MEDICAID PROVIDER BULLETIN
December 2017

Quarterly pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at the 3rd quarter Pharmacy and Therapeutics Committee meeting held on June 29. Effective February 1, 2018, 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 February 1, 2018			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
ANTIPSYCHOTICS	PIMOZIDE 1 MG TABLET PIMOZIDE 2 MG TABLET	PREFERRED	N/A
CONTRACEPTIVES-LONG ACTING REVERSIBLE CONTRACEPTIVES	LILETTA 52 MG SYSTEM KYLEENA 19.5 MG SYSTEM MIRENA SYSTEM SKYLA SYSTEM PARAGARD T 380-A IUD NEXPLANON 68 MG IMPLANT	MEDICAL BENEFIT ONLY	N/A
ENZYMES	CO Q-10 (OTC)	NONPREFERRED	N/A
ESTROGENS	ALORA 0.05 MG PATCH ALORA 0.1 MG PATCH MINIVELLE 0.05 MG PATCH MINIVELLE 0.1 MG PATCH	NONPREFERRED	N/A
ESTROGEN COMBINATIONS	ESTRADIOL-NORETH 1-0.5 MG TAB MIMVEY 1-0.5 MG TABLET	PREFERRED	N/A
ESTROGEN COMBINATIONS	MIMVEY LO 0.5-0.1 MG TABLET LOPREEZA 1 MG-0.5 MG TABLET	PREFERRED	N/A
HEPATITIS C	EPCLUSA 400 MG-100 MG TABLET	NONPREFERRED WITH PA	ZEPATIER MAVYRET WITH PA REQUIRED
HEPATITIS C	MAVYRET 100-40 MG TABLET	PREFERRED WITH PA AS OF 11/1/17	N/A
MISCELLANEOUS AGENTS — DEXTROSE	ENFAMIL 5% GLUCOSE IN WATER	NONPREFERRED	N/A
MISCELLANEOUS AGENTS — LEVOCARNITINE	CARNITOR SF 100 MG/ML ORAL SOL LEVOCARNITINE 1 G/10 ML SOLN	NONPREFERRED	LEVOCARNITINE 330 MG TABLET
MISCELLANEOUS AGENTS — BONE RESORPTION INHIBITORS	ETIDRONATE DISODIUM 200 MG TAB ETIDRONATE DISODIUM 400 MG TAB	NONPREFERRED	ALENDRONATE ORAL SOLUTION ALENDRONATE TABLETS
MISCELLANEOUS AGENTS — BULK CHEMICALS	BENZYL ALCOHOL LIQUID COTTONSEED OIL BENZYL BENZOATE LIQUID	NONPREFERRED	N/A

