Provider Bulletin
October 2018

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Quarterly pharmacy formulary change notice

The formulary changes listed in the table below apply to all Anthem HealthKeepers Plus patients. The changes listed in the table below marked with an * also apply to all Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) patients. These changes were reviewed and approved at the second quarter Pharmacy and Therapeutics Committee meeting.

Effective October 1, 2018, formulary changes, nonformulary changes and prior authorization requirements will apply.

Effective for all Anthem HealthKeepers Plus patients on October 1, 2018			
Therapeutic class	**Medication**	**Formulary status change**	**Potential alternatives (preferred products)**
DIABETIC SUPPLIES*	BD PEN NEEDLES BD INSULIN SYRINGES	PREFERRED	N/A
DIABETIC SUPPLIES*	ALL OTHER PEN NEEDLES AND INSULIN SYRINGES/MANUFACTURERS	NON-PREFERRED WITH STEP THERAPY (ST)	BD PEN NEEDLES BD INSULIN SYRINGES
HIV THERAPY *	CIMDUO 300-300 MG TABLET SYMFI 600-300-300 MG TABLET TROGARZO 200 MG/1.33 ML VIAL	COVERED	N/A
PROTON PUMP INHIBITORS (PPI)	BRAND PRILOSEC OTC 20 MG TABLET BRAND PRILOSEC OTC 20.6 MG TABLET BRAND OTC NEXIUM 24HR 20 MG CAPSULE	PREFERRED	N/A
EDITS *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*			
ADHD AGENTS	METHYLPHENIDATE ER 72 MG TAB	ADD PA ADD ST ADD QUANTITY LIMIT (QL) 1 TABLET PER DAY	
ANTICOAGULANTS	FRAGMIN 2,500 UNITS/0.2 ML SYR FRAGMIN 5,000 UNITS/0.2 ML SYR	REVISED QL 6 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 7,500 UNITS/0.3 ML SYR	REVISED QL 9 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 10,000 UNITS/ML SYR	REVISED QL 30 ML (30 SYRINGES) PER 30 DAYS	

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ANTICOAGULANTS	FRAGMIN 12,500 UNITS/0.5 ML	REVISED QL 15 ML (30 SYRINGES) PER 30 DAYS
ANTICOAGULANTS	FRAGMIN 15,000 UNITS/0.6 ML	REVISED QL 18 ML (30 SYRINGES) PER 30 DAYS
ANTICOAGULANTS	FRAGMIN 18,000 UNITS/0.72 ML	REVISED QL 22ML (30 SYRINGES) PER 30 DAYS
ANTICOAGULANTS	FRAGMIN 25,000 UNITS/3.8 ML VL	REVISED QL 22.8 ML (6 VIALS) PER 30 DAYS
ANTIHYPERTENSIVES	TEKTURNA 37.5MG ORAL PELLETS	ADD QL 8 PELLETS PER DAY
ANTINEOPLASTIC AGENTS*	IMBRUVICA 140 MG CAPSULE	REVISE QL 4 CAPSULE PER DAY
ANTINEOPLASTIC DRUGS*	IMBRUVICA 70 MG CAPSULE	REVISE QL 1 TABLET PER DAY
ANTINEOPLASTIC AGENTS*	IMBRUVICA 140 MG TABLET	REVISE QL 1 TABLET PER DAY
ANTIPARASITICS*	ALBENZA 200 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
ANTIPARASITICS*	IMPAVIDO 50 MG CAPSULE	ADD QL 84 CAPSULES PER FILL 1 FILL EVERY 30 DAYS
APPETITE STIMULATOR	MEGESTROL TABLET MEGESTROL ORAL SUSP	PA REQUIRED
ASTHMA	BREO ELLIPTA 200-25 MCG INH BREO ELLIPTA 100-25 MCG INH FLUTICASONE-SALMETEROL 55-14 FLUTICASONE-SALMETEROL 113-14 FLUTICASONE-SALMETEROL 232-14 DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER AIRDUO RESPICLICK 55-14 MCG AIRDUO RESPICLICK 113-14 MCG AIRDUO RESPICLICK 232-14 MCG ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 500-50 DISKUS ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	REMOVING REQUIREMENT FOR ICS BEFORE ICS/LABA STEP THERAPY EFFECTIVE DATE 08.01.18 STEP THERAPY FOR T/F OF PREFERRED ICS/LABA STILL REQUIRED
BOWEL PREP AGENTS*	CLENPIQ SOLUTION	ADD QL 320 MLS PER 30 DAYS
CHEMOTHERAPY*	BEXAROTENE 75 MG CAPSULE	ADD QL 10 CAPSULES PER DAY
CHEMOTHERAPY*	CABOMETYX 20 MG TABLET	REVISE QL 1 TABLET PER DAY
CHEMOTHERAPY*	ZYKADIA 150 MG CAPSULE	REVISE QL 3 CAPSULES PER DAY

