Amerigroup
District of Columbia

**Provider update**

# Quarterly pharmacy formulary change notice

**Summary**: Effective November 1, 2019, the preferred formulary changes detailed in the table below will apply to Amerigroup District of Columbia, Inc. members enrolled in the District of Columbia Healthy Families Program (DCHFP), Alliance and the Immigrant Children's Program (ICP). Additionally, effective November 1, 2019, there will be changes to the nonpreferred and prior authorization requirements of these formulary items. These formulary changes were reviewed and approved at the second quarter pharmacy and therapeutics committee meeting.

| FORMULARY CHANGES EFFECTIVE NOVEMBER 1, 2019 | | | |
|---|---|---|---|
| **Therapeutic class** | **Medication** | **Formulary status change** | **Potential alternatives (preferred products)** |
| **HEREDITARY ANGIOEDEMA (HAE) PREVENTION** | HAEGARDA 2;000 UNIT VIAL<br>HAEGARDA 3;000 UNIT VIAL<br>TAKHZYRO 300 MG/2 ML VIAL | PREFERRED WITH PRIOR AUTHORIZATION (PA) | N/A |
| **HEREDITARY ANGIOEDEMA (HAE) TREATMENT** | BERINERT 500 UNIT KIT<br>FIRAZYR 30 MG/3 ML SYRINGE<br>KALBITOR 10 MG/ML VIAL<br>RUCONEST 2;100 UNIT VIAL | PREFERRED WITH PA | N/A |
| **INSULIN- RAPID** | INSULIN LISPRO (AUTHORIZED GENERIC HUMALOG)<br>INSULIN LISPRO KWIKPEN (AUTHORIZED GENERIC HUMALOG) | PREFERRED | N/A |
| **MULTIPLE SCLEROSIS** | AUBAGIO TAB 14MG<br>AUBAGIO TAB 7MG<br>GLATOPA INJ 40MG/ML<br>GLATIRAMER INJ 40MG/ML | PREFERRED WITH PA | N/A |
| **MULTIPLE SCLEROSIS** | GILENYA CAP 0.5MG | NON-PREFERRED WITH PA | AUBAGIO TAB 7MG<br>AUBAGIO TAB 14MG |
| **MUSCLE RELAXANTS & ANTISPASMODIC AGENTS** | CHLORZOXAZONE 250 MG TABLET | NON-PREFERRED | TIZANIDINE HCL TABS<br>CARISOPRODOL TABS<br>CYCLOBENZAPRINE 5 MG TABS<br>CYCLOBENZAPRINE 10 MG TABS<br>METHOCARBAMOL TABS<br>ORPHENADRINE CITRATE ER TABS |
| **NASAL STEROIDS** | (OTC GENERIC) | PREFERRED | N/A |

| | BUDESONIDE SUS 32MCG<br>RHINOCORT SUS ALLERGY | | |
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| **NASAL STEROIDS** | (OTC BRAND)<br>FLONASE ALLERGY SPRAY 50MCG<br>NASACORT ALLERGY SPRAY 55MCG/AC | NON-PREFERRED | BUDESONIDE SUS 32MCG (OTC GENERIC)<br>RHINOCORT SUS ALLERGY (OTC GENERIC) |
| **PRENATAL VITAMINS** | OTC PRENATAL VITAMINS (VARIOUS) | PREFERRED | N/A |
| **PRENATAL VITAMINS** | NESTAB TABLETS (RX) | PREFERRED | N/A |
| **PRENATAL VITAMINS** | PRENATAL VITAMINS (RX)<br>EXCEPT NESTAB | NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED) | OTC PRENATAL VITAMINS (VARIOUS) |
| **THYROID** | NATURE-THROID<br>WESTHROID<br>NP THYROID<br>LEVOTHYROXINE/LIOTHYRONINE TAB<br>(ALL STRENGTHS) | NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED) | LEVOTHYROXIN TABS<br>LEVO-T TAB<br>EUTHYROX TAB<br>(ALL STRENGTHS) |
| **THYROID** | LEVO-T TAB<br>EUTHYROX TAB<br>(ALL STRENGTHS) | PREFERRED | NA |
| **UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN NOVEMBER 1, 2019**<br>*NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY* | | | |
| **ADRENERGIC ANTAGONISTS & RELATED DRUGS** | GUANFACINE 2 MG TABLET | REVISE QUANTITY LIMIT (QL)<br>1 PER DAY | |
| **ADHD AGENTS** | EVEKEO ODT 5 MG TABLET<br>EVEKEO ODT 10 MG TABLET<br>EVEKEO ODT 15 MG TABLET<br>EVEKEO ODT 20 MG TABLET | PA REQUIRED<br>ADD QL<br>2 TABLETS PER DAY | |
| **ADHD DRUGS** | ADHANSIA XR 25 MG CAPSULE<br>ADHANSIA XR 35 MG CAPSULE<br>ADHANSIA XR 45 MG CAPSULE<br>ADHANSIA XR 55 MG CAPSULE<br>ADHANSIA XR 70 MG CAPSULE<br>ADHANSIA XR 85 MG CAPSULE | ADD PA<br>ADD STEP THERAPY (ST)<br>ADD QL<br>1 CAPSULE DAILY | |
| **ANDROGENS INJECTABLE** | XYOSTED | ADD PA<br>ADD QL<br>60 CAP KIT 5 KITS PER 30 DAYS<br>92 CAP KIT 3 KITS PER 30 DAYS | |

