June 2019

Quarterly pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at our first quarter 2019 Pharmacy and Therapeutics Committee meeting.

Effective August 1, 2019, the changes outlined below apply to all Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) members. **Remember to read the footnotes at the end of the table.**

Effective for all members on August 1, 2019			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives (preferred products)**
THERAPY FOR ACNE	PANOXYL-4 ACNE CREAMY WASH	NON-PREFERRED	OTC BENZOYL PEROXIDE (BP) 10% AND 5% WASH BP 5% AND 10% GEL
ANTIHISTAMINES	CHILD ALLEGRA ALLERGY 30 MG/5 ML	NON-PREFERRED	CHILD LORATADINE 5 MG/5 ML SOL ALLER-EASE 30 MG/5 ML SUSP
DERMATOLOGICALS – MISCELLANEOUS	CETAPHIL MOISTURIZING CREAM	NON-PREFERRED	AMLACTIN 12% LOTION CERAVE MOISTURIZING CREAM
OTHER ELECTROLYTES	K-PHOS NEUTRAL TABLET	NON-PREFERRED	PHOSPHA 250 NEUTRAL TABLET POTASSIUM CITRATE ER 5, 10 OR 15 MEQ TAB
OTHER ELECTROLYTES	PEDIALYTE SOLUTION (BRAND)	NON-PREFERRED	PEDIATRIC ELECTROLYTE SOLUTION
GASTROINTESTINAL AGENTS – MISCELLANEOUS	FLEET GLYCERIN ADULT SUPPOSITORY	NON-PREFERRED	GENERIC ADULT GLYCERIN SUPPOSITORY
GASTROINTESTINAL AGENTS – MISCELLANEOUS	CITRUCEL 500 MG CAPLET	NON-PREFERRED	OTC GENERIC FIBER THERAPY 500 MG CAPLET
VITAMINS & HEMATINICS	D-VI-SOL 400 UNITS/ML DROP FLINTSTONES TAB CHEW FLINTSTONES MULTI-VIT GUMMIES POLY-VI-SOL DROPS POLY-VI-SOL WITH IRON DROPS	NON-PREFERRED	PEDIATRIC VITAMINS: TRI-VIT-FLUOR 0.25 MG/ML DROP CHILDREN'S CHEWABLES
VITAMINS & HEMATINICS	FEOSOL 200MG TABLET	NON-PREFERRED	FERROUS GLUCONATE 324 MG TAB SLOW RELEASE IRON 45 MG TAB EZFE 200 CAPSULE

https://mediproviders.anthem.com/nv

ANVPEC-0981-19 June 2019

VITAMINS & HEMATINICS	NEPHRO-VITE RX TABLET	NON-PREFERRED	RENA-VITE RX TABLET VP-VITE RX TABLET
EDITS *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*			
TOPICAL AGENTS FOR ACNE AND ROSACEA	ALTRENO 0.05% LOTION	PA REQUIRED ADD QL 45 GRAMS PER 30 DAYS	
TOPICAL AGENTS FOR ACNE AND ROSACEA	PLIXDA 0.1% SWAB	PA REQUIRED ADD QL 1 SWAB PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	DAURISMO 25 MG TABLET	PA REQUIRED ADD QL 2 TABLETS PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	DAURISMO 100 MG TABLET	PA REQUIRED ADD QL 1 TABLET PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	XOSPATA 40 MG TABLET	PA REQUIRED ADD QL 3 TABLETS PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	LORBRENA 25 MG TABLET	PA REQUIRED ADD QL 3 TABLETS	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	LORBRENA 100 MG TABLET	PA REQUIRED ADD QL 1 TABLET PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	TALZENNA 0.25 MG CAPSULE	PA REQUIRED ADD QL 3 CAPSULES PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	TALZENNA 1 MG CAPSULE	PA REQUIRED ADD QL 1 CAPSULE PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	VITRAKVI 25 MG CAPSULE	PA REQUIRED ADD QL 6 TABLETS PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	VITRAKVI 100 MG CAPSULE	PA REQUIRED ADD QL 2 TABLETS PER DAY	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	LUTRATE DEPOT 22.5MG	ADD QL 1 KIT PER 12 WEEKS	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	ELZONRIS 1;000 MCG/ML VIAL	PA REQUIRED	
MISCELLANEOUS ANTINEOPLASTIC DRUGS	VENCLEXTA 100 MG TABLET	REVISE QL 6 TABLETS PER DAY	
ANTICOAGULANT – ORAL AGENTS	XARELTO 2.5MG	REVISE QL 2 TABLETS PER DAY	

