Amerigroup
District of Columbia

Provider update

Quarterly pharmacy formulary change notice

Summary: Effective February 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 February 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 third quarter 2018 pharmacy and therapeutics committee meeting.

UM EDITS – EFFECTIVE FOR ALL MEMBERS ON FEBRUARY 1, 2019 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
Therapeutic class	**Medication**	**Formulary status change**
AMYLOIDOSIS	ONPATTRO 10 MG/5 ML VIAL	ADD PA
ANTICONVULSANT	EPIDIOLEX	ADD PA
ANTIPSORIATICS AGENTS	CALCIPOTRIENE 0.005% CREAM	REMOVE PA
ANTIPSYCHOTICS	NUPLAZID 34 MG CAPSULE NUPLAZID 10 MG TABLET NUPLAZID 17 MG TABLET	REVISE QL 1 TABLET/CAPSULE PER DAY
ANTIPSYCHOTICS	ARISTADA INITIO ER 675 MG/2.4	ADD PA ADD QL 1 PRE-FILLED SYRINGE PER FILL
CANCER DRUGS	BRAFTOVI 50 MG CAPSULE	ADD QL — 4 CAPSULES PER DAY
CANCER DRUGS	BRAFTOVI 75 MG CAPSULE	ADD QL — 6 CAPSULES PER DAY
CANCER DRUGS	MEKTOVI 15 MG TABLET	ADD QL — 6 TABLETS PER DAY
CANCER DRUGS	AKYNZEO 300-0.5 MG CAPSULE AKYNZEO 235-0.25 MG VIAL	ADD QL 5 VIALS PER 30 DAYS
FABRY DISEASE	GALAFOLD 123 MG CAPSULE	ADD PA ADD QL 14 CAPSULES PER 28 DAYS
GNRH	ORILISSA 150 MG TABLET	ADD PA ADD QL 1 TABLET PER DAY
GNRH	ORILISSA 200 MG TABLET	ADD PA ADD QL 2 TABLETS PER DAY
HEREDITARY HYPOPHOSPHATEMIA	CRYSVITA 10 MG/ML VIAL CRYSVITA 20 MG/ML VIAL CRYSVITA 30 MG/ML VIAL	ADD PA
MIGRAINE AGENTS	AJOVY 225 MG/1.5 ML SYRINGE	ADD PA ADD ST ADD QL 3 SYRINGES PER 90 DAYS
MOVEMENT DISORDERS	OSMOLEX ER 129 MG TABLET OSMOLEX ER 193 MG TABLET OSMOLEX ER 258 MG TABLET	ADD PA ADD ST ADD QL 1 TABLET PER DAY
MULTIPLE SCLEROSIS	GILENYA 0.25 MG CAPSULE	REVISE QL — 1 CAPSULE PER DAY
MULTIPLE SCLEROSIS	GLATOPA 40 MG/ML SYRINGE	REVISE QL — 12 SYRINGES PER 28 DAYS
MULTIPLE SCLEROSIS	OCREVUS 300 MG/10 ML VIAL	REVISE QL — 2 VIALS PER 6 MONTHS
NARCOTIC ANTAGONISTS	BUPRENORPHN-NALOXN 2-0.5 MG SL	REVISE QL — 12 TABLETS PER DAY
NARCOTIC ANTAGONISTS	BUPRENORPHIN-NALOXON 8-2 MG SL	REVISE QL — 3 TABLETS PER DAY
NARCOTIC ANTAGONISTS	SUBOXONE 12 MG-3 MG SL FILM	REVISE QL — 2 FILMS PER DAY
NARCOTIC ANTAGONISTS	SUBOXONE 2 MG-0.5 MG SL FILM	REVISE QL — 12 FILMS PER DAY
NARCOTIC ANTAGONISTS	SUBOXONE 4 MG-1 MG SL FILM	REVISE QL — 6 FILMS PER DAY
NARCOTIC ANTAGONISTS	SUBOXONE 8 MG-2 MG SL FILM	REVISE QL — 3 FILMS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 0.7-0.18 MG TABLET SL	REVISE QL — 23 SL TABS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 1.4-0.36 MG TABLET SL	REVISE QL — 12 SL TABLS PER DAY

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Therapeutic class	**Medication**	**Formulary status change**
NARCOTIC ANTAGONISTS	ZUBSOLV 5.7-1.4 MG TABLET SL	REVISE QL — 3 SL TABLS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 2.9-0.71 MG TABLET SL	REVISE QL — 4 SL TABS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 8.6-2.1 MG TABLET SL	REVISE QL — 2 SL TABS PER DAY
NARCOTIC ANTAGONISTS	ZUBSOLV 11.4-2.9 MG TABLET SL	REVISE QL — 1 SL TAB PER DAY
NARCOTIC ANTAGONISTS	BUNAVAIL 6.3-1 MG FILM	REVISE QL — 2 FILMS PER DAY
NARCOTIC ANTAGONISTS	BUNAVAIL 2.1-0.3 MG FILM	REVISE QL — 6 FILMS PER DAY
NARCOTIC ANTAGONISTS	BUNAVAIL 4.2-0.7 MG FILM	REVISE QL — 3 FILMS PER DAY
OPIOID & OPIOID COMBINATIONS	APADAZ ROXYBOND 5 MG TABLET ROXYBOND 15 MG TABLET ROXYBOND 30 MG TABLET	REVISE QL 6 TABLETS PER DAY
POLYCYSTIC KIDNEY DISEASE	JYNARQUE 45 MG-15 MG TABLET JYNARQUE 90 MG-30 MG TABLET JYNARQUE 60 MG-30 MG TABLET	ADD PA ADD QL 1 CARTON PER 28 DAYS
PHENYLKETONURIA	PALYNZIQ 10 MG/0.5 ML SYRINGE PALYNZIQ 20 MG/ML SYRINGE PALYNZIQ 2.5 MG/0.5 ML SYRINGE	ADD PA ADD QL 2 SYRINGES PER DAY
PARKINSON'S DISEASE	RYTARY ER 48.75 MG-195 MG CAP RYTARY ER 23.75 MG-95 MG CAP	REVISE QL 12 CAPSULES PER DAY
PARKINSON'S DISEASE	RYTARY ER 36.25 MG-145 MG CAP	REVISE QL — 9 CAPSULES PER DAY
SUBSTANCE USE DISORDER	LUCEMYRA 0.18 MG TABLET	ADD QL 16 TABLETS PER DAY 14 DAY SUPPLY PER FILL
SULFONYLUREAS	GLYNASE TABLET AMARYL TABLET GLUCOTROL XL TABLET GLUCOTROL TABLET STARLIX TABLET GLIMEPIRIDE TABLET GLYBURIDE MICRONIZED TABLET GLYBURIDE TABLET CHLORPROPAMIDE TABLET TOLBUTAMIDE TABLET TOLAZAMIDE TABLET GLIPIZIDE ER TABLET GLIPIZIDE TABLET REPAGLINIDE TABLET NATEGLINIDE TABLET PRANDIN TABLET GLIPIZIDE XL TABLET GLUCOVANCE TABLET GLIPIZIDE-METFORMIN TABLET GLYBURIDE-METFORMIN HCL TABLET REPAGLINIDE-METFORMIN HCL TABLET	ADD STEP THERAPY
VACCINES	INFLUENZA VIRUS VACCINE	REVISE QL 1 FILL PER 180 DAYS EXCEPT FOR INDIVIDUALS UNDER 9 YEARS OF AGE DURING THEIR FIRST VACCINATION SEASON

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.