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

	PHENOL LIQUID DMSA POWDER SUCCIMER DMSA POWDER PEG 3350-GRX POWDER SULFADIAZINE SODIUM POWDER		
ALPHA-1-PROTEINASE INHIBITOR	ZEMAIRA 1,000 MG VIAL ARALAST NP 500 MG VIAL ARALAST NP 1,000 MG VIAL GLASSIA 1 GM/50 ML VIAL	NONPREFERRED WITH PA	N/A
MISCELLANEOUS AGENTS — SODIUM CHLORIDE	SODIUM CHLORIDE 0.9% VIAL	NONPREFERRED	N/A
MISCELLANEOUS AGENTS — SUCCIMER	CHEMET 100 MG CAPSULE	NONPREFERRED WITH PA	N/A
MISCELLANEOUS AGENTS — SKIN TISSUE REPLACEMENT	APLIGRAF DISK	NONPREFERRED	N/A
MISCELLANEOUS AGENTS — GLYCEROL PHENYLBUTYRATE	RAVICTI 1.1 GRAM/ML LIQUID	NONPREFERRED WITH PA AND QL 17.5ML PER DAY	N/A
MISCELLANEOUS AGENTS — SODIUM POLYSTYRENE SULFONATE	SPS 50 GM/200 ML ENEMA KIONEX 15 GM/60 ML SUSPENSION	NONPREFERRED	SPS 15 GM/60 ML SUSPENSION SPS 30 GM/120 ML ENEMA
MISCELLANEOUS AGENTS	AZO TEST STRIP	PREFERRED	N/A
MISCELLANEOUS AGENTS	URINARY TRACT INFECT TEST STRP	PREFERRED	N/A
MISCELLANEOUS AGENTS — HYDROPHILIC OINT	DERMAFIX OINTMENT	NONPREFERRED	N/A
MISCELLANEOUS OPHTHALMOLOGICS (OTC)	REFRESH 0.5% EYE DROPS LUBRICANT 0.5% EYE DROPS ZADITOR DROPS ARTIFICIAL TEARS (SINGLE USE DROP DISPENSER)	NONPREFERRED	N/A
NEUTRACEUTICALS	ECHINACEA CAPSULE (OTC)	NONPREFERRED	N/A
OPTHALMIC ANTI-INFECTIVES	GATIFLOXACIN 0.5% EYE DROPS MOXIFLOXACIN 0.5% EYE DROPS (GENERIC VIGAMOX)	PREFERRED	N/A
OPTHALMIC ANTI-INFECTIVES	LEVOFLOXACIN 0.5% EYE DROPS	PREFERRED	N/A
MISCELLANEOUS UROLOGICALS	CYTRA-K ORAL SOLUTION POTASSIUM CIT-CITRIC ACID SOLN	PREFERRED	N/A
VASOCONSTRICTOR DECONGESTANTS	PHENYLEPHRINE 2.5% EYE DROP PHENYLEPHRINE 10% EYE DROPS ADVANCED FORMULA EYE DROPS ARTIFICIAL TEARS DROPS	PREFERRED	N/A
VASOCONSTRICTOR DECONGESTANTS	NAPHCON-A EYE DROPS VISINE LONG LASTING EYE DROPS	NONPREFERRED	VISINE A-EYE DROPS GENERIC OTC EYE ALLERGY RELIEF DROPS

VASOCONSTRICTOR DECONGESTANTS	EYE ALLERGY RELIEF DROP VISINE-A EYE DROPS EYE DROPS ADVANCED RELIEF	PREFERRED	N/A
EDITS *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS — REVISION OR ADDITION TO UM EDIT ONLY*			
ANTICOAGULANTS	BEVYXXA 40 MG CAPSULE BEVYXXA 80 MG CAPSULE	31 PER 30 DAYS LIMIT OF 42 DAYS SUPPLY IN 60 DAYS	N/A
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG	AVODART DUTASTERIDE DUTASTERIDE-TAMSULOSIN FINASTERIDE JALYN PROSCAR	AL REMOVED	N/A
ADHD	COTEMPLA XR-ODT 8.6 MG TABLET COTEMPLA XR-ODT 17.3 MG TABLET COTEMPLA XR-ODT 25.9 MG TABLET	ADD QL 2 PER DAY	N/A
ADHD	VYVANSE 10 MG CHEWABLE TABLET VYVANSE 20 MG CHEWABLE TABLET VYVANSE 30 MG CHEWABLE TABLET VYVANSE 40 MG CHEWABLE TABLET VYVANSE 50 MG CHEWABLE TABLET VYVANSE 60 MG CHEWABLE TABLET	ADD QL 1 PER DAY	N/A
ADHD	METADATE ER METHYLPHENIDATE HCL METHYLPHENIDATE ER, CD, LA DEXMETHYLPHENIDATE HCL IR & ER ATOMOXETINE HCL CLONIDINE HCL ER DEXTROAMPHETAMINE SULFATE IR & ER DEXTROAMPHETAMINE-AMPHETAMINE IR & ER	REVISED AGE LIMIT: 19 YEARS AND OLDER REQUIRE PA	N/A
MISCELLANEOUS ANALGESICS	ULTRAM 50 MG TABLET TRAMADOL HCL 50 MG TABLET CONZIP 100 MG CAPSULE CONZIP 200 MG CAPSULE CONZIP 300 MG CAPSULE TRAMADOL HCL ER 100 MG TABLET TRAMADOL HCL ER 200 MG TABLET TRAMADOL HCL ER 300 MG TABLET TRAMADOL HCL ER 100 MG CAPSULE TRAMADOL HCL ER 150 MG CAPSULE TRAMADOL HCL ER 200 MG CAPSULE TRAMADOL HCL ER 300 MG CAPSULE ULTRACET TABLET TRAMADOL-ACETAMINOPHN 37.5-325	ADD AL >=18	N/A
ANTI-INFECTIVES	DAXBIA 333 MG CAPSULE	ADD QL 168 PER 30 DAYS	N/A
ANTIMETABOLITES	XATMEP 2.5 MG/ML ORAL SOLUTION	ADD PA	N/A
ANTINEOPLASTICS	KISQALI FEMARA 200 MG CO-PACK KISQALI FEMARA 400 MG CO-PACK	ADD QL	N/A

