



Drug Formulary Update, January 2016 Commercial and State Programs

Updates to the HealthPartners Commercial and State Program Drug Formularies are listed below. Updates apply to all Commercial groups (PreferredRx, GenericsPlusRx, EnhancedRx, and GenericsAdvantageRx) and to HealthPartners Minnesota Health Care Programs (Medicaid and Minnesota Care “State Programs”) Drug Formulary. Please see www.healthpartners.com/formularies for details.

Positive changes (additions) are generally effective January 1, and negative changes (deletions) are generally effective April 1.

| Formulary Updates | | |
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| Medication | Status | Notes |
| Acyclovir ointment | NF-QL | Acyclovir ointment (generic Zovirax ointment) remains non-formulary, and a quantity limit of 15 grams per prescription has been added, effective April 1. Acyclovir ointment is used for cold sores. |
| Adcirca | NF-PA | Adcirca (tadalafil). Prior authorization coverage criteria have been updated, and a dose limit of 40mg daily has been added. Adcirca is used for pulmonary arterial hypertension, and is considered a specialty medication. |
| Addyi | NF-PA | Flibanserin (Addyi), for hypoactive sexual desire disorder, is non-formulary with prior authorization. Addyi is reserved for members meeting all three criteria: 1. for FDA-approved labeling, AND 2. for patients who have tried and failed standard treatments including bupropion, AND 3. for patients for whom HSDD is causing medical problems. Coverage remains dependent on benefit language (some groups do not allow coverage of sexual dysfunction medications). |
| Alprazolam ER | F-QL | Alprazolam ER has been added to formulary. Quantity limits remain. |

Formulary abbreviations: F = Formulary, PA = Prior Authorization, NF = Non-Formulary, NC = Not Covered.

| Medication | Status | Notes |
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| Aplenzin | NF-PA | <p>Bupropion ER (Aplenzin) remains non-formulary, and prior authorization coverage criteria have been added, effective January 1. Aplenzin is reserved for the treatment of depression in patients who have tried and failed generic bupropion, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Aplenzin has been extended through January 31.</p> |
| Astagraf XL | NF-PA | <p>Tacrolimus XL (Astagraf XL) remains non-formulary, and prior authorization coverage criteria have been added, effective April 1. Astagraf XL is reserved for patients who have tried and failed generic tacrolimus, with significant clinical rationale suggesting improved outcomes.</p> |
| Ativan | NF-PA | <p>Lorazepam (Ativan, Brand-only) tablets remain non-formulary, and prior authorization coverage criteria have been added, effective January 1. Generic lorazepam remains on-formulary.</p> <p>Ativan tablets are reserved for the treatment of anxiety in patients who tried and failed generic equivalents, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Ativan has been extended through January 31.</p> |
| Aubagio | NF-PA | <p>Aubagio (teriflunomide), for multiple sclerosis, remain non-formulary and prior authorization coverage criteria have been updated, effective January 1.</p> |
| Benzaclin | NF-PA | <p>Benzaclin (clindamycin/ benzoyl peroxide gel, Brand-only), remains non-formulary and prior authorization coverage criteria have been updated, effective January 1. Generic clindamycin/ benzoyl peroxide gel remains as a non-formulary medication.</p> <p>Benzaclin is reserved for the treatment of acne in patients who have tried and failed topical clindamycin plus benzoyl peroxide, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Benzaclin has been extended through January 31.</p> |

