Anthem Blue Cross and Blue Shield Medicaid

MEDICAID PROVIDER BULLETIN
March 2019

Quarterly pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at the fourth quarter pharmacy and therapeutics committee meeting. Effective May 1, 2019, the following formulary changes will apply. This notice applies to Anthem Blue Cross and Blue Shield Medicaid (Anthem) members enrolled in Medicaid.

Effective for all patients on May 1, 2019			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
COLONY STIMULATING FACTORS – LONG ACTING	FULPHILA 6 MG/0.6 ML SYRINGE	PREFERRED WITH PRIOR AUTHORIZATION (pa) ADD QUANTITY LIMIT (QL) 2 SYRINGES PER 28 DAYS	N/A
COLONY STIMULATING FACTORS – LONG ACTING	NEULASTA 6 MG/0.6 ML SYRINGE	PREFERRED WITH PA	N/A
COLONY STIMULATING FACTORS - SA	ZARXIO 300 MCG/0.5 ML SYRINGE ZARXIO 480 MCG/0.8 ML SYRINGE	PREFERRED WITH PA	N/A
ERYTHROPOIETIN STIMULATING AGENTS - (ESA)	PROCRIT 4;000 UNITS/ML VIAL PROCRIT 2;000 UNITS/ML VIAL PROCRIT 10;000 UNITS/ML VIAL PROCRIT 10;000 UNITS/ML VIAL PROCRIT 20;000 UNITS/ML VIAL PROCRIT 40;000 UNITS/ML VIAL PROCRIT 3;000 UNITS/ML VIAL	NON-PREFERRED WITH STEP THERAPY (ST)	RETACRIT (PA REQUIRED)
ERYTHROPOIETIN STIMULATING AGENTS - (ESA)	RETACRIT 4;000 UNIT/ML VIAL RETACRIT 2;000 UNIT/ML VIAL RETACRIT 10;000 UNIT/ML VIAL RETACRIT 40;000 UNIT/ML VIAL RETACRIT 3;000 UNIT/ML VIAL	PREFERRED WITH PA ADD QL 12 VIALS (12 ML) PER 28 DAYS	N/A
HIV	COMPLERA TABLET SYMTUZA 800-150-200-10 MG TABLET ODEFSEY TABLET DELSTRIGO 100-300-300 MG TABLET	PREFERRED	N/A

https://mediproviders.anthem.com/ky

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.
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Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
HIV	RESCRIPTOR 200 MG TABLET RESCRIPTOR 100 MG TABLET CRIXIVAN 200 MG CAPSULE CRIXIVAN 400 MG CAPSULE KALETRA 100-25 MG TABLET KALETRA 200-50 MG TABLET VIDEX 2 GM PEDIATRIC SOLN VIDEX 4 GM PEDIATRIC SOLN VIRACEPT 250 MG TABLET VIRACEPT 625 MG TABLET	COVERED	N/A
ORAL STERIODS	PREDNISOLONE 10 MG/5 ML SOLN PREDNISOLONE 20 MG/5 ML SOLN PREDNISOLONE ODT 10 MG TABLET PREDNISOLONE ODT 15 MG TABLET PREDNISOLONE ODT 30 MG TABLET MILLIPRED DP 5 MG 6-DAY PACK MILLIPRED DP 5 MG 12-DAY PACK VERIPRED 20 20 MG/5 ML SOLN DECADRON 0.5 MG/5 ML ELIXIR DECADRON 0.5 MG TABLET DECADRON 0.75 MG TABLET DECADRON 4 MG TABLET DECADRON 6 MG TABLET DEXAMETHASONE 6 DAY 1.5 MG TAB DEXAMETHASONE 10 DAY 1.5 MG TB DEXAMETHASONE 13 DAY 1.5 MG TB DELTASONE 20 MG TABLET	PREFERRED	N/A
INJECTABLE STEROIDS	BETAMETHASONE AC-SP 6 MG/ML VL TRIAMCINOLONE ACET 50MG/5ML VL TRIAMCINOLONE ACET 40MG/ML VL METHYLPREDNISOLONE SS 40 MG VL METHYLPREDNISOLONE SS 125 MG METHYLPREDNISOLONE SS 1 GM VL DEXAMETHASONE 10 MG/50 ML-NS DEXAMETHASONE 10 MG/ML VIAL TRIAMCINOLONE ACET 40 MG/ML VL TRIAMCINOLONE 200 MG/5 ML VIAL TRIAMCINOLONE 400 MG/10 ML VL DEXAMETHASONE 4 MG/ML SYRINGE	PREFERRED	N/A

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INJECTABLE STEROIDS	SOLU-CORTEF 1;000 MG VIAL SOLU-CORTEF 100 MG VIAL SOLU-CORTEF 250 MG VIAL SOLU-CORTEF 500 MG VIAL	NON-PREFERRED	N/A
MISCELLANEOUS* ANTIVIRALS	XOFLUZA 20 MG TABLET XOFLUZA 40 MG TABLET	PREFERRED WITH QL 1 DOSE PACK PER FILL; 1 FILL PER 90 DAYS	N/A

