

	<p style="text-align: center;">Alameda Alliance for Health FORMULARY UPDATE</p> <p style="text-align: center;"><u>Effective May 6, 2020 unless indicated below under Committee Actions.</u></p>
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Alameda Alliance for Health Pharmacy & Therapeutics (P&T) Committee Decisions

The P&T Committee reviewed the efficacy, safety, cost, and utilization profiles of the following therapeutic categories and drug monographs at the March 17, 2020 meeting:

Therapeutic/Monograph Class Reviews		
<ul style="list-style-type: none"> • Antispasmodics- GI class review • Direct oral anticoagulants class review • Tolcapone (Tasmar) • Antibiotic Eye Drops • Tretinoin (Retin-A) • Banzel (rufinamide) • Rapid-Acting Insulin • Modafinil and Armodafinil • Ophthalmic Antihistamines • Synagis 	<ul style="list-style-type: none"> • Quantity Limit Exception • Cialis (tadalafil) for BPH • Elmiron (pentosane polysulfate sodium) • Symlin (pramlintide) • Atovaquone (Mepron) • Rifabutin (Mycobutin) • Pyridostigmine (Mestinon) • Tranexamic acid (Lysteda) • Safety Edit Exception • Altoprev (lovastatin ER) and Fluvastatin, Fluvastatin ER • Brilinta (ticagrelor) tablet • Linezolid • First generation antihistamines class review 	<ul style="list-style-type: none"> • Inhaled anticholinergics class review • Vasodilators-direct and coronary class review • Pulmonary biologics class review • Idiopathic pulmonary fibrosis class review • Cystic fibrosis class review • Androgens testosterone agents class review • Glucagon comparative review • Oxbryta monograph • Rybelsus monograph

The P&T Committee approved the following modifications to the formulary for the Alliance’s Medi-Cal, and Alliance Group Care programs.

<i>Generic Name & Strength/Dosage Form</i>	Brand Name	Committee Actions
Xeljanz XR oral tablets 22 mg	Xeljanz	Add to formulary with Prior Authorization
Aptiom 200mg	Aptiom	Add to formulary with Prior Authorization
Aptiom 400mg	Aptiom	Add to formulary with Prior Authorization
Aptiom 600mg	Aptiom	Add to formulary with Prior Authorization
Aptiom 800mg	Aptiom	Add to formulary with Prior Authorization
Mayzent 0.25 starter pack	Mayzent	Add to formulary with Prior Authorization

Generic Name & Strength/Dosage Form	Brand Name	Committee Actions
Mayzent 0.5mg tab	Mayzent	Add to formulary with Prior Authorization
Mayzent 2mg tab	Mayzent	Add to formulary with Prior Authorization
PRETOMANID 200 MG TABLET	PRETOMANID	Add to formulary with Prior Authorization
SIRTURO 100 MG TABLET	SIRTURO	Add to formulary with Prior Authorization
NPLATE 250 MCG VIAL	NPLATE	Add to formulary with Prior Authorization
NPLATE 500 MCG VIAL	NPLATE	Add to formulary with Prior Authorization
NPLATE 125 MCG VIAL	NPLATE	Add to formulary with Prior Authorization
Doptelet	Doptelet	Add to formulary with Prior Authorization
ESTRADIOL VALERATE 20 MG/ML VL	ESTRADIOL	Add to formulary with quantity limit #5 for 30 day supply
ESTRADIOL VALERATE 40 MG/ML VL	ESTRADIOL	Add to formulary with quantity limit #5 for 30 day supply
Testosterone 1% (12.5 mg/1.25 g) gel pump	Testosterone	Add to formulary with quantity limit #300 for 30 day supply
Chlorpheniramine 12 mg tablet, ER (OTC)	Chlorphen SR®	IHSS 636 Members only Change to Non-formulary
Chlorpheniramine 2 mg/5 ml syrup (OTC)	EdChloped Jr.®	IHSS 636 Members only Change to Non-formulary
Clemastine 1.34 mg tablet (OTC)	Dayhist®	IHSS 636 Members only Change to Non-formulary
Diphenhydramine 12.5 mg/5 ml liquid (OTC)	Diphenhydramine	IHSS 636 Members only Change to Non-formulary
Diphenhydramine 12.5 mg/5 ml elixir (OTC)	Diphenhydramine	IHSS 636 Members only Change to Non-formulary
BAQSIMI 3 MG SPRAY	BAQSIMI	Add to formulary with quantity limit #1 for 30 day supply. 3 fills in 365 days
OFEV 100 MG CAPSULE	OFEV	Add to formulary with Prior Authorization
OFEV 150 MG CAPSULE	OFEV	Add to formulary with Prior Authorization
ESBRIET 267 MG CAPSULE	ESBRIET	Add to formulary with Prior Authorization
ESBRIET 267 MG TABLET	ESBRIET	Add to formulary with Prior Authorization