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| Buphenyl | NF-PA | Buphenyl (sodium phenylbutyrate) remains non-formulary and prior authorization coverage criteria have been updated, effective April 1. Buphenyl is considered a specialty medication. |
| Bydureon | F-QL | Exenatide ER (Bydureon). A quantity limit of 2 mg per week (4 units per 28 days) has been added, effective April 1, per the FDA maximum dose. Additional communications are being sent to providers and members who are affected by this new quantity limit. |
| Byetta | F-QL | Exenatide (Byetta). A quantity limit of 10 mcg BID has been added, effective April 1, per the FDA maximum dose. Byetta 5 mcg will be limited to 60 doses per month (1.2 mL per 30 days), and Byetta 10 mcg will be limited to 60 doses per month (2.4 mL per 30 days). Additional communications are being sent to providers and members who are affected by this new quantity limit. |
| Carac | NF-PA | Fluorouracil 0.5% cream (Carac, Brand-only) remains non-formulary, and prior authorization coverage criteria have been added, effective April 1. Generic fluorouracil 0.5% cream remains non-formulary. Carac is reserved for the treatment of actinic keratosis for patients who have tried generic fluorouracil 0.5% cream, with significant clinical rationale suggesting improved outcomes. |
| Cardizem CD | NF-PA | Cardizem CD (diltiazem CD, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic diltiazem CD remains on-formulary. Cardizem CD is reserved for the treatment of hypertension in patients who have tried and failed generic diltiazem, with significant clinical rationale suggesting improved outcomes. Additional communications are being sent to affected members and their providers. Coverage for members currently receiving Cardizem CD has been extended through January 31. |

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| Cardizem LA | NF-PA | <p>Cardizem LA (diltiazem LA, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic diltiazem LA remains on-formulary.</p> <p>Cardizem LA is reserved for the treatment of hypertension in patients who have tried and failed generic diltiazem, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Cardizem LA has been extended through January 31.</p> |
| Cayston | PA | <p>Aztreonam (Cayston) inhalation. Prior authorization coverage criteria have been updated, effective January 1.</p> <p>Cayston is used for cystic fibrosis, and is considered a specialty medication.</p> |
| Cephalexin tablets | NF-PA | <p>Cephalexin tablets have been removed from the formulary, effective April 1, and prior authorization coverage criteria have been added. Cephalexin capsules remain on-formulary.</p> <p>Cephalexin tablets are reserved for the treatment of bacterial infections in patients who have tried and failed cephalexin capsules, with significant clinical rationale suggesting improved outcomes.</p> <p>Cephalexin capsules are less costly.</p> |
| Chenodal | NF-PA | <p>Chenodiol (Chenodal) tablets remain non-formulary and prior authorization coverage criteria have been updated, effective January 1.</p> |
| <p>Chronic Inflammatory Disease Agents</p> <p>Enbrel, Humira</p> <p>Actemra, Cosentyx, Cimzia, Kineret, Orencia, Otezla, Simponi, Stelara, Xeljanz</p> | <p>F-PA</p> <p>NF-PA</p> | <p>Prior authorization coverage criteria have been updated, adding requirements for at least two concurrent first-line therapies at therapeutic doses for three months, annual provider attestations for therapeutic benefit and medical necessity when using regimens higher than the FDA-approved dose.</p> |

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| Cialis | NF-PA | <p>Tadalafil (Cialis) remains non-formulary and add prior authorization coverage criteria have been added, effective April 1.</p> <p>Cialis will be covered per Benefit language, AND reserved for patients who have tried and failed generic sildenafil tablets.</p> <p>Cialis averages \$250 per Rx, and generic sildenafil 20mg is expected to cost \$20-40. Most members have lower costs for generics (\$10-15, versus \$50-90 for Brands).</p> <p>No changes are required for members with current authorizations for Cialis (existing prior authorizations for Cialis will be allowed to expire – these authorizations generally have a one year-duration).</p> <p>Members with coverage for Cialis as a non-formulary medication will be affected starting April 1.</p> <p>All members receiving Cialis will receive a communication informing them of the availability of generic sildenafil 20mg as a lower-cost alternative.</p> |
| Contraceptives | F | <p>The gender-edit is being removed, per ACA requirements.</p> <p>This update applies to both formulary and non-formulary contraceptives, and will be effective February 1.</p> |
| Cuprimine | NF-PA | <p>Penicillamine (Cuprimine) will be non-formulary with prior authorization, effective April 1.</p> <p>Cuprimine is used for Wilson’s disease.</p> |
| Daklinza | NF-PA | <p>Daclatasvir (Daklinza) remains non-formulary and prior authorization coverage criteria have been added, effective January 1.</p> <p>Daklinza is used for hepatitis C, and is considered a specialty medication.</p> |
| Daraprim | NF-PA | <p>Pyrimethamine (Daraprim) remains non-formulary and prior authorization coverage criteria have been added, effective January 1.</p> <p>Daraprim is reserved for the treatment of toxoplasmosis.</p> |
| Desmopressin tablets | F-AGE | <p>Desmopressin tablets. Prior authorization criteria have been removed, and an age edit of 8 has been added.</p> <p>This allows coverage for patients 8 years of age and older.</p> |

