Steward Health Care Network

HEALTH CHOICE ARIZONA

2018 Formulary Changes – Year to Date

Health Choice Arizona may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, and/or move a drug at a higher cost-sharing tier, we will notify you of the change at least 60 days before the date that the change becomes effective. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary.

This table shows drugs that have been removed from the 2018 Steward Health Choice Arizona Formulary.

Name of Drug	Description of Change	Alternative Drug*	Effective Date
ALECENSA	Removed from Formulary	Available via medical necessity review	1/1/2018
BOSULIF	Removed from Formulary	Available via medical necessity review	1/1/2018
COMETRIQ	Removed from Formulary	Available via medical necessity review	1/1/2018
COTELLIC	Removed from Formulary	Available via medical necessity review	1/1/2018
DICLEGIS	Removed from Formulary	ondansetron	1/1/2018
Differin Gel/Cream	Removed from Formulary	Differin OTC Gel	4/1/2018
EPCLUSA	Removed from Formulary	MAVYRET	1/1/2018
EPIPEN	Removed from Formulary	epinephrine	1/1/2018
FORTEO	Removed from Formulary	Available via medical necessity review	10/1/2018
FULYZAQ	Removed from Formulary	MYTESI	1/1/2018
GILOTRIF	Removed from Formulary	Available via medical necessity review	1/1/2018
HARVONI	Removed from Formulary	MAVYRET	1/1/2018
HYSINGLA ER	Removed from Formulary	XTAMPZA ER	1/1/2018
LENVIMA	Removed from Formulary	Available via medical necessity review	1/1/2018
NINLARO	Removed from Formulary	Available via medical necessity review	1/1/2018

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This table shows drugs that have been removed from the 2018 Health Choice Arizona Formulary.

Name of Drug	Description of Change	Alternative Drug*	Effective Date
ORKAMBI	Removed from Formulary	Available via medical necessity review	10/1/2018
OXYCONTIN	Removed from Formulary	XTAMPZA ER	1/1/2018
POLMALYST	Removed from Formulary	Available via medical necessity review	1/1/2018
Qvar	Removed from Formulary	Pulmicort Flexhaler	4/1/2018
STIVARGA	Removed from Formulary		1/1/2018
SYNRIBO	Removed from Formulary	Available via medical necessity review	1/1/2018
TECHNIVIE	Removed from Formulary	MAVYRET	1/1/2018
VIEKIRA/VIEKIRA XR	Removed from Formulary	MAVYRET	1/1/2018
XTANDI	Removed from Formulary	Available via medical necessity review	1/1/2018
ZEPATIER	Removed from Formulary	MAVYRET	1/1/2018

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This table outlines the upcoming positive changes to our formulary that may impact you.

Name of Drug	Description of Change	Drug Coverage	Previous Coverage	Effective Date
AccuCheck	Addition to the Formulary	Preferred Drug		5/1/2018
AUBAGIO	Addition to the Formulary	PA		1/1/2018
BESEVSPI AEROSPHERE	Addition to the Formulary	PA		7/1/2018
CALCIUM CARBONATE	Addition to the Formulary			10/15/2018
CALCIUM CITRATE	Addition to the Formulary			10/15/2018
COSENTYX	Addition to the Formulary	PA		10/1/2018
Differin OTC Gel	Addition to the Formulary			4/1/2018
ELIGARD	Addition to the Formulary	PA		1/1/2018
ELMIRON	Addition to the Formulary	PA		10/1/2018
ESBRIET	Addition to the Formulary	PA		7/1/2018
GLYXAMBI	Addition to the Formulary	PA		7/1/2018
HEMLIBRA	Addition to the Formulary	PA		10/1/2018
levalbuterol nebs sol	Addition to the Formulary	PA > 4 years old		7/1/2018
LUPRON	Addition to the Formulary	PA		1/1/2018
melatonin OTC	Addition to the Formulary			4/1/2018
montelukast granules	Addition to the Formulary	PA > 4 years old		7/1/2018
MYTESI	Addition to the Formulary	PA & QL 60/30 Days		1/1/2018
NALTREXONE ORAL	Addition to the Formulary	Preferred Drug		1/1/2018
naratriptan tabs	Addition to the Formulary			7/1/2018
Oyster Shell Calcium Tabs	Addition to the Formulary			10/15/2018
PROMACTA	Addition to the Formulary	PA		10/1/2018
Pulmicort Flexhaler	Addition to the Formulary	Preferred Drug		4/1/2018
RENVELA TABS	Addition to the Formulary			7/1/2018
STIOLTO RESPIMATE	Addition to the Formulary	PA		7/1/2018

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Name of Drug	Description of Change	Drug Coverage	Previous Coverage	Effective Date
SUBOXONE SUBLINGUAL FILM	Addition to the Formulary	Preferred Drug		1/1/2018
VESANOID	Addition to the Formulary	PA > 26 years old		1/1/2018
VIVITROL IM	Addition to the Formulary	Preferred Drug		1/1/2018
XTAMPZA ER	Addition to the Formulary	Preferred Drug		1/1/2018
zolmitriptan ODT	Addition to the Formulary			7/1/2018
zolmitriptan tabs	Addition to the Formulary			7/1/2018
SUBOXONE SUBLINGUAL FILM	Addition to the Formulary	Preferred Drug		1/1/2018

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This table outlines the upcoming changes to Prior Authorization Criteria that may impact you.

