



Summary of 2022 Highmark Wholecare Medicare Assured Formulary Changes

November 1, 2021

Dear Valued Provider,

This notice is to inform you of changes to the Highmark Wholecare Medicare Assured formulary, **effective January 1, 2022.**

To ensure that our members maintain continuity in their care, before the effective date of January 1, 2022, we ask prescribers to transition their patient(s) to a formulary alternative and/or submit a request for an exception or prior authorization when applicable.

If a prescriber believes their patient needs to continue on a medication that is no longer on Highmark Wholecare's formulary, the prescriber should **fax** a Highmark Wholecare Medicare Assured Request for Drug Coverage form (attached) to Highmark Wholecare's Pharmacy Department at **1-888-447-4369**. You may also access our website to view additional forms, the entire Drug Formulary, and utilization management requirements such as prior authorization, step therapy criteria, and quantity limits of covered drugs.

2022 Formulary Additions

Drug Name	Notes
AMPHOTERICIN B IV SOLN	PA
ARMODAFINIL TAB	PA, QL
COARTEM TAB	
GOCOVRI ER CAP	ST, QL
HAEGARDA SUBQ SOLN	PA
IMVEXXY VAGINAL INSERT	
INTRAROSA VAGINAL INSERT	
KYNMOBI SUBLINGUAL FILM	QL
LEVOFLOXACIN IN D5W IV SOLN (500 MG/100ML and 750/150	

Drug Name	Notes
PREVYMIS TAB	PA, QL
REGGRANEX	PA
SYMJEPI INJECTION SOLN	
TOLTERODINE ER CAP	QL
TRIJARDY XR TAB	QL
TYMLOS	QL
XERMELO	PA, QL
ZEPOSIA	PA, QL
ZTLIDO	PA, QL

Key: PA = Prior Authorization
ST = Step Therapy QL = Quantity Limit



2022 Formulary Deletions (and Alternatives)

**Refer to the 2022 Medicare Part D Formulary for more therapeutic alternatives. Drugs may be subject to prior authorization, step therapy, or quantity limitations.*

Removed Drug	*Example 2022 Formulary Alternatives
ALCOHOL SWABS (certain manufacturers)	ALCOHOL SWABS: BD, ULTIMED, ALLISON, ETC.
APOKYN CARTRIDGE	KYNMOBI
CINRYZE IV INJ SOLN	HAEGARDA, ICATIBANT ACETATE SUBQ SOLN
DILTIAZEM HCL ER COATED BEADS CAPSULE 24 HOUR 360 MG (generic Cardizem CD)	DILTIAZEM HCL ER COATED BEADS CAPSULE 24 HOUR 180 MG (generic Cardizem CD), CARTIA XT ER 24 HOUR 180 MG, ETC.
DULERA INHALER	ADVAIR DISKUS, ADVAIR HFA, BREO ELLIPTA, SYMBICORT
FABRAZYME IV SOLN	AVAILABLE THROUGH PART B BENEFIT
HEPARIN SODIUM (PORCINE) PF INJECTION SOLUTION 5000 UNIT/0.5ML	HEPARIN SODIUM (PORCINE) INJECTION SOLUTION 10000 UNIT/ML, ETC.
INPEN/BD PEN MINI/CEQUR SIMPLICITY	NOVOPEN ECHO
INSULIN SYRINGES (certain manufacturers)	INSULIN SYRINGES: BD, ULTIMED, ALLISON, TRIVIDA, MHC, ETC.
KEPIVANCE IV SOLN	AVAILABLE THROUGH PART B BENEFIT
LIDOCAINE MOUTH/THROAT 4% SOLN	LIDOCAINE VISCOUS MOUTH/THROAT 2% SOLN
MORPHINE SULFATE PF IV SOLN (0.5%, 1%, 10%)	MORPHINE SULFATE IV SOLN (1%, 50%)
MOXEZA OPTH SOLN	MOXIFLOXACIN, TOBRAMYCIN, OFLOXACIN, TOBRADEX, ETC.
MOXIFLOXACIN HCL (2X DAY) OPTH SOLN 0.5%	MOXIFLOXACIN, TOBRAMYCIN, OFLOXACIN, TOBRADEX, ETC.
PEN NEEDLES (certain manufacturers)	PEN NEEDLES: BD, ULTIMED, ALLISON, TRIVIDA, MHC, NOVO, OWEN, ETC.
QVAR REDHALER	ARNUITY ELLIPTA, FLOVENT DISKUS, FLOVENT HFA, PULMICORT FLEXHALER
SYLVANT IV SOLN	AVAILABLE THROUGH PART B BENEFIT
TEMSIROLIMUS IV SOLN	AVAILABLE THROUGH PART B BENEFIT
TOBREX OPTH OINT	MOXIFLOXACIN, TOBRAMYCIN, OFLOXACIN, TOBRADEX, ETC.
ZIOPTAN OPTH SOLN	LUMIGAN, VYZULTA



2022 Formulary Brand-Generic Changes

**Refer to 2022 Medicare Part D Formulary for more therapeutic alternatives. Drugs may be subject to prior authorization, step therapy, or quantity limitations.*

