Anthem Blue Cross and Blue Shield Medicaid

MEDICAID PROVIDER BULLETIN
October 2019

Quarterly pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at the second quarter 2019 Pharmacy and Therapeutics Committee meeting. Effective November 1, 2019, the following formulary changes will apply. This notice applies to Anthem Blue Cross and Blue Shield Medicaid (Anthem) benefits in Kentucky.

EFFECTIVE FOR ALL PATIENTS ON NOVEMBER 1, 2019			
Therapeutic class	**Drug name**	**Revised status**	**Potential alternatives**
HEREDITARY ANGIOEDEMA (HAE) PREVENTION	HAEGARDA 2;000 UNIT VIAL HAEGARDA 3;000 UNIT VIAL TAKHZYRO 300 MG/2 ML VIAL	PREFERRED WITH PRIOR AUTHORIZATION (PA)	N/A
HEREDITARY ANGIOEDEMA (HAE) TREATMENT	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
HIV	DOVATO TAB 50-300MG	COVERED ADD QUANTITY LIMIT (QL) 1 PER DAY	N/A
HIV	TEMIXYS*	PREFERRED	N/A
INSULIN- RAPID	INSULIN LISPRO (AUTHORIZED GENERIC HUMALOG) INSULIN LISPRO KWIKPEN (AUTHORIZED GENERIC HUMALOG)	PREFERRED	N/A
MULTIPLE SCLEROSIS	AUBAGIO TAB 14MG AUBAGIO TAB 7MG GLATOPA INJ 40MG/ML GLATIRAMER INJ 40MG/ML	PREFERRED WITH PA	N/A
MULTIPLE SCLEROSIS	GILENYA CAP 0.5MG	NON-PREFERRED WITH PA	AUBAGIO TAB 7 MG AUBAGIO TAB 14 MG
MUSCLE RELAXANTS & ANTISPASMODIC AGENTS	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

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PLEASE NOTE: Information being presented is current as of the date of publication and is subject to change based on guidance from the Department for Medicaid Services.
AKYPEC-2181-19 September 2019

NASAL STEROIDS	(OTC GENERIC) BUDESONIDE SUS 32MCG RHINOCORT SUS ALLERGY	PREFERRED	N/A
NASAL STEROIDS	(OTC BRAND) FLONASE ALLERGY SPRAY 50MCG NASACORT ALLERGY SPRAY 55MCG/AC	NON-PREFERRED	(OTC GENERIC) BUDESONIDE SUS 32MCG RHINOCORT SUS ALLERGY
PRENATAL VITAMINS	OTC PRENATAL VITAMINS (VARIOUS)	PREFERRED	N/A
PRENATAL VITAMINS	NESTAB TABLETS (RX)	PREFERRED	N/A
PRENATAL VITAMINS	PRENATAL VITAMINS (RX) EXCEPT NESTAB	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	OTC PRENATAL VITAMINS (VARIOUS)
THYROID	NATURE-THROID WESTHROID NP THYROID LEVOTHYROXINE/LIOTHYRONINE (ALL STRENGTHS)	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	LEVOTHYROXIN TABS LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)
THYROID	LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)	PREFERRED	NA
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN NOVEMBER 1, 2019 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*			
ADRENERGIC ANTAGONISTS & RELATED DRUGS	GUANFACINE 2 MG TABLET	REVISE QL; 1 PER DAY	
ADHD AGENTS	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	
ADHD DRUGS	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	
ANDROGENS INJECTABLE	XYOSTED	ADD PA AND ADD QL 60 CAP KIT 5 KITS PER 30 DAYS 92 CAP KIT 3 KITS PER 30 DAYS	
INJECTABLE ANTICOAGULANT AGENTS	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	

ANTIDEPRESSANT	ZULRESSO	ADD PA
ANTIDEPRESSANTS	BUPROPION XL SSB	ADD PA
ANTIFUNGAL AGENTS	TOLSURA 65 MG CAPSULE	PA REQUIRED ADD ST ADD QL 126 CAPSULES PER 30 DAYS
ANTIMALARIALS	ARAKODA 100 MG TABLET	REVISE QL 64 TABLETS PER YEAR
ANTINEOPLASTIC DRUGS	SIGNIFOR LAR 10 MG KIT SIGNIFOR LAR 30 MG KIT	ADD QL 1 KIT PER 28 DAYS
ANTINEOPLASTIC DRUGS	BALVERSA 3 MG TABLET	ADD PA AND ADD QL 3 PER DAY
ANTINEOPLASTIC DRUGS	BALVERSA 4 MG TABLET	ADD PA AND ADD QL 2 PER DAY
ANTINEOPLASTIC DRUGS	BALVERSA 5 MG TABLET	ADD PA AND ADD QL 1 PER DAY
ANTIPSORIATIC / ANTISEBORRHEIC	SKYRIZ 75 MG/0.83 ML	ADD PA ADD QL 2 PREFILLED SYRINGES (1 CARTON) PER 84 DAYS (12 WEEKS)
BETA BLOCKERS	KAPSPARGO SPRINKLE 200 MG CAP	REVISE QL 2 PER DAY
CARDIOVASCULAR AGENTS	CORLANOR 5 MG/5 ML ORAL SOLUTION AMPULE	ADD QL 4 AMPULES PER DAY 4 CARTONS/28 DAYS
COAGULATION AGENTS	CABLIVI 11 MG KIT	ADD PA
COLONY STIMULATING FACTORS	UDENYCA 6 MG/0.6 ML SYRINGE	PA REQUIRED ADD QL 2 SYRINGES PER 28 DAYS
ESTROGEN IMPLANT AGENTS	YUTIQ	ADD PA
GOUT AGENTS	GLOPERBA 0.6 MG/5 ML	ADD PA ADD QL; 300 MLS (2 BOTTLES) PER 30 DAYS
HEADACHE THERAPY	AIMOVIG 140 MG/ML AUTOINJECTOR	ADD PA ADD ST ADD QL 1 PER 30 DAYS
HEADACHE THERAPY	AIMOVIG 70 MG/ML SYRINGE/AUTOINJECTOR	ADD PA ADD ST ADD QL 1 PER 30 DAYS
HEADACHE THERAPY	AIMOVIG 140 MG/2ML DOSE-2 AUTOINJ	ADD PA AND ST ADD QL 2 PER 30 DAYS
HEADACHE THERAPY	EMGALITY 120 MG/ML	ADD PA AND ST ADD QL 1 PER 30 DAYS

