

## Quarterly pharmacy formulary change notice

**Summary:** The formulary changes listed in the table below were reviewed and approved at our second quarter 2019 pharmacy and therapeutics committee meeting.

Effective November 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 NOVEMBER 1, 2019			
Therapeutic class	Drug	Revised status	Potential alternatives
<b>HEREDITARY ANGIOEDEMA (HAE) PREVENTION</b>	HAEGARDA 2;000 UNIT VIAL HAEGARDA 3;000 UNIT VIAL TAKHZYRO 300 MG/2 ML VIAL	PREFERRED WITH PRIOR AUTHORIZATION (PA)	N/A
<b>HEREDITARY ANGIOEDEMA (HAE) TREATMENT</b>	BERINERT 500 UNIT KIT FIRAZYR 30 MG/3 ML SYRINGE KALBITOR 10 MG/ML VIAL RUCONEST 2;100 UNIT VIAL	PREFERRED WITH PA	N/A
<b>HIV</b>	DOVATO TAB 50-300MG	COVERED ADD QUANTITY LIMIT (QL) 1 PER DAY	N/A
<b>HIV</b>	TEMIXYS*	PREFERRED	N/A
<b>INSULIN- RAPID</b>	INSULIN LISPRO (AUTHORIZED GENERIC HUMALOG) INSULIN LISPRO KWIKPEN (AUTHORIZED GENERIC HUMALOG)	PREFERRED	N/A
<b>MULTIPLE SCLEROSIS</b>	AUBAGIO TAB 14MG AUBAGIO TAB 7MG GLATOPA INJ 40MG/ML GLATIRAMER INJ 40MG/ML	PREFERRED WITH PA	N/A
<b>MULTIPLE SCLEROSIS</b>	GILENYA CAP 0.5MG	NON-PREFERRED WITH PA	AUBAGIO TAB 14MG AUBAGIO TAB 7MG
<b>MUSCLE RELAXANTS &amp; ANTISPASMODIC AGENTS</b>	CHLORZOXAZONE 250 MG TABLET	NON-PREFERRED	TIZANIDINE HCL TABS CARISOPRODOL TABS CYCLOBENZAPRINE 5 MG TAB CYCLOBENZAPRINE 10 MG TAB METHOCARBAMOL TABS ORPHENADRINE CITRATE ER TABS
<b>NASAL STEROIDS</b>	(OTC GENERIC) BUDESONIDE SUS 32MCG RHINOCORT SUS ALLERGY	PREFERRED	N/A
<b>NASAL STEROIDS</b>	(OTC BRAND) FLONASE ALLERGY SPRAY 50MCG NASACORT ALLERGY SPRAY 55MCG/AC	NON-PREFERRED	(OTC GENERIC) BUDESONIDE SUS 32MCG RHINOCORT SUS ALLERGY

<b>PRENATAL VITAMINS</b>	OTC PRENATAL VITAMINS (VARIOUS)	PREFERRED	N/A
<b>PRENATAL VITAMINS</b>	NESTAB TABLETS (RX)	PREFERRED	N/A
<b>PRENATAL VITAMINS</b>	PRENATAL VITAMINS (RX) EXCEPT NESTAB	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	OTC PRENATAL VITAMINS (VARIOUS)
<b>THYROID</b>	NATURE-THROID WESTHROID NP THYROID LEVOTHYROXINE/LIOTHYRONINE (ALL STRENGTHS)	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)
<b>THYROID</b>	LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)	PREFERRED	NA
<b>UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN NOVEMBER 1, 2019</b> <i>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>			
<b>ADRENERGIC ANTAGONISTS &amp; RELATED DRUGS</b>	GUANFACINE 2 MG TABLET		REVISE QL; 1 PER DAY
<b>ADHD AGENTS</b>	EVEKEO ODT 5 MG TABLET EVEKEO ODT 10 MG TABLET EVEKEO ODT 15 MG TABLET EVEKEO ODT 20 MG TABLET		PA REQUIRED ADD QL 2 TABLETS PER DAY
<b>ADHD DRUGS</b>	ADHANSIA XR 25 MG CAPSULE ADHANSIA XR 35 MG CAPSULE ADHANSIA XR 45 MG CAPSULE ADHANSIA XR 55 MG CAPSULE ADHANSIA XR 70 MG CAPSULE ADHANSIA XR 85 MG CAPSULE		ADD PA ADD STEP THERAPY (ST) ADD QL 1 CAPSULE DAILY
<b>ANDROGENS INJECTABLE</b>	XYOSTED		ADD PA ADD QL 60 CAP KIT 5 KITS PER 30 DAYS 92 CAP KIT 3 KITS PER 30 DAYS
<b>INJECTABLE ANTICOAGULANT AGENTS</b>	LOVENOX 30 MG/0.3 ML SYRINGE LOVENOX 40 MG/0.4 ML SYRINGE LOVENOX 60 MG/0.6 ML SYRINGE LOVENOX 80 MG/0.8 ML SYRINGE LOVENOX 100 MG/ML SYRINGE LOVENOX 120 MG/0.8 ML SYRINGE LOVENOX 150 MG/ML SYRINGE LOVENOX 300 MG/3 ML VIAL		REVISE QL 30 SYRINGES PER 30 DAYS
<b>ANTIDEPRESSANT</b>	ZULRESSO		ADD PA
<b>ANTIDEPRESSANTS</b>	BUPROPION XL SSB		ADD PA
<b>ANTIFUNGAL AGENTS</b>	TOLSURA 65 MG CAPSULE		PA REQUIRED ADD ST

