**MEDICAID PROVIDER BULLETIN**
June 27, 2016

# Quarterly pharmacy formulary change notice

## Summary of change

The Pharmacy and Therapeutics Committee reviewed and approved the formulary changes listed in the table below on March 29, 2016.

## What this means to you

The changes outlined below apply to all members of Anthem Blue Cross and Blue Shield Medicaid (Anthem) effective April 15, June 1, August 1 and October 1, 2016, respectively.

**What is the impact of this change?**

| Therapeutic class | Medication | Revised status | Potential alternatives |
|---|---|---|---|
| **Effective for all patients on April 15, 2016** | | | |
| **NALOXONE PRODUCTS** | NALOXONE 0.4 MILLIGRAM (MG)/MILLILITER (ML) SYRINGE<br>NALOXONE 2 MG/2 ML SYRINGE<br>NALOXONE 0.4 MG/ML VIAL<br>NALOXONE 4 MG/10 ML VIAL<br>NARCAN 4 MG NASAL SPRAY | PREFERRED | NOT APPLICABLE (N/A) |
| **Effective for all patients on June 1, 2016** | | | |
| **ANTHELMINTICS** | IVERMECTIN 3 MG TABLET<br>ALBENZA 200 MG TABLET<br>BILTRICIDE 600 MG TABLET | PREFERRED | N/A |
| **ORAL ATYPICAL ANTIPSYCHOTIC** | PALIPERIDONE EXTENDED RELEASE (ER) 1.5 MG TABLET<br>PALIPERIDONE ER 3 MG TABLET<br>PALIPERIDONE ER 6 MG TABLET<br>PALIPERIDONE ER 9 MG TABLET | PREFERRED | N/A |
| **ORAL ATYPICAL ANTIPSYCHOTIC** | ARIPIPRAZOLE 2 MG TABLET<br>ARIPIPRAZOLE 5 MG TABLET<br>ARIPIRAZOLE 10 MG TABLET<br>ARIPIRAZOLE 15 MG TABLET<br>ARIPIRAZOLE 20 MG TABLET<br>ARIPIRAZOLE 30 MG TABLET | PREFERRED | N/A |
| **HEPATITIS C** | ZEPATIER 50-100 MG TABLET | PREFERRED WITH PRIOR AUTHORIZATION (PA) | N/A |
| **DIABETIC SUPPLIES AND TEST STRIPS** | TRUE METRIX TEST STRIPS | PREFERRED WITH QUANTITY LIMIT (QL) | N/A |

| Effective for all patients on August 1, 2016 | | | |
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| **ANTI-FUNGAL** | VORICONAZOLE VIAL<br>VORICONAZOLE SUSPENSION<br>VORICONAZOLE TABLET | PA REQUIRED | N/A |
| **SGLT2S** | JARDIANCE 10 MG TABLET<br>JARDIANCE 25 MG TABLET<br>SYNJARDY 5-500 MG TABLET<br>SYNJARDY 12.5-500 MG TABLET<br>SYNJARDY 5-1,000 MG TABLET | PREFERRED WITH STEP THERAPY (ST) | N/A |
| **ORAL ESTROGEN** | MENEST 0.3 MG TABLET<br>MENEST 0.625MG TABLET<br>MENEST 1.25 MG TABLET<br>MENEST 2.5 MG TABLET | NONPREFERRED | N/A |
| **ORAL ESTROGEN** | PREMARIN 0.3 MG TABLET<br>PREMARIN 0.625 MG TABLET<br>PREMARIN 0.9 MG TABLET<br>PREMARIN 1.25 MG TABLET<br>PREMARIN 0.45 MG TABLET | NONPREFERRED | N/A |
| **ACNE – GENERIC TOPICAL TRETINOINS** | TRETINOIN GEL MICRO 0.1% TUBE<br>TRETINOIN 0.05% EMOLLIENT CREAM | PREFERRED | N/A |
| **ACNE – GENERIC TOPICAL ANTI-INFECTIVES** | CLINDAMYCIN PH 1% GEL | PREFERRED | N/A |
| **ACNE – GENERIC TOPICAL ANTI-INFECTIVES** | ERYTHROMYCIN 2% SOLUTION | NONPREFERRED | CLINDAMYCIN PH 1% GEL<br>ERYTHROMYCIN 2% PLEDGETS<br>ERYTHROMYCIN 2% SOLUTION |
| **ACNE THERAPY** | ADAPALENE | ST REQUIRED | TRETINOIN 0.01% GEL<br>TRETINOIN 0.025% GEL<br>TRETINOIN 0.05% GEL<br>TRETINOIN 0.025% CREAM<br>TRETINOIN 0.05% CREAM<br>TRETINOIN 0.1% CREAM |

