINERET 100 MG/0.67 ML SYRINGE	NON-PREFERRED	N/A
<b>MISCELLANEOUS RHEUMATOLOGICAL AGENTS</b>	XELJANZ XR TABLET	ADD PA AND QL	N/A
<b>UTI PROPHYLAXIS</b>	NITROFURANTOIN MCR 25 MG CAP	PREFERRED	N/A
<b>UTI PROPHYLAXIS</b>	NITROFURANTOIN 25 MG/5 ML SUSP	NON-PREFERRED	N/A
<b>VACCINES &amp; MISCELLANEOUS IMMUNOLOGICALS</b>	CYTOGAM 2.5 GM/50 ML VIAL	NON-PREFERRED	N/A

**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 provider website at <https://providers.amerigroup.com/MD>.

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