Umpqua Health Alliance

List of Medication Coverage Changes

INTRODUCTION

The Umpqua Health Alliance (UHA) Pharmacy and Therapeutics (P&T) Committee composed of pharmacists and physicians determine which drugs should be covered, the coverage restrictions, and the PA guidelines. The goal of the P&T Committee is to create a formulary (list of covered drugs) with medications that are safe and effective and that offer the best value.

Our formulary and prior authorization guidelines are usually updated quarterly. **This document contains all updates made to the UHA formulary and PA guidelines since January 1, 2020.** The current versions of our formulary and PA guidelines are available on the UHA Pharmacy Services webpage: https://www.umpquahealth.com/pharmacy-services/.

LEGEND

The following are restriction and coverage abbreviations found in this document:

ABBREVIATIONS	DEFINITION	EXPLANATION
PA	Prior Authorization Required	Prior authorization (e.g. prior approval) is required before filling a prescription for this drug. Without prior authorization, we may not cover this drug. The provider must submit a request for prior authorization with the appropriate documentation (including recent chart notes) before the drug is covered. A specific PA guideline policy number beginning with "RX" may be referenced in the "Description" column. Visit the UHA Pharmacy Services webpage for our PA guidelines: https://www.umpquahealth.com/pharmacy-services/.
ST	Step Therapy Restriction	We require trial and failure of one or more lower-cost or preferred drug(s) ("Step 1 drug") before using the more expensive or non-preferred drug ("Step 2 drug"). If it is medically necessary for a member to use a Step 2 drug first, the prescriber will need to submit a request for prior authorization.
AR	Age Restriction	Coverage of this drug is limited to a specific age range. Covered ages are listed. A prior authorization is required for members outside of the listed age range.
QL	Quantity Limit	We will cover this drug only up to a certain quantity or limit per time or per fill. The specific quantity limit is listed. If it is medically necessary to exceed the quantity limit, the prescriber will need to submit a request for prior authorization.
SPEC	Specialty Drug	Coverage for specialty drugs will only be provided if the drug is obtained through our contracted specialty pharmacy, MedImpact Direct Specialty Hub. *MedImpact Direct Specialty Hub* *Telephone: (877) 391-1103* *Fax: (888) 807-5716* *Website: www.medimpactdirect.com*