	KISQALI FEMARA 600 MG CO-PACK	1 CARTON PER 30 DAYS	
ANTINEOPLASTICS	RUBRACA 250 MG TABLET	ADD QL 4 PER DAY	N/A
ANTINEOPLASTICS	ZYTIGA 500 MG TABLET	ADD QL 2 PER DAY	N/A
ANTIPARKINSONISM AGENTS	XADAGO 50 MG TABLET	ADD PA AND QL 2 PER DAY	N/A
ANTIPARKINSONISM AGENTS	XADAGO 100 MG TABLET	ADD PA AND QL 1 PER DAY	N/A
ANTIPARKINSONISM AGENTS	ZELAPAR 1.25 MG ODT TABLET	ADD PA AND QL 2 PER DAY	N/A
ANTIPSORIATIC AGENTS	TREMFYA 100 MG/ML SYRINGE	ADD QL 1 PER 56 DAYS	N/A
ANTIPSYCHOTICS	FAZACLO 200 MG ODT CLOZAPINE ODT 200 MG TABLET CLOZAPINE 200 MG TABLET	QL REVISION 4 PER DAY	N/A
ANTIPSYCHOTICS	ALL PREFERRED PRODUCTS	UPPER AL REVISED >=18 YEARS OLD	N/A
ANTISPASMODICS	GELNIQUE 10% GEL PUMP	ADD QL 1 PUMP PER 30 DAYS	N/A
ANTIVIRALS	FAMCICLOVIR 125 MG TABLET FAMCICLOVIR 250 MG TABLET VALTREX 500 MG CAPLET VALACYCLOVIR HCL 500 MG TABLET	ADD QL 60 PER 30 DAYS	N/A
CODEINE CONTAINING AGENTS	ALL RX AND OTC PRODUCTS	ADD AL >=12 YEARS OLD	N/A
HEPATITIS C	RIBAVIRIN 200 MG CAPSULE RIBAVIRIN 200 MG TABLET	PA REMOVED	N/A
GROWTH HORMONES	SAIZEN 8.8 MG CLICK.EASY CARTG SAIZEN 8.8 MG SAIZENPREP CART	ADD QL 1 CARTRIDGE PER DAY	N/A
MISCELLANEOUS GASTROINTESTINAL AGENTS	RENFLEXIS 100 MG VIAL	PA REQUIRED ADD QL 2 PER 28 DAYS	N/A
HYPERPARATHYROIDISM	RAYALDEE 30MCG SENSIPAR 30MG & 60MG	ADD QL 2 PER DAY	N/A
HYPERPARATHYROIDISM	SENSIPAR 90MG	ADD QL 4 PER DAY	N/A
HYPNOTIC AGENTS	BUTISOL SODIUM 30 MG/5 ML ELX BUTISOL SODIUM 30 MG TABLET	NEW: 14 DAY TREATMENT PERIOD	N/A
INTRANASAL STEROIDS	FLUTICASONE 50 MCG SPRAY (OTC) NASACORT ALLERGY 24 HR (OTC) FLONASE SENSIMIST 27.5 MCG SPR	ADD QL 1 PER 30 DAYS	N/A
LIPID/CHOLESTEROL LOWERING AGENTS	VASCEPA 0.5 MG	ADD QL 8 PER DAY	N/A
MISCELLANEOUS AGENTS — SODIUM PHENYLBUTYRATE	BUPHENYL 500MG	ADD QL 40 PER DAY	N/A

