



AmeriHealth Caritas™

New Hampshire

To: AmeriHealth Caritas New Hampshire Providers

Date: January 22, 2024

Subject: AmeriHealth Caritas New Hampshire Formulary Changes

Summary: Effective January 29, 2024, the changes below will be made to the AmeriHealth Caritas New Hampshire formulary.

FORMULARY CHANGES:

Medications added to the formulary:

- polyethylene glycol-electrolyte solution (PEG-ES) (Na₂SO₄, NaHCO₃, NaCl, KCl) (CoLyte with Flavor Packs), 240 gram powder
- Brixadi (buprenorphine) extended-release (ER) weekly subcutaneous (SC) syringe, 8 mg/0.16 mL, with a quantity limit
- Brixadi (buprenorphine) ER weekly SC syringe, 16 mg/0.32 mL, with a quantity limit
- Brixadi (buprenorphine) ER weekly SC syringe, 24 mg/0.48 mL, with a quantity limit
- Brixadi (buprenorphine) ER weekly SC syringe, 32 mg/0.64 mL, with a quantity limit
- Brixadi (buprenorphine) ER monthly SC syringe, 64 mg/0.18 mL, with a quantity limit
- Brixadi (buprenorphine) ER monthly SC syringe, 96 mg/0.27 mL, with a quantity limit
- Brixadi (buprenorphine) ER monthly SC syringe, 128 mg/0.36 mL, with a quantity limit
- Daybue (trofinetide), with a prior authorization requirement
- Elfabrio (pegunigalsidase alfa-iwxj), with a prior authorization requirement
- Gohibic (EUA) (vilobelimab) 10 mg/mL, intravenous solution
- Joenja (leniolisib), with a prior authorization requirement
- Kalydeco (ivacaftor) 5.8 mg, 13.4 mg oral granules in packet, with a prior authorization requirement
- Lumryz (sodium oxybate), extended-release oral packet, with a prior authorization requirement
- Qalsody (tofersen), with a prior authorization requirement
- Skyclarys (omaveloxolone), with a prior authorization requirement
- Trikafta (elexacaftor/tezacaftor/ivacaftor) 80 mg-40 mg-60 mg (d)/59.5 mg (n) granule pack, with a prior authorization requirement
- Trikafta (elexacaftor/tezacaftor/ivacaftor) 100 mg-50 mg-75 mg (d)/75 mg (n) granule pack
- Vowst (fecal microbiota spores, live-brpk) with a prior authorization requirement
- Vyvgart Hytrulo (efgartigimod-hyaluronidas-qvfc) 1,008 mg-11,200 unit/5.6 mL subcutaneous solution, with a prior authorization requirement



AmeriHealth Caritas™

New Hampshire

- Zeposia (ozanimod) Starter Kit (28-day) 0.23 mg-0.46 mg-0.92 mg capsules dose pack, with a prior authorization requirement

Medications removed from the formulary:

- Pro Comfort Spacer — Adult Mask
- Pro Comfort Spacer — Child Mask
- neomycin-bacitracin-polymyxin B-hydrocortisone (Neo Polycin HC) 3.5 mg-400 units-10,000 g (1%) eye ointment
- neomycin-polymyxin-hydrocortisone (Cortisporin) 3.5 mg-10,000 units-10 mg/mL eye drop, suspension

Quantity limit (QL) additions:

- tobramycin-dexamethasone (TobraDex) 0.3% – 0.1% eye drops suspension, QL (10 mL per 30 days)
- Tobrex (tobramycin) 0.3% eye ointment, QL (3.5 gm [1 tube]/30 days)
- neomycin-bacitracin-polymyxin (Neosporin) 3.5 mg-400 unit-10,000 unit/gram eye ointment, QL (3.5 gm per 30 days)
- moxifloxacin (Vigamox) 0.5% eye drops, QL (3 mL per 30 days)
- Brixadi (buprenorphine) ER weekly subcutaneous (SC) syringe 8 mg/0.16 mL, QL (0.64 mL/28)
- Brixadi (buprenorphine) ER weekly (SC) syringe 16 mg/0.32 mL, QL (1.28 mL/28)
- Brixadi (buprenorphine) ER weekly (SC) syringe 24 mg/0.48 mL, QL (1.92 mL/28)
- Brixadi (buprenorphine) ER weekly (SC) syringe 32 mg/0.64 mL, QL (2.56 mL/28)
- Brixadi (buprenorphine) ER monthly (SC) syringe 64 mg/0.18 mL, QL (0.18 mL/28)
- Brixadi (buprenorphine) ER monthly (SC) syringe 96 mg/0.27 mL, QL (0.27 mL/28)
- Brixadi (buprenorphine) ER monthly (SC) syringe 128 mg/0.36 mL, QL (0.36 mL/28)

Quantity limit (QL) increases:

- clarithromycin ER 500 mg tablet, extended release, QL (28/14)
- azithromycin (Zithromax) 250 mg, QL, (30/30)
- azithromycin (Zithromax) 500 mg, QL, (30/30)

New clinical prior authorization criteria additions:

- Daybue
- Joenja
- Skyclarys
- Qalsody (tofersen)
- Aduhelm (aducanumab)
- Leqembi (lecanemab-irmb)

Clinical prior authorization revisions:

- insulin-like growth factor-1 receptor (Igf-1r) antagonists for thyroid eye disease



AmeriHealth Caritas™

New Hampshire

- calcitonin gene-related peptide inhibitors for acute migraine treatment
- sleep disorder therapy
- ileal bile acid transporter inhibitor (IBAT)
- chelating agents
- Difucid (fidaxomicin)
- enzyme replacement therapies for Fabry disease
- fecal microbiota
- adenosine triphosphate-citrate lyase (ACL) inhibitors
- antifibrotic respiratory tract agents
- chronic dry eye agents
- insulin pumps
- rituximab
- Verquvo
- vesicular monoamine transporter 2 (VMAT2) inhibitors for Huntington's disease
- Adakveo (crizanlizumab-tmca)

The following criteria will be retired:

- anti-amyloid monoclonal antibodies (mAb)

Age limit (AL) additions (in years of age):

- N/A

Drug utilization review changes:

- N/A

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)**.