2018 Formulary Changes – Year to Date

Health Choice Arizona may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, and/or move a drug at a higher cost-sharing tier, we will notify you of the change at least 60 days before the date that the change becomes effective. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary.

This table shows drugs that have been removed from the 2018 Health Choice Arizona Formulary.

Name of Drug	Description of Change	Alternative Drug*	Effective Date
ALECENSA	Removed from Formulary	Available via medical necessity review	1/1/2018
BOSULIF	Removed from Formulary	Available via medical necessity review	1/1/2018
COMETRIQ	Removed from Formulary	Available via medical necessity review	1/1/2018
COTELLIC	Removed from Formulary	Available via medical necessity review	1/1/2018
DICLEGIS	Removed from Formulary	ondansetron	1/1/2018
EPCLUSA	Removed from Formulary	MAVYRET	1/1/2018
EPIPEN	Removed from Formulary	epinephrine	1/1/2018
FULYZAQ	Removed from Formulary	MYTESI	1/1/2018
GILOTRIF	Removed from Formulary	Available via medical necessity review	1/1/2018
HARVONI	Removed from Formulary	MAVYRET	1/1/2018

This table shows drugs that have been removed from the 2018 Health Choice Arizona Formulary.

Name of Drug	Description of Change	Alternative Drug*	Effective Date
HYSINGLA ER	Removed from Formulary	XTAMPZA ER	1/1/2018
LENVIMA	Removed from Formulary	Available via medical necessity review	1/1/2018
NINLARO	Removed from Formulary	Available via medical necessity review	1/1/2018
OXYCONTIN	Removed from Formulary	XTAMPZA ER	1/1/2018
POLMALYST	Removed from Formulary	Available via medical necessity review	1/1/2018
STIVARGA	Removed from Formulary	Available via medical necessity review	1/1/2018
SYNRIBO	Removed from Formulary	Available via medical necessity review	1/1/2018
TECHNIVIE	Removed from Formulary	MAVYRET	1/1/2018
VIEKIRA/VIEKIRA XR	Removed from Formulary	MAVYRET	1/1/2018
XTANDI	Removed from Formulary	Available via medical necessity review	1/1/2018
ZEPATIER	Removed from Formulary	MAVYRET	1/1/2018

This table outlines the upcoming positive changes to our formulary that may impact you.

Name of Drug	Description of Change	Drug Coverage	Previous Coverage	Effective Date
AUBAGIO	Addition to the Formulary	PA	NA	1/1/2018
MYTESI	Addition to the Formulary	PA & QL 60/30 Days	NA	1/1/2018
NALTREXONE ORAL	Addition to the Formulary	Preferred Drug	NA	1/1/2018
SUBOXONE SUBLINGUAL FILM	Addition to the Formulary	Preferred Drug	NA	1/1/2018
VESANOID	Addition to the Formulary	PA > 26 years old	NA	1/1/2018
VIVITROL IM	Addition to the Formulary	Preferred Drug	NA	1/1/2018
XTAMPZA ER	Addition to the Formulary	Preferred Drug	NA	1/1/2018
LUPRON	Addition to the Formulary	PA	NA	1/1/2018
ELIGARD	Addition to the Formulary	PA	NA	1/1/2018

This table outlines the upcoming changes to Prior Authorization Criteria that may impact you.

Name of Drug	Description of Change	Effective Date
ARIMIDEX	PA Required Added	1/1/2018
AROMASIN	PA Required Added	1/1/2018
AUBAGIO	Oral Multiple Sclerosis PA Criteria Update	1/1/2018
AVONEX	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
BETASERON	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
CAPRESLA	PA Required Added	1/1/2018
COPAXONE	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
CYTOXAN	PA Required Added	1/1/2018
FARESTON	PA Required Added	1/1/2018
GILENYA	Oral Multiple Sclerosis PA Criteria Update	1/1/2018

This table outlines the upcoming changes to Prior Authorization Criteria that may impact you.

Name of Drug	Description of Change	Effective Date
GLEOSTINE	PA Required Added	1/1/2018
HEXALEN	PA Required Added	1/1/2018
LEUCOVORIN	PA Required Added	1/1/2018
MATULANE VESANOID	PA Required Added	1/1/2018
PLEGRIDY	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
REBIF	Injectable Multiple Sclerosis PA Criteria Update	1/1/2018
TECFIDERA	Oral Multiple Sclerosis PA Criteria Update	1/1/2018
ZOLINA	PA Required Added	1/1/2018