Generic Name & Strength/Dosage Form	Brand Name	Committee Actions
TUDORZA PRESSAIR 400 MCG	TUDORZA PRESSAIR	Change to Non-formulary
OXBRYTA 500 MG TABLET	OXBRYTA	Add to formulary with Prior Authorization
Dupixent 200 mg/1.14 mL SQ syringe	Dupixent	Add to formulary with Prior Authorization
Dupixent 300 mg/2 mL SQ syringe	Dupixent	Add to formulary with Prior Authorization
mepolizumab 100 mg SQ vial	Nucala®	Add to formulary with Prior Authorization
mepolizumab 100 mg/mL SQ autoinjector	Nucala®	Add to formulary with Prior Authorization
mepolizumab 100 mg/mL SQ syringe	Nucala®	Add to formulary with Prior Authorization
benralizumab 30 mg/mL SQ syringe	Fasenra®	Add to formulary with Prior Authorization
benralizumab 30 mg/mL SQ autoinjector	Fasenra® Pen	Add to formulary with Prior Authorization
reslizumab 10 mg/mL IV vial	Cinqair	Add to formulary with Prior Authorization
RYBELSUS 3 MG TABLET	RYBELSUS	Add to formulary with step therapy trial and failure of metformin-containing product. Add quantity limit #30 for 30 day supply.
RYBELSUS 7 MG TABLET	RYBELSUS	Add to formulary with step therapy trial and failure of metformin-containing product. Add quantity limit #30 for 30 day supply.
RYBELSUS 14 MG TABLET	RYBELSUS	Add to formulary with step therapy trial and failure of metformin-containing product. Add quantity limit #30 for 30 day supply.
nitroglycerin 0.3 mg/hr patch	Nitro-Dur	Change to Non-formulary
nitroglycerin 0.8 mg/hr patch	Nitro-Dur	Change to Non-formulary
nitroglycerin 0.1mg/hr transdermal 24 hour patch	Nitro-Dur	Add to formulary
nitroglycerin 0.2mg/hr transdermal 24 hour patch	Nitro-Dur	Add to formulary
nitroglycerin 0.4mg/hr transdermal 24 hour patch	Nitro-Dur	Add to formulary
nitroglycerin 0.6mg/hr transdermal 24 hour patch	Nitro-Dur	Add to formulary
LEMTRADA 12 MG/1.2 ML VIAL	LEMTRADA	Change to Non-formulary
TYSABRI 300 MG/15 ML VIAL	TYSABRI	Change to Non-formulary