EDITS EFFECTIVE MAY 1, 2019 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
Therapeutic class	**Drug**	**Revised status**
ADALIMUMAB AGENTS	HYRIMOZ 40 MG/0.8 ML PREFILLED PEN/SYRINGE	ADD QL 2 PENS/SYRINGES PER 28 DAYS
ANTICONVULSANT	DIACOMIT	ADD PA ADD QL 250MG CAPS OR POWDER PACKETS; 12 PER DAY 500MG CAPSULES OR POWDER PACKETS; 6 PER DAY
ANTIMALARIALS	ARAKODA 100 MG TABLET	ADD QL 56 TABLETS PER YEAR
ANTIMALARIALS	KRINTAFEL 150 MG TABLET	ADD QL 2 TABLETS PER FILL; 1 FILL PER 30 DAYS
ANTIMIGRAINE PREPARATIONS	EMGALITY 120 MG/ML SYRINGE	ADD PA AND ADD QL 1 SYRINGE PER 30 DAYS
MISCELLANEOUS ANTINEOPLASTIC DRUGS	LUMOXITI 1 MG VIAL	ADD PA
MISCELLANEOUS ANTINEOPLASTIC DRUGS	COPIKTRA 15 MG CAPSULE COPIKTRA 25 MG CAPSULE	ADD PA AND ADD QL 2 PER DAY
MISCELLANEOUS ANTINEOPLASTIC DRUGS	VIZIMPRO 15 MG TABLET VIZIMPRO 30 MG TABLET VIZIMPRO 45 MG TABLET	ADD PA AND ADD QL 1 PER DAY
MISCELLANEOUS ANTINEOPLASTIC DRUGS	LIBTAYO 350 MG/7 ML VIAL	ADD PA
MISCELLANEOUS ANTINEOPLASTIC DRUGS	SIGNIFOR LAR 10 MG KIT SIGNIFOR LAR 30 MG KIT	ADD QL 1 KIT PER 28 DAYS
MISCELLANEOUS ANTINEOPLASTIC DRUGS	TIBSOVO 250 MG TABLET	ADD QL 2 TABLETS PER DAY

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Therapeutic class	**Drug**	**Revised status**
MISCELLANEOUS ANTINEOPLASTIC DRUGS	LENVIMA 4 MG DAILY DOSE LENVIMA 12 MG DAILY DOSE	ADD QL 1 PACK PER 30 DAYS
ANTIPARASITICS	MOXIDECTIN 2 MG	ADD QL 4 TABLETS PER FILL; ONE TIME DOSE
ANTIVERTIGO & ANTIEMETIC AGENTS	CINVANTI 130 MG/18 ML VIAL	ADD PA
BOWEL EVACUANTS	PLENVU POWDER PACKETS	ADD PA AND QL 1 KIT PER 30 DAYS
MISCELLANEOUS COAGULATION AGENTS	TAVALISSE 100 MG TABLET TAVALISSE 150 MG TABLET	ADD PA AND ADD QL 2 TABLETS PER DAY
CONTRACEPTIVES	ANNOVERA	ADD QL 1 RING PER YEAR
CONTRACEPTIVES	BALCOLTRA TABLET	ADD QL 1 PER DAY
MISCELLANEOUS DERMATOLOGICALS	QBREXZA 2.4% CLOTH	ADD PA AND QL 1 CLOTH PER DAY
MISCELLANEOUS DERMATOLOGICALS	DUPIXENT 200 MG/1.14 ML SYRINGE	ADD QL 2 SYRINGES PER 28 DAYS
HEMOPHILIA TREATMENT AGENTS	HEMLIBRA 60 MG/0.4 ML VIAL HEMLIBRA 105 MG/0.7 ML VIAL HEMLIBRA 30 MG/ML VIAL HEMLIBRA 150 MG/ML VIAL	ADD PA
HEMOSTATICS	DOPTELET 20 MG TAB	ADD PA AND QL 3 TABLETS PER DAY FOR 5 DAYS
HEMOSTATICS	MULPLETA 3 MG TABLET	ADD PA AND ADD QL 1 TABLET PER DAY 7 DAYS
INSULIN THERAPY	NOVOLIN R FLEXPEN NOVOLIN N FLEXPEN NOVOLIN 70-30 FLEXPEN	ADD QL 30 ML PER DAY
MISCELLANEOUS AGENTS	TIGLUTIK 50 MG/10 ML SUSP	ADD PA AND QL 40 ML PER DAY
MISCELLANEOUS AGENTS	PARSABIV 5 MG/ML VIAL PARSABIV 2.5 MG/0.5 ML VIAL PARSABIV 10 MG/2 ML VIAL	ADD PA
MISCELLANEOUS NEUROLOGICAL THERAPY	TEGSEDI 284 MG/1.5 ML SYRINGE	ADD PA AND ADD QL 4 SYRINGES PER 28 DAYS
MISCELLANEOUS PSYCHOTHERAPEUTIC AGENTS	RELEXXII ER 72 MG TABLET	ADD PA AND QL 1 TABLET PER DAY
MISCELLANEOUS PSYCHOTHERAPEUTIC AGENTS	JORNAY 20 PM CAPSULE JORNAY 40 PM CAPSULE JORNAY 60 PM CAPSULE JORNAY 80 PM CAPSULE JORNAY 100 PM CAPSULE	ADD PA AND QL 1 CAPSULES PER DAY

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Therapeutic class	**Drug**	**Revised status**
MISCELLANEOUS PSYCHOTHERAPEUTIC AGENTS	PERSERIS ER INJECTABLE SUSPENSION	ADD PA AND QL 1 KIT PER 30 DAYS
MISCELLANEOUS PULMONARY AGENTS	TAKHZYRO 300 MG/2 ML VIAL	ADD PA AND ADD QL 2 SYRINGES PER MONTH
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	OLUMIANT 2 MG TABLET	ADD QL 1 PER DAY
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	XELJANZ 10 MG TABLET	UPDATE PA AND ADD QL 2 TABLETS PER DAY

* Implemented on January 15, 2019.

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** > Pharmacy.

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