AmeriHealth Caritas New Hampshire

PHARMACY FAST FACTS
Important Formulary Update for our Providers

To: AmeriHealth Caritas New Hampshire Providers

Date: October 1, 2020

Subject: AmeriHealth Caritas New Hampshire Formulary Change

Summary: Effective December 1, 2020, the changes below will be made to the AmeriHealth Caritas New Hampshire formulary.

FORMULARY CHANGES:

Medications moved to non-preferred: (Members can still receive these medications with prior authorization).

- Deferasirox (Exjade®) dispersible tablet; formulary alternative: Chemet (succimer)
- Deferasirox (Jadenu®) tablet; formulary alternative: Chemet (succimer)
- Jadenu® Sprinkle oral packet; formulary alternative: Chemet (succimer)
- Isoniazid 50 mg/5 mL oral solution formulary alternative: Isoniazid oral tablets
- Clever Choice Peak Flow Meter formulary alternative: Preferred peak flow meters

Medications added to the formulary:

- Nivestym® (filgrastim-aafi) (with PA)
- Granix® (TBO-filgrastim) (with PA)
- Ziextenzo™ (pegfilgrastim-bmez) (with PA)
- Fulphila® (pegfilgrastim-jmdb) (with PA)
- Udenyca® (pegfilgrastim-cbqv) (with PA)
- Nexletol® (with PA)
- Nexlizet™ (with PA)
- Tivicay® PD tablets for oral suspension
- Fensolvi® (leuprolide acetate)(with PA)
- Sovaldi® 150 mg, 200 mg pellet pack (with PA)
- Harvoni® 45-200 mg, 33.75-150 mg pellet pack (with PA)
- Avsola™ (infliximab-axxq) 100 mg vial (with PA)
- DayVigo™ (lemborexant) tablets (with PA)
- Lyumjev™ (insulin lispro-aabc) vial (with PA)
- Lyumjev™ (insulin lispro-aabc) KwikPen (with PA)
- Cequa™ (ST)

New Clinical Prior Authorization Criteria Additions:

- Adenosine Triphosphate-Citrate Lyase (ACL) inhibitors
- Agents for Atopic Dermatitis

- Brineura®
- Crinone®
- Transderm-Scop
- Voriconazole (Vfend®)
- Xifaxan®
- Dificid® (Fidaxomicin)
- Vimizim®
- Increlex®
- Mucopolysaccharidosis II (Hunter Syndrome) agents
- Remdesivir

Clinical Prior Authorization Revisions:

- Oxbryta®
- Adakveo®
- White Blood Cell Stimulator
- Anti FGF23 Monoclonal Antibody
- Chelating Agents
- Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors for Huntington's Disease
- Agents for Gender Dysphoria
- Idiopathic Pulmonary Fibrosis
- Synagis®
- Toremifene
- Oral and Injectable Oncology Medications
- Specialty Drugs

Retired Clinical Criteria:

- Agents for Atopic Dermatitis (Replace with new criteria)
- Tysabri® (replace with NF criteria)
- New Step Therapy:
- Chronic Dry Eye Agents

Quantity Limit Additions:

- Pazeo® (olopatadine) 0.7% drops QL (2.5 ml/25 days)
- Chemet (succimer) 19 day supply

Quantity Limit removals:

- All preferred peak flow meters

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).**