Umpqua Health Alliance

List of Medication Coverage Changes

(Updated 12/30/2020)

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	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	5 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	10 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	1 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	3 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	5 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	10 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	3 MG	ORAL	TAB RAPDIS	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	5 MG	ORAL	TAB RAPDIS	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	10 MG	ORAL	TAB MPHASE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	SEDATIVE-HYPNOTICS,NON-BARBITURATE	ZOLPIDEM TARTRATE	5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (2 TABLETS PER DAY).
PHARMACY	2/1/2021	SEDATIVE-HYPNOTICS,NON-BARBITURATE	ZOLPIDEM TARTRATE	10 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (1 TABLET PER DAY).
PHARMACY	2/1/2021	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)	ENTRESTO (SACUBITRIL/VALSARTAN)	24 MG-26MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX052). QL (60 TABLETS PER 30 DAYS).

PHARMACY	2/1/2021	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)	ENTRESTO (SACUBITRIL/VALSARTAN)	49 MG-51MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX052). QL (60 TABLETS PER 30 DAYS).
PHARMACY	2/1/2021	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)	ENTRESTO (SACUBITRIL/VALSARTAN)	97MG-103MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX052). QL (60 TABLETS PER 30 DAYS).
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	MICONAZOLE NITRATE	2 %	TOPICAL	CREAM (G)	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	NYSTATIN	100000/G	TOPICAL	CREAM (G)	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	NYSTATIN	100000/G	TOPICAL	OINT. (G)	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	NYSTATIN	100000/G	TOPICAL	POWDER	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	TERBINAFINE HCL	1 %	TOPICAL	CREAM (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE DIPROP AUGMENTED	0.05 %	TOPICAL	CREAM (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE DIPROP AUGMENTED	0.05 %	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE VALERATE	0.1 %	TOPICAL	CREAM (G)	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE VALERATE	0.1 %	TOPICAL	OINT. (G)	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY, NSAIDS	DICLOFENAC SODIUM	1 %	TOPICAL	GEL (GRAM)	CHANGED QL RESTRICTION	QL (100 GRAMS PER 12 DAYS).
PHARMACY	2/1/2021	TOPICAL LOCAL ANESTHETICS	LIDOCAINE	5 %	TOPICAL	ADH. PATCH	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	TOPICAL LOCAL ANESTHETICS	LIDOCAINE-PRILOCAINE	2.5 %-2.5%	TOPICAL	CREAM (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.

PHARMACY	2/1/2021	ANTIFUNGAL AGENTS	TERBINAFINE HCL	250 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	50 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	100 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	200 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	400 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	LAXATIVES AND CATHARTICS	POLYETHYLENE GLYCOL 3350	17G/DOSE	ORAL	POWDER	CHANGED QL RESTRICTION	QL (510 GRAMS PER 30 DAYS).
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	0.25 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	0.5 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	1 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	2 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	3 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	4 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	5 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	100 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.

PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	250 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	500 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	1000 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	100 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	125 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	250 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	500 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	1000 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN D PREPARATIONS	CHOLECALCIFEROL (VITAMIN D3)	100 MCG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN D PREPARATIONS	CHOLECALCIFEROL (VITAMIN D3)	250 MCG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	2/1/2021	VITAMIN D PREPARATIONS	CHOLECALCIFEROL (VITAMIN D3)	25 MCG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	11/1/2020	ANALGESICS,NARCOTICS	OXYCODONE HCL ER	10 MG	ORAL	TAB ER 12H	ADDED PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX005).
PHARMACY	11/1/2020	ANALGESICS,NARCOTICS	METHADONE HCL	10 MG	ORAL	TABLET	ADDED PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX005).
PHARMACY	11/1/2020	ANALGESICS,NARCOTICS	METHADONE HCL	5 MG	ORAL	TABLET	ADDED PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX005).
PHARMACY	11/1/2020	GLUCOCORTICOIDS, ORALLY INHALED	ARNUITY ELLIPTA (FLUTICASONE FUROATE)	100 MCG	INHALATION	BLST W/DEV	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.

PHARMACY	11/1/2020	GLUCOCORTICOIDS, ORALLY INHALED	ARNUITY ELLIPTA (FLUTICASONE FUROATE)	200 MCG	INHALATION	BLST W/DEV	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	11/1/2020	GLUCOCORTICOIDS, ORALLY INHALED	ARNUITY ELLIPTA (FLUTICASONE FUROATE)	50 MCG	INHALATION	BLST W/DEV	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	SPIRIVA (TIOTROPIUM BROMIDE)	18 MCG	INHALATION	CAP W/DEV	CHANGED ST RESTRICTION	MUST FIRST TRY INCRUSE ELLIPTA (TUDORZA NO LONGER REQUIRED).
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	SPIRIVA RESPIMAT (TIOTROPIUM BROMIDE)	1.25 MCG	INHALATION	MIST INHAL	CHANGED ST RESTRICTION	MUST FIRST TRY INCRUSE ELLIPTA (TUDORZA NO LONGER REQUIRED).
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	SPIRIVA RESPIMAT (TIOTROPIUM BROMIDE)	2.5 MCG	INHALATION	MIST INHAL	CHANGED ST RESTRICTION	MUST FIRST TRY INCRUSE ELLIPTA (TUDORZA NO LONGER REQUIRED).
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	TUDORZA PRESSAIR (ACLIDINIUM BROMIDE)	400 MCG	INHALATION	AER POW BA	REMOVED FROM FORMULARY	INCRUSE ELLIPTA IS PREFERRED AGENT.
PHARMACY	11/1/2020	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	DULERA (MOMETASONE/FORMOTEROL)	50MCG-5MCG	INHALATION	HFA AER AD	ADDED TO FORMULARY WITH ST RESTRICTION	MUST FIRST TRY FLUTICASONE/SALMETEROL (GENERIC ADVAIR OR AIRDUO).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AIMOVIG AUTOINJECTOR (ERENUMAB-AOOE)	70 MG/ML	SUBCUTANE.	AUTO INJCT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AIMOVIG AUTOINJECTOR (2 PACK) (ERENUMAB-AOOE)	70 MG/ML	SUBCUTANE.	AUTO INJCT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AIMOVIG AUTOINJECTOR (ERENUMAB-AOOE)	140 MG/ML	SUBCUTANE.	AUTO INJCT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AJOVY SYRINGE (FREMANEZUMAB-VFRM)	225 MG/1.5	SUBCUTANE.	SYRINGE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AJOVY AUTOINJECTOR (FREMANEZUMAB-VFRM)	225 MG/1.5	SUBCUTANE.	AUTO INJCT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).

PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	EMGALITY PEN (GALCANEZUMAB-GNLM)	120 MG/ML	SUBCUTANE.	PEN INJCTR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	EMGALITY SYRINGE (GALCANEZUMAB-GNLM)	120 MG/ML	SUBCUTANE.	SYRINGE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	EMGALITY SYRINGE (GALCANEZUMAB-GNLM)	300MG/3ML	SUBCUTANE.	SYRINGE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	UBRELVY (UBROGEPANT)	50 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	UBRELVY (UBROGEPANT)	100 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	VYEPTI (EPTINEZUMAB-JJMR)	100 MG/ML	INTRAVEN.	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	NURTEC ODT (RIMEGEPANT SULFATE)	75 MG	ORAL	TAB RAPDIS	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN ODT	5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG ZMT (ZOLMITRIPTAN)	5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN ODT	2.5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG ZMT (ZOLMITRIPTAN)	2.5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN	2.5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG (ZOLMITRIPTAN)	2.5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN	5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG (ZOLMITRIPTAN)	5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	REYVOW (LASMIDITAN SUCCINATE)	50 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX023). QL (4 TABLETS PER 30 DAYS).

PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	REYVOW (LASMIDITAN SUCCINATE)	100 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX023). QL (4 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN SUCCINATE	6 MG/0.5ML	SUBCUT ANE.	SYRINGE	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX023). QL (1 PACKAGE PER 30 DAYS).
PHARMACY	10/1/2020	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	PROAIR RESPICLICK (ALBUTEROL SULFATE)	90 MCG	INHALATI ON	AER POW BA	REMOVED FROM FORMULARY	GENERIC ALBUTEROL INHALERS ARE PREFERRED AGENTS.
PHARMACY	8/1/2020	THROMBIN INHIBITORS,SELECTIVE, DIRECT, & REVERSIBLE	PRADAXA (DABIGATRAN ETEXILATE MESYLATE)	110 MG	ORAL	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	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	100 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	100 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	75 MG	ORAL	CAPSULE	REMOVED FROM FORMULARY	50 MG OR 100 MG CAPSULES ARE AVAILABLE.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	150 MG	ORAL	CAPSULE	REMOVED FROM FORMULARY	50 MG OR 100 MG CAPSULES ARE AVAILABLE.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	50 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	100 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 75/FLUORIDE/IRO N	0.25-10/ML	ORAL	DROPS	ADDED AGE RESTRICTION	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 45/FLUORIDE/IRO N	0.25-10/ML	ORAL	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	ORAL	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	ORAL	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	ORAL	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.
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	SUBCUTANE.	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)	SUBCUTANE.	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	SUBCUTANE.	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	ORAL	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	ORAL	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)	14 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB	FARXIGA (DAPAGLIFLOZIN PROPANEDIOL)	10 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB	FARXIGA (DAPAGLIFLOZIN PROPANEDIOL)	5 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB	JARDIANCE (EMPAGLIFLOZIN)	10 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB	JARDIANCE (EMPAGLIFLOZIN)	25 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	5 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	15 MG	ORAL	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5110); SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NIVESTYM (FILGRASTIM-AAFI)	480MCG/1.6	INJECTION	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	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	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	50 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	75 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	100 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	150 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	200 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.

PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	300 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	225 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	4/10/2020	NARCOTIC ANTAGONISTS	NARCAN (NALOXONE HCL)	4 MG	NASAL	SPRAY	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART	100/ML	SUBCUT ANE.	VIAL	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART FLEXPEN	100/ML (3)	SUBCUT ANE.	INSULN PEN	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART PENFILL	100/ML	SUBCUT ANE.	CARTRID GE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
PHARMACY	3/4/2020	INSULINS	NOVOLOG (INSULIN ASPART)	100/ML	SUBCUT ANE.	CARTRID GE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
MEDICAL	2/11/2020	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	REMICADE (INFLIXIMAB)	100 MG	INTRAVE N.	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	ORAL	TABLET DR	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITH NO RESTRICTIONS.
MEDICAL	1/1/2020	ANTI-ALCOHOLIC PREPARATIONS	VIVITROL (NALTREXONE MICROSPHERES)	380 MG	INTRAM USC.	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	INJECTIO N	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	INJECTIO N	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	INJECTIO N	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	3000/ML	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	INJECTION	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	SUBLINGUAL	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	SUBLINGUAL	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (3 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	4MG-1MG	SUBLINGUAL	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (6 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	12 MG-3 MG	SUBLINGUAL	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	SUBCUTANE.	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	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	ORAL	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITHOUT PA (HCPCS = J0571).