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| **GENERIC LONG-ACTING NARCOTICS** | GENERIC AVINZA:<br>MORPHINE SULFATE ER 30 MG CAPSULE (CAP)<br>MORPHINE SULFATE ER 45 MG CAP<br>MORPHINE SULFATE ER 60 MG CAP<br>MORPHINE SULFATE ER 75 MG CAP<br>MORPHINE SULFATE ER 90 MG CAP<br>MORPHINE SULFATE ER 120 MG CAP<br>GENERIC KADIAN:<br>MORPHINE SULFATE ER 10 MG CAP<br>MORPHINE SULFATE ER 20 MG CAP<br>MORPHINE SULFATE ER 30 MG CAP<br>MORPHINE SULFATE ER 50 MG CAP<br>MORPHINE SULFATE ER 60 MG CAP<br>MORPHINE SULFATE ER 80 MG CAP<br>MORPHINE SULFATE ER 100 MG CAP | NONPREFERRED CURRENT UTILIZERS WILL BE GRANDFATHERED | MORPHINE SULFATE ER TABLET<br>METHADONE SOLUTION<br>METHADONE TABLET<br>METHADOSE<br>FENTANYL 25 MICROGRAM/HOUR (MCG/HR) PATCH<br>FENTANYL 50 MCG/HR PATCH<br>FENTANYL 75 MCG/HR PATCH<br>FENTANYL 12 MCG/HR PATCH<br>FENTANYL 100 MCG/HR PATCH |
| **AGENTS FOR TUBERCULOSIS (TB)** | PRIFTIN 150 MG TABLET | PREFERRED | N/A |
| **WILSON'S DISEASE** | DEPEN TITRATAB<br>SYPRINE CAPSULES | PREFERRED | N/A |
| **DIABETIC SUPPLIES AND TEST STRIPS** | ALL OTHER DIABETIC TEST STRIPS | NONPREFERRED WITH QL<br>UNDER 18 YEARS OF AGE – 200/MONTH<br>ADULTS 18 YEARS OF AGE OLDER (NO INSULIN) – 50/MONTH<br>ADULTS 18 YEARS OF AGE OLDER (ON INSULIN) – 150/MONTH | N/A |

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| **DIABETIC SUPPLIES AND TEST STRIPS** | LANCETS | ADD QL<br>UNDER 18 YEARS OF AGE– 200/MONTH<br>ADULTS 18 YEARS OF AGE AND OLDER (NO INSULIN) – 100/MONTH<br>ADULTS 18 YEARS OF AGE AND OLDER (ON INSULIN) – 200/MONTH | N/A |
| **ANTIPSYCHOTICS** | VRAYLAR CAPSULE | ADD PA AND QL | N/A |
| **ANTIPSYCHOTICS** | INVEGA SUSTENNA INJECTION (INJ)<br>INVEGA TRINZA INJ | ADD PA AND QL | N/A |
| **ANTIPSYCHOTICS** | ARISTADA | ADD QL | N/A |
| **MISCELLANEOUS PULMONARY AGENTS** | PULMOZYME<br>TYVASO<br>UPTRAVI | PA REQUIRED | N/A |
| **ANTI-VIRAL AGENTS** | ZOVIRAX CREAM<br>XERESE<br>DENAVIR CREAM<br>SITAVIG BUCCAL TABLET | ADD QL | N/A |
| **ANTI-VIRAL AGENTS** | VIRAZOLE VIAL | PA REQUIRED | N/A |
| **BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY** | AVODART<br>JALYN | ADD AGE LIMIT AND GENDER LIMIT | N/A |
| **INTERLEUKINS** | ARCALYST INJ<br>ILARIS VIAL | ADD QL | N/A |
| **MISCELLANEOUS RHEUMATOLOGICAL AGENTS** | ACTEMRA VIALS/SYRINGE<br>KINERET SYRINGE<br>ORENCIA VIAL/SYRINGE | ADD QL | N/A |
| **MISCELLANEOUS RHEUMATOLOGICAL AGENTS** | HUMIRA PEN INJECTOR KIT<br>HUMIRA SYRINGE KIT | QUANTITY LIMIT REVISION | N/A |
| **MISCELLANEOUS GASTROINTESTINAL AGENTS** | CIMZIA VIAL | ADD QL | N/A |
| **MISCELLANEOUS CARDIOVASCULAR AGENTS** | RANEXA ER | PA REQUIRED | N/A |
| **MISCELLANEOUS CARDIOVASCULAR AGENTS** | AGGRENOX | ST REQUIRED | N/A |
| **AGENTS FOR ACTINIC KERATOSIS** | CARAC<br>EFUDEX<br>FLUOROPLEX<br>PICATO<br>ZYCLARA | ST REQUIRED | N/A |

