

24Q1 Pharmacy Update

Top Drugs REJECTED and DENIED for Prior Authorization Peach State Health Plan

Dear Prescriber,

As your partner in healthcare, we want to provide you with helpful formulary information. We reviewed pharmacy claims that were rejected for authorization requirements, as well as prior authorizations which denied, and identified several high-volume products that have a formulary alternative.

To ensure our members receive the highest quality healthcare as efficiently as possible, we are sharing with you the list of the top claim rejected and prior authorization denied medications. Take a moment to see if these are commonly prescribed in your office.

TOP REJECTED MEDICATIONS

Top Rejected Drugs:	Formulary Alternatives: *Generic mandatory	Formulary Requirements: *Preferred Drugs, Edits, or Limits
Topical Immunomodulators: -Elidel (pimecrolimus) -Protopic (tacrolimus)	Medium potency corticosteroids (Pediatric): -Luxiq® (Betamethasone Valerate) *CREAM, OINT, LOTION -Cutivate® (Fluticasone Propionate) *CREAM OINT -Locoid® (Hydrocortisone Butyrate) *SOLUTION 0.1% -Elocon® (Mometasone Furoate) *CREAM & OINT -Kenalog® (Triamcinolone Acetonide) *OINT & LOTION -Triderm® (Triamcinolone Acetonide) High-Very High potency corticosteroids (Adults): -Diprolene® (Augmented Betamethasone) -Clobetasol Propionate E® (Clobetasol Propionate) -Temovate® (Clobetasol) *CREAM & OINTMENT -Diprolene AF® (Augmented Betamethasone Dipropionate) -Topicort® (Desoximetasone) *CREAM 0.05% -Fluocinonide -Kenalog® (Triamcinolone Acetonide) *CREAM	Preferred Drug/Formulary Alternative Trial Necessary

24Q1 Pharmacy Update

Top Rejected Drugs:	Formulary Alternatives: *Generic mandatory	Formulary Requirements: *Preferred Drugs, Edits, or Limits
Blood Glucose Monitoring Supplies: -Non-preferred meters & strips -Test Strip Quantity Limits	OneTouch Ultra OneTouch Verio	Meter Coupon Code: BIN# 601341 RxPCN: OHS Group ID#: LVUMV384 Member ID#: NOCHARGEMTR Test Strip Quantity Limit: -INSULIN USERS: 0-17 year old #200/30 day supply; 18+ year old #150/30 day supply -Gestational Diabetes #150/30 day supply; -NON-INSULIN USER: #100/90 day supply
Type 2 Diabetes Mellitus: synthetic GLP-1 receptor agonist (INJECTION): -Bydurion BCise® (exenatide pen) -Byetta® (exenatide pen) -Trulicity (dulaglutide pen)	Biguanide Antidiabetic -Metformin SGLT2 inhibitor: -Steglatro™ (ertugliflozin) -Segluromet™ (ertugliflozin/ metformin)	Preferred Drug/Formulary Alternative Trial Necessary
Non-Stimulant ADHD -Clonidine -Guanfacine -Intuniv (Guanfacine ER)	*Generic formulations are Preferred Drug	Limited to one (1) Alpha Agonist per month for members under 18 years old
Continuous Glucose Monitor -Freestyle Libre	* Prior authorization is required	Prior Authorization is required for preferred product
Epilepsy with Seizure Cluster Episodes - RESCUE -Valtoco® (Diazepam Nasal) -Nayzilam® (Midazolam Nasal)	Diazepam Rectal Gel	Preferred Drug/Formulary Alternative Trial Necessary *Should be on maintenance Antiepileptic therapy
Oral Retinoids for Acne: -Isotretinoin (Amnesteem®, Claravis™, Myorisan™, Zenatane®)	Topical antibiotics: clindamycin, erythromycin Topical anti-infectives: benzoyl peroxide 10% gel, benzoyl peroxide 10% lotion Topical retinoids: tretinoin 0.025% gel, tretinoin 0.05% cream, tretinoin 0.1% cream; Oral antibiotics used concurrently with topical agents: e.g., doxycycline, erythromycin, minocycline	Preferred Drug/Formulary Alternative Trial Necessary *Prior authorization may be required for tretinoin topical for age ≥ 30 years *Absorica®, Absorica LD™ are Non-Preferred