ANTICONVULSANTS	SYMPAZAN 5 MG FILM	PA REQUIRED ADD QL 1 FILM PER DAY
ANTICONVULSANTS	SYMPAZAN 10 MG FILM SYMPAZAN 20 MG FILM	PA REQUIRED ADD QL 2 FILMS PER DAY
ANTICONVULSANTS	OXTELLAR XR TABLET	PA REQUIRED
ANTICONVULSANTS	DIACOMIT	ADD STEP THERAPY (ST)
ANTICONVULSANTS	ELEPSIA XR*	PA REQUIRED ADD QL 2 TABLETS PER DAY
ANTIDEPRESSANTS – MISCELLANEOUS	SPRAVATO 56 MG DOSE PACK SPRAVATO 84 MG DOSE PACK	ADD QL 4 KITS PER 28 DAYS
ANTIDIURETIC AND VASOPRESSOR HORMONES	NOCDURNA 27.7 MCG TABLET SL NOCDURNA 55.3 MCG TABLET SL	PA REQUIRED ADD QL 1 TABLET PER DAY
ANTIINFECTIVES - MISCELLANEOUS	ARIKAYCE 590 MG/8.4 ML VIAL	PA REQUIRED ADD QL 1 KIT (28 VIALS) PER 28 DAYS
ANTIINFECTIVES - MISCELLANEOUS	AEMCOLO DR 194 MG TABLET	PA REQUIRED ADD QL 12 TABLETS PER FILL
BETA AGONISTS INHALERS	PROAIR DIGIHALER*	ADD QL 2 INHALERS PER 30 DAYS
ESTROGEN COMBINATIONS	BIJUVA 1 MG-100 MG CAPSULE	ADD ST ADD QL 1 CAPSULE PER DAY
GASTROINTESTINAL AGENTS – MISCELLANEOUS	MOTEGRITY 1 MG TABLET MOTEGRITY 2 MG TABLET	PA REQUIRED ADD QL 1 TABLET PER DAY
MISCELLANEOUS IMMUNOLOGICALS	ORALAIR	ADD QL 3 TABLETS PER GRASS POLLEN SEASON FOR DOSE TITRATION FOR INDIVIDUALS AGES 5 -17 YEARS
IMMUNO-SUPPRESSANT DRUGS	GAMIFANT 10 MG/2 ML VIAL GAMIFANT 50 MG/10 ML VIAL	PA REQUIRED
INHALED CORTICOSTEROIDS	ARNUITY ELLIPTA INH	ADD QL 1 INHALER (30 BLISTERS) PER 30 DAYS
MISCELLANEOUS AGENTS	REVCOVI 2.4 MG/1.5 ML VIAL	PA REQUIRED
MISCELLANEOUS AGENTS	ULTOMIRIS 300 MG/30 ML VIAL	PA REQUIRED ADD QL 12 VIALS PER 56 DAYS

NEUROLOGICAL THERAPY-MISCELLANEOUS	FIRDAPSE 10 MG TABLET	PA REQUIRED ADD QL 8 TABLETS PER DAY
OPIOID WITHDRAWAL THERAPY AGENTS	CASSIPA 16MG 4MG SL FILM*	ADD QL 1 SUBLINGUAL FILM PER DAY
OPHTHALMOLOGICS – MISCELLANEOUS	OXERVATE 0.002% EYE DROP	PA REQUIRED ADD QL 2 VIALS PER DAY
OPHTHALMOLOGICS – MISCELLANEOUS	CEQUA 0.09% SOLUTION	ADD ST ADD QL 2 VIALS PER DAY
PULMONARY AGENTS – MISCELLANEOUS	DALIRESP 250 MCG TABLET DALIRESP 500 MCG TABLET	ADD QL 1 TABLET PER DAY
PULMONARY AGENTS - MISCELLANEOUS	YUPELRI 175 MCG/3 ML SOLUTION	ADD QL 1 CARTON (30 VIALS) PER 30 DAYS
RHEUMATOLOGICAL AGENTS – MISCELLANEOUS	ACTEMRA ACTPEN 162 MG/0.9 ML	ADD QL 4 PER 28 DAYS
TETRACYCLINES	SEYSARA 60 MG TABLET SEYSARA 100 MG TABLET SEYSARA 150 MG TABLET	ADD ST ADD QL 1 TABLET PER DAY
TETRACYCLINES	NUZYRA 150 MG TABLET NUZYRA 150 MG TABLET-7 DAY NUZYRA 150 MG-7 DAY WITH LOAD	PA REQUIRED ADD QL 30 TABLETS PER FILL 1 FILL PER 30 DAYS
TOPICAL CORTICOSTEROIDS MEDIUM POTENCY	CORDRAN 0.025% CREAM	ADD QL 120 GMS PER 30 DAYS
TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY	BRYHALI 0.01% LOTION	ADD QL 100 GMS PER 30 DAYS
TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY	HALOBETASOL PROP 0.05% FOAM	NON-PREFERRED
SELECTED AGENTS FOR INTRAOCULAR PRESSURE	XELPROS 0.005% EYE DROP	ADD QL 5 MLS PER 30 DAYS
SINGLE AGENT SHORT-ACTING OPIOID ANALGESICS	MITIGO 200 MG/20 ML VIAL MITIGO 500 MG/20 ML VIAL	ADD QL 2 VIALS PER MONTH

**As these new drugs come to market, clinical edits will be put in place.*

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 (PA) 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 **1-844-396-2330** and follow the voice prompts for pharmacy PA. You can find the *Preferred Drug List* on our provider website at **https://mediproviders.anthem.com/nv**.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-844-396-2330**.