

## Quarterly pharmacy formulary change notice

This table is used by HealthKeepers, Inc. to indicate formulary changes applicable to all Anthem HealthKeepers Plus members. These changes were reviewed and approved at the fourth-quarter Pharmacy and Therapeutics Committee meeting.

Effective May 1, 2018, formulary changes, nonformulary changes and prior authorization (PA) requirements will apply.

Effective for all Anthem HealthKeepers Plus members on May 1, 2018			
Therapeutic class	Medication	Formulary status change	Potential alternatives (preferred products)
<b>INHALED CORTICOSTEROIDS</b>	FLOVENT HFA INHALER FLOVENT DISKUS	PREFERRED FOR ALL AGES EFFECTIVE 4/15/18	N/A
<b>INHALED CORTICOSTEROIDS</b>	AEROSPAN 80 MCG INHALER	NONPREFERRED	N/A
<b>PROTON PUMP INHIBITORS</b>	ZEGERID 20 MG OTC ACID REDUCER DR 20 MG CAP	PREFERRED	N/A
<b>PROTON PUMP INHIBITORS</b>	OMEPRAZOLE DR 20 MG CAPSULE	PREFERRED FOR MEMBERS < 6 YEARS OF AGE	N/A
<b>ANTICOAGULANTS</b>	XARELTO	COVERED	N/A
<b>ANTICOAGULANTS</b>	SAVAYSA	COVERED	N/A
<b>MISC ANTINEOPLASTIC</b>	KADCYLA	ADD PA	N/A
<b>BULK CHEMICALS</b>	CALCIUM CARBONATE POWDER	NONPREFERRED	N/A
<b>COUGH AND COLD PREPARATIONS</b>	MULTISYMP TOM COLD LIQUID (OTC) MULTISYMP TOM COLD CAPLET/SOFTGEL COLD & ALLERGY ELIXIR (OTC) HYDROXYZINE 50 MG/25 ML SYRUP CYPROHEPTADINE 4 MG/10 ML SYRP	NONPREFERRED	N/A
<b>COUGH AND COLD PREPARATIONS</b>	OTC GENERIC 12-HR DECONGEST 120 MG CAPLET	PREFERRED	N/A

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

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc  
AVAPEC-1678-18 April 2018

<b>FOLIC ACID PREPARATION</b>	L-METHYLFOLATE FORTE 7.5 MG CP L-METHYLFOLATE FORTE 15 MG CAP	NONPREFERRED	N/A
<b>GLP-1 RECEPTOR AGONIST</b>	OZEMPIC	PREFERRED WITH ST AND QL 0.25 MG DOSE; 1 PEN/28 DAYS 1 MG DOSE; 2 PENS/28 DAYS EFFECTIVE 4/1/18	N/A
<b>HEPATITIS C</b>	SOVALDI	NONPREFERRED WITH PA	EPCLUSA ZEPATIER PA REQUIRED
<b>HYPERAMMONEMIA</b>	SODIUM PHENYL BUTYRATE POWDER SODIUM PHENYL BUTYRATE 500 MG TAB	PREFERRED WITH PA	N/A
<b>IRON REPLACEMENT</b>	DEXFERRUM 50 MG/ML VIAL DEXFERRUM 100 MG/2 ML VIAL FERRIC X-150 CAPSULE DUOFER 28 MG TABLET FOCALGIN DSS TABLET CHEWABLE IRON 30 MG TABLET	PREFERRED	N/A
<b>POTASSIUM REPLACEMENT</b>	POTASSIUM CL ER 8 MEQ CAPSULE POTASSIUM CL ER 20 MEQ TABLET K-SOL 20% (40 MEQ/15 ML) LIQ K-TAB ER 8 MEQ TABLET	PREFERRED	N/A
<b>URINARY PH MODIFIERS</b>	K-PHOS NEUTRAL TABLET PHOSPHA 250 NEUTRAL TABLET VIRT-PHOS 250 NEUTRAL TABLET	PREFERRED	N/A
<b>VITAMINS &amp; HEMATINICS</b>	COD LIVER OIL	NONPREFERRED	N/A
<b>VITAMINS &amp; HEMATINICS</b>	BETA-CAROTENE 25,000 UNITS CAP OTC BETA-CAROTENE 10,000 UNITS CAP OTC	NONPREFERRED	N/A