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| Diastat | NF-PA-QL | <p>Diazepam (Diastat, Brand-only) rectal remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic diazepam rectal remains on-formulary.</p> <p>Diastat brand is reserved for the treatment of seizures in patients who have tried and failed generic diazepam rectal.</p> <p>The quantity limit remains unchanged.</p> |
| Edecrin | NF-PA | <p>Ethacrynic acid (Edecrin) will be non-formulary with prior authorization coverage criteria, effective April 1.</p> <p>Edecrin is reserved for the treatment of edema in patients who have tried two or more preferred products (furosemide, torsemide, and bumetanide).</p> <p>Additional communications are being sent to affected members and their providers.</p> |
| Efudex | NF-PA | <p>Fluorouracil 5% cream (Efudex, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic fluorouracil 5% cream remains on-formulary.</p> <p>Efudex is reserved for the treatment of actinic keratosis or basal cell carcinoma in patients who have tried generic fluorouracil 5% cream, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Efudex has been extended through January 31 to allow time for communications.</p> |
| Epiduo | NF-PA | <p>Epiduo (adapalene/ benzoyl peroxide) remains non-formulary and prior authorization coverage criteria have been added, effective April 1.</p> <p>Epiduo is reserved for patients who have tried and failed adapalene and benzoyl peroxide given separately, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> |
| Episil | NC | <p>Episil is not eligible for pharmacy coverage.</p> |

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| Ertaczo | NF-PA | Sertaconazole (Ertaczo) cream remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Ertaczo is reserved for the treatment of tinea pedis in patients who have tried and failed preferred topical antifungal products such as terbinafine OTC, clotrimazole OTC, ciclopirox, nystatin, and ketoconazole. Additional communications are being sent to affected members and their providers. Coverage for members currently receiving Ertaczo has been extended through January 31. |
| Eszopiclone | F-QL, AGE | Eszopiclone (generic Lunesta) has been added to formulary. Eszopiclone is a low-cost generic. Quantity limits and age edits remain. |
| Fluorouracil 0.5% cream | NF-PA | Fluorouracil 0.5% cream (generic Carac) remains non-formulary, and prior authorization coverage criteria have been added, effective April 1. Fluorouracil 0.5% cream is reserved for the treatment of actinic keratosis for patients who have tried two or more preferred products (liquid nitrogen, imiquimod, fluorouracil 5% solution, and fluorouracil 5% cream). |
| Gilenya | F-PA | Fingolimod (Gilenya). Prior authorization coverage criteria have been updated, effective January 1. Gilenya is used for multiple sclerosis, and is considered a specialty medication. |
| Granix | F | Filgrastim (Granix) has been added to formulary, effective February 1. Granix is a biosimilar for Neupogen, for neutropenia. Granix is also covered as a medical claim. |
| Guanfacine ER | F-QL | Guanfacine ER (generic Intuniv). The age-limit has been removed. Guanfacine ER is used for ADHD. The quantity limits remains, per FDA-maximum dose limits. |
| Humira | F-PA | Adalimumab (Humira). Prior authorization coverage criteria have been updated, adding requirements for at least two concurrent first-line therapies at therapeutic doses for three months, provider attestations for therapeutic benefit annually and medical necessity when using regimens higher than the FDA-approved dose. The new indication for hidradenitis suppurativa has been added. |
| Iressa | F-PA | Gefitinib (Iressa) has been added to formulary with prior authorization coverage criteria, effective February 1. |

