Amerigroup
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Provider update

Quarterly pharmacy formulary change notice

Effective January 1, 2018, the changes outlined below apply to all Amerigroup patients. These formulary changes are occurring due to the state mandated Apple Health *Preferred Drug List* (*PDL*).

Effective for all patients on January 1, 2018			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
ANAPHYLAXIS THERAPY AGENTS: VASOPRESSORS	EPINEPHRINE 0.3 MG AUTO-INJECT EPINEPHRINE 0.15 MG AUTO-INJCT	NON-PREFERRED	EPINEPHRINE SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML EPINEPHRINE SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML
ANTICOAGULANTS: THROMBIN INHIBITORS - HIRUDIN TYPE	PRADAXA 110 MG CAPSULE PRADAXA 150 MG CAPSULE PRADAXA 75 MG CAPSULE	PREFERRED	N/A
ANTIDIABETICS: INSULIN	HUMALOG 100 UNITS/ML VIAL HUMALOG 100 UNITS/ML CARTRIDGE HUMALOG JR 100 UNIT/ML KWIKPEN HUMALOG 200 UNITS/ML KWIKPEN HUMALOG 100 UNITS/ML KWIKPEN LANTUS 100 UNIT/ML VIAL LANTUS SOLOSTAR 100 UNIT/ML LEVEMIR 100 UNITS/ML VIAL LEVEMIR FLEXTOUCH 100 UNITS/ML NOVOLOG 100 UNIT/ML VIAL NOVOLOG 100 UNITS/ML FLEXPEN NOVOLOG 100 UNIT/ML CARTRIDGE	PREFERRED	N/A
ANTIDIABETICS: INSULIN	APIDRA 100 UNITS/ML VIAL APIDRA SOLOSTAR 100 UNITS/ML BASAGLAR 100 UNIT/ML KWIKPEN NOVOLIN R 100 UNITS/ML NOVOLIN N 100 UNITS/ML NOVOLIN 70/30 100 UNITS/ML	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED FOR 3 MONTHS)	HUMALOG HUMALOG MIX HUMULIN R HUMULIN N NOVOLOG NOVOLOG MIX LANTUS LEVEMIR
ASTHMA AND COPD AGENTS: BETA ADRENERGICS - SHORT ACTING	METAPROTERENOL 10 MG/5 ML SYR TERBUTALINE SULFATE 2.5 MG TAB TERBUTALINE SULFATE 5 MG TAB	NON-PREFERRED	ALBUTEROL SULFATE SYRUP ALBUTEROL SULFATE TABS ALBUTEROL SULFATE ER TABS
ASTHMA AND COPD AGENTS: BETA ADRENERGICS - SHORT ACTING	VENTOLIN HFA 90 MCG INHALER	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED FOR 3 MONTHS)	PROAIR HFA PROVENTIL HFA
ASTHMA AND COPD AGENTS: SHORT ACTING BETA ADRENERGICS	PROAIR HFA 90 MCG INHALER PROVENTIL HFA 90 MCG INHALER	PREFERRED	N/A

The information in this update may be an update or change to your provider manual. Find the most current manual at:
https://providers.amerigroup.com

ASTHMA AND COPD AGENTS: INHALED STEROID	FLOVENT 50 MCG DISKUS FLOVENT 250 MCG DISKUS FLOVENT 100 MCG DISKUS FLOVENT HFA 44 MCG INHALER FLOVENT HFA 110 MCG INHALER FLOVENT HFA 220 MCG INHALER	PREFERRED	N/A
ASTHMA AND COPD AGENTS: INHALED STEROID	AEROSPAN 80 MCG INHALER ARNUITY ELLIPTA 100 MCG INH ARNUITY ELLIPTA 200 MCG INH	NON-PREFERRED (CURRENT UTILIZERS OF ARNUITY ELLIPTA WILL BE GRANDFATHERED FOR 6 MONTHS)	FLOVENT FLOVENT HFA BUDESONIDE RESPULES
ASTHMA AND COPD AGENTS: INHALED STEROID - LABA COMBINATIONS	ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 500-50 DISKUS ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER FLUTICASONE-SALMETEROL 55-14 FLUTICASONE-SALMETEROL 113-14 FLUTICASONE-SALMETEROL 232-14 SYMBICORT 160-4.5 MCG INHALER SYMBICORT 80-4.5 MCG INHALER	PREFERRED	N/A
ASTHMA AND COPD AGENTS: INHALED STEROID - LABA COMBINATIONS	BREO ELLIPTA 100-25 MCG INH BREO ELLIPTA 200-25 MCG INH	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED FOR 6 MONTHS)	ADVAIR HFA DULERA FLUTICASONE/SALMETEROL SYMBICORT
ASTHMA AND COPD AGENTS: LAMA - LABA COMBINATIONS	ANORO ELLIPTA 62.5-25 MCG INH	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED FOR 6 MONTHS)	COMBIVENT RESPIMAT STIOLTO RESPIMAT
ASTHMA AND COPD AGENTS: LAMA - LABA COMBINATIONS	STIOLTO RESPIMAT INHAL SPRAY	PREFERRED	N/A
ASTHMA AND COPD AGENTS: LONG ACTING MUSCARINIC AGENTS (LAMA)	SPIRIVA 18 MCG CP-HANDIHALER	PREFERRED	N/A
ASTHMA AND COPD AGENTS: LONG ACTING MUSCARINIC AGENTS (LAMA)	SPIRIVA RESPIMAT 2.5 MCG INH SPIRIVA RESPIMAT 1.25 MCG INH	NON-PREFERRED	SPIRIVA HANDIHALER
ASTHMA AND COPD AGENTS: SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS	DALIRESP 500 MCG TABLET	PREFERRED	N/A
ASTHMA AND COPD AGENTS: ANTI-	CROMOLYN 20 MG/2 ML NEB SOLN	NON-PREFERRED	N/A