<b>VITAMINS &amp; HEMATINICS</b>	BRAND OTC PREPARATIONS VITAMIN A VITAMIN B VITAMIN C VITAMIN D VITAMIN D COMBO VITAMIN E MISCELLANEOUS VITAMINS	NONPREFERRED	N/A
<b>VITAMINS &amp; HEMATINICS</b>	GENERIC OTC PREPARATIONS VITAMIN A VITAMIN B VITAMIN C VITAMIN D VITAMIN D COMBO VITAMIN E MISCELLANEOUS VITAMINS	PREFERRED	N/A
<b>EDITS</b> <i>NO CHANGES IN PREFERRED/NONPREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>			
<b>ACNE AND ROSACEA AGENTS</b>	MINOLIRA, AKTIPAK		ADD ST
<b>ACNE AND ROSACEA AGENTS</b>	DIFFERIN GEL 0.1% GEL, OTC		ADD QL 45 GMS PER DAY
<b>ACNE THERAPY</b>	ADAPALENE 0.1% LOTION		QL REVISED 59 ML PER 30 DAYS
<b>ALZHEIMER'S THERAPY; NMDA RECEPTOR ANTAGONISTS</b>	MEMANTINE HCL 10 MG TABLET		ADD QL 2 TABLETS PER DAY
<b>ANTICONVULSANTS</b>	APTIOM 200 MG APTIOM 400 MG		ADD QL 1 TABLET PER DAY
<b>ANTICONVULSANTS</b>	APTIOM 600 MG APTIOM 800 MG		ADD QL 2 TABLETS PER DAY
<b>ANTIEMETICS AND ANTIVERTIGO</b>	CINVANTI INFUSION		ADD QL 5 VIALS PER 30 DAYS
<b>ANTIEMETICS AND ANTIVERTIGO</b>	VARUBI INJECTION		ADD QL 2 VIALS PER 28 DAYS
<b>ANTIMIGRAINE PREPARATIONS</b>	IMITREX 6 MG/0.5 ML VIAL (ML)		QL REVISION 4 SYRINGES PER 30 DAYS
<b>ANTIPARASITICS</b>	SOLOSEC		ADD QL 2 G PER FILL; 1 FILL PER 30 DAYS

<b>CANCER</b>	COMETRIQ 80 MG	ADD QL 1 CAPSULE PER DAY
<b>CANCER</b>	VENCLEXTA STARTING PACK	ADD QL 1 PACK PER 365 DAYS
<b>CANCER</b>	VERZENIO	ADD QL 2 TABLETS PER DAY
<b>DIABETES</b>	BYDUREON BCISE	ADD QL 4 AUTOINJECT ORS PER 28 DAYS
<b>EPINEPHRINE</b>	SYMJEPI	ADD QL 2 BOXES (2 PREFILLED SYRINGES) PER FILL
<b>ERYTHROPOIESIS STIMULATING AGENTS</b>	MIRCERA 30 MCG/0.3 ML 150 MCG/0.3 ML	ADD QL 2 SYRINGES (0.6 ML) PER 28 DAYS
<b>ESTROGENS TRANSDERMAL</b>	ESTRADIOL TDS PATCH ESTRADIOL PATCH MENOSTAR PATCH VIVELLE-DOT PATCH MINIVELLE PATCH CLIMARA PATCH ALORA PATCH	REMOVE ST FOR T/F OF AN ORAL AGENT
<b>ESTROGENS TRANSDERMAL</b>	MENOSTAR PATCH VIVELLE-DOT PATCH MINIVELLE PATCH CLIMARA PATCH ALORA PATCH	ADD ST FOR A PREFERRED TD ESTROGEN
<b>GNRH ANALOG</b>	TRIPTODUR	ADD QL 1 KIT EVERY 24 WEEKS
<b>HIV ANTIRETROVIRALS</b>	ISENTRESS HD	ADD QL 2 TABLETS PER DAY
<b>HYPERAMMONEMIA</b>	RAVICTI	ADD STEP THERAPY
<b>IDIOPATHIC PULMONARY FIBROSIS</b>	ESBRIET 267 MG TABLET	ADD QL 9 TABLETS PER DAY
<b>IDIOPATHIC PULMONARY FIBROSIS</b>	ESBRIET 801 MG	ADD QL 3 TABLETS PER DAY
<b>INHERITED DISORDERS OF METABOLISM</b>	BUPHENYL 250 GM POWDER	QL REVISED 750 GM PER 30 DAYS

<b>INSULIN</b>	AFREZZA 90 CARTRIDGES (12 UNIT)	REVISED QL 3 BOXES PER 30 DAYS
<b>INSULIN</b>	AFREZZA 180 CARTRIDGES (60X4 UNIT AND 60X8 UNIT AND 60X12 UNIT)	REVISED QL 2 BOXES PER 30 DAYS
<b>INSULIN</b>	FIASP, FIASP FLEXTOUCH	REVISED QL 2 BOXES PER 30 DAYS
<b>INSULIN</b>	HUMALOG JUNIOR KWIKPEN	REVISED QL 2 BOXES PER 30 DAYS
<b>MOVEMENT DISORDER</b>	GOCOVRI ER 68.5 MG	ADD QL 1 PER DAY
<b>MOVEMENT DISORDER</b>	GOCOVRI ER 137 MG	ADD QL 2 PER DAY
<b>SUBLINGUAL IMMUNOTHERAPY</b>	ODACTRA	ADD PA AND QL 1 TABLET PER DAY
<b>TARGETED IMMUNE MODIFIERS</b>	ENBREL MINI WITH AUTOTOUCH	ADD QL 4 CARTRIDGES PER 28 DAYS

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 PA to continue coverage beyond the applicable effective date.

We recognize the unique aspects of members' 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 PA. You can find the *Preferred Drug List* (formulary) on our 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**.