AmeriHealth Caritas™
New Hampshire

To: AmeriHealth Caritas New Hampshire Providers

Date: June 12, 2023

Subject: AmeriHealth Caritas New Hampshire Formulary Changes

Summary: Effective June 1, 2023, the changes below will be made to the AmeriHealth Caritas New Hampshire formulary, drug prior authorization criteria, and quantity limits.

FORMULARY CHANGES

Medications added to the formulary

- Dexcom G7 sensor – requires history of insulin; quantity limit of 3 sensors per 30 days
- Dexcom G7 receiver – requires history of insulin; quantity limit of 1 receiver per 365 days

- Fragmin 10000 unit/4mL – prior authorization required
- Oxbryta 300 mg – prior authorization required
- Skyrizi 180 mg/1.2 mL (150 mg/mL) – prior authorization required
- Spevigo – prior authorization required
- Tzield – prior authorization required
- Xenpozyme – prior authorization required

Medications with changed requirements for quantity limits:

- ambrisentan/Letairis – new quantity limit (QL) of 30 tablets per 30 days
- amlodipine /Norvasc – new QL of 30 tablets per 30 days
- amlodipine-atorvastatin/Caduet – new QL of 30 tablets per 30 days
- amlodipine-benazepril/Lotrel – new QL of 30 capsules per 30 days
- amlodipine-olmesartan/Azor – new QL of 30 tablets per 30 days
- amlodipine-olmesartan-hydrochlorothiazide/Tribenzor – new QL of 30 tablets per 30 days
- amlodipine-valsartan/Exforge – new QL of 30 capsules per 30 days
- Anoro Ellipta – new QL of 60 blisters (1 inhaler) per 30 days
- bosentan/Tracleer – new QL of 60 tablets per 30 days
- Combivent Respimat – new QL of 8 grams (2 inhalers) per 30 days
- dabigatran/Pradaxa capsules – new QL of 60 capsules per 30 days
- diltiazem CD/Cardizem CD/Cartia XT:
    i. 120 mg, 300 mg, 360 mg – new QL of 30 capsules per 30 days
    ii. 180 mg – new QL of 90 capsules per 30 days
    iii. 240 mg – new QL of 60 capsules per 30 days
- diltiazem ER/Taztia XT/Tiadylt ER/Tiazac ER:
    i. 120 mg, 300 mg, 360 mg, 420 mg – new QL of 30 capsules per 30 days

ii. 180 mg – new QL of 90 capsules per 30 days
iii. 240 mg – new QL of 60 capsules per 30 days

- Eliquis:
  i. 2.5 mg – new QL of 60 tablets per 30 days
  ii. 5 mg – new QL of 74 tablets per 30 days
  iii. 5 mg dose pack – new QL of 74 tablets per 180 days
- nifedipine ER/Adalat CC/Procardia XL – new QL of 30 tablets per 30 days
- nifedipine ER/Procardia XL – new QL of 30 tablets per 30 days
- Stiolto Respimat – new QL of 4 grams (1 inhaler) per 30 days
- verapamil ER (SR)/Calan SR:
  i. 120 mg – new QL of 30 tablets per 30 days
  ii. 180 mg, 240 mg – new QL of 60 tablets per 30 days
- verapamil ER/Verelan:
  i. 120 mg, 180 mg, 360 mg – new QL of 30 tablets per 30 days
  ii. 240 mg – new QL of 60 tablets per 30 days
- Xarelto:
  i. Oral suspension – new QL of 300 mL per 30 days and age restriction of 0-17 years
  ii. 2.5 mg – new QL of 60 tablets per 30 days
  iii. 10 mg, 20 mg – new QL of 30 tablets per 30 days
  iv. 15 mg – new QL of 42 tablets per 30 days
  v. 15 mg-20 mg dose pack – new QL of 51 tablets per 180 days

Prior authorization and criteria changes

The following criteria are new:

1. Enzyme replacement therapy for acid sphingomyelinase deficiency (ASMD)
2. Generalized Pustular Psoriasis (GPP) Agents
3. Relyvrio
4. Tzield

The following criteria are updated with changes:

1. Agents for Graft Versus Host Disease
2. Agents for Homozygous Familial Hypercholesterolemia – previously titled Juxtapid
3. Amifampridine
4. Anti FGF23 Monoclonal Antibody
5. Anti-Fungal Medications – previously titled Anti-Fungal Medications for Onychomycosis
6. Benlysta
7. Botulinum Toxins A&B
8. Brand Drug and Non-Specialty Reference Biologics
9. Continuous Glucose Monitors

10. Dojolvi
11. Drugs for Chronic Bowel Disorders/GI Motility
12. Erythropoiesis-Stimulating Agents (ESAs)
13. Glycopyrrolate
14. Gonadotropin Releasing Hormone (GNRH) Agonists
15. Growth Hormone (GH) for Growth Failure or GH Deficiency
16. Injectable/Infusible Bone-Modifying Agents for Osteoporosis and Paget's Disease
17. Non-Preferred/ Prior Authorization Required Medications
18. Oxbryta
19. Oxlumo
20. Pulmonary Biologics for Asthma and Eosinophilic Conditions
21. Rho Kinase Inhibitors
22. Rituximab
23. SMN2 Splicing Modifiers for the Treatment of Spinal Muscular Atrophy (SMA)
24. Somatostatin Analogs
25. Specialty Drugs
26. Transthyretin-mediated Amyloidosis Agents
27. Vasodilators for Pulmonary Hypertension

The following criteria are updated with no clinical changes:

1. Adrenal Enzyme Inhibitors for Cushing's Disease
2. Adrenergic, alpha-receptor-blocking agent
3. Alpha-1 Proteinase Inhibitors (Human)
4. Anti-Parkinson's Agents for OFF Episodes
5. Carisoprodol
6. Corlanor
7. Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators
8. Emflaza
9. Ileal bile acid transporter inhibitor (IBAT)
10. Medications for Use in ADHD Treatment for Members 21 and Older
11. Mucopolysaccharidosis IV (Maroteaux-Lamy Syndrome) Agents
12. Ocalvia
13. Tavneos

The following criteria are retired:

1. Natpara
2. 5-Hydroxytryptamine-3 Serotonin Receptor Antagonists (5-HT3 RA), Substance P/Neurokinin 1 Receptor Antagonists (NK1 RA), and Combination Agents
3. ACFC Oncology Drugs
4. Anti-CD19 CAR-T Immunotherapies
5. B-Cell Maturation Antigen (BCMA) Directed Chimeric Antigen Receptor (CAR) T-Cell Therapy

6. Blincyto
7. Dendritic Cell Tumor Peptide Immunotherapy
8. Infusible Bone-Modifying Agents for Oncology Indications
9. Toremifene (Fareston)
10. White Blood Cell Stimulators

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).**

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