

To: AmeriHealth Caritas Pennsylvania (PA) and AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) Providers

Date: September 20, 2023

Re: Update: Formulary Changes

1. The following products will have new or updated quantity limits.

Members/Participants currently receiving more than the quantity limit, for whom it is not medically advisable to change therapy, will require prior authorization effective **November 20, 2023**.

Formulary Limits	
Product List	Quantity Limit
Bicillin L-A Intramuscular Suspension Prefilled Syringe 2400000 UNIT/4ML	0.59 mL per day
buPROPion HCl ER (SR) Oral Tablet Extended Release 12 Hour 100 MG, 150MG	2 tablets per day
Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT	0.2 grams per day
Jornay PM Oral Capsule Extended Release 24 Hour 20 MG	1 capsule per day
Morphine Sulfate ER Oral Tablet Extended Release 60 MG	2 tablets per day
Pegasys Subcutaneous Solution Prefilled Syringe 180 MCG/0.5ML	0.04 mL per day
Reyvow Oral Tablet 100 MG	0.27 tablets per day
Reyvow Oral Tablet 50 MG	0.14 tablets per day
RisperDAL Consta Intramuscular Suspension Reconstituted ER 12.5 MG, 25MG, 37.5MG	0.08 syringes per day
Scopolamine Transdermal Patch 72 Hour 1 MG/3DAYS	0.34 patches per day
SUMATriptan Succinate Refill Subcutaneous Solution Cartridge 6 MG/0.5ML	0.14 mL per day
SUMATriptan Succinate Subcutaneous Solution Auto-injector 4 MG/0.5ML	0.14 mL per day
Transderm-Scop Transdermal Patch 72 Hour 1 MG/3DAYS	0.34 patches per day
Ubrelvy Oral Tablet 50MG, 100 MG	0.54 tablets per day
Zolpidem Tartrate Oral Tablet 10 MG	1 tablet per day

2. The following products will be removed from the AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Pennsylvania Community HealthChoices drug formulary.

Members/Participants currently receiving the product listed below will require a new prescription for an alternative product effective **November 20, 2023**. Members/Participants for whom it is not medically advisable to change therapy will require prior authorization to continue to receive coverage for the formulary changed products.

Formulary Removals	
Product List	Alternative Product(s)
diphenhydrAMINE HCl Oral Elixir 12.5 MG/5ML	diphenhydrAMINE HCl Oral Liquid 12.5 MG/5ML, Allergy Childrens Oral Liquid 12.5 MG/5ML, Siladryl Allergy Oral Liquid 12.5 MG/5ML
Gas-X Extra Strength Oral Capsule 125 MG GNP Gas Relief Extra Strength Oral Capsule 125 MG	Simethicone Oral Tablet Chewable 125 MG, SM Gas Relief Oral Tablet Chewable 125 MG, HM Gas Relief Oral Tablet Chewable 125 MG
Enemeez Mini Rectal Enema 283 MG/5ML from formulary	Fleet Pediatric Rectal Enema 3.5-9.5 GM/59ML, Glycerin (Pediatric) Rectal Suppository 1.2 GM, Pedia-Lax Rectal Suppository 1 GM
Senna Oral Capsule 8.6 MG	Senna Oral Tablet 8.6 MG, Senna-Time Oral Tablet 8.6 MG, Senna-Tabs Oral Tablet 8.6 MG
Santyl	No alternative products. If medically necessary, submit for prior authorization.

Additional prior authorization criteria may apply. Please refer to the most recent drug formulary and prior authorization information available on-line at:

www.amerihealthcaritaspa.com → Providers → Resources → Pharmacy Services

www.amerihealthcaritaschc.com → For Providers → Pharmacy Services

If you have any questions regarding this notice, please contact Pharmacy Services:

Plan Name	Telephone Number
AmeriHealth Caritas Pennsylvania	1-866-610-2774
AmeriHealth Caritas Pennsylvania Community HealthChoices	1-888-674-8720