

January 2019

## Quarterly pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at our third-quarter 2018, Pharmacy and Therapeutics Committee meeting. Effective February 1, 2019, the changes outlined below apply to all Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) members.

<b>UM EDITS – EFFECTIVE FOR ALL MEMBERS ON FEBRUARY 1, 2019</b>		
<i>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>		
<b>Therapeutic class</b>	<b>Drug</b>	<b>Revised status</b>
<b>AMYLOIDOSIS</b>	ONPATTRO 10 MG/5 ML VIAL	ADD PA
<b>ANTICONVULSANT</b>	EPIDIOLEX	ADD PA
<b>ANTIPSORIATICS AGENTS</b>	CALCIPOTRIENE 0.005% CREAM	REMOVE PA
<b>ANTIPSYCHOTICS</b>	NUPLAZID 34 MG CAPSULE NUPLAZID 10 MG TABLET NUPLAZID 17 MG TABLET	REVISE QL 1 TABLET/CAPSULE PER DAY
<b>ANTIPSYCHOTICS</b>	ARISTADA INITIO ER 675 MG/2.4	ADD PA ADD QL 1 PRE-FILLED SYRINGE PER FILL
<b>CANCER DRUGS</b>	BRAFTOVI 50 MG CAPSULE	ADD QL 4 CAPSULES PER DAY
<b>CANCER DRUGS</b>	BRAFTOVI 75 MG CAPSULE	ADD QL 6 CAPSULES PER DAY
<b>CANCER DRUGS</b>	MEKTOVI 15 MG TABLET	ADD QL 6 TABLETS PER DAY
<b>CANCER DRUGS</b>	AKYNZEO 300-0.5 MG CAPSULE AKYNZEO 235-0.25 MG VIAL	ADD QL 5 VIALS PER 30 DAYS
<b>FABRY DISEASE</b>	GALAFOLD 123 MG CAPSULE	ADD PA ADD QL 14 CAPSULES PER 28 DAYS
<b>GNRH</b>	ORILISSA 150 MG TABLET	ADD PA ADD QL 1 TABLET PER DAY
<b>GNRH</b>	ORILISSA 200 MG TABLET	ADD PA ADD QL 2 TABLETS PER DAY
<b>HEREDITARY HYPOPHOSPHATEMIA</b>	CRYSVITA 10 MG/ML VIAL CRYSVITA 20 MG/ML VIAL CRYSVITA 30 MG/ML VIAL	ADD PA
<b>MIGRAINE AGENTS</b>	AJOVY 225 MG/1.5 ML SYRINGE	ADD PA ADD ST ADD QL 3 SYRINGES PER 90 DAYS
<b>MOVEMENT DISORDERS</b>	OSMOLEX ER 129 MG TABLET OSMOLEX ER 193 MG TABLET OSMOLEX ER 258 MG TABLET	ADD PA ADD ST ADD QL 1 TABLET PER DAY
<b>MULTIPLE SCLEROSIS</b>	GILENYA 0.25 MG CAPSULE	REVISE QL — 1 CAPSULE PER DAY
<b>MULTIPLE SCLEROSIS</b>	GLATOPA 40 MG/ML SYRINGE	REVISE QL 12 SYRINGES PER 28 DAYS
<b>MULTIPLE SCLEROSIS</b>	OCREVUS 300 MG/10 ML VIAL	REVISE QL — 2 VIALS PER 6 MONTHS
<b>NARCOTIC ANTAGONISTS</b>	BUPRENORPHIN-NALOXN 2-0.5 MG SL	REVISE QL — 12 TABLETS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	BUPRENORPHIN-NALOXON 8-2 MG SL	REVISE QL — 3 TABLETS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	SUBOXONE 12 MG-3 MG SL FILM	REVISE QL — 2 FILMS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	SUBOXONE 2 MG-0.5 MG SL FILM	REVISE QL — 12 FILMS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	SUBOXONE 4 MG-1 MG SL FILM	REVISE QL — 6 FILMS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	SUBOXONE 8 MG-2 MG SL FILM	REVISE QL — 3 FILMS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	ZUBSOLV 0.7-0.18 MG TABLET SL	REVISE QL — 23 SL TABS PER DAY
<b>NARCOTIC ANTAGONISTS</b>	ZUBSOLV 1.4-0.36 MG TABLET SL	REVISE QL — 12 SL TABLS PER DAY