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| **FLUOROQUINOLONE OTIC** | CETRAXAL 0.2% EAR SOLUTION<br>CIPRO HC OTIC SUSPENSION | ST REQUIRED | N/A |
| **MISCELLANEOUS ANTIDEPRESSANTS** | APLENZIN ER<br>FORFIVO XL | PA REQUIRED | N/A |
| **ANTI-PLATELET DRUGS** | ZONTIVITY<br>DURLAZA ER | PA REQUIRED | N/A |
| **ANTI-PLATELET DRUGS** | BRILINTA | ADD QL | N/A |
| **MISCELLANEOUS PULMONARY AGENTS** | DALIRESP | PA REQUIRED | N/A |
| **MISCELLANEOUS PULMONARY AGENTS** | UTIBRON NEOHALER<br>SEEBRI NEOHALER | QL ADDED | N/A |
| **ALZHEIMER'S THERAPY AGENTS** | NAMZARIC | PA REQUIRED | N/A |
| **MISCELLANEOUS OPHTHALMOLOGICS** | RESTASIS EYE EMULSION | PA REQUIRED | N/A |
| **MISCELLANEOUS AGENTS** | ORFADIN<br>STRENSIQ | PA REQUIRED | N/A |
| **MISCELLANEOUS AGENTS** | XURIDEN GRANULE | PA REQUIRED<br>ADD QL | N/A |
| **HEPATITIS B TREATMENT AGENTS** | TYZEKA | PA REQUIRED | N/A |
| **MISCELLANEOUS NEUROLOGICAL THERAPY** | HORIZANT ER | PA REQUIRED | N/A |
| **NSAIDS** | DUEXIS<br>VIMOVO | ST REQUIRED | N/A |
| **MISCELLANEOUS ANTI-NEOPLASTIC DRUGS** | COTELLIC<br>TAGRISSO<br>NINLARO<br>ALECENSA | PA REQUIRED | N/A |
| **TREATMENT (TX) FOR ADHD/NARCOLEPSY** | QUILLICHEW<br>DYANAVEL SUSP | PA REQUIRED<br>ADD QL | N/A |
| **TOPICAL CORTICOSTEROIDS** | DERMACIN RX<br>SILAZONE | PA REQUIRED | N/A |
| **ANTI-PSORIATIC/ ANTI-SEBORRHEIC** | STELARA<br>COSENTYX | QL REVISION | N/A |
| **ANTI-CONVULSANTS** | SPRITAM | ADD QL | N/A |
| **Effective for all patients on October 1, 2016** | | | |
| **ORAL INHALED (INH) CORTICOSTERIODS** | ARNUITY ELLIPTA 100 MCG INH<br>ARNUITY ELLIPTA 200 MCG INH | PREFERRED | N/A |

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| **ORAL INHALED CORTICOSTERIODS** | ASMANEX TWISTHALER 110 MCG<br>ASMANEX TWISTHALER 220 MCG<br>ASMANEX HFA 100 MCG INHALER<br>ASMANEX HFA 200 MCG INHALER<br>PULMICORT 180 MCG FLEXHALER<br>PULMICORT 90 MCG FLEXHALER<br>FLOVENT HFA 110 MCG INHALER<br>FLOVENT HFA 44 MCG INHALER<br>FLOVENT HFA 220 MCG INHALER<br>FLOVENT 50 MCG DISKUS<br>FLOVENT 100 MCG DISKUS<br>FLOVENT 250 MCG DISKUS<br>QVAR 40 MCG ORAL INHALER<br>QVAR 80 MCG ORAL INHALER | NONPREFERRED | ARNUITY ELLIPTA<br>AERSOPAN |
| **ORAL INHALED CORTICOSTERIOIDS COMBINATION** | BREO ELLIPTA 200-25 MCG INH<br>BREO ELLIPTA 100-25 MCG INH | PREFERRED<br>ST REQUIRED | N/A |
| **ORAL INHALED CORTICOSTERIOIDS COMBINATION** | SYMBICORT 80-4.5 MCG INHALER<br>SYMBICORT 160-4.5 MCG INHALER | NONPREFERRED | BREO ELLIPTA<br>DULERA<br>ST REQUIRED |

**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**.