| INJECTABLE ANTICOAGULANT AGENTS | LOVENOX 30 MG/0.3 ML SYRINGE<br>LOVENOX 40 MG/0.4 ML SYRINGE<br>LOVENOX 60 MG/0.6 ML SYRINGE<br>LOVENOX 80 MG/0.8 ML SYRINGE<br>LOVENOX 100 MG/ML SYRINGE<br>LOVENOX 120 MG/0.8 ML SYRINGE<br>LOVENOX 150 MG/ML SYRINGE<br>LOVENOX 300 MG/3 ML VIAL | REVISE QL<br>30 SYRINGES PER 30 DAYS |
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| **ANTIDEPRESSANT** | ZULRESSO | ADD PA |
| **ANTIDEPRESSANTS** | BUPROPION XL SSB | ADD PA |
| **ANTIFUNGAL AGENTS** | TOLSURA 65 MG CAPSULE | PA REQUIRED<br>ADD ST<br>ADD QL<br>126 CAPSULES PER 30 DAYS |
| **ANTIMALARIALS** | ARAKODA 100 MG TABLET | REVISE QL<br>64 TABLETS PER YEAR |
| **ANTINEOPLASTIC DRUGS** | SIGNIFOR LAR 10 MG KIT<br>SIGNIFOR LAR 30 MG KIT | ADD QL<br>1 KIT PER 28 DAYS |
| **ANTINEOPLASTIC DRUGS** | BALVERSA 3 MG TABLET | ADD PA<br>ADD QL<br>3 PER DAY |
| **ANTINEOPLASTIC DRUGS** | BALVERSA 4 MG TABLET | ADD PA<br>ADD QL<br>2 PER DAY |
| **ANTINEOPLASTIC DRUGS** | BALVERSA 5 MG TABLET | ADD PA<br>ADD QL<br>1 PER DAY |
| **ANTIPSORIATIC / ANTISEBORRHEIC** | SKYRIZ 75 MG/0.83 ML | ADD PA<br>ADD QL<br>2 PREFILLED SYRINGES<br>(1 CARTON)<br>PER 84 DAYS (12 WEEKS) |
| **BETA BLOCKERS** | KAPSPARGO SPRINKLE 200 MG CAP | REVISE QL<br>2 PER DAY |
| **CARDIOVASCULAR AGENTS** | CORLANOR 5 MG/5 ML ORAL SOLUTION AMPULE | ADD QL<br>4 AMPULES PER DAY<br>4 CARTONS/28 DAYS |
| **COAGULATION AGENTS** | CABLIVI 11 MG KIT | ADD PA |
| **COLONY STIMULATING FACTORS** | UDENYCA 6 MG/0.6 ML SYRINGE | PA REQUIRED<br>ADD QL<br>2 SYRINGES PER 28 DAYS |

