Amerigroup RealSolutions in healthcare

Provider update

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

Quarterly pharmacy formulary change notice

Summary: The formulary changes listed in the table below were reviewed and approved at our December 19, 2016, Pharmacy and Therapeutics Committee meeting.

Effective May 1, 2017, the changes outlined below apply to all Amerigroup Community Care patients.

Effective for all patients on May 1, 2017			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
ACNE THERAPY	ACNE MEDICATION 5% LOTION (BENZOYL PEROXIDE) ACNE MEDICATION 10% LOTION (BENZOYL PEROXIDE)	REVISE QUANTITY LIMIT (QL) 177 ML PER 30 DAYS	N/A
ANAPHYLAXIS THERAPY AGENTS	SELF-INJECTED EPINEPHRINE	REVISE QL 2 PER FILL 4 PER FILL ONCE A YEAR	N/A
ANTICONVULSANTS	LAMOTRIGINE ER TABLETS LAMOTRIGINE ODT TABLETS AND KITS ROWEEPRA 500 MG TABLET	PREFERRED	N/A
ANTICONVULSANTS	(BRAND ONLY) GABITRIL 12 MG TABLET GABITRIL 16 MG TABLET CARBATROL ER CAPSULES TEGRETOL 100 MG/ 5 ML SUSP TEGRETOL TABLETS TEGRETOL XR TABLETS DEPAKOTE DR TABLETS DEPAKOTE EC TABLETS DEPAKOTE SPRINKLE CAPS DEPAKENE CAPSULES DEPAKOTE ER TABLETS DILANTIN 125 MG/5 ML SUSP DILANTIN INFATABS DILANTIN CAPSULES DILANTIN KAPSEALS PHENYTEK CAPSULES	NONPREFERRED PRIOR AUTHORIZATION (PA) REQUIRED (CURRENT UTILIZERS WILL BE GRANDFATHERED.)	GENERIC AVAILABLE PRODUCTS PREFERRED

ANTIEMETIC AGENTS	SYNDROS	PA REQUIRED	N/A
ANTIHYPERTENSIVE AGENTS	BYVALSON 5 MG-80 MG TABLET	ADD QL 1 PER DAY	N/A
ANTIHYPERTENSIVE AGENTS	QBRELIS 1 MG/ML SOLUTION	ADD QL 40 ML PER DAY	N/A
BIOSIMILARS	AMJEVITA (HUMIRA BIOSIMILAR)	PA REQUIRED ADD QL	N/A
BIOSIMILARS	ERELZI (ENBREL BIOSIMILAR)	PA REQUIRED ADD QL	N/A
BIOSIMILARS	INFLECTRA 100 MG VIAL	PA REQUIRED ADD QL	N/A
DIGOXIN AGENTS	(BRAND ONLY) LANOXIN TABLETS	NONPREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED.)	DIGOXIN TABLETS
TOPICAL SCABICIDES/ PEDICULICIDES	RID ESSENTIAL LICE KIT	PREFERRED	N/A
HEMOSTATICS	PROMACTA 12.5 MG TABLET PROMACTA 25 MG TABLET PROMACTA 50 MG TABLET PROMACTA 75 MG TABLET	QL REVISION 3 TABS PER DAY	N/A
INSULIN THERAPY	SOLIQUA XULTOPHY	ADD QL 5 PENS (1 PACK) PER 25 DAYS	N/A
IRON CHELATORS	EXJADE 125 MG TABLET EXJADE 250 MG TABLET EXJADE 500 MG TABLET	NONPREFERRED WITH PA	N/A
ISOTRETINOINS	CLARAVIS CAPSULES MYORISAN CAPSULES ZENATANE CAPSULES	PREFERRED WITH PA	N/A
LONG-ACTING OPIOIDS	TROXYCA XR	NONPREFERRED ADD QL 2 PER DAY	(PA REQUIRED) MORPHINE SULFATE ER TABLETS METHADONE TABLETS FENTANYL PATCHES
MISCELLANEOUS AGENTS	CEREZYME 400 UNITS VIAL	REMOVE QL	N/A
MISCELLANEOUS AGENTS	ELELYSO 200 UNITS VIAL	REMOVE QL	N/A
MISCELLANEOUS AGENTS	CARBAGLU 200 MG DISPER TABLET	PA REQUIRED	N/A
MISCELLANEOUS AGENTS	SAMSCA 15 MG TABLET SAMSCA 30 MG TABLET	PA REQUIRED	N/A
MISCELLANEOUS ANTINEOPLASTIC DRUGS	HERCEPTIN 440 MG VIAL	REMOVE PA	N/A

