HealthPartners®

Drug Formulary Update, January 2017

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 1st, and negative changes (deletions) are generally effective April 1st.

Additional communications are sent to all affected members and their providers.

Drug Name	Current Status	New Status	Effective Date	Comments
Acyclovir (Zovirax), Brand-only	NF	NF PA	4/1/2017	Zovirax Brands will be reserved for: 1. patients who have tried and failed the equivalent generic due to a documented allergic reaction, and 2. patients who have tried and failed at least one additional preferred alternative such as valacyclovir and famciclovir. Acyclovir remains on formulary.
Aripiprazole (Abilify), Brand-only	NF	NF PA	4/1/2017	Abilify Brand is reserved for patients who have tried and failed the equivalent generic due to a documented allergic reaction. Aripiprazole (generic Abilify) remains on formulary).
Canakinumab (Ilaris)	F PA	F PA	1/1/2017	Coverage criteria have been updated.

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Drug Name	Current Status	New Status	Effective Date	Comments
Coenzyme Q10 powder	NF	NF PA	4/1/2017	Coenzyme Q10 powder has been added to the "PA-required" compounding list.
Desvenlafaxine (Khedezla)	NF PA	NF	1/1/2017	Desvenlafaxine (Khedezla) prior authorization criteria have been removed for State Programs, and desvenlafaxine is non-formulary for all formularies.
Dexamethasone dose pack (Dexpak)	NF	NF PA	4/1/2017	Dexpak is reserved for: patients who have tried and failed generic dexamethasone due to a documented allergic reaction.
Dexmethylphenidate XR	NF	F	1/1/2017	Dexmethylphenidate XR (generic Focalin XR) has been added to formulary.
Dextroamphetamine (Dexedrine), Brand-only	NF	NF PA	4/1/2017	Dexedrine Brand is reserved for 1. patients who have tried and failed the equivalent generic due to a documented allergic reaction, and 2. patients who have tried and failed at least one additional preferred alternative such as amphetamine/ dextroamphetamine and Vyvanse. Dextroamphetamine (generic Dexedrine) remains on formulary.
Doxycycline monohydrate 40mg	NF	NF PA	4/1/2017	Doxycycline monohydrate 40mg (Brand Oracea and generic) are non-formulary with prior authorization. Oracea Brand is reserved for patients who have tried and failed the equivalent generic due to a documented allergic reaction. Doxycycline monohydrate 40mg (generic Oracea) is reserved for patients who have tried preferred generic doxycycline products, with significant clinical rationale suggesting improved outcomes.

Drug Name	Current Status	New Status	Effective Date	Comments
Dutasteride	NF	F	1/1/2017	Dutasteride (generic Avodart) has been added to State Programs, and is now on all Drug Formularies.
Dutoprol (metoprolol/ HCTZ) ER	NF	NF PA	4/1/2017	Dutoprol (Brand and generic) are reserved for patients who have tried and failed metoprolol and hydrochlorothiazide given separately, due to a documented allergic reaction.
Efinaconazole (Jublia)	NF PA	NF PA	1/1/2017	Jublia coverage criteria have been updated.
Epiduo Forte (adapalene 0.3%/ benzoyl peroxide 2.5%) gel	NF PA	NF PA	1/1/2017	Epiduo Forte coverage criteria have been updated. Epiduo Forteo is reserved for patients who have tried and failed adapalene 0.3% and benzoyl peroxide given separately, due to a documented allergic reaction.
Eplerenone	F PA	F	1/1/2017	Eplerenone (generic Inspra) coverage criteria have been removed, and eplerenone is on formulary with no restrictions.
Fluoxetine (Prozac), Brand-only	NF	NF PA	4/1/2017	Prozac Brand is reserved for patients who have tried and failed the equivalent generic due to a documented allergic reaction. Fluoxetine remains on formulary.
Hepatitis C			1/1/2017	Coverage criteria have been updated, removing fibrosis requirements. Preferred products have been updated for State Programs. Zepatier (elbasvir/ grazoprevir) is preferred for genotypes 1 and 4.
Insulin glargine (Basaglar)	NF	F	1/1/2017	Basaglar has been added to formulary, and will replace Lantus and Toujeo.