| ESTROGEN IMPLANT AGENTS | YUTIQ | ADD PA |
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| GOUT AGENTS | GLOPERBA 0.6 MG/5 ML | ADD PA<br>ADD QL;<br>300 MLS (2 BOTTLES) PER 30 DAYS |
| HEADACHE THERAPY | AIMOVIG 140 MG/ML AUTOINJECTOR | ADD PA<br>ADD ST<br>ADD QL<br>1 PER 30 DAYS |
| HEADACHE THERAPY | AIMOVIG 70 MG/ML SYRINGE/AUTOINJECTOR | ADD PA<br>ADD ST<br>ADD QL<br>1 PER 30 DAYS |
| HEADACHE THERAPY | AIMOVIG 140 MG/2ML DOSE-2 AUTOINJ | ADD PA<br>ADD ST<br>ADD QL<br>2 PER 30 DAYS |
| HEADACHE THERAPY | EMGALITY 120 MG/ML | ADD PA<br>ADD ST<br>ADD QL<br>1 PER 30 DAYS |
| SELECTED AGENTS FOR HYPERSOMNIA | SUNOSI 37.5 MG<br>SUNOSI 75 MG<br>SUNOSI 150 MG | ADD PA<br>ADD ST<br>ADD QL<br>1 PER DAY |
| INSULIN THERAPY | AFREZZA 90-8 UNIT / 90-12 UNIT 180 CARTRIDGES | ADD QL<br>2 BOXES PER 30 DAYS |
| INSULIN THERAPY | TRESIBA 100 UNIT/ML VIAL | ADD QL<br>30 MLS PER 30 DAYS |
| INTRANASAL STEROIDS | FLONASE SENSIMIST 27.5 MCG SPR | REVISE QL<br>2 INHALERS PER 30 DAYS |
| AGENTS FOR INCREASED INTRAOCULAR PRESSURE | ROCKLATAN 0.02% - 0.005% OPHTHALMIC SOLN | ADD QL<br>2.5ML PER 30 DAYS |
| MULTIPLE SCLEROSIS | MAYZENT 0.25MG STARTER PACK | ADD PA<br>ADD ST<br>ADD QL<br>1 PACK PER FILL,<br>ONE TIME FILL |
| MULTIPLE SCLEROSIS | MAYZENT 0.25MG | ADD PA<br>ADD ST<br>ADD QL |

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| | | 4 PER DAY |
| **MULTIPLE SCLEROSIS** | MAYZENT 2MG | ADD PA<br>ADD ST<br>ADD QL<br>1 PER DAY |
| **MULTIPLE SCLEROSIS** | MAVENCLAD 10MG | ADD PA<br>ADD ST<br>ADD QL<br>1 BOX PER FILL;<br>2 FILLS PER 46 WEEKS |
| **COMBINATION NARCOTIC /ANALGESICS** | APADAZ 4.08-325 MG TABLET<br>APADAZ 6.12-325 MG TABLET<br>APADAZ 8.16-325 MG TABLET | ADD QL<br>6 PER DAY |
| **NSAID - ORAL** | QMIIZ 7.5 MG<br>QMIIZ 15 MG | ADD ST<br>ADD QL<br>1 TABLET PER DAY |
| **NSAID - TOPICAL** | FLECTOR 1.3% PATCH | REVISE QL<br>2 PER DAY |
| **NSAID - TOPICAL** | LICART TOPICAL SYSTEM | ADD QL<br>1 PER DAY |
| **ONCOLOGY AGENT** | ASPARLAS 4.08/325 MG<br>ASPARLAS 8.16/325 MG | ADD PA<br>ADD QL<br>6 PER DAY |
| **OSTEOPOROSIS THERAPY** | EVENITY 105 MG/1.17 ML SYRINGE<br>EVENITY 210 MG DOSE-2 SYRINGES | ADD QL<br>1 CARTON (2 PREFILLED SYRINGES) PER MONTH |
| **SHORT-ACTING OPIOID AGENTS** | INFUMORPH 200 MG/20 ML AMPUL<br>INFUMORPH 500 MG/20 ML AMPUL | REVISE QL<br>2 VIALS (40 ML) PER MONTH |
| **LONG-ACTING OPIOID AGENTS** | LEVORPHANOL | ADD QL<br>6 PER DAY |
| **AGENTS FOR PARKINSON'S** | INBRIJA 60 CAPSULE KIT | ADD PA<br>ADD ST<br>ADD QL<br>5 KITS PER 30 DAYS |
| **AGENTS FOR PARKINSON'S** | INBRIJA 92 CAPSULE KIT | ADD PA<br>ADD ST<br>ADD QL<br>3 KITS PER 30 DAYS |
| **TAFAMIDIS AGENTS** | VYNDAMAX 61 MG | ADD PA<br>ADD QL |

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| | | 1 PER DAY |
| **TAFAMIDIS AGENTS** | VYNDAQEL | ADD PA<br>ADD QL<br>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<br>ADD QL<br>2 TUBES PER MONTH |
| **TRIPTAN AGENTS** | SUMATRIPTAN 4 MG/0.5 ML<br>SUMATRIPTAN 6 MG/0.5 ML PEN INJECTOR/SYRINGE<br>SUMAVEL DOSEPRO 4 MG/0.5 ML | REVISE QL<br>6 UNITS PER 30 DAYS |
| **TRIPTAN AGENTS** | TOSYMRA 10MG NASAL SPRAY | ADD QL<br>12 UNITS PER 30 DAYS |

**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 Amerigroup 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 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 1-800-454-3730 and follow the voice prompts for pharmacy prior authorization.

You can find the *Preferred Drug List* on our provider website at https://providers.amerigroup.com/DC > Pharmacy.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.