Amerigroup
District of Columbia

Provider update

Quarterly pharmacy formulary change notice

Effective October 1, 2018, 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, Alliance and the Immigrant Children's Program. Additionally, effective October 1, 2018, 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.

Effective for all patients starting October 1, 2018			
Therapeutic class	**Medication**	**Formulary status change**	**Potential alternatives (preferred products)**
DIABETIC SUPPLIES	BD PEN NEEDLES BD INSULIN SYRINGES	PREFERRED	N/A
DIABETIC SUPPLIES	ALL OTHER PEN NEEDLES AND INSULIN SYRINGES/MANUFACTURERS	NON-PREFERRED WITH STEP THERAPY (ST)	BD PEN NEEDLES BD INSULIN SYRINGES
PROTON PUMP INHIBITORS (PPI)	BRAND PRILOSEC OTC 20 MG TABLET BRAND PRILOSEC OTC 20.6 MG TABLET BRAND OTC NEXIUM 24HR 20 MG CAPSULE	PREFERRED	N/A
EDITS *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*			
ADHD AGENTS	METHYLPHENIDATE ER 72 MG TAB	ADD PA ADD ST ADD QUANTITY LIMIT (QL) 1 TABLET PER DAY	
ANTICOAGULANTS	FRAGMIN 2,500 UNITS/0.2 ML SYR FRAGMIN 5,000 UNITS/0.2 ML SYR	REVISED QL 6 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 7,500 UNITS/0.3 ML SYR	REVISED QL 9 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 10,000 UNITS/ML SYR	REVISED QL 30 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 12,500 UNITS/0.5 ML	REVISED QL 15 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 15,000 UNITS/0.6 ML	REVISED QL 18 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 18,000 UNITS/0.72 ML	REVISED QL 22 ML (30 SYRINGES) PER 30 DAYS	
ANTICOAGULANTS	FRAGMIN 25,000 UNITS/3.8 ML VL	REVISED QL 22.8 ML (6 VIALS) PER 30 DAYS	

ANTIHYPERTENSIVES	TEKTURNA 37.5 MG ORAL PELLETS	ADD QL 8 PELLETS PER DAY
ANTINEOPLASTIC AGENTS	IMBRUVICA 140 MG CAPSULE	REVISE QL 4 CAPSULE PER DAY
ANTINEOPLASTIC DRUGS	IMBRUVICA 70 MG CAPSULE	REVISE QL 1 CAPSULE PER DAY
ANTINEOPLASTIC AGENTS	IMBRUVICA 140 MG TABLET	REVISE QL 1 TABLET PER DAY
ANTIPARASITICS	ALBENZA 200 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
ANTIPARASITICS	IMPAVIDO 50 MG CAPSULE	ADD QL 84 CAPSULES PER FILL 1 FILL EVERY 30 DAYS
APPETITE STIMULATOR	MEGESTROL TABLET MEGESTROL ORAL SUSP	PA REQUIRED
ASTHMA	BREO ELLIPTA 200-25 MCG INH BREO ELLIPTA 100-25 MCG INH FLUTICASONE-SALMETEROL 55-14 FLUTICASONE-SALMETEROL 113-14 FLUTICASONE-SALMETEROL 232-14 DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER AIRDUO RESPICLICK 55-14 MCG AIRDUO RESPICLICK 113-14 MCG AIRDUO RESPICLICK 232-14 MCG ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 500-50 DISKUS ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	REMOVING REQUIREMENT FOR ICS BEFORE ICS/LABA STEP THERAPY EFFECTIVE DATE 08.01.18 STEP THERAPY FOR T/F OF PREFERRED ICS/LABA STILL REQUIRED
BOWEL PREP AGENTS	CLENPIQ SOLUTION	ADD QL 320 MLS PER 30 DAYS
CHEMOTHERAPY	BEXAROTENE 75 MG CAPSULE	ADD QL 10 CAPSULES PER DAY
CHEMOTHERAPY	CABOMETYX 20 MG TABLET	REVISE QL 1 TABLET PER DAY
CHEMOTHERAPY	ZYKADIA 150 MG CAPSULE	REVISE QL 3 CAPSULES PER DAY
CML	TASIGNA 50 MG CAPSULE	ADD QL 4 CAPSULES PER DAY
DERMATOLOGICAL AGENTS	QUINJA 1.25%-1% GEL	ADD QL 60 GMS PER 30 DAYS
EPINEPHRINE AGENTS	AUVI-Q 0.1 MG AUTO-INJECTOR	ADD QL 1 BOX (2 PENS) PER FILL