		ADD QL 126 CAPSULES PER 30 DAYS
<b>ANTIMALARIALS</b>	ARAKODA 100 MG TABLET	REVISE QL 64 TABLETS PER YEAR
<b>ANTINEOPLASTIC DRUGS</b>	SIGNIFOR LAR 10 MG KIT SIGNIFOR LAR 30 MG KIT	ADD QL 1 KIT PER 28 DAYS
<b>ANTINEOPLASTIC DRUGS</b>	BALVERSA 3 MG TABLET	ADD PA ADD QL 3 PER DAY
<b>ANTINEOPLASTIC DRUGS</b>	BALVERSA 4 MG TABLET	ADD PA ADD QL 2 PER DAY
<b>ANTINEOPLASTIC DRUGS</b>	BALVERSA 5 MG TABLET	ADD PA ADD QL 1 PER DAY
<b>ANTIPSORIATIC / ANTISEBORRHEIC</b>	SKYRIZ 75 MG/0.83 ML	ADD PA ADD QL 2 PREFILLED SYRINGES (1 CARTON) PER 84 DAYS (12 WEEKS)
<b>BETA BLOCKERS</b>	KAPSPARGO SPRINKLE 200 MG CAP	REVISE QL 2 PER DAY
<b>CARDIOVASCULAR AGENTS</b>	CORLANOR 5 MG/5 ML ORAL SOLUTION AMPULE	ADD QL 4 AMPULES PER DAY 4 CARTONS/28 DAYS
<b>COAGULATION AGENTS</b>	CABLIVI 11 MG KIT	ADD PA
<b>COLONY STIMULATING FACTORS</b>	UDENYCA 6 MG/0.6 ML SYRINGE	PA REQUIRED ADD QL 2 SYRINGES PER 28 DAYS
<b>ESTROGEN IMPLANT AGENTS</b>	YUTIQ	ADD PA
<b>GOUT AGENTS</b>	GLOPERBA 0.6 MG/5 ML	ADD PA ADD QL; 300 MLS (2 BOTTLES) PER 30 DAYS
<b>HEADACHE THERAPY</b>	AIMOVIG 140 MG/ML AUTOINJECTOR	ADD PA ADD ST ADD QL 1 PER 30 DAYS
<b>HEADACHE THERAPY</b>	AIMOVIG 70 MG/ML SYRINGE/AUTOINJECTOR	ADD PA ADD ST ADD QL 1 PER 30 DAYS
<b>HEADACHE THERAPY</b>	AIMOVIG 140 MG/2ML DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL 2 PER 30 DAYS

