History of Formulary Changes

Post-Single PDL Changes (after October 1, 2020)

Revised for 2/1/2021

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Medicaid Health Plan Common Formulary Changes Effective February 1, 2021

Drug Class	Drug Name	New Status
Antineoplastic - Alkylating Agent - Nitrogen Mustards	cyclophosphamide 25mg, 50mg capsule	Covered on formulary with Quantity Limit
Acne Therapy Topical - Anti-infective-Keratolytic Combinations	erythromycin-benzoyl peroxide gel (generic Benzamycin Gel)	Covered on formulary
Dermatological Irritants-Counter-Irritant Single Agents	capsaicin 0.025% cream	Not Covered on formulary
Dermatological - Topical Local Anesthetic Amides	lidocaine 3% cream, 5% ointment	Covered on formulary with Quantity Limit
Antiemetic - Substance P-Neurokinin 1 (NK1) Receptor Antagonists	Emend 40mg Capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Somatostatic Agents	Bynfezia 2,500 mcg/ml Pen	Not Covered on formulary
LHRH (GnRH) Agonist Analog Pit Suppres - Central Precocious Puberty	Fensolvi 45mg Syringe Kit	Not Covered on formulary
Inflammatory Bowel Agent - Glucocorticoids	Ortikos ER 6mg, 9mg Capsule	Not Covered on formulary
Acne Therapy Topical - Anti-infective -Tetracycline	Zilxi 1.5% Foam	Not Covered on formulary
Antimigraine Agents, Preventive Treatment	Aimovig 70mg/ml, 140mg,ml Autoinjector	Covered on formulary with Prior Authorization and Quantity Limit – Preferred ***Effective 12/15/2020***
Skeletal Muscle Relaxants	methocarbamol 500mg, 750mg tablet	Covered on formulary – Preferred ***Effective 12/15/2020***
Narcotics – Long Acting	tramadol ER 100mg, 200mg, 300mg tablet	Covered on formulary - Preferred
Narcotics – Transdermal	Butrans 5mcg/HR, 7.5mcg/ HR, 10mcg/ HR, 15mcg/ HR, 20mcg/ HR Patch	Covered on formulary Quantity Limit – Preferred
Narcotics – Short and Intermediate Acting	tramadol-acetaminophen 37.5-325	Covered on formulary - Preferred
Alpha Adrenergic Agents	Catapres-TTS 1, Catapres-TTS 2, Catapres-TTS 3 Patch	Covered on formulary Quantity Limit – Preferred
Alpha Adrenergic Agents	clonidine 0.1mg/day, 0.2mg/day, 0.3mg/day patch	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antiparkinson's Agents - Other	carbidopa-levodopa ER 25-100, 50-200 tablet	Covered on formulary - Preferred
Antiparkinson's Agents - Dopamine Agonists	Neupro 1 mg/24 HR, 2 mg/24 HR, 3 mg/24 HR, 4 mg/24 HR, 6 mg/24 HR, 8 mg/24 HR Patch	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Neuropathic Pain	Savella 12.5mg, 25mg, 50mg, 100mg Tablet, Savella Titration Pack	Covered on formulary with Quantity Limit – Preferred
Antimigraine Agents, Acute Treatment - Triptans	Relpax 20mg, 40mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2021, continued

