

## Quarterly pharmacy formulary change notice

**Summary:** The formulary changes listed in the table below were reviewed and approved at our second quarter, 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			
Therapeutic class	Drug	Revised status	Potential alternatives
<b>DIABETIC SUPPLIES</b>	BD PEN NEEDLES BD INSULIN SYRINGES	PREFERRED	N/A
<b>DIABETIC SUPPLIES</b>	ALL OTHER PEN NEEDLES AND INSULIN SYRINGES/MANUFACTURERS	NON-PREFERRED WITH STEP THERAPY (ST)	BD PEN NEEDLES BD INSULIN SYRINGES
<b>HIV THERAPY</b>	CIMDUO 300-300 MG TABLET SYMFI 600-300-300 MG TABLET TROGARZO 200 MG/1.33 ML VIAL	COVERED	N/A
<b>PROTON PUMP INHIBITORS (PPI)</b>	BRAND PRILOSEC OTC 20 MG TABLET BRAND PRILOSEC OTC 20.6 MG TABLET BRAND OTC NEXIUM 24HR 20 MG CAPSULE	PREFERRED	N/A
EDITS			
<i>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>			
<b>ADHD AGENTS</b>	METHYLPHENIDATE ER 72 MG TAB	ADD PA ADD ST ADD QUANTITY LIMIT (QL) 1 TABLET PER DAY	
<b>ANTICOAGULANTS</b>	FRAGMIN 2,500 UNITS/0.2 ML SYR FRAGMIN 5,000 UNITS/0.2 ML SYR	REVISED QL 6 ML (30 SYRINGES) PER 30 DAYS	
<b>ANTICOAGULANTS</b>	FRAGMIN 7,500 UNITS/0.3 ML SYR	REVISED QL 9 ML (30 SYRINGES) PER 30 DAYS	
<b>ANTICOAGULANTS</b>	FRAGMIN 10,000 UNITS/ML SYRING	REVISED QL 30 ML (30 SYRINGES) PER 30 DAYS	
<b>ANTICOAGULANTS</b>	FRAGMIN 12,500 UNITS/0.5 ML	REVISED QL 15 ML (30 SYRINGES) PER 30 DAYS	
<b>ANTICOAGULANTS</b>	FRAGMIN 15,000 UNITS/0.6 ML	REVISED QL 18 ML (30 SYRINGES) PER 30 DAYS	
<b>ANTICOAGULANTS</b>	FRAGMIN 18,000 UNITS/0.72 ML	REVISED QL 22ML (30 SYRINGES) PER 30 DAYS	
<b>ANTICOAGULANTS</b>	FRAGMIN 25,000 UNITS/3.8 ML VL	REVISED QL 22.8 ML (6 VIALS) PER 30 DAYS	
<b>ANTIHYPERTENSIVES</b>	TEKTURNA 37.5MG ORAL PELLETS	ADD QL 8 PELLETS PER DAY	

<b>ANTINEOPLASTIC AGENTS</b>	IMBRUVICA 140 MG CAPSULE	REVISE QL 4 CAPSULE PER DAY
<b>ANTINEOPLASTIC DRUGS</b>	IMBRUVICA 70 MG CAPSULE	REVISE QL 1 CAPSULE PER DAY
<b>ANTINEOPLASTIC AGENTS</b>	IMBRUVICA 140 MG TABLET	REVISE QL 1 TABLET PER DAY
<b>ANTIPARASITICS</b>	ALBENZA 200 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
<b>ANTIPARASITICS</b>	IMPAVIDO 50 MG CAPSULE	ADD QL 84 CAPSULES PER FILL 1 FILL EVERY 30 DAYS
<b>APPETITE STIMULATOR</b>	MEGESTROL TABLET MEGESTROL ORAL SUSP	PA REQUIRED
<b>ASTHMA</b>	BREO ELLIPTA 200-25 MCG INH BREO ELLIPTA 100-25 MCG INH FLUTICASONE-SALMETEROL 55-14 FLUTICASONE-SALMETEROL 113-14 FLUTICASONE-SALMETEROL 232-14 DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER AIRDUO RESPICLICK 55-14 MCG AIRDUO RESPICLICK 113-14 MCG AIRDUO RESPICLICK 232-14 MCG ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 500-50 DISKUS ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	REMOVING REQUIREMENT FOR ICS BEFORE ICS/LABA STEP THERAPY  EFFECTIVE DATE 08.01.18  STEP THERAPY FOR T/F OF PREFERRED ICS/LABA STILL REQUIRED
<b>BOWEL PREP AGENTS</b>	CLENPIQ SOLUTION	ADD QL 320 MLS PER 30 DAYS
<b>CHEMOTHERAPY</b>	BEXAROTENE 75 MG CAPSULE	ADD QL 10 CAPSULES PER DAY
<b>CHEMOTHERAPY</b>	CABOMETYX 20 MG TABLET	REVISE QL 1 TABLET PER DAY
<b>CHEMOTHERAPY</b>	ZYKADIA 150 MG CAPSULE	REVISE QL 3 CAPSULES PER DAY
<b>CML</b>	TASIGNA 50 MG CAPSULE	ADD QL 4 CAPSULES PER DAY
<b>DERMATOLOGICAL AGENTS</b>	QUINJA 1.25%-1% GEL	ADD QL 60 GMS PER 30 DAYS
<b>EPINEPHRINE AGENTS</b>	AUVI-Q 0.1 MG AUTO-INJECTOR	ADD QL 1 BOX (2 PENS) PER FILL

