Amerigroup
An Anthem Company

Provider update

Quarterly pharmacy formulary change notice

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

Effective August 1, 2018, the changes outlined below apply to all HealthChoice members.

Effective for all patients on August 1, 2018			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
INSULIN	APIDRA 100 UNITS/ML VIAL APIDRA SOLOSTAR 100 UNITS/ML	NONPREFERRED EFFECTIVE FOR NEW STARTS ON 8/1/18; EFFECTIVE FOR CURRENT UTILIZERS ON 10/1/18	ADMELOG 100 UNIT/ML VIAL ADMELOG SOLOSTAR 100 UNIT/ML
INSULIN	ADMELOG 100 UNIT/ML VIAL ADMELOG SOLOSTAR 100 UNIT/ML	PREFERRED ADD QL 30MLS PER 30 DAYS	N/A
INSULIN (EDIT ONLY)	HUMULIN R 500 UNITS/ML VIAL HUMULIN R 500 UNITS/ML KWIKPEN	ADDING PA TO PREFERRED PRODUCT	N/A
ANTIPERSPIRANTS	HYPERCARE 15% SOLUTION	PREFERRED	N/A
DPP4s	JENTADUETO 2.5 MG-1000 MG TAB JENTADUETO 2.5 MG-500 MG TAB JENTADUETO 2.5 MG-850 MG TAB JENTADUETO XR 2.5 MG-1;000 MG JENTADUETO XR 5 MG-1;000 MG TB TRADJENTA 5 MG TABLET	NONPREFERRED	JANUVIA JANUMET XR ST APPLIES
GLP1s	TANZEUM 30 MG PEN INJECT TANZEUM 50 MG PEN INJECT	NONPREFERRED	OZEMPIC VICTOZA ST APPLIES
GLP1s	OZEMPIC 0.25-0.5 MG DOSE PEN OZEMPIC 1 MG DOSE PEN	PREFERRED WITH STEP THERAPY EFFECTIVE 4/1/18	N/A
ICS/LABA	(AUTHORIZED GENERIC OF AIRDUO RESPICLICK) FLUTICASONE-SALMETEROL 55-14 FLUTICASONE-SALMETEROL 113-14 FLUTICASONE-SALMETEROL 232-14	PREFERRED	N/A
ICS/LABA	DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER	NONPREFERRED CURRENT UTILIZERS WILL BE GRANDFATHERED	*AUTHORIZED GENERIC FOR AIRDUO RESPICLK FLUTICASONE-SALMETEROL BREO ELLITA

<table>
<tr><td>IRON SUPPLEMENTS</td><td>POLY-VI-SOL WITH IRON DROPS
POLY-VI-SOL DROPS</td><td>PREFERRED</td><td>N/A</td></tr>
<tr><td>MISCELLANEOUS ANTINEOPLASTIC DRUGS</td><td>MITOXANTRONE 20 MG/10 ML VIAL
MITOXANTRONE 25 MG/12.5 ML VL
MITOXANTRONE 30 MG/15 ML VIAL</td><td>COVERED</td><td>N/A</td></tr>
<tr><td>MISCELLANEOUS OPHTHALMOLOGICS</td><td>VISUDYNE 15 MG VIAL</td><td>COVERED</td><td>N/A</td></tr>
<tr><td>IMMUNOMODULATORS</td><td>PROLEUKIN 22 MILLION UNIT VIAL</td><td>NONPREFERRED
ADD PA</td><td>N/A</td></tr>
<tr><td>LAMA/LABA</td><td>STIOLTO RESPIMAT INHAL SPRAY</td><td>PREFERRED</td><td>N/A</td></tr>
<tr><td>PHOSPHATE BINDERS</td><td>LANTHANUM CARB 500 MG TAB CHEW
LANTHANUM CARB 750 MG TAB CHEW
LANTHANUM CARB 1;000 MG TB CHW
SEVELAMER 0.8 GM POWDER PACKET
SEVELAMER 2.4 GM POWDER PACKET
SEVELAMER CARBONATE 800 MG TAB</td><td>PREFERRED WITH PA</td><td>N/A</td></tr>
<tr><td>PHOSPHATE BINDERS</td><td>VELPHORO 500 MG CHEWABLE TAB</td><td>NONPREFERRED
CURRENT UTILIZERS WILL BE GRANDFATHERED</td><td>ELIPHOS 667 MG TABLET
CALCIUM ACETATE 667 MG
LANTHANUM CHEW TAB
SEVELAMER TAB/PACKET</td></tr>
<tr><td>PRENATAL VITAMINS</td><td>GENERIC OTC PRODUCTS ONLY</td><td>PREFERRED</td><td>N/A</td></tr>
<tr><td>PRENATAL VITAMINS</td><td>BRAND OTC
ALL RX PRODUCTS</td><td>NONPREFERRED
CURRENT UTILIZERS WILL BE GRANDFATHERED</td><td>GENERIC OTC PRENATALS</td></tr>
<tr><td colspan="4">EDITS
No changes in preferred/nonpreferred status revision or addition to UM edit only.</td></tr>
<tr><td>ANTIBIOTICS</td><td>BAXDELA 450 MG TABLET</td><td colspan="2">ADD QL
28 TABLETS PER FILL;
1 FILL PER 30 DAYS</td></tr>
<tr><td>COUGH AND COLD</td><td>COUGH AND COLD PRODUCTS CONTAINING HYDROCODONE</td><td colspan="2">ADD AL
MEMBERS EQUAL TO OR LESS THAN 18 REQUIRE PA</td></tr>
<tr><td>COUGH AND COLD</td><td>COUGH AND COLD PRODUCTS CONTAINING CODEINE</td><td colspan="2">ADD AL
MEMBERS EQUAL TO OR LESS THAN 18 REQUIRE PA</td></tr>
<tr><td>ANTIVIRALS</td><td>PREVYMIS 240 MG/12 ML VIAL
PREVYMIS 480 MG/24 ML VIAL</td><td colspan="2">ADD QL
1 VIAL PER DAY
100 DAYS OF TREATMENT</td></tr>
<tr><td>ANTIVIRALS</td><td>PREVYMIS 240 MG TABLET
PREVYMIS 480 MG TABLET</td><td colspan="2">ADD QL
1 TABLET PER DAY 100 DAYS OF TREATMENT</td></tr>
<tr><td>ASTHMA</td><td>XOPENEX 30 VIALS</td><td colspan="2">90 VIALS PER 30 DAYS</td></tr>
</table>

