

## Quarterly pharmacy formulary change notice

**Summary:** The formulary changes listed in the table below were reviewed and approved at our first quarter 2019 Pharmacy and Therapeutics Committee meeting.

Effective August 1, 2019, the changes outlined below apply to all Amerigroup Community Care members. **Please remember to read the footnotes at the end of the table.**

Effective for all patients on August 1, 2019			
Therapeutic class	Drug	Revised status	Potential alternatives
THERAPY FOR ACNE	PANOXYL-4 ACNE CREAMY WASH	NON-PREFERRED	OTC BENZOYL PEROXIDE (BP) 10% AND 5% WASH BP 5% AND 10% GEL
ANTIHISTAMINES	CHILD ALLEGRA ALLERGY 30 MG/5 ML	NON-PREFERRED	CHILD LORATADINE 5 MG/5 ML SOL ALLER-EASE 30 MG/5 ML SUSP
DERMATOLOGICALS – MISCELLANEOUS	CETAPHIL MOISTURIZING CREAM	NON-PREFERRED	AMLACTIN 12% LOTION CERAVE MOISTURIZING CREAM
OTHER ELECTROLYTES	K-PHOS NEUTRAL TABLET	NON-PREFERRED	PHOSPHA 250 NEUTRAL TABLET POTASSIUM CITRATE ER 5, 10 OR 15 MEQ TAB
OTHER ELECTROLYTES	PEDIALYTE SOLUTION (BRAND)	NON-PREFERRED	PEDIATRIC ELECTROLYTE SOLUTION
GASTROINTESTINAL AGENTS – MISCELLANEOUS	FLEET GLYCERIN ADULT SUPPOSITORY	NON-PREFERRED	GENERIC ADULT GLYCERIN SUPPOSITORY
GASTROINTESTINAL AGENTS – MISCELLANEOUS	CITRUCEL 500 MG CAPLET	NON-PREFERRED	OTC GENERIC FIBER THERAPY 500 MG CAPLET
VITAMINS & HEMATINICS	D-VI-SOL 400 UNITS/ML DROP FLINTSTONES TAB CHEW FLINTSTONES MULTI-VIT GUMMIES POLY-VI-SOL DROPS POLY-VI-SOL WITH IRON DROPS	NON-PREFERRED	PEDIATRIC VITAMINS: TRI-VIT-FLUOR 0.25 MG/ML DROP CHILDREN'S CHEWABLES
VITAMINS & HEMATINICS	FEOSOL 200MG TABLET	NON-PREFERRED	FERROUS GLUCONATE 324 MG TAB SLOW RELEASE IRON 45 MG TAB EZFE 200 CAPSULE
VITAMINS & HEMATINICS	NEPHRO-VITE RX TABLET	NON-PREFERRED	RENA-VITE RX TABLET VP-VITE RX TABLET

<b>EDITS</b>		
<i>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>		
<b>TOPICAL AGENTS FOR ACNE AND ROSACEA</b>	ALTRENO 0.05% LOTION	PA REQUIRED ADD QL 45 GRAMS PER 30 DAYS
<b>TOPICAL AGENTS FOR ACNE AND ROSACEA</b>	PLIXDA 0.1% SWAB	PA REQUIRED ADD QL 1 SWAB PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	DAURISMO 25 MG TABLET	PA REQUIRED ADD QL 2 TABLETS PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	DAURISMO 100 MG TABLET	PA REQUIRED ADD QL 1 TABLET PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	XOSPATA 40 MG TABLET	PA REQUIRED ADD QL 3 TABLETS PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	LORBRENA 25 MG TABLET	PA REQUIRED ADD QL 3 TABLETS
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	LORBRENA 100 MG TABLET	PA REQUIRED ADD QL 1 TABLET PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	TALZENNA 0.25 MG CAPSULE	PA REQUIRED ADD QL 3 CAPSULES PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	TALZENNA 1 MG CAPSULE	PA REQUIRED ADD QL 1 CAPSULE PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	VITRAKVI 25 MG CAPSULE	PA REQUIRED ADD QL 6 TABLETS PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	VITRAKVI 100 MG CAPSULE	PA REQUIRED ADD QL 2 TABLETS PER DAY
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	LUTRATE DEPOT 22.5MG	ADD QL 1 KIT PER 12 WEEKS
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	ELZONRIS 1;000 MCG/ML VIAL	PA REQUIRED
<b>MISCELLANEOUS ANTINEOPLASTIC DRUGS</b>	VENCLEXTA 100 MG TABLET	REVISE QL 6 TABLETS PER DAY
<b>ANTICOAGULANT – ORAL AGENTS</b>	XARELTO 2.5MG	REVISE QL 2 TABLETS PER DAY
<b>ANTICONVULSANTS</b>	SYMPAZAN 5 MG FILM	PA REQUIRED ADD QL 1 FILM PER DAY

