Formulary Changes, 2017 Quarter 1

Attention Providers:

Ensuring that you have the most current information about our Preferred Drug List (PDL) is important to us. Here are the Preferred Drug List (PDL) changes that will be effective 01/01/2017.

The following medicines will be **added** to the Humana–CareSource PDL on January 1st, 2017:

Tresiba FlexTouch 100 Units/mL, 200 Units/mL Solution Pen-Injector

Basaglar 100 units/mL Solution

Trulicity 0.75 mg/0.5 mL, 1.5 mg/0.5 mL Solution Pen-Injector (requires step therapy through metformin)

Tecfidera Starter Pack 120-240 mg (requires clinical review)

Tecfidera 120 mg, 240 mg Capsule (requires clinical review)

Aubagio 7 mg, 14 mg Tablet (requires clinical review)

Rebif 22 mcg/0.5 mL, 44 mcg/0.5 mL PF Syringe (requires clinical review)

Rebif 8.8 mcg & 22 mcg Titration Pack (requires clinical review)

Rebif Rebidose 22 mcg/0.5 mL, 44 mcg/0.5 mL Pen-Injector (requires clinical review)

Breo Ellipta 100-25 mcg, 200-25 mcg Inhaler

Rhinocort Allergy OTC 32 mcg Nasal Suspension

Omnitrope 5.8 mg Solution (requires clinical review)

Zarxio 300 mcg/0.5 mL, 480 mcg/0.8 mL PF Syringe

Zubsolv 1.4-0.36 mg, 2.9-0.71 mg, 5.7-1.4 mg, 8.6-2.1 mg, 11.4-2.9 mg SL Tablet (requires clinical review)

Epclusa Tablet– (Two agents will be preferred – Zepatier for genotypes 1 and 4, Epclusa for 2, 3, and 6) (requires clinical review)

Olmesartan (Benicar) 5 mg, 20 mg, 40 mg Tablet

Olmesartan-Hydrochlorothiazide (Benicar HCT) 12.5-20 mg, 12.5-40 mg, 25-40 mg Tablet

Amlodipine-Olmesartan (Azor) (all strengths)

Olmesartan-Amlodipine-Hydrochlorothiazide (Tribenzor) (all strengths)

Quetiapine ER Tablet (Seroquel XR)

The following medicines will be **removed** from the Humana–CareSource PDL on January 1st, 2017:

Tradjenta 5mg Tablet

Jentadueto (all strengths)

Tudorza Pressair 400 mcg Inhaler

Spiriva Handihaler only (Spiriva Respimat is preferred)

Symbicort 80-4.5 mcg, 160-4.5 mcg Inhaler

Neupogen 300 mcg/mL, 480 mcg/1.6 mL Vial

Neupogen 300 mcg/0.5 mL, 480 mcg/0.8 mL PF Syringe

Granix 300 mcg/0.5 mL, 480 mcg/0.8 mL PF Syringe

Trazodone 300 mg

Latuda 20 mg, 40 mg, 60 mg, 80 mg, 120 mg Tablet

Lantus 100 Units/mL Vial

Lantus SoloStar 100 Units/mL Pen-Injector

Byetta 5 mcg/0.02 mL, 10 mcg/0.04 mL Pen-Injector

Bydureon 2 mg Pen-Injector

Pradaxa 75 mg, 110 mg, 150 mg Capsule

Rabeprazole (Aciphex EC) 20 mg Tablet

Harvoni Tablet

Sovaldi Tablet

Norditropin FlexPro 5 mg/1.5 mL, 10 mg/1.5 mL, 15 mg/1.5 mL, 30 mg/3 mL Pen-Injector

The following medicines will have a **restriction change** on the Humana–CareSource PDL on January 1st, 2017:

Selzentry 150 mg and 300 mg Tablet

Testosterone Cypionate (Depo-testosterone) 100 mg/mL, 200 mg/mL Injection Oil

Testosterone Enanthate 200 mg/mL Injection

Hemophilia agents (patient's weight is required every 3 months at minimum)

If you would like a list of your Humana – Caresource patients who are taking any of the drugs above, to help minimize disruption to your patients' therapy, please send an email to PharmacyConversionProgram@caresource.com. Also, please work with your Electronic Medical Record system vendor or your internal support to ensure your system is configured to support these changes.

For the most up-to-date information, please utilize the Formulary Search Tool Online Search Tool-Kentucky Medicaid or the Preferred Drug List (PDL) on CareSource.com.

If you have questions, call Humana–CareSource at 1-855-852-7005 and follow the prompts to Pharmacy. Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern Time.