MEDICAID PROVIDER BULLETIN
February 1, 2017

This is an update about information in the provider manual. For access to the latest manual, go online to **https://mediproviders.anthem.com/ky**.

Quarterly pharmacy formulary change notice

Summary of change

The formulary changes listed in the table below were reviewed and approved at the third quarter Pharmacy and Therapeutics Committee meeting held on September 27, 2016.

What this means to you

Effective February 1, 2017, the following formulary changes will apply. This notice applies to Anthem Blue Cross Blue Shield Medicaid (Anthem) benefits in Kentucky.

What is the impact of this change?

Effective for all patients on February 1, 2017			
Therapeutic class	**Medication**	**Revised status**	**Potential alternatives**
INSULIN THERAPY — LONG-ACTING*	BASAGLAR KWIKPEN	PREFERRED	N/A
INSULIN THERAPY — LONG-ACTING	LANTUS 100 UNITS/ML VIAL LANTUS SOLOSTAR 100 UNITS/ML	NONPREFERRED **NEW STARTS: 02/01/17** CURRENT UTILIZERS 05/01/17	BASAGLAR KWIKPEN
ACNE — BENZOYL PEROXIDE COMBOS	CLIND PH-BENZOYL PEROX 1.2-5% CLINDAMYCIN-BENZOYL PEROX 1-5% CLINDA-BENZOYL PEROX 1-5% PUMP	PREFERRED	N/A
ACNE — BENZOYL PEROXIDE COMBOS	ERYTHROMYCIN-BENZOYL GEL	NONPREFERRED STEP THERAPY (ST) REQUIRED	CLINDAMYCIN-BENZOYL PEROX 1-5% GEL
ACNE THERAPY	ERYTHROMYCIN/BENZOYL PEROXIDE ACANYA GEL PUMP ONEXTON GEL PUMP BENZACLIN GEL BENZAMYCIN GEL DUAC GEL	ST (AN APPROVAL FOR NONPREFERRED AGENTS WILL BE CONSIDERED WHERE CLINDAMYCIN/BENZOYL PEROXIDE GEL IS NOT APPROPRIATE BASED ON A MEMBER'S HISTORY OF MEDICAL CONDITIONS.)	CLINDAMYCIN-BENZOYL PEROX 1-5% GEL
ADHD/NARCOLEPSY	ADZENYS XR-ODT	ADD QL	N/A
ANDROGENS	TESTOSTERONE 25 MG/2.5 GM PKT	ADD QL	N/A
ANTI-EMETICS	EMEND	NONPREFERRED PA REQUIRED	N/A

Effective for all patients on February 1, 2017			
ANTI-NEOPLASTIC AGENTS	TECENTRIQ 1,200 MG/20 ML VIAL	ADD QL	N/A
ANTI-VIRALS — MISCELLANEOUS	RELENZA 5 MG DISKHALER TAMIFLU SUSPENSION TAMIFLU CAPSULES	REVISED QL	N/A
EMERGENCY CONTRACEPTIVES	ELLA 30 MG TABLET REACT 1.5 MG TABLET	PREFERRED	N/A
EPINEPHRINE — SELF-INJECTED*	EPINEPHRINE 0.15 MG AUTO-INJECT EPINEPHRINE 0.3 MG AUTO-INJECT EPINEPHRINE 0.1 MG/ML SYRINGE EPINEPHRINE 1 MG/ML VIAL	PREFERRED	N/A
EYE ANTI-INFLAMMATORY AGENTS	DICLOFENAC 0.1% EYE DROPS	PREFERRED	N/A
EYE ANTI-INFLAMMATORY AGENTS	KETOROLAC 0.4% OPHTH SOLUTION KETOROLAC 0.5% OPHTH SOLUTION ACUVAIL 0.45% OPHTH SOLUTION	NONPREFERRED ST REQUIRED	DICLOFENAC 0.1% EYE DROPS
GASTROINTESTINAL AGENTS — MISCELLANEOUS	APRISO ER 0.375 GRAM CAPSULE AZULFIDINE 500 MG TABLET AZULFIDINE ENTAB 500 MG CANASA 1,000 MG SUPPOSITORY DELZICOL DR 400 MG CAPSULE DIPENTUM 250 MG CAPSULE ENTOCORT EC 3 MG CAPSULE GIAZO 1.1 GM TABLET LIALDA DR 1.2 GM TABLET PENTASA 250 MG CAPSULE PENTASA 500 MG CAPSULE ROWASA 4 GM/60 ML ENEMA KIT SFROWASA 4 GM/60 ML ENEMA UCERIS 9 MG ER TABLET	ADD QL	N/A
HEPARIN AND RELATED PREPARATIONS	FRAGMIN PRODUCTS LOVENOX PRODUCTS	ADD QL	N/A
LANCETS	MANUFACTURER: US DIAGNOSTICS ANCETS MIS 28G LANCETS MIS 30G SAFETY MIS LANCETS	NONPREFERRED	LANCETS: MANUFACTURER— TARGET WALGREENS CVS CHAIN DRUG CONS GOOD NEIGHBOR KROGER/PERRIGO
LIPID/CHOLESTEROL-LOWERING AGENTS	NIACOR 500 MG TABLET	ADD QL	N/A
MENTAL HEALTH MEDICATIONS	MENTAL HEALTH MEDICATIONS, INCLUDING ANTIDEPRESSANTS, ANTI-	NO FORMULARY STATUS CHANGE	N/A

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	PSYCHOTICS, ADHD AGENTS, AND HYPNOTIC AGENTS	ADD DUPLICATE THERAPY REVIEW	
NEUROLOGICAL THERAPY — MISCELLANEOUS	NAMZARIC CAPSULES	ADD QL	N/A
OPHTHALMOLOGICS — MISCELLANEOUS	RESTASIS 0.05% EYE EMULSION	ADD QL	N/A
OPHTHALMOLOGICS — MISCELLANEOUS	XIIDRA 5% EYE DROPS LACRISERT 5 MG EYE INSERT	ADD QL	N/A
ORAL HYPOGLYCEMIC AGENTS	JENTADUETO XR	ADD QL	N/A
ORAL SKELETAL MUSCLE RELAXANTS	TIZANIDINE HCL CAPSULES	NONPREFERRED WITH ST	TIZANIDINE HCL 2 MG TABLET TIZANIDINE HCL 4 MG TABLET
OTIC STEROID/ ANTIBIOTIC	FLOXIN 0.3% EAR DROPS	PREFERRED	N/A
OTIC STEROID/ ANTIBIOTIC	CIPRODEX OTIC SUSPENSION CORTISPORIN-TC OTIC	NONPREFERRED WITH ST	FLOXIN 0.3% EAR DROPS CIPROFLOXACIN 0.2% OTIC SOLN OFLOXACIN 0.3% EAR DROPS NEOMYCIN-POLYMYXIN-HC EAR SOLN

** These changes will be effective immediately upon the release of the epinephrine authorized generic release and Basaglar release.*

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**.