<b>ANTICONVULSANTS</b>	SYMPAZAN 10 MG FILM SYMPAZAN 20 MG FILM	PA REQUIRED ADD QL 2 FILMS PER DAY
<b>ANTICONVULSANTS</b>	OXTELLAR XR TABLET	PA REQUIRED
<b>ANTICONVULSANTS</b>	DIACOMIT	ADD STEP THERAPY (ST)
<b>ANTICONVULSANTS</b>	ELEPSIA XR*	PA REQUIRED ADD QL 2 TABLETS PER DAY
<b>ANTIDEPRESSANTS – MISCELLANEOUS</b>	SPRAVATO 56 MG DOSE PACK SPRAVATO 84 MG DOSE PACK	ADD QL 4 KITS PER 28 DAYS
<b>ANTIIDIURETIC AND VASOPRESSOR HORMONES</b>	NOC DURNA 27.7 MCG TABLET SL NOC DURNA 55.3 MCG TABLET SL	PA REQUIRED ADD QL 1 TABLET PER DAY
<b>ANTIINFECTIVES - MISCELLANEOUS</b>	ARIKAYCE 590 MG/8.4 ML VIAL	PA REQUIRED ADD QL 1 KIT (28 VIALS) PER 28 DAYS
<b>ANTIINFECTIVES - MISCELLANEOUS</b>	AEMCOLO DR 194 MG TABLET	PA REQUIRED ADD QL 12 TABLETS PER FILL
<b>BETA AGONISTS INHALERS</b>	PROAIR DIGIHALER*	ADD QL 2 INHALERS PER 30 DAYS
<b>ESTROGEN COMBINATIONS</b>	BIJUVA 1 MG-100 MG CAPSULE	ADD ST ADD QL 1 CAPSULE PER DAY
<b>GASTROINTESTINAL AGENTS – MISCELLANEOUS</b>	MOTEGRITY 1 MG TABLET MOTEGRITY 2 MG TABLET	PA REQUIRED ADD QL 1 TABLET PER DAY
<b>MISCELLANEOUS IMMUNOLOGICALS</b>	ORALAIR	ADD QL 3 TABLETS PER GRASS POLLEN SEASON FOR DOSE TITRATION FOR INDIVIDUALS AGES 10 5 -17 YEARS
<b>IMMUNOSUPPRESSANT DRUGS</b>	GAMIFANT 10 MG/2 ML VIAL GAMIFANT 50 MG/10 ML VIAL	PA REQUIRED
<b>INHALED CORTICOSTEROIDS</b>	ARNUITY ELLIPTA INH	ADD QL 1 INHALER (30 BLISTERS) PER 30 DAYS
<b>MISCELLANEOUS AGENTS</b>	REVCovi 2.4 MG/1.5 ML VIAL	PA REQUIRED
<b>MISCELLANEOUS AGENTS</b>	ULTOMIRIS 300 MG/30 ML VIAL	PA REQUIRED ADD QL 12 VIALS PER 56 DAYS
<b>NEUROLOGICAL THERAPY- MISCELLANEOUS</b>	FIRDAPSE 10 MG TABLET	PA REQUIRED ADD QL 8 TABLETS PER DAY
<b>OPIOID WITHDRAWAL THERAPY AGENTS</b>	CASSIPA 16MG 4MG SL FILM*	ADD QL 1 SUBLINGUAL FILM PER DAY
<b>OPHTHALMOLOGICS – MISCELLANEOUS</b>	OXERVATE 0.002% EYE DROP	PA REQUIRED ADD QL 2 VIALS PER DAY

<b>OPHTHALMOLOGICS – MISCELLANEOUS</b>	CEQUA 0.09% SOLUTION	ADD ST ADD QL 2 VIALS PER DAY
<b>PULMONARY AGENTS – MISCELLANEOUS</b>	DALIRESP 250 MCG TABLET DALIRESP 500 MCG TABLET	ADD QL 1 TABLET PER DAY
<b>PULMONARY AGENTS - MISCELLANEOUS</b>	YUPELRI 175 MCG/3 ML SOLUTION	ADD QL 1 CARTON (30 VIALS) PER 30 DAYS
<b>RHEUMATOLOGICAL AGENTS – MISCELLANEOUS</b>	ACTEMRA ACTPEN 162 MG/0.9 ML	ADD QL 4 PER 28 DAYS
<b>TETRACYCLINES</b>	SEYSARA 60 MG TABLET SEYSARA 100 MG TABLET SEYSARA 150 MG TABLET	ADD ST ADD QL 1 TABLET PER DAY
<b>TETRACYCLINES</b>	NUZYRA 150 MG TABLET NUZYRA 150 MG TABLET-7 DAY NUZYRA 150 MG-7 DAY WITH LOAD	PA REQUIRED ADD QL 30 TABLETS PER FILL 1 FILL PER 30 DAYS
<b>TOPICAL CORTICOSTEROIDS MEDIUM POTENCY</b>	CORDRAN 0.025% CREAM	ADD QL 120 GMS PER 30 DAYS
<b>TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY</b>	BRYHALI 0.01% LOTION	ADD QL 100 GMS PER 30 DAYS
<b>TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY</b>	HALOBETASOL PROP 0.05% FOAM	NON-PREFERRED
<b>SELECTED AGENTS FOR INTRAOCULAR PRESSURE</b>	XELPROS 0.005% EYE DROP	ADD QL 5 MLS PER 30 DAYS
<b>SINGLE AGENT SHORT-ACTING OPIOID ANALGESICS</b>	MITIGO 200 MG/20 ML VIAL MITIGO 500 MG/20 ML VIAL	ADD QL 2 VIALS PER MONTH

*\*As these new drugs come to market, clinical edits will be put in place.*

#### **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/NJ>.

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