INFLAMMATORY AGENTS			
ANTIEMETICS: 5-HT3 RECEPTOR ANTAGONISTS	GRANISETRON HCL 1 MG TABLET GRANISETRON HCL 4 MG/4 ML VIAL GRANISETRON HCL 1 MG/ML VIAL GRANISETRON HCL 0.1 MG/ML VIAL ONDANSETRON 4 MG/5 ML SOLUTION ONDANSETRON 40 MG/20 ML VIAL ONDANSETRON HCL 4 MG/2 ML VIAL ONDANSETRON HCL 4 MG TABLET ONDANSETRON HCL 8 MG TABLET ONDANSETRON 4 MG/2 ML ISECURE ONDANSETRON HCL 24 MG TABLET ONDANSETRON HCL 4 MG/2 ML SYR	PREFERRED	N/A
ANTIRETROVIRALS: ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES	ZIAGEN SOLN 20 MG/ML	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED LIFETIME)	ABACAVIR VIDEX DIDANOSINE
DIGESTIVE ENZYMES: PANCREATIC ENZYMES	ZENPEP DR 5;000 UNITS CAPSULE ZENPEP DR 15;000 UNITS CAPSULE ZENPEP DR 20;000 UNITS CAPSULE ZENPEP DR 3;000 UNITS CAPSULE ZENPEP DR 25;000 UNITS CAPSULE ZENPEP DR 10;000 UNITS CAPSULE ZENPEP DR 40;000 UNITS CAPSULE	PREFERRED	N/A
ENDOCRINE AND METABOLIC AGENTS - MISC.: GROWTH HORMONES	GENOTROPIN 5 MG CARTRIDGE GENOTROPIN 12 MG CARTRIDGE GENOTROPIN MINIQUICK 0.2 MG GENOTROPIN MINIQUICK 0.4 MG GENOTROPIN MINIQUICK 0.6 MG GENOTROPIN MINIQUICK 0.8 MG GENOTROPIN MINIQUICK 1 MG GENOTROPIN MINIQUICK 1.2 MG GENOTROPIN MINIQUICK 1.4 MG GENOTROPIN MINIQUICK 1.6 MG GENOTROPIN MINIQUICK 1.8 MG GENOTROPIN MINIQUICK 2 MG NORDITROPIN FLEXPRO 30 MG/3 ML NORDITROPIN FLEXPRO 5 MG/1.5 NORDITROPIN FLEXPRO 10 MG/1.5 NORDITROPIN FLEXPRO 15 MG/1.5	PREFERRED WITH PA REQUIRED	N/A
ENDOCRINE AND METABOLIC AGENTS - MISC.: GROWTH HORMONES	ZOMACTON 5 MG VIAL ZOMACTON 10 MG VIAL	NON-PREFERRED	GENOTROPIN NORDITROPIN (PA REQUIRED)
MULTIPLE SCLEROSIS AGENTS: MULTIPLE SCLEROSIS AGENTS	COPAXONE 20 MG/ML SYRINGE COPAXONE 40 MG/ML SYRINGE	PREFERRED	N/A
MULTIPLE SCLEROSIS AGENTS: MULTIPLE SCLEROSIS AGENTS	GLATOPA 20 MG/ML SYRINGE	NON-PREFERRED (CURRENT UTILIZERS WILL BE	AVONEX COPAXONE GILENYA

		GRANDFATHERED LIFETIME)	REBIF REBIF REBIDOSE BETASERON TECFIDERA
MULTIPLE SCLEROSIS AGENTS: MULTIPLE SCLEROSIS AGENTS - INTERFERONS	EXTAVIA 0.3 MG KIT EXTAVIA 0.3 MG VIAL	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED LIFETIME)	AVONEX COPAXONE GILENYA REBIF REBIF REBIDOSE BETASERON TECFIDERA
OPIOID ANALGESICS: OPIOID PARTIAL AGONISTS	BUPRENORPHINE 5 MCG/HR PATCH BUPRENORPHINE 10 MCG/HR PATCH BUPRENORPHINE 15 MCG/HR PATCH BUPRENORPHINE 20 MCG/HR PATCH BUPRENORPHINE 7.5 MCG/HR PATCH	PREFERRED	N/A
SUBSTANCE USE DISORDER: OPIOID PARTIAL AGONISTS	SUBOXONE 2 MG-0.5 MG SL FILM SUBOXONE 4 MG-1 MG SL FILM SUBOXONE 8 MG-2 MG SL FILM SUBOXONE 12 MG-3 MG SL FILM	PREFERRED	N/A
SUBSTANCE USE DISORDER: OPIOID PARTIAL AGONISTS	BUPRENORPHINE 2 MG TABLET SL BUPRENORPHINE 8 MG TABLET SL	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED LIFETIME)	SUBOXONE SL FILM BUPRENORPHINE-NALOXONE SL TAB

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 may need to obtain prior authorization (PA) to continue coverage beyond the applicable effective date. Some medications will be grandfathered.

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.