<b>GLUCOSE ELEVATING AGENTS</b>	GLUCAGEN 1 MG EMERGENCY KIT	ADD QL 2 KITS IN 30 DAYS
<b>GOUT THERAPY</b>	ULORIC 40 MG TABLET ULORIC 80 MG TABLET	ADD QL 1 TABLET PER DAY
<b>GOUT THERAPY</b>	ZURAMPIC 200 MG TABLET	ADD QL 1 TABLET PER DAY
<b>GOUT THERAPY</b>	KRYSTEXXA 8 MG/ML VIAL	ADD QL 2 VIALS (2ML) PER 28 DAYS
<b>HIGH BLOOD PRESSURE AGENTS</b>	DEMSEER 250 MG CAPSULE	ADD QL 16 CAPSULES PER DAY
<b>HIGH BLOOD PRESSURE AGENTS</b>	DIBENZYLINE 10 MG CAPSULE	ADD QL 12 CAPSULES PER DAY
<b>HIGH BLOOD PRESSURE AGENTS</b>	KAPSPARGO SPRINKLE	ADD QL 1 CAPSULE PER DAY
<b>HIGH BLOOD PRESSURE AGENTS</b>	PREXXARTAN	ADD QL 80 MLS PER DAY
<b>IBD STEROIDS</b>	UCERIS 2 MG RECTAL FOAM	ADD ST
<b>GLAUCOMA AGENTS</b>	AZOPT 1% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
<b>GLAUCOMA AGENTS</b>	BETIMOL 0.25% EYE DROPS BETIMOL 0.5% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
<b>GLAUCOMA AGENTS</b>	RHOPRESSA 0.02% OPHTH SOLUTION	ADD QL 5 MLS PER 30 DAYS
<b>GLAUCOMA AGENTS</b>	TIMOPTIC-XE 0.25% AND 0.5% EYE GEL-SOLN TIMOPTIC OCUMETER PLUS 0.25% AND 0.5 %GEL FORMING SOLN	REVISE QL 5 MLS PER 30 DAYS
<b>GLAUCOMA AGENTS</b>	TIMOPTIC 0.25% AND 0.5% OCUDOSE DROP TIMOPTIC OCUMETER PLUS 0.25% AND 0.5% SOLN	ADD QL 10 MLS PER 30 DAYS
<b>GLAUCOMA AGENTS</b>	VYZULTA 0.024% OPHTH SOLUTION	ADD QL 2.5 MLS PER 30 DAYS
<b>INTRANASAL STEROIDS</b>	XHANCE 93 MCG NASAL SPRAY	ADD PA ADD ST ADD QL 2 INHALERS PER 30 DAYS
<b>MENOPAUSAL THERAPIES</b>	IMVEXXY 10 MCG VAGINAL INSERT IMVEXXY 4 MCG VAGINAL INSERT	ADD QL 18 VAGINAL INSERTS PER 28 DAYS
<b>MIGRAINE</b>	AIMOVIG 70 MG DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL 1 AUTOINJECTOR/1 PACK PER 30 DAYS
<b>MIGRAINE</b>	AIMOVIG 140 MG DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL

		2 AUTOINJECTORS/1 PACK PER 30 DAYS
<b>MISCELLANEOUS AGENTS</b>	SAMSCA 15 MG TABLET	ADD QL 1 TABLET PER DAY
<b>MISCELLANEOUS AGENTS</b>	SAMSCA 30 MG TABLET	ADD QL 2 TABLETS PER DAY
<b>MISCELLANEOUS GASTROINTESTINAL AGENTS</b>	RECTIV 0.4% OINTMENT	ADD QL 30 GM TUBE EVERY 30 DAYS
<b>HEPATITIS B INTERFERON ANTIVIRAL THERAPY</b>	PEGASYS (PEGINTERFERON ALFA 2A) INTRON A (INTERFERON ALFA 2B)	REMOVE PA REQUIREMENTS
<b>NEUROPATHIC PAIN AND FIBROMYALGIA</b>	ZTLIDO	ADD PA ADD QL 3 PATCHES PER DAY
<b>NON-NARCOTIC ANALGESIC</b>	FIORINAL 50-325-40 MG CAPSULE BUTALBITAL-ASA-CAFFEINE CAP BUTALB-ASPIRIN-CAFFE 50-325-40 BUTALBITAL-ASA-CAFFEINE CAP	ADD QL 6 TABLETS PER DAY
<b>NSAIDS</b>	CONSENSI	ADD QL 1 TABLET PER DAY
<b>PHOSPHATE BINDERS</b>	CALCIUM ACETATE 668 MG TABLET	ADD QL 12 TABLETS PER DAY
<b>PRENATAL VITAMINS</b>	NESTABS ONE SOFTGEL	ADD QL 1 TABLET PER DAY
<b>PROGESTINS</b>	MAKENA 275 MG/1.1 ML AUTOINJCT	ADD QL 4 AUTOINJECTORS PER 28 DAYS
<b>PROSTATE CANCER</b>	ERLEADA 60 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
<b>PROSTATE CANCER</b>	YONSA 125 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
<b>TOPICAL ANTIBACTERIALS</b>	ALTABAX 1% OINTMENT	REVISE QL 30 GMS PER FILL 1 FILL PER 30 DAYS
<b>TOPICAL ANTI-INFECTIVES</b>	XEPI	ADD QL 45 GMS PER FILL 1 FILL PER 30 DAYS
<b>TOPICAL CORTICOSTEROIDS – LOW POTENCY</b>	SYNALAR 0.025% OINTMENT KIT	ADD QL 1 KIT PER 30 DAYS
<b>TOPICAL CORTICOSTEROIDS- VERY HIGH POTENCY</b>	IMPOYZ 0.025% CREAM	ADD QL 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.