Amerigroup
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**Provider update**

# Quarterly pharmacy formulary change notice

**Summary:** The formulary changes listed in the table below were reviewed and approved at our second quarter 2018, Pharmacy and Therapeutics Committee meeting.

Effective October 1, 2018, the changes outlined below apply to all Amerigroup Community Care members.

| **Effective for all patients on October 1, 2018** | | | |
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| **Therapeutic class** | **Drug** | **Revised status** | **Potential alternatives** |
| **DIABETIC SUPPLIES** | BD PEN NEEDLES<br>BD INSULIN SYRINGES | PREFERRED | N/A |
| **DIABETIC SUPPLIES** | ALL OTHER PEN NEEDLES AND INSULIN SYRINGES/MANUFACTURERS | NON-PREFERRED WITH STEP THERAPY (ST) | BD PEN NEEDLES<br>BD INSULIN SYRINGES |
| **PROTON PUMP INHIBITORS (PPI)** | BRAND PRILOSEC OTC 20 MG TABLET<br>BRAND PRILOSEC OTC 20.6 MG TABLET<br>BRAND OTC NEXIUM 24HR 20 MG CAPSULE | PREFERRED | N/A |
| **EDITS**<br>*NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY* | | | |
| **ANTICOAGULANTS** | FRAGMIN 2,500 UNITS/0.2 ML SYR<br>FRAGMIN 5,000 UNITS/0.2 ML SYR | REVISED QL<br>6 ML (30 SYRINGES) PER 30 DAYS | |
| **ANTICOAGULANTS** | FRAGMIN 7,500 UNITS/0.3 ML SYR | REVISED QL<br>9 ML (30 SYRINGES) PER 30 DAYS | |
| **ANTICOAGULANTS** | FRAGMIN 10,000 UNITS/ML SYR | REVISED QL<br>30 ML (30 SYRINGES) PER 30 DAYS | |
| **ANTICOAGULANTS** | FRAGMIN 12,500 UNITS/0.5 ML | REVISED QL<br>15 ML (30 SYRINGES) PER 30 DAYS | |
| **ANTICOAGULANTS** | FRAGMIN 15,000 UNITS/0.6 ML | REVISED QL<br>18 ML (30 SYRINGES) PER 30 DAYS | |
| **ANTICOAGULANTS** | FRAGMIN 18,000 UNITS/0.72 ML | REVISED QL<br>22ML (30 SYRINGES) PER 30 DAYS | |
| **ANTICOAGULANTS** | FRAGMIN 25,000 UNITS/3.8 ML VL | REVISED QL<br>22.8 ML (6 VIALS) PER 30 DAYS | |
| **ANTIHYPERTENSIVES** | TEKTURNA 37.5MG ORAL PELLETS | ADD QL<br>8 PELLETS PER DAY | |
| **ANTINEOPLASTIC AGENTS** | IMBRUVICA 140 MG CAPSULE | REVISE QL<br>4 CAPSULE PER DAY | |
| **ANTINEOPLASTIC DRUGS** | IMBRUVICA 70 MG CAPSULE | REVISE QL<br>1 CAPSULE PER DAY | |
| **ANTINEOPLASTIC AGENTS** | IMBRUVICA 140 MG TABLET | REVISE QL<br>1 TABLET PER DAY | |