MISCELLANEOUS AGENTS — SODIUM PHENYLBUTYRATE	BUPHENYL 250GM POWDER	ADD QL 250GM POWDER PER 12 DAYS	N/A
AGENTS TO TREAT MULTIPLE SCLEROSIS	ZINBRYTA 150 MG/ML SYRINGE	ADD QL 1 PER 28 DAYS	N/A
NARCOTICS	LAZANDA 300 MCG NASAL SPRAY	ADD QL 1 BOTTLE PER DAY	N/A
NARCOTICS	ACETAMIN-CAFF-DIHYDROCOD 325-30-16	ADD QL 10 PER DAY	N/A
NARCOTIC ANTAGONISTS	EVZIO 0.4 MG AUTO-INJECTOR EVZIO 2 MG AUTO-INJECTOR	ADD QL 6 INJ PER 90 DAYS	N/A
NARCOTIC ANTAGONISTS	NARCAN 2MG NASAL SPRAY	ADD QL 3 CARTONS PER 90 DAYS	N/A
NARCOTIC — SHORT ACTING OPIOIDS	HYDROMORPHONE 1 MG/ML INJ HYDROMORPHONE HCL 2 MG/ML INJ HYDROMORPHONE 200 MG/100 ML-NS	REVISE QL 6ML PER DAY	N/A
NARCOTIC — SHORT ACTING OPIOIDS	HYDROMORPHONE HCL 4 MG/ML INJ MORPHINE SULFATE 50 MG/ML VIAL OXYCODON 10 MG/0.5 ML ORAL SYR	REVISE QL 2ML PER DAY	N/A
NARCOTIC — SHORT ACTING OPIOIDS	DEMEROL INJ (ALL STRENGTHS) MORPHINE SULFATE 50 MG/ML VIAL MORPHINE SULFATE 25 MG/ML VIAL	REVISE QL 4ML PER DAY	N/A
NARCOTIC — SHORT ACTING OPIOIDS	MORPHINE 0.5 MG/ML INJ MORPHINE 2 MG/ML INJ MORPHINE 4 MG/ML INJ MORPHINE 5 MG/ML INJ MORPHINE 8 MG/ML INJ MORPHINE 10 MG/ML INJ	REVISE QL 6ML PER DAY	N/A
NARCOTIC — SHORT ACTING OPIOIDS	MORPHINE 20 MG/ML ORAL SYRINGE MORPHINE SULF 100 MG/5 ML SOLN	REVISE QL 9ML PER DAY	N/A
OSTEOPOROSIS THERAPY	TYMLOS 80 MCG DOSE PEN INJECTR	ADD QL 1 PEN PER 30 DAYS	N/A
PROTON-PUMP INHIBITORS	ZEGERID OTC 20-1;100 MG CAP	QL REVISION 1 PER DAY	N/A
MISCELLANEOUS PULMONARY AGENTS	HAEGARDA 3;000 UNIT VIAL	ADD QL 16 VIALS PER 28 DAYS	N/A
MISCELLANEOUS PULMONARY AGENTS	HAEGARDA 2;000 UNIT VIAL	ADD QL 24 VIALS PER 28 DAYS	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	KEVZARA 150 MG/1.14 ML SYRINGE KEVZARA 200 MG/1.14 ML SYRINGE	PA REQUIRED ADD QL 2 PER 28 DAYS	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	ORENCIA 50 MG/0.4 ML SYRINGE ORENCIA 87.5 MG/0.7 ML SYRINGE	ADD QL 4 PER 28 DAYS	N/A
CHOLESTEROL LOWERING AGENTS	NIKITA 1MG, 2MG, 4MG ZYPITAMAG 1MG, 2MG, 4MG FENOFIBRATE 43 MG CAPSULE	ADD QL 1 PER DAY	N/A

	FENOFIBRATE 130 MG CAPSULE		
TOPICAL ANTI-INFLAMMATORY — NSAIDS	VOLTAREN 1% GEL PENNSAID 2% PUMP VOPAC MDS 1.5% SPRAY KIT DICLOZOR KIT DICLOFENAC SODIUM 1% GEL FLECTOR 1.3% PATCH FROTEK 10% CREAM DERMACINRX LEXITRAL PHARMAPAK SURE RESULT DSS PREMIUM PACK DICLOTRAL PAK XELITRAL PACK DS PREP PAK XRYLIX 1.5% KIT DICLO GEL 1%-XRYLIX SHEET KIT INFLAMMA-K KIT NUDICLO SOLUPAK	ADD STEP THERAPY THROUGH DICLOFENAC 1.5% TOPICAL SOLN	N/A
VACCINES	FLU VACCINATIONS	ADD QL 0.5 ML PER FILL 2 FILLS PER 180 DAYS	N/A

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**.