Amerigroup
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Provider update

Quarterly pharmacy formulary change notice

Summary: The formulary changes listed in the table below were reviewed and approved at our second quarter 2018, Pharmacy and Therapeutics Committee meeting.

Effective October 1, 2018, the changes outlined below apply to all Amerigroup Washington, Inc. members.

Effective for all patients on October 1, 2018			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
DIABETIC SUPPLIES	BD PEN NEEDLES BD INSULIN SYRINGES	PREFERRED	N/A
DIABETIC SUPPLIES	ALL OTHER PEN NEEDLES AND INSULIN SYRINGES/MANUFACTURERS	NON-PREFERRED WITH STEP THERAPY (ST)	BD PEN NEEDLES BD INSULIN SYRINGES
ANTIARRHYTHMIC AGENTS	QUINIDINE SULFATE TABLETS	NON-PREFERRED	QUINIDINE GLUCONATE ER 324 MG TABELTS
ANTIPARKINSONISM AGENTS	BROMOCRIPTINE MESYLATE CAPSULE AND TABLET CARBIDOPA/LEVODOPA ODT CARBIDOPA/LEVODOPA/ENTACAPONE TABLETS	NON-PREFERRED	CARBIDOPA & LEVODOPA TABLETS PRAMIPEXOLE TABLETS BENZTROPINE MESYLATE TABLETS
ANXIOLYTICS	ALPRAZOLAM ODT 0.25 MG TAB ALPRAZOLAM ODT 0.5 MG TAB CLONAZEPAM ODT TABLETS CLORAZEPATE 3.75 MG TABLET CLORAZEPATE 7.5 MG TABLET OXAZEPAM 30 MG CAPSULE	NON-PREFERRED	ALPRAZOLAM TABLET DIAZEPAM TABLET LORAZEPAM TABLET
BETA BLOCKERS	NADOLOL 20 MG TABLET NADOLOL 40 MG TABLET NADOLOL 80 MG TABLET PINDOLOL 5 MG TABLET	NON-PREFERRED	ATENOLOL TABLET CARVEDILOL TABLET LABETALOL HCL TABLET METOPROLOL TARTRATE TABLET
CALCIUM CHANNEL BLOCKING AGENTS	CARTIA XT 120 MG CAPSULE CARTIA XT 180 MG CAPSULE CARTIA XT 240 MG CAPSULE CARTIA XT 300 MG CAPSULE DILTIAZEM 24HR ER 180 MG TAB DILTIAZEM 24HR ER 240 MG TAB DILTIAZEM 24HR ER 360 MG TAB DILTIAZEM 24HR ER 420 MG TAB MATZIM LA 240 MG TABLET TAZTIA XT 360 MG CAPSULE	NON-PREFERRED	DILTIAZEM HCL CAP ER 24HR 120 MG DILTIAZEM HCL CAP ER 24HR 180 MG DILTIAZEM HCL CAP ER 24HR 240 MG DILTIAZEM HCL COATED BEADS CAP ER 24HR 120 MG DILTIAZEM HCL COATED BEADS CAP ER 24HR 180 MG DILTIAZEM HCL COATED BEADS CAP ER 24HR 240 MG DILTIAZEM HCL COATED BEADS CAP ER 24HR 300 MG DILTIAZEM HCL COATED BEADS CAP ER 24HR 360 MG DILTIAZEM HCL COATED BEADS CAP ER 24HR 420 MG