| Medication | Status | Notes |
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| Juxtapid | F-PA | Lomitapide (Juxtapid) prior authorization coverage criteria have been updated, to include a trial with Repatha. Juxtapid is an oral medication for cholesterol. |
| Kalydeco | F-PA | Ivacaftor (Kalydeco). Kalydeco prior authorization coverage criteria have been updated. Kalydeco is used for cystic fibrosis, and is considered a specialty medication. |
| Kynamro | F-PA | Mipomersen (Kynamro) prior authorization coverage criteria have been updated, to include a trial with Repatha. Kynamro is a SQ injection for cholesterol. |
| Lansoprazole capsules | F* | Lansoprazole (generic Prevacid) capsules. Step therapy has been removed. Lansoprazole capsules are available as low-cost generics. * Lansoprazole remains excluded for the Generics-Plus Drug Formulary. |
| Levitra | NF-PA | Vardenafil (Levitra) remains non-formulary and prior authorization coverage criteria have been added, effective April 1. Levitra, for erectile dysfunction, will be covered per Benefit language, AND reserved for patients who have tried and failed generic sildenafil tablets. Levitra averages \$250 per Rx, and generic sildenafil 20mg is expected to cost \$20-40. Most members have lower costs for generics (\$10-15, versus \$50-90 for Brands). No changes are required for members with current authorizations for Levitra (existing prior authorizations for Levitra will be allowed to expire, although authorizations for Levitra generally have a one year-duration). Members with coverage for Levitra as a non-formulary medication will be affected starting April 1. All members receiving Levitra will receive a communication informing them of the availability of generic sildenafil 20mg as a lower-cost alternative. |
| Lonsurf | F-PA | Trifluridine/ tipiracil (Lonsurf), for colorectal cancer, has been added to formulary with prior authorization, effective February 1. |
| Memantine | F | Memantine (generic Namenda) immediate release tablets. Prior authorization criteria have been removed. Memantine is a low-cost generic. |

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| Mephyton | F-QL | <p>Phytonadione (Mephyton) tablet. A quantity limit of 3 tablets per prescription has been added, effective April 1.</p> <p>Mephyton is used for bleeding due to warfarin.</p> <p>Additional communications are being sent to affected members and their providers.</p> |
| Mestinon tablet and ER tablet | NF-PA | <p>Pyridostigmine (Mestinon, Brand-only) tablet and ER tablet is non-formulary with prior authorization coverage criteria, effective January 1. Generic pyridostigmine remains on-formulary.</p> <p>Mestinon tablets are reserved for the treatment of myasthenia gravis in patients who have tried and failed generic equivalents, with significant clinical rationale suggesting improved outcomes.</p> |
| Mestinon syrup | NF-PA | <p>Pyridostigmine (Mestinon) syrup is non-formulary with prior authorization coverage criteria, effective April 1.</p> <p>Pyridostigmine syrup is reserved for treatment of myasthenia gravis for patients who have tried and failed generic pyridostigmine tablets.</p> <p>Additional communications are being sent to affected members and their providers.</p> |
| Mysoline | NF-PA | <p>Primidone (Mysoline, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic primidone remains on-formulary.</p> <p>Mysoline is reserved for the treatment of seizures in patients who have tried and failed generic equivalents, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Mysoline has been extended through January 31.</p> |
| Nephrocaps | NF-PA | <p>Folic acid/ vitamin B (Nephrocaps, Brand-only), is non-formulary with prior authorization coverage criteria, effective January 1. Generic Nephrocaps remain on-formulary.</p> <p>Nephrocaps are reserved for vitamin replacement for patients who tried and failed generic equivalents, with significant clinical rationale suggesting improved outcomes.</p> |
| Neutrasal | NC | <p>Saliva substitute (Neutrasal) is not eligible for pharmacy coverage.</p> |