GLUCOSE ELEVATING AGENTS	GLUCAGEN 1 MG EMERGENCY KIT	ADD QL 2 KITS IN 30 DAYS
GOUT THERAPY	ULORIC 40 MG TABLET ULORIC 80 MG TABLET	ADD QL 1 TABLET PER DAY
GOUT THERAPY	ZURAMPIC 200 MG TABLET	ADD QL 1 TABLET PER DAY
GOUT THERAPY	KRYSTEXXA 8 MG/ML VIAL	ADD QL 2 VIALS (2ML) PER 28 DAYS
HIGH BLOOD PRESSURE AGENTS	DEMSER 250 MG CAPSULE	ADD QL 16 CAPSULES PER DAY
HIGH BLOOD PRESSURE AGENTS	DIBENZYLINE 10 MG CAPSULE	ADD QL 12 CAPSULES PER DAY
HIGH BLOOD PRESSURE AGENTS	KAPSPARGO SPRINKLE	ADD QL 1 CAPSULE PER DAY
HIGH BLOOD PRESSURE AGENTS	PREXXARTAN	ADD QL 80 MLS PER DAY
IBD STEROIDS	UCERIS 2 MG RECTAL FOAM	ADD ST
GLAUCOMA AGENTS	AZOPT 1% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
GLAUCOMA AGENTS	BETIMOL 0.25% EYE DROPS BETIMOL 0.5% EYE DROPS	REVISE QL 15 MLS PER 30 DAYS
GLAUCOMA AGENTS	RHOPRESSA 0.02% OPHTH SOLUTION	ADD QL 1 BOTTLE PER 30 DAYS
GLAUCOMA AGENTS	TIMOPTIC-XE 0.25% AND 0.5% EYE GEL-SOLN TIMOPTIC OCUMETER PLUS 0.25% AND 0.5% GEL FORMING SOLN	REVISE QL 5 MLS PER 30 DAYS
GLAUCOMA AGENTS	TIMOPTIC 0.25% AND 0.5% OCUDOSE DROP TIMOPTIC OCUMETER PLUS 0.25% AND 0.5% SOLN	ADD QL 10 MLS PER 30 DAYS
GLAUCOMA AGENTS	VYZULTA 0.024% OPHTH SOLUTION	ADD QL 1 BOTTLE PER 30 DAYS
INTRANASAL STEROIDS	XHANCE 93 MCG NASAL SPRAY	ADD PA ADD ST ADD QL 2 INHALERS PER 30 DAYS
MENOPAUSAL THERAPIES	IMVEXXY 10 MCG VAGINAL INSERT IMVEXXY 4 MCG VAGINAL INSERT	ADD QL 18 VAGINAL INSERTS PER 28 DAYS
MIGRAINE	AIMOVIG 70 MG DOSE-1 AUTOINJ	ADD PA ADD ST ADD QL 1 AUTOINJECTOR/1 PACK PER 30 DAYS
MIGRAINE	AIMOVIG 140 MG DOSE-2 AUTOINJ	ADD PA ADD ST ADD QL 2 AUTOINJECTORS/1 PACK PER 30 DAYS

MISCELLANEOUS AGENTS	SAMSCA 15 MG TABLET	ADD QL 1 TABLET PER DAY
MISCELLANEOUS AGENTS	SAMSCA 30 MG TABLET	ADD QL 2 TABLETS PER DAY
MISCELLANEOUS GASTROINTESTINAL AGENTS	RECTIV 0.4% OINTMENT	ADD QL 30 GM TUBE EVERY 30 DAYS
HEPATITIS B INTERFERON ANTIVIRAL THERAPY	PEGASYS (PEGINTERFERON ALFA 2A) INTRON A (INTERFERON ALFA 2B)	REMOVE PA REQUIREMENTS
NEUROPATHIC PAIN AND FIBROMYALGIA	ZTLIDO	ADD PA ADD QL 3 PATCHES PER DAY
NON-NARCOTIC ANALGESIC	FIORINAL 50-325-40 MG CAPSULE BUTALBITAL-ASA-CAFFEINE CAP BUTALB-ASPIRIN-CAFFE 50-325-40	ADD QL 6 TABLETS PER DAY
NSAIDS	CONSENSI	ADD QL 1 TABLET PER DAY
PHOSPHATE BINDERS	CALCIUM ACETATE 668 MG TABLET	ADD QL 12 TABLETS PER DAY
PRENATAL VITAMINS	NESTABS ONE SOFTGEL	ADD QL 1 TABLET PER DAY
PROGESTINS	MAKENA 275 MG/1.1 ML AUTOINJCT	ADD QL 4 AUTOINJECTORS PER 28 DAYS
PROSTATE CANCER	ERLEADA 60 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
PROSTATE CANCER	YONSA 125 MG TABLET	ADD PA ADD QL 4 TABLETS PER DAY
TOPICAL ANTIBACTERIALS	ALTABAX 1% OINTMENT	REVISE QL 30 GMS PER FILL 1 FILL PER 30 DAYS
TOPICAL ANTI-INFECTIVES	XEPI	ADD QL 45 GMS PER FILL 1 FILL PER 30 DAYS
TOPICAL CORTICOSTEROIDS — LOW POTENCY	SYNALAR 0.025% OINTMENT KIT	ADD QL 1 KIT PER 30 DAYS
TOPICAL CORTICOSTEROIDS — VERY HIGH POTENCY	IMPOYZ 0.025% CREAM	ADD QL 112 GMS PER 30 DAYS

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.