CALCIUM CHANNEL BLOCKING AGENTS	VERAPAMIL 360 MG CAP PELLET VERAPAMIL ER 120 MG CAPSULE VERAPAMIL ER 180 MG CAPSULE VERAPAMIL ER 240 MG CAPSULE VERAPAMIL SR 120 MG CAPSULE VERAPAMIL SR 180 MG CAPSULE VERAPAMIL SR 240 MG CAPSULE VERAPAMIL ER PM 100 MG CAPSULE VERAPAMIL ER PM 200 MG CAPSULE VERAPAMIL ER PM 300 MG CAPSULE	NON-PREFERRED	DILTIAZEM HCL COATED BEADS CAP ER 24HR 360 MG VERAPAMIL HCL TAB ER 120 MG VERAPAMIL HCL TAB ER 180 MG VERAPAMIL HCL TAB ER 240 MG
LIPID/CHOLESTEROL LOWERING AGENTS	COLESTIPOL HCL GRANULES PACKET	NON-PREFERRED	CHOLESTYRAMINE LIGHT POWDER 4 GM/DOSE
LIPID/CHOLESTEROL LOWERING AGENTS	FENOFIBRATE 43 MG CAPSULE FENOFIBRATE 67 MG CAPSULE FENOFIBRATE 130 MG CAPSULE FENOFIBRATE 134 MG CAPSULE FENOFIBRIC ACID DR 135 MG CAP FENOFIBRATE 200 MG CAPSULE	NON-PREFERRED	FENOFIBRATE TAB 40 MG FENOFIBRATE TAB 48 MG FENOFIBRATE TAB 54 MG FENOFIBRATE TAB 120 MG FENOFIBRATE TAB 145 MG FENOFIBRATE TAB 160 MG
MISCELLANEOUS ANTIVIRALS	AMANTADINE 100 MG TABLET	NON-PREFERRED	AMANTADINE HCL CAP 100 MG
MISCELLANEOUS OPHTHALMOLOGICS	XIIDRA 5% EYE DROPS	NON-PREFERRED	RESTASIS 0.05% EMULSION
ORAL HYPOGLYCEMIC AGENTS	PIOGLITAZONE-METFORMIN 15-500 PIOGLITAZONE-METFORMIN 15-850	NON-PREFERRED	PIOGLITAZONE HCL TAB 15 MG METFORMIN HCL TAB 500 MG METFORMIN HCL TAB 850 MG
ORAL HYPOGLYCEMIC AGENTS	SYNJARDY 12.5-1,000 MG TABLET SYNJARDY XR 25-1,000 MG TABLET	NON-PREFERRED	INVOKAMET TAB 150-500 MG INVOKAMET TAB 50-1000 MG XIGDUO XR TAB ER 24HR 2.5-1000 MG XIGDUO XR TAB ER 24HR 5-1000 MG XIGDUO XR TAB ER 24HR 10-1000 MG
TETRACYCLINE ANTIBIOTICS	DOXYCYCLINE 25 MG/5 ML SUSP DOXYCYCLINE MONO 75 MG CAPSULE DOXYCYCLINE MONO 150 MG CAP	NON-PREFERRED	DOXYCYCLINE MONOHYDRATE TAB 50 MG DOXYCYCLINE MONOHYDRATE TAB 75 MG DOXYCYCLINE MONOHYDRATE TAB 150 MG
TETRACYCLINE ANTIBIOTICS	MINOCYCLINE HCL 50 MG TABLET MINOCYCLINE HCL 75 MG TABLET MINOCYCLINE HCL 100 MG TABLET	NON-PREFERRED	MINOCYCLINE HCL CAP 50 MG MINOCYCLINE HCL CAP 75 MG MINOCYCLINE HCL CAP 100 MG
EDITS *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*			
ADHD AGENTS	METHYLPHENIDATE ER 72 MG TAB	ADD QUANTITY LIMIT (QL) 1 TABLET PER DAY FOR MEMBERS 18 YEARS OF AGE AND OLDER	
ANTIHYPERTENSIVES	TEKTURNA 37.5MG ORAL PELLETS	ADD QL 8 PELLETS PER DAY	
ANTINEOPLASTIC AGENTS	IMBRUVICA 140 MG CAPSULE	REVISE QL 4 CAPSULE PER DAY	
ANTINEOPLASTIC DRUGS	IMBRUVICA 70 MG CAPSULE	REVISE QL 1 CAPSULE PER DAY	
ANTINEOPLASTIC AGENTS	IMBRUVICA 140 MG TABLET	REVISE QL 1 TABLET PER DAY	
ANTIPARASITICS	ALBENZA 200 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY	