24Q1 Pharmacy Update

TOP DENIED MEDICATIONS

Top Denied Drugs:	Formulary Alternatives: *Generic mandatory	Formulary Requirements: *Preferred Drugs, Edits, or Limits
<p>Attention-Deficit/Hyperactivity Disorder (ADHD)</p> <ul style="list-style-type: none"> -Mydayis (Amphetamine-Dextroamphetamine) -Strattera (Atomoxetine) -Focalin XR (Dexamethylphenidate ER) -Vyvanse (Lisdexamfetamine) -Jornay PM (Methylphenidate ER) -Qelbree (Viloxazine HCl (ADHD)) 	<p>Amphetamines GENERIC ONLY</p> <ul style="list-style-type: none"> - Adderall® -Adderall XR® -Dexedrine Spansule® -Dextrostat® -Vyvanse® (except PA for chewable) <p>Methylphenidates GENERIC ONLY</p> <ul style="list-style-type: none"> -Concerta® -Focalin® -Metadate CD® -Methylin Sol® -Relexxii® (except PA for 45 and 63mg) -Ritalin® 	<p>Extended-release ADHD medications:</p> <ul style="list-style-type: none"> • only indicated for members ages 6 years old and up. • limited to 1 capsule/tablet per day (except generic methylphenidate 36mg which is 2 per day) <p>Non-Preferred ADHD medications require the trial and failure of Formulary Alternatives</p>
<p>Type 2 Diabetes Mellitus: synthetic GLP-1 receptor agonist:</p> <ul style="list-style-type: none"> -Bydurion® (exenatide ER) -Byetta® (exenatide IR) 	<p>Biguanide Antidiabetic</p> <ul style="list-style-type: none"> -Metformin <p>SGLT2 inhibitor:</p> <ul style="list-style-type: none"> -Steglatro™ (ertugliflozin) -Segluromet™ (ertugliflozin/metformin) 	<p>Preferred Drug/Formulary Alternative Trial Necessary</p>
<p>Topical Immunomodulators:</p> <ul style="list-style-type: none"> -Elidel (pimecrolimus) -Protopic (tacrolimus) 	<p>Medium potency corticosteroids (Pediatric):</p> <ul style="list-style-type: none"> -Luxiq® (Betamethasone Valerate) *CREAM, OINT, LOTION -Cutivate® (Fluticasone Propionate) *CREAM OINT - Locoid® (Hydrocortisone Butyrate) *SOLUTION 0.1% -Elocon® (Mometasone Furoate) *CREAM & OINT -Kenalog® (Triamcinolone Acetonide) *OINT & LOTION -Triderm® (Triamcinolone Acetonide) <p>High-Very High potency corticosteroids (Adults):</p> <ul style="list-style-type: none"> -Diprolene® (Augmented Betamethasone) -Clobetasol Propionate E® (Clobetasol Propionate) -Temovate® (Clobetasol) *CREAM & OINTMENT -Diprolene AF® (Augmented 	<p>Preferred Drug/Formulary Alternative Trial Necessary</p>

24Q1 Pharmacy Update

Top Denied Drugs:	Formulary Alternatives: *Generic mandatory	Formulary Requirements: *Preferred Drugs, Edits, or Limits
	Betamethasone Dipropionate) -Topicort® (Desoximetasone) *CREAM 0.05% -Fluocinonide -Kenalog® (Triamcinolone Acetonide) *CREAM	
Anti-Migraine: CGRP Antagonists (ORAL) -Nurtec® (Rimegepant) -Ubrelvy™ (Ubrogepant)	-Prophylactic migraine therapy (e.g., propranolol, topiramate, divalproex) -Acute migraine medications (e.g., sumatriptan, rizatriptan, zolmitriptan)	Preferred Drug/Formulary Alternative Trial Necessary *Nurtec is Non-Preferred
Interleukin-4 (IL-4) Inhibitors: -Dupixent (dupilumab)	Diagnosis Dependent PDL Alternatives	Preferred Drug/Formulary Alternative Trial Necessary
Oral Retinoids for Acne: -Isotretinoin (Amnesteem®, Claravis™, Myorisan™, Zenatane®)	Topical antibiotics: clindamycin, erythromycin Topical anti-infectives: benzoyl peroxide 10% gel, benzoyl peroxide 10% lotion Topical retinoids: tretinoin 0.025% gel, tretinoin 0.05% cream, tretinoin 0.1% cream; Oral antibiotics used concurrently with topical agents: e.g., doxycycline, erythromycin, minocycline	Preferred Drug/Formulary Alternative Trial Necessary <i>*Prior authorization may be required for tretinoin topical for age ≥ 30 years</i> *Absorica®, Absorica LD™ are Non-Preferred

Where appropriate, we ask you consider prescribing one of the PDL options. If you have any questions about this communication or what other medications may have a PDL alternative, please contact Pharmacy Services at **866-399-0928**. You can also call the Peach State Health Plan Pharmacy Department at **1-800-514-0083**, Option 2.

We are always here to assist you.

Thank you,
 Charles Kim
 Vice President, Pharmacy