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Insulin glargine (Lantus and Toujeo)	F	NF PA	2/1/2017	Lantus and Toujeo are being removed from the formulary. Basaglar will be preferred. Lantus and Toujeo will be reserved for patients who have tried and failed Basaglar due to documented allergic reactions.
Itraconazole	F PA	F PA	1/1/2017	Itraconazole coverage criteria have been updated.
Ivermectin (Soolantra) cream	NF	NF PA	4/1/2017	Soolantra will be reserved for patients with an inadequate response to topical tretinoin or adapalene.
Levetiracetam (Keppra), Brand-only	NF	NF PA	4/1/2017	Keppra Brands will be reserved for patients who have tried and failed the equivalent generic, due to a documented allergic reaction. Levetiracetam (generic Keppra) remains on formulary.
Levetiracetam XR	NF	F	1/1/2017	Levetiracetam XR (generic Keppra XR) has been added to formulary.
Lidocaine ointment	F	NF	4/1/2017	Lidocaine ointment has been removed from the formulary.
Metformin GR	NF	NF PA	4/1/2017	Metformin GR (Glumetza and generics) requires prior authorization.
Naproxen sodium	F	NF	4/1/2017	Naproxen sodium (generic Anaprox) has been removed from the formulary.
Novacort (hydrocortisone/ pramoxine) gel	NF	NF PA	4/1/2017	Novacort will be reserved for patients with an inadequate response to two or more topical steroids, with significant clinical rationale suggesting improved outcomes.

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Orkambi (lumacaftor/ ivacaftor)	F PA	F-PA	1/1/2017	Orkambi coverage criteria have been updated.
Paliperidone (Invega)	NF PA	NF PA	1/1/2017	Paliperidone (Brand Invega) coverage criteria have been updated. Invega is reserved for patients who have tried and failed the equivalent generic due to a documented allergic reaction. Paliperidone remains non-formulary with prior authorization.
Pantoprazole (Protonix), Brand-only	NF	NF PA	4/1/2017	Protonix Brand is reserved for patients who have tried the equivalent generic, due to a documented allergic reaction. Pantoprazole (generic Protonix) remains on formulary. Protonix (and all PPIs) remain excluded for the GenericsPlusRx Drug formulary.
Quetiapine (Seroquel), Brand-only	NF	NF PA	4/1/2017	Seroquel Brand is reserved for patients who have tried the equivalent generic, due to a documented allergic reaction. Quetiapine remains on formulary.
Quetiapine XR (Seroquel XR), Brand-only	NF PA	NF PA	1/1/2017	Coverage criteria have been updated. Seroquel XR is reserved for patients with significant documented compliance concerns with quetiapine regular release, or patients currently stable on this medication. Approvals are given for 3 years.

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Quetiapine XR	F PA	F PA	1/1/2017	Quetiapine XR (Seroquel XR) coverage criteria have been updated. Quetiapine XR is reserved for patients with significant documented compliance concerns with quetiapine regular release, or patients currently stable on this medication. Approvals are given for 3 years.
Rabeprazole	NF	F	1/1/2017	Rabeprazole (generic Aciphex) has been added to the formulary. Rabeprazole (and all PPIs) remain excluded for the GenericsPlusRx Drug formulary.
Rabeprazole (Aciphex), Brand-only	NF	NF PA	4/1/2017	Aciphex Brand is reserved for patients who have tried and failed the equivalent generic due to a documented allergic reaction. Rabeprazole is on formulary. Aciphex (and all PPIs) remain excluded for the GenericsPlusRx Drug formulary.
Rifaximin (Xifaxan)	F PA	F PA	1/1/2017	Coverage criteria have been updated.
Tavaborole (Kerydin)	NF PA	NF PA	1/1/2017	Kerydin coverage criteria have been updated.
Testosterone (Androgel and generics, Androderm, cypionate, and enanthate)	F PA	F PA	1/1/2017	The prior authorization criteria for preferred testosterone products have been updated. These are reserved for: 1. Members with a diagnosis of gender dysphoria, or 2. Male patients with a documented testosterone deficiency of less than 300 ng/dL. Renewal Criteria: Reauthorizations are given for members who have been examined by the provider within the previous 14 months, have a positive response, and continue to require this medication. Coverage Duration: Approvals are given for three years.

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Testosterone (Axiron, Fortesta, Testim, Vogelxo)	NF PA	NF PA	1/1/2017	The prior authorization criteria for non-preferred forms of testosterone have been updated. These are reserved for the following indications: 1. Members with a diagnosis of gender dysphoria, or 2. Male patients with a documented testosterone deficiency of less than 300 ng/dL, AND an inadequate response to both Androderm AND Androgel. Renewal Criteria: Reauthorizations are given for members who have been examined by the provider within the previous 14 months, have a positive response, and continue to require this medication. Coverage Duration: Approvals are given for three years.
Tolmetin	F	NF	4/1/2017	Tolmetin has been removed from the formulary.
VGo	DS PA	DS	1/1/2017	Coverage criteria have been removed. V-Go is a wearable insulin delivery device used with insulin, covered as a diabetic supply.