Pharmacy Benefit Coverage Updates
July 1, 2018

UnitedHealthcare routinely evaluates prescription benefit coverage to help ensure we offer members affordable and effective medication options. Medications may change in cost or coverage. The following summary highlights Prescription Drug List (PDL) updates for UnitedHealthcare Commercial benefit plans **effective July 1, 2018.**

Medications with New Benefit Coverage

The following medications were not previously covered under most UnitedHealthcare Commercial benefit plans and are now eligible for coverage on or before July 1, 2018.

Therapeutic Use	Medication	Tier
Blood Clots	Bevyxxa	3
Diabetes	Contour Next Diabetic Meter and Test Strips	2
	Contour Next EZ Diabetic Meter	2
	Contour Next One Diabetic Meter	2
Erectile Dysfunction	sildenafil (generic Viagra)	3
Hereditary Tyrosinemia	Nityr[1]	2
Huntington's disease	Austedo[1]	2
Mental Health	Trintellix[1]	3
Sexual Dysfunction	Intrarosa	3
Tardive Dyskinesia	Ingrezza[1]	3

Exclusions[2, 3]

The following medications will no longer be covered under our pharmacy benefit plans effective July 1, 2018.

Therapeutic Use	Medication	Lower-Cost Options
Acne	Aktipak	benzoyl peroxide 5%/erythromycin 3% gel (generic Benzamycin), erythromycin gel (generic Erygel)
	tazarotene 0.1% cream (generic Tazorac)[1]	OTC Differin, tretinoin cream (generic Retin-A)[1], Tazorac 0.1% cream[1]
ADHD	Cotempla XR-ODT[1]	methylphenidate extended-release (generic Metadate CD, Ritalin LA)[1], Adderall XR[1], Concerta[1], Vyvanse[1]
	Mydayis[1]	
Asthma	ArmonAir RespiClick	Alvesco, Asmanex (HFA or Twisthaler), QVAR
COPD	Utibron Neohaler	Anoro Ellipta, Bevespi Aerosphere

Therapeutic Use	Medication	Lower-Cost Options
Diarrhea	Motofen	OTC loperamide (generic Imodium A-D), diphenoxylate/atropine (generic Lomotil)
Erectile Dysfunction	Viagra (Brand only)	sildenafil (generic Viagra)
Heart attack/Stroke prevention	Effient (Brand only)	prasugrel (generic Effient)
Hepatitis B/HIV	Viread tablets (Brand only)	tenofovir tablets (generic Viread)
Hereditary Tyrosinemia	Orfadin[1]	Nityr[1]
HIV	Reyataz capsules (Brand only)	atazanavir capsules (Reyataz)
Hormone Replacement	Climara (Brand only)	estradiol transdermal patch (generic Climara)
Hyperphosphatemia	Fosrenol chewable tablets (Brand only)	lanthanum chewable tablets (generic Fosrenol)
Influenza	Tamiflu suspension (Brand only)	oseltamivir suspension (generic Tamiflu suspension)
Migraines	Relpax (Brand only)	eletriptan (generic Relpax)
Muscle Spasms	Chlorzoxazone 250 mg tablet	chlorzoxazone 500 mg tablet (generic Parafon Forte DSC)
Oral Steroid	Zodex - 6 and 12 day pack	dexamethasone (generic Decadron)
Pain	acetaminophen 325 mg/caffeine 30 mg/dihydrocodeine 16 mg	acetaminophen/codeine (Tylenol with codeine), Trezix
	MorphaBond ER[1]	morphine sulfate extended-release tablet (generic MS Contin)[1], Nucynta ER[1], Xtampza ER[1]
Parkinson's Disease	Gocovri	amantadine immediate-release (generic Symmetrel)
	Xadago	selegiline (generic Eldepryl), rasagiline (generic Azilect)

Tier Updates and Lower Cost Alternatives

Some medications will change tiers on July 1, 2018. Medications may move from a higher to a lower tier or from a lower to a higher tier.

Therapeutic Use	Medication	Tier	Lower-Cost Options
Huntington's disease	tetrabenazine (generic Xenazine)[1]	1 ▸ 2	None Available
Infertility	Crinone[1]	2 ▸ 3	Endometrin[1]
	Endometrin[1]	3 ▸ 2	None Available

Step Therapy Changes

Step therapy requires members to try a lower-cost medication (step 1) before coverage is approved for a higher-cost medication (step 2).

Therapeutic Use	Medication	Step 1 Medication(s)
Infertility	Crinone[1]	Secondary Amenorrhea – medroxyprogesterone (generic Provera) or progesterone capsules (generic Prometrim) All other Indications - Endometrin[1]

Prior Authorization – Notification Changes

Prior Authorization – Notification requires additional clinical information to verify members benefit coverage.

Therapeutic Use	Medication
Endocrine	Buphenyl (sodium phenylbutyrate)
Huntington's disease	Xenazine (tetrabenazine)

Prior Authorization - Medical Necessity Changes

Prior Authorization - Medical Necessity reviews evaluate the clinical appropriateness of a medication for the condition being treated, type of medication, frequency of use and duration of therapy. The following medications will require a medical necessity review in children younger than 18 years old due to the recent FDA warning regarding the potential risks associated with use of opioid-containing cough and cold products in pediatric patients. Coverage for patients 18 years of age and older will automatically process.

Therapeutic Use	Medication
Opioid-containing Cough & Cold Products	codeine/phenylephrine/promethazine
	codeine/promethazine
	Flowtuss
	Hycofenix
	hydrocodone/homatropine
	Obredon
	Tussionex (hydrocodone and chlorpheniramine)
	Tuzistra XR

[1] Step therapy or prior authorization may be required prior to coverage.
[2] Exclusion includes brand, generic and authorized generic products unless otherwise noted.
[3] For benefits that don't exclude, step therapy or prior authorization may be required.