AmeriHealth Caritas™

New Hampshire

[ES1][DJ2]

To: AmeriHealth Caritas New Hampshire Providers

Date: May 18, 2021

Subject: AmeriHealth Caritas New Hampshire formulary change

Summary: Effective April 15, 2021, the changes below were made to the AmeriHealth Caritas New Hampshire formulary.

FORMULARY CHANGES:

Medications added to the formulary:

A. The following medications will be added to tier 1 of the formulary and are preferred medications:
   1. Asenapine (Saphris®) SL tablets.
   2. Aalcipotriene 0.005% foam.
   3. Ciprofloxacin/dexamethasone (Ciprodex® Otic).
   4. Efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla®).
   5. Efavirenz-lamivudine-tenofovir disoproxil fumarate (Symfi®, Symfi® Lo).
   6. Emtricitabine (Emtriva®).
   7. Emtricitabine-tenofovir disoproxil fumarate (Truvada®).
   8. Icosapent ethyl (Vascepa®).
   9. Ivermectin (Sklice®) lotion.
   10. Lokelma®:
       a. Prior authorization (PA) required.
   11. Lubiprostone (Amitiza®):
       a. PA required.
   12. Meloxicam capsule.
   13. Pantoprazole (Protonix®) suspension.
   14. Rufinamide (Banzel®) suspension.
   15. Rukobia®.
   16. Sodium polystyrene sulfate powder.
   17. Tavaborole (Kerydin®):
       a. PA required.
   18. Timolol (Timoptic® Ocudose).
   19. Tobramycin (Bethkis®) 300 mg/4 ml ampule.
   20. Valtoco® (diazepam) nasal spray.
   21. Zolmitriptan (Zomig®) nasal spray:
       a. Quantity limit (QL) of six per 30 days.

B. The following medications will be added to tier 2 of the formulary with PA and are nonpreferred medications:
   1. Arazlo®.

2. Avsola®.
3. Binosto®.
4. Caplyta®
5. Cordran® tape
6. Dayvigo®.
7. Drizalma®.
8. Fazaclo®.
9. Fibricor®.
10. Glucagon emergency kit (Fresenius Kabi® only, Eli Lily kit remains preferred).
11. Gvoke® HypoPen.
12. Ingrezza®.
13. Kynmobi®.
14. Lyumjev®.
15. Nymalize®.
16. ProAir® Digihaler.
17. Qmiiz®.
18. Reyvow®.
19. Rinvoq®.
20. Secuado®.
21. Trijardy® XR.
22. Veltassa®.
23. Vyepti®.
24. Xcopri®.
25. Xenazine®.
26. Zeposia®.
27. Zerviate®.

C. The following medications will be moved from the supplemental formulary (tier 3) to the preferred drug list (PDL) tiers:
   1. Now tier 1 (preferred):
      a. Baqsimi®.
      b. Glucagen®.
      c. Glucagon emergency kit (Eli Lily).
      d. Proglycem®.
      e. Austedo® — PA requirement remains.
      f. Tetrabenazine® — PA requirement remains.
   2. Now tier 2 (non-preferred):
      a. Fintepla® — PA requirement remains.
      b. Ingrezza® — PA requirement remains.

D. QLs for all combination buprenorphine-naloxone (suboxone) products will be increased to allow daily doses up to 24 mg of buprenorphine per day.

E. The following medications will be added to the supplemental formulary (Tier 3):
   1. Cilostazol.
   2. Dificid® oral suspension — PA required.

3. Isturisa® — PA required.
4. Nyvepria® — PA required.
5. Orladeyo® — PA required.
6. Riabni® — PA required.
7. Ultomiris® — PA required.

F. The step therapy requirement for diclofenac 1% gel (Voltaren®) will be removed. A diagnosis code requirement (for osteoarthritis) will remain in place.

G. The following medications will be removed from the formulary. Members currently on these medications will be authorized for continued use until August 2, 2021.
   1. Loteprednol ophthalmic suspension.
   2. Ciclopirox 0.77% gel.
   3. Ciclopirox 0.77% external suspension.
   4. Ciclopirox 1% shampoo.

PA criteria updates:

A. The following criteria are new:
   1. Adrenal Enzyme Inhibitors for Cushing's Disease.
   2. Mucopolysaccharidosis VI (Maroteaux-Lamy Syndrome) Agents.

B. The following criteria are updated with changes:
   1. Acute Migraine Treatments Criteria.
   2. Agents for Atopic Dermatitis.
   3. Alpha-1 Proteinase Inhibitors (Human).
   4. Anti-Parkinson's Agents for OFF Episodes.
   5. Benlysta®.
   6. Botulinum Toxins A and B.
   7. Buprenorphine/Naloxone and Buprenorphine (Oral).
   8. Complement Inhibitors (previously titled Soliris).
   9. Emflaza®.
   10. Ocalvia®.
   11. Pulmonary Arterial Hypertension (PDE-5 inhibitors).
   12. Treatment of Hereditary Angioedema (HAE).
   13. White Blood Cell Stimulators.

C. The following criteria are updated with no clinical changes:
   1. Amifampridine.
   2. Blincyto®.
   3. Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators.
   4. Dendritic Cell Tumor Peptide Immunotherapy (Provenge®).
   5. Glycopyrrolate.
   6. Juxtapid®.

7. Natpara®.
8. Proprotein Convertase Subtilisin/Kexin 9 (PCSK9) Inhibitors.
9. Transthyretin-Mediated Amyloidosis Agents.

D. The following criteria will be retired:
   1. Diclofenac 1% Gel.
   2. Injectable/Infusible Pulmonary Arterial Hypertension Medications.

Questions:
If you have questions about this communication, please contact AmeriHealth Caritas New Hampshire Provider Pharmacy Services at **1-888-765-6394 (TTY 1-855-809-9206).**