<b>HEADACHE THERAPY</b>	EMGALITY 120 MG/ML	ADD PA ADD ST ADD QL 1 PER 30 DAYS
<b>SELECTED AGENTS FOR HYPERSOMNIA</b>	SUNOSI 37.5 MG SUNOSI 75 MG SUNOSI 150 MG	ADD PA ADD ST ADD QL 1 PER DAY
<b>INSULIN THERAPY</b>	AFREZZA 90-8 UNIT / 90-12 UNIT 180 CARTRIDGES	ADD QL 2 BOXES PER 30 DAYS
<b>INSULIN THERAPY</b>	TRESIBA 100 UNIT/ML VIAL	ADD QL 30 MLS PER 30 DAYS
<b>INTRANASAL STEROIDS</b>	FLONASE SENSIMIST 27.5 MCG SPR	REVISE QL 2 INHALERS PER 30 DAYS
<b>AGENTS FOR INCREASED INTRAOCULAR PRESSURE</b>	ROCKLATAN 0.02% - 0.005% OPHTHALMIC SOLN	ADD QL 2.5ML PER 30 DAYS
<b>MULTIPLE SCLEROSIS</b>	MAYZENT 0.25MG STARTER PACK	ADD PA ADD ST ADD QL 1 PACK PER FILL, ONE TIME FILL
<b>MULTIPLE SCLEROSIS</b>	MAYZENT 0.25MG	ADD PA ADD ST ADD QL 4 PER DAY
<b>MULTIPLE SCLEROSIS</b>	MAYZENT 2MG	ADD PA ADD ST ADD QL 1 PER DAY
<b>MULTIPLE SCLEROSIS</b>	MAVENCLAD 10MG	ADD PA ADD ST ADD QL 1 BOX PER FILL; 2 FILLS PER 46 WEEKS
<b>COMBINATION NARCOTIC /ANALGESICS</b>	APADAZ 4.08-325 MG TABLET APADAZ 6.12-325 MG TABLET APADAZ 8.16-325 MG TABLET	ADD QL 6 PER DAY
<b>NSAID - ORAL</b>	QMIIZ 7.5 MG QMIIZ 15 MG	ADD ST ADD QL 1 TABLET PER DAY
<b>NSAID - TOPICAL</b>	FLECTOR 1.3% PATCH	REVISE QL 2 PER DAY
<b>NSAID - TOPICAL</b>	LICART TOPICAL SYSTEM	ADD QL 1 PER DAY

<b>ONCOLOGY AGENT</b>	ASPARLAS 4.08/325 MG ASPARLAS 8.16/325 MG	ADD PA ADD QL 6 PER DAY
<b>OSTEOPOROSIS THERAPY</b>	EVENITY 105 MG/1.17 ML SYRINGE EVENITY 210 MG DOSE-2 SYRINGES	ADD QL 1 CARTON (2 PREFILLED SYRINGES) PER MONTH
<b>SHORT-ACTING OPIOID AGENTS</b>	INFUMORPH 200 MG/20 ML AMPUL INFUMORPH 500 MG/20 ML AMPUL	REVISE QL 2 VIALS (40 ML) PER MONTH
<b>LONG-ACTING OPIOID AGENTS</b>	LEVORPHANOL 3 MG	ADD QL 6 PER DAY
<b>AGENTS FOR PARKINSON'S</b>	INBRIJA 60 CAPSULE KIT	ADD PA ADD ST ADD QL 5 KITS PER 30 DAYS
<b>AGENTS FOR PARKINSON'S</b>	INBRIJA 92 CAPSULE KIT	ADD PA ADD ST ADD QL 3 KITS PER 30 DAYS
<b>TAFAMIDIS AGENTS</b>	VYNDAMAX 61 MG	ADD PA ADD QL 1 PER DAY
<b>TAFAMIDIS AGENTS</b>	VYNDAQEL	ADD PA ADD QL 4 PER DAY
<b>THIAZIDE &amp; RELATED DIURETICS</b>	HCTZ 12.5 mg	REMOVE QL
<b>TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY</b>	DUOBRII 0.01%-0.045% LOTION 100 GM TUBE	ADD PA ADD QL 2 TUBES PER MONTH
<b>TRIPTAN AGENTS</b>	SUMATRIPTAN 4 MG/0.5 ML SUMATRIPTAN 6 MG/0.5 ML PEN INJECTOR/SYRINGE SUMAVEL DOSEPRO 4 MG/0.5 ML	REVISE QL 6 UNITS PER 30 DAYS
<b>TRIPTAN AGENTS</b>	TOSYMRA 10MG NASAL SPRAY	ADD QL 12 UNITS PER 30 DAYS

*\*MEDICATION WILL BE ADDED TO THE FORMULARY WHEN IT IS AVAILABLE ON THE MARKET*

**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.