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| Noritate | NF-PA | <p>Metronidazole 1% cream (Noritate) is non-formulary with prior authorization coverage criteria, effective April 1.</p> <p>Noritate is reserved for the treatment of acne rosacea in patients who have tried and failed preferred metronidazole topical products (metronidazole 0.75% cream, metronidazole 1% gel), with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> |
| Odomzo | F-PA | <p>Sonidegib (Odomzo) has been added to formulary with prior authorization coverage criteria, effective February 1.</p> <p>Odomzo is used for basal cell carcinoma.</p> |
| Onexton | NF-PA | <p>Clindamycin/ benzoyl peroxide (Onexton) remains non-formulary and prior authorization coverage criteria have been added, effective January 1.</p> <p>Onexton is reserved for the treatment of acne in patients who have tried and failed topical clindamycin plus benzoyl peroxide, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Onexton has been extended through January 31.</p> |
| Orkambi | F-PA | <p>Orkambi (lumacaftor/ ivacaftor). Prior authorization coverage criteria have been updated.</p> <p>Orkambi is used for cystic fibrosis, and is considered a specialty medication.</p> |
| Oxsoralen-Ultra | NF-PA | <p>Methoxsalen (Oxsoralen-Ultra, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective April 1.</p> <p>Oxsoralen-Ultra is reserved for patients who have tried and failed generic equivalents, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> |

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| Methoxsalen | NF-PA | Methoxsalen (generic Oxsoresalen-Ultra), remains non-formulary and prior authorization coverage criteria have been added, effective April 1. Methoxsalen is reserved for prescribing by dermatology specialists, for the treatment of severe recalcitrant disabling psoriasis in patients who tried and failed standard therapies (UVB phototherapy OR systemic therapy such as methotrexate, cyclosporine, or acitretin). Additional communications are being sent to affected members and their providers. |
| Phentermine | F* | Phentermine. The one year duration limit has been removed. * Phentermine remains excluded for government programs (Medicare and State Programs). |
| Praluent | NF-PA | Alirocumab (Praluent) remains non-formulary, and prior authorization coverage criteria have been added. Repatha is preferred over Praluent. Praluent is used for cholesterol. |
| Prestalia | NF | Prestalia (perindopril/ amlodipine) remains non-formulary. Prestalia is used for hypertension. |
| Pulmozyme | F-PA | Dornase alfa (Pulmozyme). Prior authorization coverage criteria have been updated. Pulmozyme is used for cystic fibrosis, and is considered a specialty medication. |
| Ravicti | NF-PA | Glycerol phenylbutyrate (Ravicti) is non-formulary with prior authorization, effective April 1 2016. Ravicti is considered a specialty medication. |
| Relistor | F-PA | Methylnaltrexone (Relistor). Prior authorization coverage criteria have been updated, adding the new indication for opioid-induced constipation. Relistor is reserved for members meeting either criteria: 1. for treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient, OR 2. Treatment of opioid-induced constipation in adult patients with chronic non-cancer pain, when response to laxative therapy has not been sufficient. |
| Repatha | F-PA | Evolocumab (Repatha) has been added to formulary with prior authorization coverage criteria, effective January 1. Repatha is preferred over Praluent. Repatha is used for cholesterol. |

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| Restasis | PA | Cyclosporine ophthalmic (Restasis), for ocular dryness. Prior authorization coverage criteria have been updated, for the State Programs formulary. |
| Revatio suspension | F-PA | Sildenafil oral suspension (Revatio). Prior authorization coverage criteria have been updated. |
| Sildenafil 20mg | F-QL | <p>Sildenafil 20mg. The specialty-medication restriction has been removed (allowing dispensing by retail pharmacies), prior authorization criteria have been removed, and a quantity limit (#30 per month) has been added.</p> <p>The specialty change (allowing dispensing by retail pharmacies) is effective January 1.</p> <p>Removing the prior authorization and adding the quantity limit will be effective April 1.</p> <p>Generic sildenafil 20mg is preferred over Viagra, Cialis, and Levitra.</p> <p>For erectile dysfunction, for members with coverage, sildenafil 20mg is covered for up to #30 tablets per month.</p> <p>For pulmonary hypertension, prior authorization is required. Requests will be approved for #90 tablets per month, per FDA dosing guidelines.</p> |
| Silvrstat | NC | Topical silver (Silvrstat) is not eligible for pharmacy coverage. |
| Synjardy | F-ST | <p>Synjardy (empagliflozin/ metformin), for diabetes, has been added to formulary with step-therapy, effective February 1.</p> <p>Synjardy, for diabetes, is reserved after metformin.</p> |
| Technivie | NF-PA | <p>Ombitasvir/ paritaprevir/ ritonavir (Technivie) remains non-formulary and prior authorization coverage criteria have been added.</p> <p>Technivie is used for hepatitis C, and is considered a specialty medication.</p> |
| Thiola | NF-PA | Tiopronin (Thiola) remains non-formulary and prior authorization coverage criteria have been added. |

