

UnitedHealthcare Community Plan: Q1 2023 preferred drug list updates

The following are changes to the UnitedHealthcare Community Plan preferred drug list (PDL). Our Pharmacy and Therapeutics Committee updates this PDL quarterly.

These changes apply to:

- The following states: Arizona (AZ), Colorado (CO), Florida (FL), Hawaii (HI), Indiana (IN), Louisiana (LA), Maryland (MD), Michigan (MI), Minnesota (MN), Mississippi (MS), Nebraska (NE), New Jersey (NJ), Nevada (NV), New York (NY), Pennsylvania (PA), Rhode Island (RI), Virginia (VA) and Washington (WA).
- The following programs and plans: New York Children's Health Insurance Program (NY CHIP), New York Essential Plan (NY EPP) and Pennsylvania CHIP (PA CHIP).

These changes don't apply to Community Plan of California, Kansas, Kentucky, North Carolina, Ohio or Texas.

New medications on PDL

The following changes became effective **Jan. 1, 2023**:

Medication	Description	States and plans in scope
Asmanex® Twisthaler®	For the maintenance treatment of asthma as prophylactic therapy. We require prior authorization.	CO, HI, IN, MD, NV, NJ, NY and RI
Asmanex Twisthaler	For maintenance treatment of asthma as prophylactic therapy.	NY EPP
DEKAs® and DEKAs Plus (capsules, liquid and tablets)	DEKAs medications replaces the discontinued AquaDEKs medications. We require a diagnosis.	AZ, CO, HI, IN, MD, MN, NJ, NV, NY CHIP, NY EPP, NY, PA CHIP, PA, RI and VA
Efavirenz-Emtricitabine-Tenofovir Disoproxil Fumarate Tablets	For the treatment of HIV infection, either complete regimen or in combination with other antiretroviral agents. We require a diagnosis.	CO, IN, MD, MN, NE, NV, NY, NY EPP, NY CHIP, PA CHIP and RI
Estradiol transdermal patch (twice weekly)	For treatment of moderate to severe vasomotor symptoms associated with menopause, vulvar and vaginal atrophy and hypoestrogenism due to hypogonadism, castration or primary ovarian failure.	CO, HI, IN, MD, MN, MS, NE, NV, NJ, NY, NY CHIP, NY EPP, PA CHIP, RI and VA
Breo™ Ellipta™ fluticasone furoate and vilanterol inhalation powder*	For maintenance treatment in patients with chronic obstructive pulmonary disease (COPD) and asthma. We require prior authorization.	CO, HI, IN, MD, NJ, NV, NY, NY CHIP, PA CHIP and RI

*Only the authorized generic is on our preferred PDL.

The following changes became effective **July 15, 2022**:

Medication	Description	States and plans in scope
Divalproex Sodium Delayed-Release Tablets	For manic episodes associated with bipolar disorder, monotherapy and adjunctive therapy in patients with multiple seizure types and prophylaxis of migraine headaches.	CO, HI, NE, NV, NJ, NY, NY CHIP, NY EPP, PA CHIP and RI
Eszopiclone tablets	For the treatment of insomnia. We require a diagnosis.	CO, HI, NV, NJ, NY, NY CHIP, NY EPP, PA CHIP and RI
Fluticasone hydrofluoroalkane (HFA)*	For maintenance treatment of asthma as prophylactic therapy.	CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI
Irbesartan tablets	For treatment of hypertension and diabetic nephropathy.	CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI
Propranolol extended-release capsules	For multiple heart conditions, including hypertension, prophylaxis of common migraines and management of essential tremors.	CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI
Telmisartan tablets	For treatment of hypertension and cardiovascular risk reduction.	AZ, CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI
Valsartan tablets	For treatment of hypertension, heart failure and post-myocardial infarction.	CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI

The following changes became effective **Oct. 1, 2022**:

Medication	Description	States and plans in scope
INVEGA HAFYERA™ injection	For treatment of schizophrenia. We require prior authorization.	CO, NE, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI
Non-insulin syringes	For additional non-insulin syringes.	AZ, CO, FL, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA, PA CHIP, RI, VA and WA

Changes to PDL coverage

The following changes became effective **Jan. 1, 2023**:

Medication	Description	States and plans in scope
Asmanex® HFA	We now require prior authorization for members younger than age 8. Current users ages younger than age 8 may continue therapy through Dec. 31, 2023.	CO, IN, HI, MD, NV, NJ and RI
Tretinoin cream	We no longer require step therapy. Effective July 1, 2022, we require preferred open access for members younger than age 18 and a diagnosis check for members 18 years and older.	CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI

Medications no longer on PDL

The following changes became effective **Jan. 1, 2023**:

Medication	Description	Preferred alternative(s)	States and plans in scope
Arnuity™ Ellipta®	For maintenance treatment of asthma. Current users younger than age 8 may continue therapy through Dec. 31, 2023. We require prior authorization.	Generic Flovent HFA and Asmanex	CO, HI, IN, MD, NV, NJ, NY and RI
Lansoprazole orally dissolving tablet (ODT)	For multiple gastric-duodenal conditions including ulcers and gastroesophageal reflux disease (GERD). Applies to prescription only. The prescription formulation is on our non-preferred drug list.	Over-the-counter Lansoprazole ODT	AZ, CO, HI, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI
Qvar® Redihaler™	For the maintenance treatment of asthma. Current users ages 12 and older may continue therapy through Dec. 31, 2023. We require prior authorization.	Generic Flovent HFA and Asmanex	CO, IN, MD, NJ, NV, NY, NY CHIP, NY EPP, PA CHIP and RI

Medication alternatives

We may cover medication alternatives for medications not on our PDL. If you feel a medication alternative is medically appropriate for a patient and you'd like to prescribe it, please do one of the following:

- Contact the member's pharmacy to request the prescription
- Submit an electronic prescription using Optum Rx ePrescribe
 - For more information, visit [Electronic Prescribing \(eRx\) to Optum Rx](#) at [optum.com](#)
- Write a new prescription and give it to your patient (where state regulations permit)

If a preferred alternative medication isn't medically appropriate for a patient, please request a PDL prior authorization exception by calling Optum Rx prescriber prior authorization at **800-310-6826**. If the medication meets our medical necessity criteria, we'll continue to cover it for that patient.

Resources

You can view the changes at [UHCprovider.com/plans](#) > Health Plans by State > Medicaid (Community Plan) > Pharmacy Resources and Physician Administered Drugs.



Questions

Please call the Optum Rx prescriber prior authorization line at **800-310-6826**.