MISCELLANEOUS PULMONARY AGENTS	BEVESPI AEROSPHERE INHALER	NONPREFERRED ADD QL 1 INHALER PER 30 DAYS	ANORO ELLIPTA INHALER
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	OTREXUP AUTO-INJ	PA REQUIRED ADD QL 4 PER 28 DAYS	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	ORENCIA 250 MG VIAL	PA REQUIRED ADD QL 4 VIALS PER 28 DAYS	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	STELARA 130 MG/26 ML (5 MG/ML) VIAL	REVISED QL 4 VIALS (8-WEEK SUPPLY, ONE-TIME FILL)	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	STELARA 45 MG/0.5 ML SINGLE-USE PREFILLED SYRINGE STELARA 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE	REVISED QL 1 SYRINGE PER 84 DAYS (12 WEEKS)	N/A
NON-INSULIN HYPOGLYCEMIC AGENTS	ADLYXIN 20 MCG MAINTENANCE PK ADLYXIN 10-20 MCG STARTER PACK	NONPREFERRED ADD QL STARTER PACK: 1 PACK PER ONE-TIME FILL MAINTENANCE PACK: 1 PACK (2 PENS) PER 28 DAYS	VICTOZA AND TANZEUEM (STEP THERAPY REQUIRED)
NSAIDS	FENORTHO 200 MG CAPSULE	NONPREFERRED ADD QL 6 PER DAY	FENOPROFEN 600 MG TABLET NAPROXEN SODIUM IBUPROFEN PIROXICAM KETOPROFEN
NSAIDS	FENORTHO 400 MG CAPSULE	NONPREFERRED ADD QL 4 PER DAY	FENOPROFEN 600 MG TABLET NAPROXEN SODIUM IBUPROFEN PIROXICAM KETOPROFEN
ORAL CONTRACEPTIVES	ALL ORAL CONTRACEPTIVES (NOT INCLUDING EMERGENCY AGENTS)	ADD QL 1 PER DAY	N/A
ORAL HYPOGLYCEMIC AGENTS	INVOKAMET XR 150-1,000 MG TAB INVOKAMET XR 50-1,000 MG TAB INVOKAMET XR 150-500 MG TABLET INVOKAMET XR 50-500 MG TABLET	NONPREFERRED ADD QL 2 PER DAY	JARDIANCE SYNJARDY (STEP THERAPY REQUIRED)

OTIC COMBINATION AGENTS	OTOVEL 0.3%-0.025% EAR DROPS	NONPREFERRED	NEOMYCIN-POLYMYXIN-HC EAR SOLN CIPROFLOXACIN 0.2% OTIC SOLN OFLOXACIN 0.3% EAR DROPS
SPACERS	COMPACT SPACE CHAMBER COMPACT SPACE CHAMBER-LRG MASK COMPACT SPACE CHAMBER-MED MASK COMPACT SPACE CHAMBER-SM MASK	PREFERRED	N/A
THYROID HORMONES	(BRAND PRODUCTS ONLY) ARMOUR THYROID TABLETS WP THYROID TABLETS SYNTHROID TABLETS CYTOMEL TABLETS	NONPREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED.)	GENERIC AVAILABLE PRODUCTS PREFERRED
THYROID HORMONES	UNITHROID 137 MCG TABLET	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 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.