

Quarterly pharmacy formulary change notice

HealthKeepers, Inc. is notifying you of the formulary changes listed in the table below. The changes apply to all Anthem HealthKeepers Plus members enrolled in in the FAMIS (CHIP) and Medallion (Medicaid) programs as well as Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) members. These changes were reviewed and approved at the second quarter pharmacy and therapeutics committee meeting.

Effective November 1, 2019, formulary changes, non-formulary changes and prior authorization requirements will apply. Remember to read the footnotes at the end of the table.

Effective for all members on November 1, 2019			
Therapeutic class	Medication	Formulary status change	Potential alternatives (preferred products)
HIV	DOVATO TAB 50-300MG	COVERED ADD QUANTITY LIMIT (QL) 1 PER DAY	N/A
HIV	TEMIXYS*	PREFERRED	N/A
PRENATAL VITAMINS	OTC PRENATAL VITAMINS (VARIOUS)	PREFERRED	N/A
PRENATAL VITAMINS	NESTAB TABLETS (RX)	PREFERRED	N/A
PRENATAL VITAMINS	PRENATAL VITAMINS (RX) EXCEPT NESTAB	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	OTC PRENATAL VITAMINS (VARIOUS)
THYROID	NATURE-THROID WESTHROID NP THYROID LEVOTHYROXINE/LIOTHYRONINE (ALL STRENGTHS)	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	LEVOTHYROXIN TABS LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)
THYROID	LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)	PREFERRED	NA

Edits effective November 1, 2019		
No changes in preferred/nonpreferred status revision or addition to UM edit only		
Therapeutic class	Medication	Formulary status change
ANTIDEPRESSANT	ZULRESSO	ADD PA
ANTIMALARIALS	ARAKODA 100 MG TABLET	REVISE QL 64 TABLETS PER YEAR

<https://mediproviders.anthem.com/va>

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Edits effective November 1, 2019		
No changes in preferred/nonpreferred status revision or addition to UM edit only		
Therapeutic class	Medication	Formulary status change
ANTINEOPLASTIC DRUGS	SIGNIFOR LAR 10 MG KIT SIGNIFOR LAR 30 MG KIT	ADD QL 1 KIT PER 28 DAYS
ANTINEOPLASTIC DRUGS	BALVERSA 3 MG TABLET	ADD PA ADD QL 3 PER DAY
ANTINEOPLASTIC DRUGS	BALVERSA 4 MG TABLET	ADD PA ADD QL 2 PER DAY
ANTINEOPLASTIC DRUGS	BALVERSA 5 MG TABLET	ADD PA ADD QL 1 PER DAY
ANTIPSORIATIC / ANTISEBORRHEIC	SKYRIZ 75 MG/0.83 ML	ADD PA ADD QL 2 PREFILLED SYRINGES (1 CARTON) PER 84 DAYS (12 WEEKS)
CARDIOVASCULAR AGENTS	CORLANOR 5 MG/5 ML ORAL SOLUTION AMPULE	ADD QL 4 AMPULES PER DAY 4 CARTONS/28 DAYS
COAGULATION AGENTS	CABLIVI 11 MG KIT	ADD PA
COLONY STIMULATING FACTORS	UDENYCA 6 MG/0.6 ML SYRINGE	PA REQUIRED ADD QL 2 SYRINGES PER 28 DAYS
SELECTED AGENTS FOR HYPERSOMNIA	SUNOSI 37.5 MG SUNOSI 75 MG SUNOSI 150 MG	ADD PA ADD ST ADD QL 1 PER DAY
AGENTS FOR INCREASED INTRAOCULAR PRESSURE	ROCKLATAN 0.02% - 0.005% OPTHALMIC SOLN	ADD QL 2.5ML PER 30 DAYS
MULTIPLE SCLEROSIS	MAYZENT 0.25MG STARTER PACK	ADD PA ADD QL 1 PACK PER FILL, ONE TIME FILL
MULTIPLE SCLEROSIS	MAYZENT 0.25MG	ADD PA ADD QL 4 PER DAY
MULTIPLE SCLEROSIS	MAYZENT 2MG	ADD PA ADD ST ADD QL 1 PER DAY
MULTIPLE SCLEROSIS	MAVENCLAD 10MG	ADD PA ADD ST ADD QL

Edits effective November 1, 2019		
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Therapeutic class	Medication	Formulary status change
		1 BOX PER FILL; 2 FILLS PER 46 WEEKS
NSAID - ORAL	QMIIZ 7.5 MG QMIIZ 15 MG	ADD ST ADD QL 1 TABLET PER DAY
NSAID - TOPICAL	LICART TOPICAL SYSTEM	ADD QL 1 PER DAY
ONCOLOGY AGENT	ASPARLAS 4.08/325 MG ASPARLAS 8.16/325 MG	ADD PA ADD QL 6 PER DAY
OSTEOPOROSIS THERAPY	EVENITY 105 MG/1.17 ML SYRINGE EVENITY 210 MG DOSE-2 SYRINGES	ADD QL 1 CARTON (2 PREFILLED SYRINGES) PER MONTH
SHORT-ACTING OPIOID AGENTS	INFUMORPH 200 MG/20 ML AMPUL INFUMORPH 500 MG/20 ML AMPUL	REVISE QL 2 VIALS (40 ML) PER MONTH
LONG-ACTING OPIOID AGENTS	LEVORPHANOL 3 MG	ADD QL 6 PER DAY
AGENTS FOR PARKINSON'S	INBRIJA 60 CAPSULE KIT	ADD PA ADD ST ADD QL 5 KITS PER 30 DAYS
AGENTS FOR PARKINSON'S	INBRIJA 92 CAPSULE KIT	ADD PA ADD ST ADD QL 3 KITS PER 30 DAYS
TAFAMIDIS AGENTS	VYNDAMAX 61 MG	ADD PA ADD QL 1 PER DAY
TAFAMIDIS AGENTS	VYNDAQEL	ADD PA ADD QL 4 PER DAY
THIAZIDE & RELATED DIURETICS	HCTZ 12.5 mg	REMOVE QL
TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY	DUOBRII 0.01%-0.045% LOTION 100 GM TUBE	ADD PA ADD QL 2 TUBES PER MONTH

**MEDICATION WILL BE ADDED TO THE FORMULARY WHEN IT IS AVAILABLE ON THE MARKET*

What action do I need to take?

Please review these changes and work with your Anthem HealthKeepers Plus patients and/or Anthem CCC 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 patients cannot be converted to a formulary alternative, call our Pharmacy department at **1-800-901-0020** (Anthem HealthKeepers Plus members) or **1-855-323-4687** (Anthem CCC Plus members) 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> > Pharmacy > Medicaid Common Core Formulary > Common Core Preferred Drug List.

If you have any questions about this communication, call our Provider Services team at **1-800-901-0020** or call the Anthem CCC Plus Provider Services at **1-855-323-4687**.