Drug Class	Drug Name	New Status
Antimigraine Agents, Acute Treatment - Triptans	Imitrex 5mg, 20mg Nasal Spray	Covered on formulary with Quantity Limit – Preferred
Antimigraine Agents, Acute Treatment - Triptans	Zomig 2.5mg, 5mg Nasal Spray	Covered on formulary with Prior Authorization– Non-Preferred
Neuropathic Pain	Horizant ER 300mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Neuropathic Pain	Gralise ER 300mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Combination Benzoyl Peroxide and Clindamycin	clindamycin-benzoyl peroxide 1-5%, clind PH-benzoyl peroxide 1.2-5%, clinda-benzoyl peroxide 1-5% pump, clind PH-benzoyl pero 1.2-2.5%	Covered on formulary - Preferred
Topical Steroids – High Potency	betamethasone dipropionate 0.05% cream, lotion, ointment	Covered on formulary - Preferred
Multiple Sclerosis Agents	Rebif 22mcg/0.5ml Syringe, Rebif Titration Pack, Rebif Rebidose 22mcg/0.5ml, 44mcg/0.5ml, Rebif Rebidose Titration Pack	Covered on formulary with Prior Authorization– Non-Preferred
Multiple Sclerosis Agents	Rebif 44mcg/0.5ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Immunomodulators: Atopic Dermatitis	Eucrisa 2% Ointment	Covered on formulary with Prior Authorization and Quantity Limit – Preferred
Opioid Withdrawal Symptom Management	Lucemyra 0.18mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Uterine Disorder Treatments	Orilissa 150mg, 2000mg Tablet	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Uterine Disorder Treatments	Oriahnn 300-1-0.5mg/300mg Capsule	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Antiparkinson's Agents - Dopamine Agonists	Kynmobi 10mg, 15mg, 20mg, 25mg, 30mg SL Film, Kynmobi Titration Kit	Covered on formulary with Prior Authorization– Non-Preferred
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)	Licart 1.3% Patch	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Insulins, Rapid Acting	Lyumjev 100 Unit/ml KwikPen	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Lipotropics: Other	Nexlizet 180-10mg Tablet	Covered on formulary with Prior Authorization, and Age Edit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2021, continued

Drug Class	Drug Name	New Status
Topical Antibiotics	Xepi 1% Cream	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Multiple Sclerosis Agents	Zeposia 0.23-0.46mg Starter Pack, 0.23-0.46-0.95mg Kit, Zeposia 0.92mg Capsule	Covered on formulary with Prior Authorization– Non-Preferred
Opioid Withdrawal Symptom Management	Clonidine HCL 0.1mg, 0.2mg, 0.3mg Tablet	Covered on formulary - Preferred
Opioid Withdrawal Symptom Management	Catapres 0.1mg, 0.2mg, 0.3mg Tablet	Covered on formulary with Prior Authorization– Non-Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	Nexium 2.5mg, 5mg, 10mg, 20mg, 40mg Suspension Packets	Covered on formulary - Preferred

Medicaid Health Plan Common Formulary Changes Effective January 1, 2021

Drug Class	Drug Name	New Status
Dermatological - Antipsoriatic Agents Topical	Arazlo 0.045% Lotion	Not Covered on formulary
Cortisol synthesis inhibitor	Isturisa 1 mg, 5 mg, 10 mg	Not Covered on formulary
Allergenic Extracts - Peanuts	Palforzia initial Dose Pack, 3 mg (Level 1), 6 mg (Level 2), 12 mg (Level 3), 20 mg (Level 4), 40 mg (Level 5), 80 mg (Level 6), 120 mg (Level 7), 160 mg (Level 8), 200 mg (Level 9), 240 mg (Level 10), 300 mg (Level 11) 300 mg (Maintenance)	Covered on formulary with Prior Authorization and Age Edit
Progestins	Makena 275 mg/1.1 ml Autoinjector, 250 mg/ml, 1,250 mg/5 ml Vial	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Progestins	hydroxyprogesterone 250 mg/ml, 1,250 mg/5 ml vial	Covered on formulary with Prior Authorization and Quantity Limit - Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Neulasta 6 mg/0.6 ml Syringe, Neulasta Onpro 6 mg/0.6 ml Kit	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Fulphila 6 mg/0.6 ml Syringe	Covered on formulary with Quantity Limit - Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Udenyca 6 mg/0.6 ml Syringe	Covered on formulary with Quantity Limit - Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Ziextenzo 6 mg/0.6 ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Glucocorticoids	Emflaza	Covered on formulary with Prior Authorization and Age Edit ***This change is retroactively effective 10/1/2020**
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Invokana 100mg, 300mg Tablet	Covered on formulary - Preferred
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Farxiga 5mg, 10mg Tablet	Covered on formulary - Preferred
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Jardiance 10mg, 25mg Tablet	Covered on formulary - Preferred
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	Spiriva 18mcg CP-Handihaler	Covered on formulary with Quantity Limit - Preferred

