Provider Bulletin

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

June 24, 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

- Effective April 15, June 1, August 1 and September 1, 2016, formulary changes apply.
- Effective August 1, 2016, and September 1, 2016, nonformulary changes and prior authorization (PA) requirements will apply.
- This notice applies to HealthKeepers, Inc. benefits for Anthem HealthKeepers Plus members.

Therapeutic class	Drug	Revised status	Potential alternatives (formulary products)
Effective for all patients on April 15, 2016			
NALOXONE PRODUCTS	NALOXONE 0.4 MILLIGRAM (MG)/MILLILITER (ML) SYRINGE NALOXONE 2 MG/2 ML SYRINGE NALOXONE 0.4 MG/ML VIAL NALOXONE 4 MG/10 ML VIAL NARCAN 4 MG NASAL SPRAY	PREFERRED	NOT APPLICABLE (N/A)
Effective for all patients on June 1, 2016			
ANTHELMINTICS	IVERMECTIN 3 MG TABLET ALBENZA 200 MG TABLET BILTRICIDE 600 MG TABLET	PREFERRED	N/A
HEPATITIS C	ZEPATIER 50-100 MG TABLET	PREFERRED WITH PA	N/A
ORAL ATYPICAL ANTIPSYCHOTIC	PALIPERIDONE EXTENDED RELEASE (ER) 1.5 MG TABLET PALIPERIDONE ER 3 MG TABLET PALIPERIDONE ER 6 MG TABLET PALIPERIDONE ER 9 MG TABLET	PREFERRED	N/A
ORAL ATYPICAL ANTIPSYCHOTIC	ARIPIPRAZOLE 2 MG TABLET ARIPIPRAZOLE 5 MG TABLET ARIPIRAZOLE 10 MG TABLET ARIPIRAZOLE 15 MG TABLET ARIPIRAZOLE 20 MG TABLET ARIPIRAZOLE 30 MG TABLET	PREFERRED	N/A

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Therapeutic class	Drug	Revised status	Potential alternatives (formulary products)
DIABETIC SUPPLIES AND TEST STRIPS	TRUE METRIX TEST STRIPS	PREFERRED WITH QUANTITY LIMIT (QL)	N/A
Effective for all patients on August 1, 2016			
ANTI-FUNGAL	VORICONAZOLE VIAL VORICONAZOLE SUSPENSION VORICONAZOLE TABLET	PA REQUIRED	N/A
SGLT2S	JARDIANCE 10 MG TABLET JARDIANCE 25 MG TABLET SYNJARDY 5-500 MG TABLET SYNJARDY 12.5-500 MG TABLET SYNJARDY 5-1,000 MG TABLET	PREFERRED WITH STEP THERAPY (ST)	N/A
ORAL ESTROGEN	MENEST 0.3 MG TABLET MENEST 0.625 MG TABLET MENEST 1.25 MG TABLET MENEST 2.5 MG TABLET	NONPREFERRED	ESTRADIOL 0.5 MG, 1 MG, 2 MG TABLET ESTROPIPATE 0.625 (0.75 MG), 1.25 (1.5 MG) and 2.5 (3 MG) TABLET
ORAL ESTROGEN	PREMARIN 0.3 MG TABLET PREMARIN 0.625 MG TABLET PREMARIN 0.9 MG TABLET PREMARIN 1.25 MG TABLET PREMARIN 0.45 MG TABLET	NONPREFERRED	ESTRADIOL 0.5 MG, 1 MG, 2 MG TABLET ESTROPIPATE 0.625 (0.75 MG), 1.25 (1.5 MG) and 2.5 (3 MG) TABLET
ACNE – GENERIC TOPICAL TRETINOINS	TRETINOIN GEL MICRO 0.1% TUBE TRETINOIN 0.05% EMOLLIENT CREAM	PREFERRED	N/A
ACNE – GENERIC TOPICAL ANTI-INFECTIVES	CLINDAMYCIN PH 1% GEL	PREFERRED	CLINDAMYCIN PH 1% GEL ERYTHROMYCIN 2% PLEDGETS ERYTHROMYCIN 2% SOLUTION
ACNE – GENERIC TOPICAL ANTI-INFECTIVES	ERYTHROMYCIN 2% SOLUTION	NONPREFERRED	TRETINOIN 0.01% GEL TRETINOIN 0.025% GEL TRETINOIN 0.05% GEL TRETINOIN 0.025% CREAM TRETINOIN 0.05% CREAM TRETINOIN 0.1% CREAM