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| **ANTIPARASITICS** | ALBENZA 200 MG TABLET | ADD PA<br>ADD QL<br>4 TABLETS PER DAY |
| **ANTIPARASITICS** | IMPAVIDO 50 MG CAPSULE | ADD QL<br>84 CAPSULES PER FILL<br>1 FILL EVERY 30 DAYS |
| **APPETITE STIMULATOR** | MEGESTROL TABLET<br>MEGESTROL ORAL SUSP | PA REQUIRED |
| **ASTHMA** | BREO ELLIPTA 200-25 MCG INH<br>BREO ELLIPTA 100-25 MCG INH<br>FLUTICASONE-SALMETEROL 55-14<br>FLUTICASONE-SALMETEROL 113-14<br>FLUTICASONE-SALMETEROL 232-14<br>DULERA 100 MCG/5 MCG INHALER<br>DULERA 200 MCG/5 MCG INHALER<br>AIRDUO RESPICLICK 55-14 MCG<br>AIRDUO RESPICLICK 113-14 MCG<br>AIRDUO RESPICLICK 232-14 MCG<br>ADVAIR 100-50 DISKUS<br>ADVAIR 250-50 DISKUS<br>ADVAIR 500-50 DISKUS<br>ADVAIR HFA 115-21 MCG INHALER<br>ADVAIR HFA 45-21 MCG INHALER<br>ADVAIR HFA 230-21 MCG INHALER<br>SYMBICORT 80-4.5 MCG INHALER<br>SYMBICORT 160-4.5 MCG INHALER | REMOVING REQUIREMENT FOR ICS BEFORE ICS/LABA STEP THERAPY<br><br>EFFECTIVE DATE 08.01.18<br><br>STEP THERAPY FOR T/F OF PREFERRED ICS/LABA STILL REQUIRED |
| **BOWEL PREP AGENTS** | CLENPIQ SOLUTION | ADD QL<br>320 MLS PER 30 DAYS |
| **CHEMOTHERAPY** | BEXAROTENE 75 MG CAPSULE | ADD QL<br>10 CAPSULES PER DAY |
| **CHEMOTHERAPY** | CABOMETYX 20 MG TABLET | REVISE QL<br>1 TABLET PER DAY |
| **CHEMOTHERAPY** | ZYKADIA 150 MG CAPSULE | REVISE QL<br>3 CAPSULES PER DAY |
| **CML** | TASIGNA 50 MG CAPSULE | ADD QL<br>4 CAPSULES PER DAY |
| **DERMATOLOGICAL AGENTS** | QUINJA 1.25%-1% GEL | ADD QL<br>60 GMS PER 30 DAYS |
| **EPINEPHRINE AGENTS** | AUVI-Q 0.1 MG AUTO-INJECTOR | ADD QL<br>1 BOX (2 PENS) PER FILL |
| **GLUCOSE ELEVATING AGENTS** | GLUCAGEN 1 MG EMERGENCY KIT | ADD QL<br>2 KITS IN 30 DAYS |
| **GOUT THERAPY** | ULORIC 40 MG TABLET<br>ULORIC 80 MG TABLET | ADD QL<br>1 TABLET PER DAY |
| **GOUT THERAPY** | ZURAMPIC 200 MG TABLET | ADD QL<br>1 TABLET PER DAY |
| **GOUT THERAPY** | KRYSTEXXA 8 MG/ML VIAL | ADD QL<br>2 VIALS (2ML) PER 28 DAYS |