Generic Name & Strength/Dosage Form	Brand Name	Committee Actions
tetracyclines	tetracyclines	Hard error at POS if a member has 180 days cumulative day supply of any drug within STC W1C within the previous 360 days.
TOBRAMYCIN/DEXAMETHASONE OINTMENT	Tobradex	Add to formulary with quantity limit 2 fills per 12 months
TOBRAMYCIN 0.3% EYE DROP	Tobradex	Add to formulary with quantity limit 2 fills per 12 months
CIPROFLOXACIN 0.3% EYE DROP	Ciloxan	Add to formulary with quantity limit 2 fills per 12 months
ERYTHROMYCIN 0.5% EYE OINTMENT	ERYTHROMYCIN	Add to formulary with quantity limit 2 fills per 12 months
GENTAMICIN 0.3% EYE DROP	GENTAMICIN	Add to formulary with quantity limit 2 fills per 12 months
TOBRAMYCIN 0.3% EYE DROP		Add to formulary with quantity limit 2 fills per 12 months
OFLOXACIN 0.3% EYE DROPS		Add to formulary with quantity limit 2 fills per 12 months
CLINDAMYCIN PH 1% SOLUTION	CLINDAMYCIN	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add to formulary with quantity limit 6 fills per 12 months
CLINDAMYCIN PH 1% GEL	CLINDAMYCIN	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit #60 for 30 day supply and 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add quantity limit #60 for 30 day supply and 6 fills per 12 months
CLINDAMYCIN PHOS 1% PLEDGET	CLINDAMYCIN	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add to formulary with quantity limit 6 fills per 12 months

Generic Name & Strength/Dosage Form	Brand Name	Committee Actions
CLINDAMYCIN PHOSP 1% LOTION	CLINDAMYCIN	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add to formulary with quantity limit 6 fills per 12 months
ERYTHROMYCIN 2% SOLUTION	ERYTHROMYCIN	Add to formulary with quantity limit 6 fills per 12 months
ERYTHROMYCIN 2% GEL	ERYTHROMYCIN	Add to formulary with quantity limit 6 fills per 12 months
ERYTHROMYCIN- BENZOYL GEL	ERYTHROMYCIN	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add to formulary with quantity limit 6 fills per 12 months
Erythromycin 2 % topical swab	ERYTHROMYCIN	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add to formulary with quantity limit 6 fills per 12 months
Erythromycin with Ethanol 2% topical solution	EryMax	Add to formulary with step therapy. Prior use of benzoyl peroxide. Add quantity limit 6 fills per 12 months (Step Therapy apply to NEW starts only) IHSS 636 Members only Add to formulary with quantity limit 6 fills per 12 months

PRIOR AUTHORIZATION GUIDELINE UPDATES

Self-administered Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)	Healthcare professional (HCP) administered/IV Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)
Pulmonary Arterial Hypertension (PAH) Criteria	Medications for the treatment of Multi-Drug Resistant Tuberculosis
Thrombocytopenia Agents	Low Molecular Weight Heparins
Drugs for Gender Dysphoria For Less Than 21 Years Old and Drugs for Gender Dysphoria For At Least 21 Years Old	Estrogen Patches and Injectables
Ezetimibe (Zetia)	Injectable/Specialty Medications
Oral and Injectable Oncology Medications	Brand Medications When a Generic Available
Tolcapone (Tasmar)	Antibiotic Eye Drops
Tretinoin (Retin-A)	Banzel (rufinamide)
Rapid-Acting Insulin	Modafinil and Armodafinil
Ophthalmic Antihistamines	Synagis
Quantity Limit Exception	Cialis (tadalafil) for BPH
Elmiron (pentosane polysulfate sodium)	Symlin (pramlintide)
Atovaquone (Mepron)	

PRIOR AUTHORIZATION GUIDELINES REVIEWED (NO UPDATES)

Rifabutin (Mycobutin)	Pyridostigmine (Mestinon)
Tranexamic acid (Lysteda)	Safety Edit Exception
Altoprev (lovastatin ER) and Fluvastatin, Fluvastatin ER	Brilinta (ticagrelor) tablet
Linezolid	

**For questions, please contact the Alliance's Pharmacy Services department at:
(510) 747-4541.**