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

Therapeutic class	Drug	Revised status	Potential alternatives (formulary products)
DIABETIC SUPPLIES AND TEST STRIPS	LANCETS	ADD QL UNDER 18 YEARS OF AGE – 200/MONTH ADULTS 18 YEARS OF AGE AND OLDER (NO INSULIN) – 100/MONTH 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) INVEGA TRINZA INJ	ADD PA AND QL	N/A
ANTIPSYCHOTICS	ARISTADA	ADD QL	N/A
MISCELLANEOUS PULMONARY AGENTS	PULMOZYME TYVASO UPTRAVI	PA REQUIRED	N/A
ANTI-VIRAL AGENTS	ZOVIRAX CREAM XERESE DENAVIR CREAM LIDOVIR SITAVIG BUCCAL TABLET	ADD QL	N/A
ANTI-VIRAL AGENTS	VIRAZOLE VIAL	PA REQUIRED	N/A
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY	AVODART JALYN	ADD AGE LIMIT AND GENDER LIMIT	N/A
INTERLEUKINS	ARCALYST INJ ILARIS VIAL	ADD QL	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	ACTEMRA VIALS/SYRINGE KINERET SYRINGE ORENCIA VIAL/SYRINGE	ADD QL	N/A
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	HUMIRA PEN INJECTOR KIT 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

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AGENTS FOR ACTINIC KERATOSIS	CARAC EFUDEX FLUOROPLEX PICATO ZYCLARA	ST REQUIRED	N/A
FLUOROQUINOLONE OTIC	CETRAXAL 0.2% EAR SOLUTION CIPRO HC OTIC SUSPENSION	ST REQUIRED	N/A
MISCELLANEOUS ANTIDEPRESSANTS	APLENZIN ER FORFIVO XL	PA REQUIRED	N/A
ANTI-PLATELET DRUGS	ZONTIVITY DURLAZA ER	PA REQUIRED	N/A
ANTI-PLATELET DRUGS	BRILINT	ADD QL	N/A
MISCELLANEOUS PULMONARY AGENTS	DALIRESP	PA REQUIRED	N/A
MISCELLANEOUS PULMONARY AGENTS	UTIBRON NEOHALER 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 STRENSIQ	PA REQUIRED	N/A
MISCELLANEOUS AGENTS	XURIDEN GRANULE	PA REQUIRED ADD QL	N/A
HEPATITIS B TREATMENT AGENTS	TYZEKA	PA REQUIRED	N/A
MISCELLANEOUS NEUROLOGICAL THERAPY	HORIZANT ER	PA REQUIRED	N/A
NSAIDS	DUEXIS VIMOVO	ST REQUIRED	N/A
MISCELLANEOUS ANTI-NEOPLASTIC DRUGS	COTELLIC TAGRISSO NINLARO ALECENSA	PA REQUIRED	N/A
TREATMENT (TX) FOR ADHD/NARCOLEPSY	QUILLICHEW DYANAVEL SUSP	PA REQUIRED ADD QL	N/A
TOPICAL CORTICOSTEROIDS	DERMACIN RX SILAZONE	PA REQURED	N/A
ANTI-PSORIATIC/ ANTI-SEBORRHEIC	STELARA COSENTYX	QL REVISION	N/A
ANTI-CONVULSANTS	SPRITAM	ADD QL	N/A

Therapeutic class	Drug	Revised status	Potential alternatives (formulary products)
Effective for all patients on September 1, 2016			
ORAL INHALED (INH) CORTICOSTERIODS	ARNUITY ELLIPTA 100 MCG INH ARNUITY ELLIPTA 200 MCG INH	PREFERRED	N/A
ORAL INHALED CORTICOSTERIODS	ASMANEX TWISTHALER 110 MCG ASMANEX TWISTHALER 220 MCG ASMANEX HFA 100 MCG INHALER ASMANEX HFA 200 MCG INHALER PULMICORT 180 MCG FLEXHALER PULMICORT 90 MCG FLEXHALER FLOVENT HFA 110 MCG INHALER FLOVENT HFA 44 MCG INHALER FLOVENT HFA 220 MCG INHALER FLOVENT 50 MCG DISKUS FLOVENT 100 MCG DISKUS FLOVENT 250 MCG DISKUS QVAR 40 MCG ORAL INHALER QVAR 80 MCG ORAL INHALER	NONPREFERRED	ARNUITY ELLIPTA AEROSPAN
ORAL INHALED CORTICOSTERIOIDS COMBINATION	BREO ELLIPTA 200-25 MCG INH BREO ELLIPTA 100-25 MCG INH	PREFERRED ST REQUIRED	N/A
ORAL INHALED CORTICOSTERIOIDS COMBINATION	SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	NONPREFERRED	BREO ELLIPTA DULEREA ST REQUIRED

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** 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**.