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| Tiazac | NF-PA | <p>Diltiazem LA (Tiazac, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic diltiazem LA remains on-formulary.</p> <p>Tiazac is reserved for the treatment of hypertension in patients who have tried and failed generic diltiazem, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Tiazac has been extended through January 31.</p> |
| Timoptic Ocudose | NF-PA | <p>Timolol (Timoptic Ocudose) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Timoptic Ocudose is reserved for the treatment of elevated intraocular pressure AND sensitivities to preservatives in preferred products such as generic timolol eye drops.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Timoptic Ocudose has been extended through January 31.</p> |
| Tobramycin inhalation | PA | <p>Tobramycin inhalation (Tobi, Tobi Podhaler, Bethkis, Kitabis Pak, and the tobramycin nebulization solution). Prior authorization coverage criteria have been updated.</p> <p>Tobramycin inhalation is used for cystic fibrosis, and is considered a specialty medication.</p> |
| TransDerm-Scop | F* | <p>Scopolamine patch (TransDerm-Scop). Prior authorization has been removed.</p> <p>Transderm-Scop remains non-formulary for the generics-preferred formularies (GenericsPlusRx and GenericsAdvantageRx).</p> |
| Trulicity | F-PA-QL | <p>Trulicity (dulaglutide). A quantity limit of 1.5 mg per week (2 mL per 28 days) has been added, effective April 1, per the FDA maximum dose. Trulicity is reserved for diabetes, after exenatide and liraglutide.</p> <p>Additional communications are being sent to providers and members who are affected by this new quantity limit.</p> |
| Valsartan | F | <p>Valsartan (generic Diovan), step therapy has been removed.</p> <p>Valsartan is a low-cost generic.</p> <p>This change is effective for Commercial plans on January 1, and for State Programs on March 1.</p> |

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| Valsartan/ HCTZ | F | <p>Valsartan/ HCTZ (generic Diovan HCT), step therapy has been removed. Valsartan/ HCTZ is a low-cost generic.</p> <p>This change is effective for Commercial plans on January 1, and for State Programs on March 1.</p> |
| Vasotec | NF-PA | <p>Enalapril (Vasotec, Brand-only) tablets, remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic enalapril remains on-formulary.</p> <p>Vasotec is reserved for the treatment of hypertension for patients who have tried and failed generic enalapril, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Vasotec has been extended through January 31.</p> |
| Viagra | NF-PA | <p>Sildenafil (Viagra) remains non-formulary and prior authorization coverage criteria have been added, effective April 1.</p> <p>Viagra, for erectile dysfunction, will be covered per Benefit language, AND reserved for patients who have tried and failed generic sildenafil tablets.</p> <p>Viagra averages \$250 per Rx, and generic sildenafil 20mg is expected to cost \$20-40. Most members have lower costs for generics (\$10-15, versus \$50-90 for Brands).</p> <p>No changes are required for members with current authorizations for Viagra (existing prior authorizations for Viagra will be allowed to expire, although authorizations for Viagra generally have a one year-duration).</p> <p>Members with coverage for Viagra as a non-formulary medication will be affected starting April 1.</p> <p>All members receiving Viagra will receive a communication informing them of the availability of generic sildenafil 20mg as a lower-cost alternative.</p> |
| Victoza | QL | <p>Liraglutide (Victoza). A quantity limit of 1.8 mg per day (0.3 mL/ day) has been added, effective April 1, per the FDA maximum dose for diabetes.</p> <p>Additional communications are being sent to providers and members who are affected by this new quantity limit.</p> |

