1st Quarter 2020 Preferred Drug List Update

UnitedHealthcare Community Plan of Virginia

UnitedHealthcare Community Plan's Preferred Drug List (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. Please review the changes and update your references as necessary.

You may also view the changes at UHCprovider.com/plans > Choose Your State > Medicaid (Community Plan) > Pharmacy Resources and Physician Administered Drugs.

We provided a list of available alternatives to UnitedHealthcare Community Plan members whose current treatment includes a medication removed from the PDL. Please provide affected members a prescription for a preferred alternative in one of the following ways:

- Call or fax the pharmacy.
- Use e-Script.
- Write a new prescription and give it directly to the member.

If a preferred alternative is not appropriate, please call **800-310-6826** for prior authorization for the UnitedHealthcare Community Plan member to remain on their current medication.

Changes will be effective January 1, 2020

PDL Additions

Brand Name	Generic Name	Comments
Balversa™	Erdafitinib tablet	Indicated for the treatment of urothelial carcinoma. Prior authorization required. Available through specialty pharmacy.
Dovato®	Dolutegravir/lamivudine tablet	Indicated as a complete regimen for the treatment of HIV. Diagnosis required.
Emgality® 100mg/mL	Galcanezumab-gnlm prefilled syringe	Indicated for the treatment of episodic cluster headaches. Prior authorization required.
Mayzent®	Siponimod fumarate tablet	Indicated for the treatment of relapsing forms of multiple sclerosis. Prior authorization required. Available through specialty pharmacy.
Piqray®	Alpelisib tablet	Indicated for the treatment of breast cancer. Prior authorization required. Available through specialty pharmacy.
Ruzurgi®	Amifampridine tablet	Indicated for the treatment of Lambert-Eaton myasthenic syndrome. Prior authorization required. Available through specialty pharmacy.
Vyndamax™	Tafamidis capsule	Indicated for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis. Prior authorization required. Available through specialty pharmacy.
Vyndaqel®	Tafamidis meglumine capsule	Indicated for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis. Prior authorization required. Available through specialty pharmacy.
Avapro®	Irbesartan	Indicated for the treatment of hypertension.
Benicar®	Olmesartan	Indicated for the treatment of hypertension.
Avalide®	Irbesartan/HCTZ	Indicated for the management of hypertension.
Benicar HCT®	Olmesartan/HCTZ	Indicated for the management of hypertension.

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Alyq	tadalafil	Indicated for the treatment of pulmonary arterial hypertension. Prior authorization required.
Cialis®	tadalafil 5mg	Indicated for the treatment of benign prostatic hyperplasia. Step edit applies.
Onfi® tab	clobazam tab	Indicated for the treatment of seizures. Prior authorization required.
Norditropin FlexPro®	somatropin	Growth Hormone. Prior authorization required.
Blephamide®	sulfacetamide/prednisolone	Indicated for inflammatory ocular conditions.
Rhopressa®	netarsudil	Indicated for the treatment of elevated intraocular pressure
Rocklatan®	netarsudil and latanoprost	Indicated for the treatment of elevated intraocular pressure

PDL Modifications

Brand Name	Generic Name	Comments
Albenza®*	Albendazole tablet	Indicated for the treatment of various parasitic worm infections. Remove prior authorization. Diagnosis required.
Alinia®	Nitazoxanide tablet	Remove prior authorization for cryptosporidiosis only. Diagnosis required. Diagnosis of giardiasis will continue to require a prior authorization, including a step through metronidazole.
Benznidazole	Benznidazole tablet	Indicated for the treatment of Chagas disease. Remove prior authorization. Diagnosis required.
Lysteda®*	Tranexamic acid tablet	Indicated for the treatment of cyclic heavy menstrual bleeding. Remove prior authorization. Diagnosis required.
Advair® Diskus	fluticasone/salmeterol powder	Indicated for the treatment of asthma and chronic obstructive pulmonary disease. Generic replacing brand as preferred. Age limits apply.
Canasa® rectal suppository	mesalamine rectal suppository	Indicated for the treatment of mild to moderate ulcerative proctitis. Generic replacing brand as preferred.
Entresto™	Sacubitril and valsartan	Indicated to reduce the risk of cardiovascular death. Remove prior authorization. Quantity limit 2/day.
N/A	Opioids – short-acting and long-acting	Maximum daily MME reduced from 120MME to 90MME. Other prior authorization requirements remain in place.
Lyrica®	pregabalin	Indicated for the treatment of neuropathic pain, fibromyalgia. Generic replacing brand as preferred. Step therapy requirement removed.
Dilantin® cap	phenytoin cap	Indicated for the treatment of seizures. Generic replacing brand as preferred.
Nutropin AQ® NuSpin®	somatropin	Growth hormone. Norditropin FlexPro® replacing as preferred.

*Only generics are preferred

Removed from PDL

Brand Name	Generic Name	Comments
Emcyt®	Estramustine capsule	Various other options exist for the treatment of prostate cancer. Current utilizers will not be grandfathered.
N/A	Metaproterenol syrup	Albuterol sulfate inhaler and nebulizer are alternate options. Current utilizers will not be grandfathered.

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N/A	Propantheline tablet	Lansoprazole capsules and omeprazole capsules are alternate options. Current utilizers will not be grandfathered.
N/A	Terbutaline tablet	Albuterol sulfate inhaler and nebulizer are alternate options. Current utilizers will not be grandfathered.
Ridaura®	Auranofin capsule	Methotrexate, leflunomide, and sulfasalazine are alternate options. Current utilizers will not be grandfathered.
Adcirca™	Tadalafil	Indicated for treatment of pulmonary arterial hypertension.
Simbrinza™	Brinzolamide/Brimonidine Tartrate ophthalmic	Indicated to reduce intraocular pressure in glaucoma or ocular hypertension. Available alternatives are Azopt 1% AND Brimonidine 0.2%
Vigamox®	Moxifloxacin	Indicated for the treatment of ocular bacterial infection. Available alternative Moxeza drops
Tobi Podhaler®	Tobramycin inhalation nebulizer solution	Indicated for bacterial infection in cystic fibrosis. Available alternatives brand Tobi Podhaler® Prior authorization required. Use of Bethkis® or Kitabis™ Pak preferred.

Contact Us

If you have any questions, please call UnitedHealthcare Community Plan's Pharmacy Department at 800-310-6826. Thank you.

Doc#: PCA-1-016188-06112019_06212019

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