Medicaid Health Plan Common Formulary Changes Effective November 1, 2020

Drug Class	Drug Name	New Status
Androgen - Single Agents	Androgel 1%(2.5G), 1%(5G), 1.62%(1.25G), 1.62%(2.5G) Gel Packet, 1.62% Gel Pump	Covered on formulary with Prior Authorization - Non-Preferred
Growth Hormones	Nutropin AQ Nuspin 5, 10, 20 Injector	Covered on formulary with Prior Authorization - Non-Preferred
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	Forteo 600 mcg/2.4 ml Pen Inj	Covered on formulary with Prior Authorization - Non-Preferred
Human Insulins - Fixed Combinations	Humulin 70/30 KwikPen	Covered on formulary with Quantity Limit - Preferred
Human Insulins - Fixed Combinations	Novolin 70-30 Flexpen	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Gallstone Solubilizing (Litholysis) Agents	ursodiol 300 mg capsule	Covered on formulary - Preferred
IBS Agent - Gastrointestinal Chloride Channel Activator Agents	Amitiza 8 mcg Capsule	Covered on formulary - Preferred
IBS-C/CIC Agents, Guanylate Cyclase-C Agonist	Linzess 72 mcg, 145 mcg, 290 mcg Capsule	Covered on formulary - Preferred
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)	Vesicare 5 mg, 10 mg Tablet	Covered on formulary with Prior Authorization - Non-Preferred
Erythropoietins	Epogen 2,000 units/ml, 3,000 units/ml, 4,000 units/ml, 10,000 units/ml, 20,000 units/ 2ml, 20,000 units/ml Vials	Covered on formulary with Prior Authorization - Preferred
Erythropoietins	Procrit 2,000 units/ml, 3,000 units/ml, 4,000 units/ml, 10,000 units/ml, 20,000 units/ml, 40,000 units/ml Vials	Covered on formulary with Prior Authorization - Non-Preferred
Antipsoriatic Agents, Systemic	Taltz 80 mg/ml Autoinj (2-Pk), Taltz 80 mg/ml Syringe, Taltz 80 mg/ml Autoinjector, Taltz 80 mg/ml Autoinj (3-Pk)	Covered on formulary with Prior Authorization - Non-Preferred
Phosphate Binders	sevelamer 0.8 gm, 2.4 gm powder packet, sevelamer 800 mg tablet	Covered on formulary with Prior Authorization - Non-Preferred
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	Tymlos 80 mcg Dose Pen Injector	Covered on formulary with Prior Authorization - Non-Preferred
Antihyperglycemic, Incretin Mimetic,GLP-1 Receptor Agonist Analog-Type	Ozempic 0.25-0.5 mg, 1 mg Dose Pen	Covered on formulary with Prior Authorization - Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective November 1, 2020, continued

Drug Class	Drug Name	New Status
Androgen - Single Agents	testosterone 1.62% gel pump	Covered on formulary with Prior Authorization - Preferred
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)	solifenacin 5 mg, 10 mg tablet	Covered on formulary - Preferred
Insulin Response Enhancers - Biguanides	metformin hcl 500 mg/5 ml solution	Covered on formulary with Prior Authorization - Non-Preferred
Adenosine triphosphate-citrate lyase (ACL) inhibitor	Nexletol 180 mg Tablet	Covered on formulary with Prior Authorization and Age Edit - Non-Preferred
Migraine Therapy - Calcitonin Gene-Related Peptide Antagonist	Nurtec ODT 75 mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit - Preferred
Migraine Therapy - Selective Serotonin Agonists 5-HT(1)	Reyvow 50 mg, 100 mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit - Non-Preferred
Peptic Ulcer-Treatment H. Pylori - Proton Pump Inhibitor & Antibiotics	Talicia DR 10-250-12.5 mg Capsule	Covered on formulary with Prior Authorization - Non-Preferred
Antihyperglycemic - SGLT-2 Inhibitor- DPP-4 Inhibitor & Biguanide Combinations	Trijardy XR 5-2.5-1,000 mg, 12.5-2.5-1,000 mg, 10-5-1,000 mg, 25-5-1,000 mg	Covered on formulary with Prior Authorization - Non-Preferred
Ophthalmic - Antihistamines	Zerviate 0.24% Eye Drop	Covered on formulary with Prior Authorization - Non-Preferred