1st Quarter 2023 preferred drug list update

UnitedHealthcare Community Plan of Rhode Island

UnitedHealthcare Community Plan's preferred drug list (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. Please review the below changes which are effective as of **January 1, 2023**.

Drugs added to the Preferred Drug List

Drug/ Product Name	Comments
Asmanex® Twisthaler®	Indicated for the maintenance treatment of asthma as prophylactic therapy. **Prior authorization is required.**
DEKAS® Products (Caps, Liquid, Chew)	AquaDEKs has been discontinued and has been replaced with DEKAs products. **Move to preferred with Dx2Rx**.
Divalproex Sodium ER Tablets	Indicated for manic episodes associated with bipolar disorder, monotherapy and adjunctive therapy in patients with multiple seizure types, and prophylaxis of migraine headaches. **Moved to preferred effective 7/15/2022.**
Efavirenz-Emtricitabine-Tenofovir Tablets	Indicated as a complete regimen or in combination with other antiretroviral agents for the treatment of HIV infection.
Estradiol TD Patch (Twice-Weekly)	Indicated for the treatment of moderate-to-severe vasomotor symptoms associated with the menopause, vulvar and vaginal atrophy, and hypoestrogenism due to hypogonadism, castration, or primary ovarian failure.
Eszopiclone Tablets	Indicated for the treatment of insomnia. **Moved to preferred effective 7/15/2022.**
Fluticasone-Vilanterol ELLIPTA Powder for Inhalation*	Indicated for maintenance treatment in patients with chronic obstructive pulmonary disease (COPD) and treatment of asthma. **Prior authorization is required.**
Fluticasone HFA*	Indicated for the maintenance treatment of asthma as prophylactic therapy. **Moved to preferred effective 7/15/2022.**
INVEGA HAFYERA™ Injection	Indicated for the treatment of schizophrenia. **Prior authorization is required. Moved to preferred effective 10/1/2022.**
Irbesartan Tablets	Indicated for the treatment of hypertension and diabetic nephropathy. **Moved to preferred effective 7/15/2022.**
Non-Insulin Syringes	Additional non-insulin syringes have been made preferred under the pharmacy benefit. **Moved to Preferred effective 10/1/2022.**
Propranolol ER Capsules	Indicated for multiple heart conditions including hypertension as well as prophylaxis of common migraines and management of essential tremors. **Moved to preferred effective 7/15/2022.**
Telmisartan Tablets	Indicated for the treatment of hypertension and cardiovascular risk reduction. **Moved to preferred effective 7/15/2022.**

PCA-1-21-02493-PH-WEB_07092021

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Valsartan Tablets	Indicated for the treatment of hypertension, heart failure, and post-myocardial infarction. **Moved to preferred effective 7/15/2022.**

*Only the authorized generic is preferred

Changes to coverage within Preferred Drug List

Drug/ Product Name	Comments
Asmanex® HFA	For members under 8 years old, move to Preferred with Prior Authorization. Current utilizers under 8 will be able to continue therapy through 12/31/2023. **Prior Authorization will be required for all members.**
Omnipod® 5 (Kit and Pods)	Added to the pharmacy benefit as non-preferred effective 6/20/2022. **Prior authorization is required.**
Tretinoin Cream	Removed Step Therapy. **Moved to Preferred Open Access for <18 year old and requires Dx2Rx for =/> 18 year old effective 7/1/2022.**

Drugs removed from the Preferred Drug List

Drug/ Product Name	Comments
ARNUITY ELLIPTA	Indicated for the maintenance treatment of asthma. The authorized generic of Flovent HFA and Asmanex are preferred alternatives. Current utilizers under 12 will be able to continue therapy through 12/31/2023. **Prior Authorization is Required.**
Lansoprazole ODT	Indicated for multiple gastric-duodenal conditions including ulcers and Gastroesophageal Reflux Disease (GERD). Applies to RX Form only. The prescription formulation will be non-preferred. The over-the-counter Lansoprazole ODT will remain as the preferred alternative.
Qvar Redihaler®	Indicated for the maintenance treatment of asthma. The authorized generic of Flovent HFA and Asmanex are preferred alternatives. Current utilizers under 12 will be able to continue therapy through 12/31/2023. **Prior Authorization is Required.**

For medications which have been removed from the PDL, we have provided potential alternatives for UnitedHealthcare Community Plan members. If the drug alternative is medically appropriate, please provide members with a new prescription for a preferred alternative, via:

- Call or fax the pharmacy
- Use e-Script
- Write a new prescription and give it directly to the member (where permitted by state regulations)

If a preferred alternative is not medically appropriate, please call **800-310-6826** for prior authorization for the UnitedHealthcare Community Plan member to remain on their current medication.

You may also view the changes at **UHCprovider.com/plans** > Choose Your State > Medicaid (Community Plan) > Pharmacy Resources and Physician-Administered Drugs.

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Contact us

If you have any questions, call UnitedHealthcare Community Plan's Pharmacy department at **800-310-6826**. Thank you.

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