MEDICATION COVERAGE CHANGES

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	8/1/2020	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	PRADAXA (DABIGATRAN ETEXILATE MESYLATE)	110 MG	CAPSULE	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH PA; SEE PA GUIDELINES FOR DETAILS (RX014).
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	50 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	100 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	100 MG	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	75 MG	CAPSULE	REMOVED FROM FORMULARY	50 MG OR 100 MG CAPSULES ARE AVAILABLE.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	150 MG	CAPSULE	REMOVED FROM FORMULARY	50 MG OR 100 MG CAPSULES ARE AVAILABLE.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	50 MG	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	100 MG	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 75/FLUORIDE/IRON	0.25-10/ML	DROPS	ADDED AGE RESTRICTION	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 45/FLUORIDE/IRON	0.25-10/ML	DROPS	ADDED AGE RESTRICTION	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT NO.2 W-FLUORIDE	0.25 MG/ML	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT NO.2 W-FLUORIDE	0.5 MG/ML	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 45/FLUORIDE/IRON	0.25-10/ML	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	7/1/2020	DOACS (DIRECT FACTOR XA INHIBITORS; THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE)	BEVYXXA (BETRIXABAN MALEATE), PRADAXA (DABIGATRAN ETEXILATE MESYLATE), SAVAYSA (EDOXABAN TOSYLATE), XARELTO (RIVAROXABAN)			CHANGED PA CRITERIA	UPDATED PA GUIDELINES TO ALIGN WITH NATIONAL GUIDELINES. WARFARIN FAILURE NO LONGER REQUIRED FOR ATRIAL FIBRILLATION. SEE PA GUIDELINES FOR DETAILS (RX014).
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	TANZEUM (ALBIGLUTIDE), TRULICITY (DULAGLUTIDE), BYETTA (EXENATIDE), BYDUREON (EXENATIDE MICROSPHERES), VICTOZA (LIRAGLUTIDE), ADLYXIN (LIXISENATIDE), OZEMPIC (SEMAGLUTIDE), RYBELSUS (SEMAGLUTIDE)			CHANGED PA CRITERIA	UPDATED PA GUIDELINES TO ALIGN WITH ADA GUIDELINES. SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	ADLYXIN (LIXISENATIDE)	20 MCG/0.2	PEN INJCTR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	ADLYXIN (LIXISENATIDE)	10-20 (1)	PEN INJCTR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	BYDUREON BCISE (EXENATIDE MICROSPHERES)	2MG/0.85ML	AUTO INJCT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	RYBELSUS (SEMAGLUTIDE)	3 MG	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	RYBELSUS (SEMAGLUTIDE)	7 MG	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	5/1/2020	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	RYBELSUS (SEMAGLUTIDE)	14 MG	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUCCOTRANSPORT2(SGLT2)INHIB	FARXIGA (DAPAGLIFLOZIN PROPANEDIOL)	10 MG	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUCCOTRANSPORT2(SGLT2)INHIB	FARXIGA (DAPAGLIFLOZIN PROPANEDIOL)	5 MG	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUCCOTRANSPORT2(SGLT2)INHIB	JARDIANCE (EMPAGLIFLOZIN)	10 MG	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUCCOTRANSPORT2(SGLT2)INHIB	JARDIANCE (EMPAGLIFLOZIN)	25 MG	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUCCOTRANSPORT2(SGLT2)INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	5 MG	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUCCOTRANSPORT2(SGLT2)INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	15 MG	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX008).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	480MCG/1.6	VIAL	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	480MCG/0.8	SYRINGE	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	300MCG/0.5	SYRINGE	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	300 MCG/ML	VIAL	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NIVESTYM (FILGRASTIM-AAFI)	300 MCG/ML	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5110); SEE PA GUIDELINES FOR DETAILS (RX043).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NIVESTYM (FILGRASTIM-AAFI)	480MCG/1.6	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5110); SEE PA GUIDELINES FOR DETAILS (RX043).
PHARMACY	5/1/2020	NITROFURAN DERIVATIVES	NITROFURANTOIN	25 MG/5 ML	ORAL SUSP	REMOVED FROM FORMULARY	ALTERNATIVES: NITROFURANTOIN CAPSULES, SULFAMETHOXAZOLE/TRIMETHOPRIM ORAL SUSPENSION, CIPROFLOXACIN ORAL SUSPENSION, LEVOFLOXACIN ORAL SOLUTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	25 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	50 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	75 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	100 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	150 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	200 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	300 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	225 MG	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	4/10/2020	NARCOTIC ANTAGONISTS	NARCAN (NALOXONE HCL)	4 MG	SPRAY	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART	100/ML	VIAL	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART FLEXPEN	100/ML (3)	INSULN PEN	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART PENFILL	100/ML	CARTRIDGE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	NOVOLOG (INSULIN ASPART)	100/ML	CARTRIDGE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
MEDICAL	2/11/2020	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	REMICADE (INFLIXIMAB)	100 MG	VIAL	REMOVED FROM FORMULARY	RENFLEXIS AND INFLECTRA ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX040).
PHARMACY	1/1/2020	ANTI-ALCOHOLIC PREPARATIONS	ACAMPROSATE CALCIUM	333 MG	TABLET DR	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
MEDICAL	1/1/2020	ANTI-ALCOHOLIC PREPARATIONS	VIVITROL (NALTREXONE MICROSPHERES)	380 MG	SUS ER REC	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT (HCPCS = J2315) WITH NO RESTRICTIONS.
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	2000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	4000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	10000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	20000/2ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	3000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	20000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	2000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	4000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	10000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	20000/2ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	3000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	20000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	40000/ML	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	2000/ML	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	3000/ML	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	4000/ML	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	10000/ML	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	40000/ML	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	2 MG-0.5MG	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (12 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	8 MG-2 MG	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (3 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	4MG-1MG	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (6 FILMS PER DAY).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	12 MG-3 MG	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (2 FILMS PER DAY).
MEDICAL	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	SUBLOCADE (BUPRENORPHINE)	300 MG/1.5	SOLER SYR	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT. INDUCTION THERAPY DOES NOT REQUIRE PA (HCPCS = Q9992). MAINTENANCE THERAPY REQUIRES A PA (HCPCS = Q9991).
MEDICAL	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	MULTIPLE	ORAL	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITHOUT PA (HCPCS = (HCPCS = J0572, J0573, J0574, J0575).
MEDICAL	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE	1 MG	ORAL	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITHOUT PA (HCPCS = J0571).