CML*	TASIGNA 50 MG CAPSULE	ADD QL 4 CAPSULES PER DAY
DERMATOLOGICAL AGENTS	QUINJA 1.25%-1% GEL	ADD QL 60 GMS PER 30 DAYS
EPINEPHRINE AGENTS	AUVI-Q 0.1 MG AUTO-INJECTOR	ADD QL 1 BOX (2 PENS) PER FILL
GLUCOSE ELEVATING AGENTS*	GLUCAGEN 1 MG EMERGENCY KIT	ADD QL 2 KITS IN 30 DAYS
GOUT THERAPY	ULORIC 40 MG TABLET ULORIC 80 MG TABLET	ADD QL 1 TABLET PER DAY
GOUT THERAPY	ZURAMPIC 200 MG TABLET	ADD QL 1 TABLET PER DAY
GOUT THERAPY	KRYSTEXXA 8 MG/ML VIAL	ADD QL 2 VIALS (2ML) PER 28 DAYS
HIGH BLOOD PRESSURE AGENTS*	DEMSER 250 MG CAPSULE	ADD QL 16 CAPSULES PER DAY
HIGH BLOOD PRESSURE AGENTS*	DIBENZYLINE 10 MG CAPSULE	ADD QL 12 CAPSULES PER DAY
HIGH BLOOD PRESSURE AGENTS	KAPSPARGO SPRINKLE	ADD QL 1 CAPSULE PER DAY
HIGH BLOOD PRESSURE AGENTS	PREXXARTAN	ADD QL 80 MLS PER DAY
IBD STEROIDS	UCERIS 2 MG RECTAL FOAM	ADD ST
GLAUCOMA AGENTS	AZOPT 1% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
GLAUCOMA AGENTS	BETIMOL 0.25% EYE DROPS BETIMOL 0.5% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
GLAUCOMA AGENTS	RHOPRESSA 0.02% OPHTH SOLUTION	ADD QL 1 BOTTLE PER 30 DAYS
GLAUCOMA AGENTS	TIMOPTIC-XE 0.25% AND 0.5% EYE GEL-SOLN TIMOPTIC OCUMETER PLUS 0.25% AND 0.5 %GEL FORMING SOLN	REVISE QL 5 MLS PER 30 DAYS
GLAUCOMA AGENTS	TIMOPTIC 0.25% AND 0.5% OCUDOSE DROP TIMOPTIC OCUMETER PLUS 0.25% AND 0.5% SOLN	ADD QL 10 MLS PER 30 DAYS
GLAUCOMA AGENTS	VYZULTA 0.024% OPHTH SOLUTION	ADD QL 1 BOTTLE PER 30 DAYS
INTRANASAL STEROIDS	XHANCE 93 MCG NASAL SPRAY	ADD PA ADD ST ADD QL 2 INHALERS PER 30 DAYS
MENOPAUSAL THERAPIES*	IMVEXXY 10 MCG VAGINAL INSERT IMVEXXY 4 MCG VAGINAL INSERT	ADD QL 18 VAGINAL INSERTS PER 28 DAYS
MIGRAINE*	AIMOVIG 70 MG DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL 1 AUTOINJECTOR/1 PACK PER 30 DAYS

MIGRAINE*	AIMOVIG 140 MG DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL 2 AUTOINJECTORS/1 PACK PER 30 DAYS
MISCELLANEOUS AGENTS*	SAMSCA 15 MG TABLET	ADD QL 1 TABLET PER DAY
MISCELLANEOUS AGENTS*	SAMSCA 30 MG TABLET	ADD QL 2 TABLETS PER DAY
MISCELLANEOUS GASTROINTESTINAL AGENTS*	RECTIV 0.4% OINTMENT	ADD QL 30GM TUBE EVERY 30 DAYS
HEPATITIS B INTERFERON ANTIVIRAL THERAPY	PEGASYS (PEGINTERFERON ALFA 2A)	REMOVE PA REQUIREMENTS
HEPATITIS B INTERFERON ANTIVIRAL THERAPY	INTRON A (INTERFERON ALFA 2B)*	REMOVE PA REQUIREMENTS
NEUROPATHIC PAIN AND FIBROMYALGIA	ZTLIDO	ADD PA ADD QL 3 PATCHES PER DAY
NON-NARCOTIC ANALGESIC*	FIORINAL 50-325-40 MG CAPSULE BUTALBITAL-ASA-CAFFEINE CAP BUTALB-ASPIRIN-CAFFE 50-325-40	ADD QL 6 TABLETS PER DAY
NSAIDS	CONSENSI	ADD QL 1 TABLET PER DAY
PHOSPHATE BINDERS	CALCIUM ACETATE 668 MG TABLET	ADD QL 12 TABLETS PER DAY
PRENATAL VITAMINS*	NESTABS ONE SOFTGEL	ADD QL 1 TABLET PER DAY
PROGESTINS	MAKENA 275 MG/1.1 ML AUTOINJCT	ADD QL 4 AUTOINJECTORS PER 28 DAYS
PROSTATE CANCER*	ERLEADA 60 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
PROSTATE CANCER*	YONSA 125 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
TOPICAL ANTIBACTERIALS	ALTABAX 1% OINTMENT	REVISE QL 30GM PER FILL 1 FILL PER 30 DAYS
TOPICAL ANTI-INFECTIVES*	XEPI	ADD QL 45 GMS PER FILL 1 FILL PER 30 DAYS
TOPICAL CORTICOSTEROIDS – LOW POTENCY	SYNALAR 0.025% OINTMENT KIT	ADD QL 1 KIT PER 30 DAYS
TOPICAL CORTICOSTEROIDS-VERY HIGH POTENCY	IMPOYZ 0.025% CREAM	ADD QL 112 GM PER 30 DAYS

What action do I need to take?
Please review these changes and work with your Anthem HealthKeepers Plus patients to transition them to formulary alternatives. If you determine 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 your Anthem HealthKeepers Plus patient cannot be converted to a formulary alternative, call our Pharmacy department at **1-800-901-0020** (Anthem CCC Plus patients should call **1-855-322-4687)** and follow the voice prompts for pharmacy prior authorization. You can find the *Preferred Drug List* (formulary) on our provider website at **https://mediproviders.anthem.com/va.**

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-800-901-0020** (for Anthem CCC Plus assistance call **1-855-323-4687**).