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| Wellbutrin XL | NF-PA | <p>Bupropion XL (Wellbutrin XL, Brand-only) remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Generic bupropion XL remains on-formulary.</p> <p>Wellbutrin XL is reserved for the treatment of depression in patients who have tried and failed generic bupropion, with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Wellbutrin XL has been extended through January 31.</p> |
| Xerese | NF-PA | <p>Acyclovir/ hydrocortisone (Xerese) cream, remains non-formulary and prior authorization coverage criteria have been added, effective January 1.</p> <p>Xerese is reserved for the treatment of recurrent herpes labialis in patients who have tried and failed two preferred alternatives (oral acyclovir, Abreva OTC, and acyclovir ointment). Acyclovir ointment remains non-formulary.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Xerese has been extended through January 31 to allow time for communications.</p> |
| Zarxio | F | <p>Filgrastim (Zarxio) has been added to formulary, effective February 1. Zarxio is a biosimilar for Neupogen, for neutropenia.</p> <p>Zarxio is also covered as a medical claim.</p> |
| Zecuity | NF-PA | <p>Sumatriptan (Zecuity) remains non-formulary and prior authorization coverage criteria have been added, effective January 1.</p> <p>Zecuity is reserved for patients who have tried and failed two preferred triptan medications.</p> |

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| Zegerid | NF-PA* | <p>Zegerid (omeprazole/ bicarbonate), remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Zegerid is reserved for the treatment of esophagitis in patients who have tried and failed three or more preferred therapies (omeprazole, pantoprazole, and lansoprazole), with significant clinical rationale suggesting improved outcomes.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Zegerid has been extended through January 31.</p> <p>* Zegerid remains excluded for the GenericsPlusRx Drug Formulary.</p> |
| Zovirax cream | NF-PA | <p>Acyclovir (Zovirax) cream remains non-formulary and prior authorization coverage criteria have been added, effective January 1. Zovirax cream is reserved for the treatment of recurrent herpes labialis in patients who have tried and failed two preferred alternatives (oral acyclovir, Abreva OTC, and acyclovir ointment).</p> <p>Oral acyclovir is on-formulary, Abreva is available OTC, and acyclovir ointment is non-formulary.</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Zovirax cream has been extended through January 31.</p> |
| Zovirax ointment | NF-PA | <p>Acyclovir (Zovirax, Brand-only) ointment remains non-formulary and prior authorization criteria have been added, effective January 1. Generic acyclovir ointment remains non-formulary.</p> <p>Zovirax ointment, used for cold sores, is reserved for the treatment of herpes in patients who have tried and failed two preferred alternatives (oral acyclovir, Abreva OTC, and generic acyclovir ointment).</p> <p>Additional communications are being sent to affected members and their providers.</p> <p>Coverage for members currently receiving Zovirax ointment has been extended through January 31.</p> |

Formulary Information and Requests

Formulary Information is available at [HealthPartners.com/ Provider/ Admin Tools/ Pharmacy Policies](http://HealthPartners.com/Provider/AdminTools/PharmacyPolicies), including the [Drug Formularies](#).

Pharmacy Customer Service is available to providers (physicians and pharmacies) by fax, phone, and mail.

- Fax submission of coverage requests is preferred: 952-853-8700 or 1-888-883-5434.
- Telephone service is available: 952-883-5813 or 1-800-492-7259. HealthPartners Pharmacy Customer Service is available from 8AM - 6PM CST, Monday through Friday. After hours calls are answered by our Pharmacy Benefit Manager.
- Mail: HealthPartners Pharmacy Services, 8170 33rd Avenue South, PO Box 1309, Mpls, MN 55440.