Neighborhood Health Benefits Exchange Formulary Changes: June 2017

The following changes to the Neighborhood Health Benefits Exchange Formulary were recently approved by the Pharmacy and Therapeutics (P&T) Committee. All changes were approved by the Neighborhood P&T Committee after a comprehensive review of pertinent clinical information. All changes to the formulary are effective immediately unless otherwise noted.

The following generic drugs have been add to formulary:

Name	Formulary Change	Coverage Restrictions
Celecoxib 50mg, 100mg and 200mg	Remove quantity limits	N/A
Chlorthalidone 25mg tablet	Add to formulary, Tier 1	N/A
Diltiazem 180mg, 300mg and 420mg	Add to formulary, Tier 1	N/A
Etodolac capsule	Add to formulary, Tier 1	N/A
Indomethacin ER 75mg capsule	Add to formulary, Tier 1	N/A
Meloxicam 7.5mg/5ml	Add to formulary, Tier 1	Age limit of 12 years. Require prior authorization for members 13 years and older.
Propranolol ER	Add to formulary, Tier 1	N/A
Riluzole	Remove age limit	N/A

The following formulary generics have had updates to formulary status:

Name	Formulary Change	Coverage Restrictions
Amlodipine-valsartan	Remove step therapy and prior authorization requirements	N/A
Flurbiprofen	Remove step therapy requirement	N/A
Fosinopril	Remove step therapy and prior authorization requirements	N/A
Fosinopril-HCTZ	Remove step therapy and prior authorization requirements	N/A

The following formulary generics have had updates to formulary status (continued):

Name	Formulary Change	Coverage Restrictions
Ketorolac 10mg tablet	Remove step therapy and prior authorization requirements	N/A
Minoxidil	Remove step therapy and prior authorization requirements	N/A
Moexipril	Remove step therapy and prior authorization requirements	N/A
Moexipril-HCTZ	Remove step therapy and prior authorization requirements	N/A
Paliperidone ER tablet	Remove Pior Authorization requirement	N/A
Perindopril	Remove step therapy and prior authorization requirements	N/A
Quinapril	Remove step therapy and prior authorization requirements	N/A
Quinapril-HCTZ	Remove step therapy and prior authorization requirements	N/A
Trandolapril	Remove step therapy and prior authorization requirements	N/A

The following brand name drugs have had updates to formulary status:

Name	Formulary Change	Coverage Restrictions	Rationale
Fosrenol Chew tablet	Add to formulary, Tier 2	Step therapy	Require calcium acetate be tried first.
Fosrenol powder packet	Add to formulary, Tier 2	Prior authorization	Require medical justification for requirement of powder packet in place of oral tablet.
Humira 10mg syringe kit	Add to formulary, Tier 4	Prior authorization	Drug line extension of formulary drug.
Humira 20mg syringe kit	Add to formulary, Tier 4	Prior authorization	Drug line extension of formulary drug.
Humira 40mg pen injector	Add to formulary, Tier 4	Prior authorization	Drug line extension of formulary drug.
Humira Pediatric Crohn's starter kit	Add to formulary, Tier 4	Prior authorization	Drug line extension of formulary drug.
Humira Psoriasis-Uveitis starter kit	Add to formulary, Tier 4	Prior authorization	Drug line extension of formulary drug.
Ilaris prefilled syringe 150mg/ml	Add to formulary, Tier 4	Prior authorization	Drug line extension of formulary drug.
Invega Sustenna	Add to formulary, Tier 2	Prior authorization	Additional long-acting SGA treatment option.
Invega Trinza	Add to formulary, Tier 2	Prior authorization	Additional long-acting SGA treatment option.
Linzess 72mcg capsule	Add to formulary, Tier 2	Step Therapy	Require polyethylene glycol & one other generic be tried first.
Renagel	Add to formulary, Tier 2	Step Therapy	Require calcium acetate be tried first.
Renvela powder packet	Add to formulary, Tier 2	Prior authorization	Require medical justification for requirement of powder packet in place of oral tablet.
Renvela tablet	Add to formulary, Tier 2	Step Therapy	Require calcium acetate be tried first.
Selzentry 25mg, 75mg tablet	Add to formulary, Tier 2	N/A	N/A

The following drugs have updated prior authorization criteria:

Drug Name	Formulary Status	Coverage Retriction Update
Risperdal Consta, Invega Sustenna, Invega Trinza	Formulary, Tier 2 w/ prior authorization	Prior Authorization. Criteria to not require recent hospitalization.

The following drugs Have been reviewed by Neighborhood's P&T Committee and will remain non-formulary:

Spinraza	Emflaza	Ocaliva

Please call the Pharmacy Help Desk at 1-401-459-6020 for pharmacy authorization requests or for further information on the Neighborhood Integrity formulary. **Explanation of Terms:** Member cost-sharing for drugs added to formulary is dependent on enrolled Plan benefit design. Tier 1 = Preferred Generics; Tier 2 = Preferred Brands; Tier 3 = Non-Preferred Brands; Tier 4 = Specialty drug. Coverage of drugs removed from formulary may be requested through the formulary exception process. Restrictions applied to drug coverage will be indicated on this form and in the electronic formulary. Drugs may be limited to certain age groups (an AGE EDIT), by demonstrating prior therapies have been attempted (a STEP EDIT), in quantity allowed per 30 days (a QUANTITY LIMIT), or by requiring precertification for use from NHPRI (a PRIOR AUTHORIZATION). Products listed as "removed" are no longer available to Neighborhood members and are considered non-formulary or benefit exclusions. Physicians may requests these products via the medical necessity request process only.