ANTIPARASITICS	IMPAVIDO 50 MG CAPSULE	ADD QL 84 CAPSULES PER FILL 1 FILL EVERY 30 DAYS
APPETITE STIMULATOR	MEGESTROL TABLET MEGESTROL ORAL SUSP	PA REQUIRED
BOWEL PREP AGENTS	CLENPIQ SOLUTION	ADD QL 320 MLS PER 30 DAYS
CHEMOTHERAPY	BEXAROTENE 75 MG CAPSULE	ADD QL 10 CAPSULES PER DAY
CHEMOTHERAPY	CABOMETYX 20 MG TABLET	REVISE QL 1 TABLET PER DAY
CHEMOTHERAPY	ZYKADIA 150 MG CAPSULE	REVISE QL 3 CAPSULES PER DAY
CML	TASIGNA 50 MG CAPSULE	ADD QL 4 CAPSULES PER DAY
DERMATOLOGICAL AGENTS	QUINJA 1.25%-1% GEL	ADD QL 60 GMS PER 30 DAYS
EPINEPHRINE AGENTS	AUVI-Q 0.1 MG AUTO-INJECTOR	ADD QL 1 BOX (2 PENS) PER FILL
GLUCOSE ELEVATING AGENTS	GLUCAGEN 1 MG EMERGENCY KIT	ADD QL 2 KITS IN 30 DAYS
GOUT THERAPY	ULORIC 40 MG TABLET ULORIC 80 MG TABLET	ADD QL 1 TABLET PER DAY
GOUT THERAPY	ZURAMPIC 200 MG TABLET	ADD QL 1 TABLET PER DAY
GOUT THERAPY	KRYSTEXXA 8 MG/ML VIAL	ADD QL 2 VIALS (2ML) PER 28 DAYS
HIGH BLOOD PRESSURE AGENTS	DEMSER 250 MG CAPSULE	ADD QL 16 CAPSULES PER DAY
HIGH BLOOD PRESSURE AGENTS	DIBENZYLINE 10 MG CAPSULE	ADD QL 12 CAPSULES PER DAY
HIGH BLOOD PRESSURE AGENTS	KAPSPARGO	ADD QL 1 CAPSULE PER DAY
HIGH BLOOD PRESSURE AGENTS	PREXXARTAN	ADD QL 80 MLS PER DAY
IBD STEROIDS	UCERIS 2 MG RECTAL FOAM	ADD ST
GLAUCOMA AGENTS	AZOPT 1% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
GLAUCOMA AGENTS	BETIMOL 0.25% EYE DROPS BETIMOL 0.5% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
GLAUCOMA AGENTS	RHOPRESSA 0.02% OPHTH SOLUTION	ADD QL 5 MLS PER 30 DAYS
GLAUCOMA AGENTS	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
GLAUCOMA AGENTS	TIMOPTIC 0.25% AND 0.5% OCUDOSE DROP TIMOPTIC OCUMETER PLUS 0.25% AND 0.5% SOLN	ADD QL 10 MLS PER 30 DAYS
GLAUCOMA AGENTS	VYZULTA 0.024% OPHTH SOLUTION	ADD QL 2.5 MLS PER 30 DAYS

INTRANASAL STEROIDS	XHANCE 93 MCG NASAL SPRAY	ADD PA ADD ST ADD QL 2 INHALERS PER 30 DAYS
MENOPAUSAL THERAPIES	IMVEXXY 10 MCG VAGINAL INSERT IMVEXXY 4 MCG VAGINAL INSERT	ADD QL 18 VAGINAL INSERTS PER 28 DAYS
MIGRAINE	AIMOVIG 70 MG DOSE-1 AUTOINJ	ADD PA ADD ST ADD QL 1 AUTOINJECTOR/PACK PER 30 DAYS
MIGRAINE	AIMOVIG 140 MG DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL 2 AUTOINJECTORS/1 PACK PER 30 DAYS
MISCELLANEOUS AGENTS	SAMSCA 15 MG TABLET	ADD QL 1 TABLET PER DAY
MISCELLANEOUS AGENTS	SAMSCA 30 MG TABLET	ADD QL 2 TABLETS PER DAY
MISCELLANEOUS GASTROINTESTINAL AGENTS	RECTIV 0.4% OINTMENT	ADD QL 30 GM TUBE EVERY 30 DAYS
HEPATITIS B INTERFERON ANTIVIRAL THERAPY	PEGASYS (PEGINTERFERON ALFA 2A) INTRON A (INTERFERON ALFA 2B)	REMOVE PA REQUIREMENTS
NEUROPATHIC PAIN AND FIBROMYALGIA	ZTLIDO	ADD PA ADD QL 3 PATCHES PER DAY
NON-NARCOTIC ANALGESIC	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
NSAIDS	CONSENSI	ADD QL 1 TABLET PER DAY
PHOSPHATE BINDERS	CALCIUM ACETATE 668 MG TABLET	ADD QL 12 TABLETS PER DAY
PRENATAL VITAMINS	NESTABS ONE SOFTGEL	ADD QL 1 TABLET PER DAY
PROGESTINS	MAKENA 275 MG/1.1 ML AUTOINJCT	ADD QL 4 AUTOINJECTORS PER 28 DAYS
PROSTATE CANCER	ERLEADA 60 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
PROSTATE CANCER	YONSA 125 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
TOPICAL ANTIBACTERIALS	ALTABAX 1% OINTMENT	REVISE QL 30GM PER FILL 1 FILL PER 30 DAYS
TOPICAL ANTI-INFECTIVES	XEPI	ADD QL 45 GMS PER FILL 1 FILL PER 30 DAYS

TOPICAL CORTICOSTEROIDS – LOW POTENCY	SYNALAR 0.025% OINTMENT KIT	ADD QL 1 KIT PER 30 DAYS
TOPICAL CORTICOSTEROIDS- VERY HIGH POTENCY	IMPOYZ 0.025% CREAM	ADD QL 112 GM 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/WA.

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