Brand Drug Removed from Formulary	*Generic Drug on Formulary
AFINITOR DISPERZ and AFINITOR TAB (10 mg)	EVEROLIMUS
ORFADIN CAP (20 mg)	NITISINONE (10 mg)
SUTENT CAP	SUNITINIB
SYPRINE CAP	TRIENTINE

2022 Formulary Policy Changes

Drug Name	UM Changes
APREPITANT	B VS D PA Added
BARACLUDE SOLN	PA Removed
BEXAROTENE CAP	PA Added
CLOBAZAM TAB and SUSPENSION	PA Added
ELIGARD INJ	PA Added
ENTECAVIR TAB	PA Removed
FELBAMATE TAB and SUSPENSION	PA Added
FETZIMA CAP	PA Added
FLUCYTOSINE	PA Removed
KCL 10 MEQ/L (0.075%) IN DEXTROSE 5% & NACL 0.45% INJ	B VS D PA Added
PEGASYS	PA Removed
SYMPAZAN FILM	PA Added
TABLOID TAB	PA Added
TOVIAZ TAB	ST Removed
TRELSTAR MIX INJ	PA Added
VORICONAZOLE FOR INJ	PA Added



2022 Quantity Limit Changes

Drug Name	Quantity Limit
BRIVIACT SOL 10MG/ML	QL (600 ML per 30 days)
BRIVIACT TAB 100MG	QL (60 tablets per 30 days)
BRIVIACT TAB 10MG	QL (120 tablets per 30 days)
BRIVIACT TAB 25MG	QL (120 tablets per 30 days)
BRIVIACT TAB 50MG	QL (120 tablets per 30 days)
BRIVIACT TAB 75MG	QL (60 tablets per 30 days)
CITALOPRAM TAB 10MG	QL (60 tablets per 30 days)
CITALOPRAM TAB 20MG	QL (60 tablets per 30 days)
LUPRON DEPOT (3 MONTH) INJ 11.25MG	QL (1 injection per 84 days)
LUPRON DEPOT (3 MONTH) INJ 22.5MG	QL (1 injection per 84 days)
PULMICORT INH 180MCG	QL (2 inhalers per 30 days)
PULMICORT INH 90MCG	QL (1 inhaler per 30 days)

2022 Drug Tier 1 Changes

Drug Name	2021 Tier	2022 Tier
LEVOXYL TAB	2,3	1
LEVO-T TAB	2,3	1
EUTHYROX TAB	2	1

We thank you in advance for adhering to our drug formulary when clinically possible. If you have any questions, please contact Highmark Wholecare's Pharmacy Services Department at 1-800-685-5209.

Sincerely,

Highmark Wholecare
Pharmacy Services Department



REQUEST FOR DRUG COVERAGE
FAX COMPLETED FORM TO: (888) 447-4369

Failure to complete this form in its entirety may result in an adverse coverage determination due to lack of information.

MEMBER INFORMATION			
First Name:	Last Name:	Date of Birth:	Member ID:
Weight:	Height:	Drug Allergies:	Type of Reaction(s):
DRUG INFORMATION			
☐ FOR ONCOLOGY USE			
Drug Name:	Strength & Route:	Frequency:	Quantity:
☐ New Prescription ☐ Existing Therapy	Date Initiated:	Was medication initiated in hospital? ☐ Yes ☐ No	Expected Length of Therapy:
Diagnosis:		ICD Code:	
BILLING INFORMATION			
This medication will be billed: ☐ At a pharmacy OR ☐ Medically, JCODE: _____			
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other			
Facility NPI: _____			
TYPE OF REQUEST			
☐ Request for prior authorization or step therapy for the prescribed drug ☐ Request for an exception to existing criteria (prior authorization or step therapy exception) ☐ Request for a drug that is not on the list of covered drugs (formulary exception) ☐ Request for an exception to the limit on the number of doses (quantity limit exception) ☐ Request for a lower copayment (tiering exception) ☐ Other (please specify): _____			
☐ Request for Expedited Review: By checking this box and signing below, I certify that applying the 72 hour review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function			
SUPPORTING STATEMENT			
When requesting an exception, the prescribing physician must provide a supporting statement indicating why the requested prescription drug is medically necessary and formulary alternatives OR the number of doses available under a dose restriction have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction. Please provide the supporting statement below and attach any additional supporting information (i.e. chart documentation).			
_____ _____ _____			
FORMULARY ALTERNATIVES TRIED			
Drug Name/Strength:	Dates Tried:	Reason for discontinuation:	
PRESCRIBER INFORMATION			
Prescriber Name (printed):		Specialty:	NPI Number:
Prescriber Address:			
Office Phone:		Office Fax:	
Prescriber Signature:		Date:	

MAY PHOTOCOPY FOR OFFICE USE

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA
If you need to speak to a Pharmacy Services Representative, call 1-800-685-5209. Formulary information can be found at
<https://highmarkwholecare.com/Medicare/Member-Tools/Medication-Benefits/Formulary-Medication>

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare"). Highmark Wholecare offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

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