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| **HIGH BLOOD PRESSURE AGENTS** | DEMSER 250 MG CAPSULE | ADD QL<br>16 CAPSULES PER DAY |
| **HIGH BLOOD PRESSURE AGENTS** | DIBENZYLINE 10 MG CAPSULE | ADD QL<br>12 CAPSULES PER DAY |
| **HIGH BLOOD PRESSURE AGENTS** | KAPSPARGO SPRINKLE | ADD QL<br>1 CAPSULE PER DAY |
| **HIGH BLOOD PRESSURE AGENTS** | PREXXARTAN | ADD QL<br>80 MLS PER DAY |
| **IBD STEROIDS** | UCERIS 2 MG RECTAL FOAM | ADD ST |
| **GLAUCOMA AGENTS** | AZOPT 1% EYE DROPS | REVISE QL<br>15 MLS PER 30 DAYS |
| **GLAUCOMA AGENTS** | BETIMOL 0.25% EYE DROPS<br>BETIMOL 0.5% EYE DROPS | REVISE QL<br>15 MLS PER 30 DAYS |
| **GLAUCOMA AGENTS** | RHOPRESSA 0.02% OPHTH SOLUTION | ADD QL<br>5 MLS PER 30 DAYS |
| **GLAUCOMA AGENTS** | TIMOPTIC-XE 0.25% AND 0.5% EYE GEL-SOLN<br>TIMOPTIC OCUMETER PLUS 0.25% AND 0.5 %GEL FORMING SOLN | REVISE QL<br>5 MLS PER 30 DAYS |
| **GLAUCOMA AGENTS** | TIMOPTIC 0.25% AND 0.5% OCUDOSE DROP<br>TIMOPTIC OCUMETER PLUS 0.25% AND 0.5% SOLN | ADD QL<br>10 MLS PER 30 DAYS |
| **GLAUCOMA AGENTS** | VYZULTA 0.024% OPHTH SOLUTION | ADD QL<br>2.5 MLS PER 30 DAYS |
| **INTRANASAL STEROIDS** | XHANCE 93 MCG NASAL SPRAY | ADD PA<br>ADD ST<br>ADD QL<br>2 INHALERS PER 30 DAYS |
| **MENOPAUSAL THERAPIES** | IMVEXXY 10 MCG VAGINAL INSERT<br>IMVEXXY 4 MCG VAGINAL INSERT | ADD QL<br>18 VAGINAL INSERTS PER 28 DAYS |
| **MIGRAINE** | AIMOVIG 70 MG DOSE-1 AUTOINJ | ADD PA<br>ADD ST<br>ADD QL<br>1 AUTOINJECTOR/1 PACK PER 30 DAYS |
| **MIGRAINE** | AIMOVIG 140 MG DOSE-2 AUTOINJ | ADD PA<br>ADD ST<br>ADD QL<br>2 AUTOINJECTORS/1 PACK PER 30 DAYS |
| **MISCELLANEOUS AGENTS** | SAMSCA 15 MG TABLET | ADD QL<br>1 TABLET PER DAY |
| **MISCELLANEOUS AGENTS** | SAMSCA 30 MG TABLET | ADD QL<br>2 TABLETS PER DAY |
| **MISCELLANEOUS GASTROINTESTINAL AGENTS** | RECTIV 0.4% OINTMENT | ADD QL<br>30 GM TUBE EVERY 30 DAYS |
| **HEPATITIS B INTERFERON ANTIVIRAL THERAPY** | PEGASYS (PEGINTERFERON ALFA 2A)<br>INTRON A (INTERFERON ALFA 2B) | REMOVE PA REQUIREMENTS |

| NEUROPATHIC PAIN AND FIBROMYALGIA | ZTLIDO | ADD PA<br>ADD QL<br>3 PATCHES PER DAY |
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| **NON-NARCOTIC ANALGESIC** | FIORINAL 50-325-40 MG CAPSULE<br>BUTALBITAL-ASA-CAFFEINE CAP<br>BUTALB-ASPIRIN-CAFFE 50-325-40<br>BUTALBITAL-ASA-CAFFEINE CAP | ADD QL<br>6 TABLETS PER DAY |
| **NSAIDS** | CONSENSI | ADD QL<br>1 TABLET PER DAY |
| **PHOSPHATE BINDERS** | CALCIUM ACETATE 668 MG TABLET | ADD QL<br>12 TABLETS PER DAY |
| **PRENATAL VITAMINS** | NESTABS ONE SOFTGEL | ADD QL<br>1 TABLET PER DAY |
| **PROGESTINS** | MAKENA 275 MG/1.1 ML AUTOINJCT | ADD QL<br>4 AUTOINJECTORS PER 28 DAYS |
| **PROSTATE CANCER** | ERLEADA 60 MG TABLET | ADD PA<br>ADD QL<br>4 TABLETS PER DAY |
| **PROSTATE CANCER** | YONSA 125 MG TABLET | ADD PA<br>ADD QL<br>4 TABLETS PER DAY |
| **TOPICAL ANTIBACTERIALS** | ALTABAX 1% OINTMENT | REVISE QL<br>30 GMS PER FILL<br>1 FILL PER 30 DAYS |
| **TOPICAL ANTI-INFECTIVES** | XEPI | ADD QL<br>45 GMS PER FILL<br>1 FILL PER 30 DAYS |
| **TOPICAL CORTICOSTEROIDS – LOW POTENCY** | SYNALAR 0.025% OINTMENT KIT | ADD QL<br>1 KIT PER 30 DAYS |
| **TOPICAL CORTICOSTEROIDS- VERY HIGH POTENCY** | IMPOYZ 0.025% CREAM | ADD QL<br>112 GMS PER 30 DAYS |

**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.

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