SELECTED AGENTS FOR HYPERSOMNIA	SUNOSI 37.5 MG SUNOSI 75 MG SUNOSI 150 MG	ADD PA AND ST ADD QL 1 PER DAY
INSULIN THERAPY	AFREZZA 90-8 UNIT / 90-12 UNIT 180 CARTRIDGES	ADD QL 2 BOXES PER 30 DAYS
INSULIN THERAPY	TRESIBA 100 UNIT/ML VIAL	ADD QL 30 MLS PER 30 DAYS
INTRANASAL STEROIDS	FLONASE SENSIMIST 27.5 MCG SPR	REVISE QL 2 INHALERS PER 30 DAYS
AGENTS FOR INCREASED INTRAOCULAR PRESSURE	ROCKLATAN 0.02% - 0.005% OPHTHALMIC SOLN	ADD QL 2.5ML PER 30 DAYS
MULTIPLE SCLEROSIS	MAYZENT 0.25MG STARTER PACK	ADD PA AND ST ADD QL 1 PACK PER FILL, ONE TIME FILL
MULTIPLE SCLEROSIS	MAYZENT 0.25MG	ADD PA ADD ST ADD QL 4 PER DAY
MULTIPLE SCLEROSIS	MAYZENT 2MG	ADD PA AND ST ADD QL 1 PER DAY
MULTIPLE SCLEROSIS	MAVENCLAD 10MG	ADD PA AND ST ADD QL 1 BOX PER FILL; 2 FILLS PER 46 WEEKS
COMBINATION NARCOTIC /ANALGESICS	APADAZ 4.08-325 MG TABLET APADAZ 6.12-325 MG TABLET APADAZ 8.16-325 MG TABLET	ADD QL 6 PER DAY
NSAID - ORAL	QMIIZ 7.5 MG QMIIZ 15 MG	ADD ST ADD QL 1 TABLET PER DAY
NSAID - TOPICAL	FLECTOR 1.3% PATCH	REVISE QL 2 PER DAY
NSAID - TOPICAL	LICART TOPICAL SYSTEM	ADD QL 1 PER DAY
ONCOLOGY AGENT	ASPARLAS 4.08/325 MG ASPARLAS 8.16/325 MG	ADD PA ADD QL 6 PER DAY
OSTEOPOROSIS THERAPY	EVENITY 105 MG/1.17 ML SYRINGE EVENITY 210 MG DOSE-2 SYRINGES	ADD QL 1 CARTON (2 PREFILLED SYRINGES) PER MONTH
SHORT-ACTING OPIOID AGENTS	INFUMORPH 200 MG/20 ML AMPUL INFUMORPH 500 MG/20 ML AMPUL	REVISE QL 2 VIALS (40 ML) PER MONTH
LONG-ACTING OPIOID AGENTS	LEVORPHANOL 3 MG	ADD QL 6 PER DAY

AGENTS FOR PARKINSON'S	INBRIJA 60 CAPSULE KIT	ADD PA AND ADD ST ADD QL 5 KITS PER 30 DAYS
AGENTS FOR PARKINSON'S	INBRIJA 92 CAPSULE KIT	ADD PA AND ADD ST ADD QL 3 KITS PER 30 DAYS
TAFAMIDIS AGENTS	VYNDAMAX 61 MG	ADD PA AND ADD QL 1 PER DAY
TAFAMIDIS AGENTS	VYNDAQEL	ADD PA ADD QL 4 PER DAY
THIAZIDE & RELATED DIURETICS	HCTZ 12.5 mg	REMOVE QL
TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY	DUOBRII 0.01%-0.045% LOTION 100 GM TUBE	ADD PA ADD QL 2 TUBES PER MONTH
TRIPTAN AGENTS	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
TRIPTAN AGENTS	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 Anthem 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 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 Anthem patient cannot be converted to a formulary alternative, call our Pharmacy department at **1-855-661-2028** and follow the voice prompts for pharmacy prior authorization. You can find the *Preferred Drug List* on our provider website at **https://mediproviders.anthem.com/ky/pages/pharmacy.aspx**.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-855-661-2028**.