Amerigroup
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Provider update

Quarterly pharmacy formulary change notice

Summary: Effective September 1, 2019, the changes outlined below apply to all Amerigroup Washington, Inc. members.

Effective for all patients on September 1, 2019			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
ANTIBIOTICS : AMINOPENICILLINS - ORAL	AMOXICILLIN CAP 500MG	Preferred	N/A
ANTIBIOTICS : ANTI-INFECTIVE AGENTS - MISC - INHALED	NEBUPENT INH 300MG	Preferred with Prior Authorization	N/A
ANTIBIOTICS : CEPHALOSPORINS - 3RD GENERATION - INJECTABLE	TAZICEF INJ 1GM TAZICEF INJ 2GM	Preferred with Prior Authorization	N/A
ANTIBIOTICS : PENICILLIN COMBINATIONS - INJECTABLE	PIPER/TAZOBA INJ 3-0.375G PIPER/TAZOBA INJ 2-0.25GM PIPER/TAZOBA INJ 4-0.5GM PIPER/TAZOBA INJ 12-1.5GM PIPER/TAZOBA INJ 36-4.5GM	Preferred with Prior Authorization	N/A
ANTIBIOTICS : TETRACYCLINES - INJECTABLE	TIGECYCLINE INJ 50MG	Preferred with Prior Authorization	N/A
ANTIBIOTICS : TETRACYCLINES - INJECTABLE	MINOCIN INJ 100MG	Preferred with Prior Authorization	N/A
ANTIBIOTICS : TETRACYCLINES - INJECTABLE	XERAVA INJ 50MG	Preferred with Prior Authorization	N/A
ANTIBIOTICS : TETRACYCLINES - INJECTABLE	NUZYRA INJ 100MG	Preferred with Prior Authorization	N/A
ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	LICE KILLING SHAMPOO 0.33-4% LICE TREATMENT SHAMPOO 0.33-4% LICIDE SHAMPOO 0.33-4% STOP LICE MS SHAMPOO 0.33-4% LICE KILLING SHAMPOO RID LICE KIL SHAMPOO 0.33-4%	Preferred	N/A
ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	PERMETHRIN CREAM 5%	Preferred	N/A
ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	EURAX CREAM 10%	Preferred	N/A

ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	LICE TREATMENT LIQUID 1% LICE TREATMENT LOTION 1%	Preferred	N/A
ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	SKLICE LOTION 0.5% CROTAN LOTION 10% RA LICE LOTION 1%	Preferred	N/A
ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	VANALICE GEL 0.3-3.5%	Preferred	N/A
ANTIPARASITICS : SCABICIDES AND PEDICULICIDES	NIX CREM RIN LIQQUID 1%	Preferred	N/A
CARDIOVASCULAR AGENTS - MISC : PERIPHERAL VASODILATORS - ORAL	ISOXSUPRINE TAB 10MG ISOXSUPRINE TAB HCL 20MG	Preferred	N/A
CARDIOVASCULAR AGENTS - MISC : PERIPHERAL VASODILATORS - ORAL	NIACIN TAB ER 500 MG NIACIN TAB ER 750 MG NIACIN TAB ER 1000 MG	Preferred	N/A
DERMATOLOGICS : BURN PRODUCTS	SULFAMYLON CREAM 85MG/GM SILVER SULFACETAMINE CREAM 1% SSD CREAM 1% SILVADENE CREAM 1% SULFAMYLON PAK 5%	Preferred with Prior Authorization	N/A
DERMATOLOGICS : BURN PRODUCTS	MAFENIDE ACE PAK 5%	Preferred with Prior Authorization	N/A
DERMATOLOGICS : BURN PRODUCTS	THERMAZENE CREAM 1%	Preferred	N/A
ENDOCRINE AND METABOLIC AGENTS : ANABOLIC STEROIDS - ORAL	OXANDROLONE TAB 2.5MG OXANDROLONE TAB 10MG	Preferred with Prior Authorization	N/A
ENDOCRINE AND METABOLIC AGENTS : ANABOLIC STEROIDS - ORAL	ANADROL-50 TAB 50MG	Preferred with Prior Authorization	N/A
ENDOCRINE AND METABOLIC AGENTS : ANABOLIC STEROIDS - ORAL	OXANDRIN TAB 10MG	Preferred	N/A
ENDOCRINE AND METABOLIC AGENTS : CORTICOTROPIN	H.P. ACTHAR INJ 80UNIT	Preferred with Prior Authorization	N/A
ENDOCRINE AND METABOLIC AGENTS : GROWTH HORMONE RECEPTOR ANTAGONISTS	SOMAVERT INJ 10MG SOMAVERT INJ 15MG SOMAVERT INJ 20MG SOMAVERT INJ 25MG SOMAVERT INJ 30MG	Preferred with Prior Authorization	N/A
ENDOCRINE AND METABOLIC AGENTS : GROWTH HORMONE RELEASING HORMONES (GHRH)	EGRIFTA SOL 1MG	Preferred with Prior Authorization	N/A

ENDOCRINE AND METABOLIC AGENTS : POSTERIOR PITUITARY HORMONES - INJECTABLE	DESMOPRESSIN INJ 4MCG/ML	Preferred with Prior Authorization	N/A
ENDOCRINE AND METABOLIC AGENTS : POSTERIOR PITUITARY HORMONES - INJECTABLE	VASOSTRICT INJ 20UNT/ML	Preferred with Prior Authorization	N/A
MIGRAINE AGENTS : ERGOT DERIVATIVES	ERGOT/CAFFEN TAB 1-100MG CAFERGOT TAB 1-100MG	Non-Preferred	ERGOMAR SUB 2MG
MIGRAINE AGENTS : ERGOT DERIVATIVES	D.H.E. 45 INJ 1MG/ML (Brand)	Non-Preferred	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML DIHYDROERGOTAMINE MESYLATE INJ 1 MG/ML (generic) with Prior Authorization Required
OPHTHALMIC AGENTS : OPHTHALMIC DECONGESTANTS	PHENYLEPHRIN SOL 2.5% OP PHENYLEPHRIN SOL 10% OP	Preferred with Prior Authorization	N/A
OPHTHALMIC AGENTS : OPHTHALMIC DECONGESTANTS	ALTAFRIN SOL 2.5% OP ALTAFRIN SOL 10% OP	Preferred	N/A
OPHTHALMIC AGENTS : OPHTHALMIC NERVE GROWTH FACTORS	OXERVATE SOL 20MCG/ML	Preferred with Prior Authorization	N/A
VASOPRESSORS : MISC - INJECTABLE	LEVOPHED INJ 1MG/ML	Preferred	N/A
VASOPRESSORS : MISC - INJECTABLE	NOREPINEPHERINE INJ 1MG/ML	Preferred	N/A
VASOPRESSORS : MISC - INJECTABLE	PHENYLEPHRINE INJ 10MG/ML	Preferred with Prior Authorization	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 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/WA.

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