Name of Drug	Description of Change	Effective Date
ACTEMRA	PA Criteria Change	10/1/2018
ADCIRCA	Pulmonary Arterial Hypertension PA Criteria Updated	4/1/2018
AFSTYLA	PA Required Added	8/1/2018
AIMOVIG	PA Criteria Change	10/1/2018
ALPROLIX	PA Required Added	8/1/2018
Antidepressants in < 6 YO	PA Criteria Change	4/1/2018
ARIMIDEX	PA Required Added	1/1/2018
AROMASIN	PA Required Added	1/1/2018
AUBAGIO	Oral Multiple Sclerosis PA Criteria Update	1/1/2018
AVONEX	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
BETASERON	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
CAPRESLA	PA Required Added	1/1/2018
CIMZIA	PA Criteria Change	10/1/2018
CINRYZE	Hereditary Angioedema PA Criteria Update	4/1/2018
COPAXONE	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
Cumulative Morphine Equivalent Dose DUR Exceptions	PA Criteria Change	10/1/2018
CYTOXAN	PA Required Added	1/1/2018
DOPTELET	Thrombocytopenia PA Criteria Update	10/1/2018
ELIQUIS 5MG	QL REMOVED	8/1/2018
ELOCTATE	PA Required Added	8/1/2018
FARESTON	PA Required Added	1/1/2018
FLOLAN	Pulmonary Arterial Hypertension PA Criteria Updated	4/1/2018
Formulary medication PA Admin Criteria	PA Criteria Change	10/1/2018
FORTEO	Human Parathyroid Hormone PA Criteria Update	10/1/2018
GILENYA	Oral Multiple Sclerosis PA Criteria Update	1/1/2018
GLEOSTINE	PA Required Added	1/1/2018

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This table outlines the upcoming changes to Prior Authorization Criteria that may impact you.

Name of Drug	Description of Change	Effective Date
HAEGARDA	Hereditary Angioedema PA Criteria Update	4/1/2018
HEXALEN	PA Required Added	1/1/2018
HUMIRA PEN KIT	PA Required Added	10/1/2018
HUMIRA PEN KIT	PA Criteria Change	10/1/2018
IDELVION	PA Required Added	8/1/2018
JULUCA	PA Criteria Change	10/1/2018
KALYDECO	Cystic Fibrosis PA Criteria Update	10/1/2018
KEVZARA	PA Criteria Change	10/1/2018
LETAIRIS	Pulmonary Arterial Hypertension PA Criteria Updated	4/1/2018
LEUCOVORIN	PA Required Added	1/1/2018
MAKENA INJ 275MG	PA Required Added	10/1/2018
MATULANE VESANOID	PA Required Added	1/1/2018
memantine er	PA Required Added	4/1/2018
NUCYNTA ER	PA Criteria Change	4/1/2018
OLUMIANT	PA Criteria Change	10/1/2018
ORENCIA	PA Criteria Change	10/1/2018
ORILISSA	PA Criteria Change	10/1/2018
ORKAMBI	Cystic Fibrosis PA Criteria Update	10/1/2018
OTEZLA	PA Criteria Change	10/1/2018
PLEGRIDY	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
REBIF	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
REBINYN	PA Required Added	8/1/2018
REMODULIN	PA Required Added	4/1/2018
REVATIO	PA Required Added	4/1/2018
rivastigmine	PA Required Added	8/1/2018
SILIQ	PA Criteria Change	10/1/2018
SIMPONI	PA Criteria Change	10/1/2018
STELARA	PA Criteria Change	10/1/2018
SYMDEKO	Cystic Fibrosis PA Criteria Update	10/1/2018

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Name of Drug	Description of Change	Effective Date
TALTZ	PA Criteria Change	10/1/2018
TAVALISSE	Thrombocytopenia PA Criteria Update	10/1/2018
TECFIDERA	Oral Multiple Sclerosis PA Criteria Update	1/1/2018
TRACLEER	Pulmonary Arterial Hypertension PA Criteria Updated	4/1/2018
TRAMADOL ER	PA Criteria Change	4/1/2018
TREMFYA	PA Criteria Change	10/1/2018
TYMLOS	Human Parathyroid Hormone PA Criteria Update	10/1/2018
TYVASO	Pulmonary Arterial Hypertension PA Criteria Updated	4/1/2018
VENTAVIS	Pulmonary Arterial Hypertension PA Criteria Updated	4/1/2018
VIIBRYD STARTER KIT	PA Required Added	8/1/2018
XELJANZ	PA Criteria Change	10/1/2018
XYREM	PA Criteria Change	10/1/2018
ZOLINA	PA Required Added	1/1/2018