BILE ACIDS	CHENODAL 250 MG TABLET	ADD QL 7 TABLETS PER DAY
CANCER AGENTS	ALUNBRIG 180 MG TABLET	ADD QL 1 TABLET PER DAY
CANCER AGENTS	ALUNBRIG 90 MG-180 MG TAB PACK	ADD QL 1 PACK IN 30 DAYS
CANCER AGENTS	ALUNBRIG 90 MG TABLET	REVISED QL 2 TABLETS DAILY
CONSTIPATION AGENTS	SYMPROIC 0.2 MG TABLET	ADD QL 1 TABLET PER DAY
COPD	BROVANA 15 MCG/2 ML SOLUTION	ADD QL 2 VIALS (4ML) PER DAY
COPD	PERFOROMIST 20 MCG/2 ML SOLN	ADD QL 2 VIALS (4ML) PER DAY
COPD	LONHALA MAGNAIR 25 MCG STARTER	ADD QL 1 KIT PER 30 DAYS
COPD	LONHALA MAGNAIR 25 MCG REFILL	ADD QL 1 PER 30 DAYS
GLP-1 RECEPTOR AGONIST	OZEMPIC 0.25-0.5 MG DOSE PEN	ADD QL 1 PEN PER 28 DAYS
GLP-1 RECEPTOR AGONIST	OZEMPIC 1 MG DOSE PEN	ADD QL 2 PENS PER 28 DAYS
HEPATITIS C TREATMENT AGENTS	PEGINTRON 50 MCG KIT PEGASYS 180 MCG/0.5 ML SYRINGE PEGASYS 180 MCG/ML VIAL PEGASYS PROCLICK 180 MCG/0.5 PEGASYS PROCLICK 135 MCG/0.5	REMOVE PA
ICS	QVAR REDIHALER 40 MCG	ADD QL 1 INHALER PER 30 DAYS
ICS	QVAR REDIHALER 80 MCG	ADD QL 2 INHALERS PER 30 DAYS
LIPID/CHOLESTEROL LOWERING AGENTS	FLOLIPID	ADD QL 5MLS PER DAY
PANCREATIC ENZYMES	PERTZYE DR 24;000 UNIT CAPSULE	ADD QL 25 CAPSULES PER DAY
PANCREATIC ENZYMES	VIOKASE	ADD QL 25 TABLETS PER DAY
POTASSIUM SPARING DIURETICS	CAROSPIR 25 MG/5 ML SUSPENSION	ADD PA AND QL 20ML PER DAY
PROGESTINS	CRINONE 4% GEL CRINONE 8% GEL	ADD QL 1 APPLICATORFUL PER DAY
PULMONARY ARTERIAL HYPERTENSION	TRACLEER 32 MG TABLET FOR SUSP	ADD QL 32 MG TABS FOR SUSP – 4 TABLETS PER DAY
SGLT2	XIGDUO XR 2.5 MG-1;000 MG TAB	ADD QL 2 TABLETS PER DAY

SGLT2	STEGLATRO 5 MG TABLET STEGLATRO 15 MG TABLET	ADD QL 1 TABLET PER DAY
SGLT2	SEGLUROMET 7.5-1;000 MG TABLET SEGLUROMET 2.5-500 MG TABLET SEGLUROMET 7.5-500 MG TABLET SEGLUROMET 2.5-1;000 MG TABLET	ADD QL 2 TABLETS PER DAY
SGLT2/DPP-4 INHIBITOR	STEGLUJAN 5-100 MG TABLET STEGLUJAN 15-100 MG TABLET	ADD QL 1 TABLET PER DAY
TOPICAL ANTIFUNGALS	LOPROX 0.77% CREAM	ADD QL 90 GMS PER 30 DAYS
TOPICAL ANTIFUNGALS	LOTRIMIN ULTRA 1% CREAM	ADD QL 30 GMS PER 30 DAYS
TOPICAL ANTIFUNGALS	NYSTATIN 100;000 UNIT/GM CREAM NYSTATIN 100;000 UNITS/GM OINT KETOCONAZOLE 2% CREAM	ADD QL 120 GMS PER 30 DAYS
TOPICAL ANTIFUNGALS	OXISTAT 1% CREAM	ADD QL 60 GMS PER 30 DAYS

What action do I need to take?
Please review these changes and work with your 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 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.