<https://medproviders.anthem.com/nv>

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Therapeutic class	Drug	Revised status
NARCOTIC ANTAGONISTS	ZUBSOLV 5.7-1.4 MG TABLET SL	REVISE QL — 3 SL TABLS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 2.9-0.71 MG TABLET SL	REVISE QL — 4 SL TABS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 8.6-2.1 MG TABLET SL	REVISE QL — 2 SL TABS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 11.4-2.9 MG TABLET SL	REVISE QL — 1 SL TAB PER DAY
NARCOTIC ANTAGONISTS	BUNAVAIL 6.3-1 MG FILM	REVISE QL — 2 FILMS PER DAY
NARCOTIC ANTAGONISTS	BUNAVAIL 2.1-0.3 MG FILM	REVISE QL — 6 FILMS PER DAY
NARCOTIC ANTAGONISTS	BUNAVAIL 4.2-0.7 MG FILM	REVISE QL — 3 FILMS PER DAY
OPIOID & OPIOID COMBINATIONS	APADAZ ROXYBOND 5 MG TABLET ROXYBOND 15 MG TABLET ROXYBOND 30 MG TABLET	REVISE QL 6 TABLETS PER DAY
POLYCYSTIC KIDNEY DISEASE	JYNARQUE 45 MG-15 MG TABLET JYNARQUE 90 MG-30 MG TABLET JYNARQUE 60 MG-30 MG TABLET	ADD PA ADD QL 1 CARTON PER 28 DAYS
PHENYLKETONURIA	PALYNZIQ 10 MG/0.5 ML SYRINGE PALYNZIQ 20 MG/ML SYRINGE PALYNZIQ 2.5 MG/0.5 ML SYRINGE	ADD PA ADD QL 2 SYRINGES PER DAY
PARKINSON'S DISEASE	RYTARY ER 48.75 MG-195 MG CAP RYTARY ER 23.75 MG-95 MG CAP	REVISE QL 12 CAPSULES PER DAY
PARKINSON'S DISEASE	RYTARY ER 36.25 MG-145 MG CAP	REVISE QL — 9 CAPSULES PER DAY
SUBSTANCE USE DISORDER	LUCEMYRA 0.18 MG TABLET	ADD QL 16 TABLETS PER DAY 14 DAY SUPPLY PER FILL
VACCINES	INFLUENZA VIRUS VACCINE	REVISE QL 1 FILL PER 180 DAYS EXCEPT FOR INDIVIDUALS UNDER 9 YEARS OF AGE DURING THEIR FIRST VACCINATION SEASON
SULFONYLUREAS	GLYNASE TABLET AMARYL TABLET GLUCOTROL XL TABLET GLUCOTROL TABLET STARLIX TABLET GLIMEPIRIDE TABLET GLYBURIDE MICRONIZED TABLET GLYBURIDE TABLET CHLORPROPAMIDE TABLET TOLBUTAMIDE TABLET TOLAZAMIDE TABLET GLIPIZIDE ER TABLET GLIPIZIDE TABLET REPAGLINIDE TABLET NATEGLINIDE TABLET PRANDIN TABLET GLIPIZIDE XL TABLET GLUCOVANCE TABLET GLIPIZIDE-METFORMIN TABLET GLYBURIDE-METFORMIN HCL TABLET REPAGLINIDE-METFORMIN HCL TABLET	ADD STEP THERAPY

**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 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**.