UnitedHealthcare Community Plan

UnitedHealthcare Community Plan of Arizona
Q1 2017 Practitioner Bulletin

UnitedHealthcare Community's Preferred Drug List (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. Please review the changes and update your references as necessary. You may also view the changes at:
UHCCommunityPlan.com > Health Care Professionals > Arizona > Pharmacy Program.

We provided a list of available alternatives to UnitedHealthcare Community Plan members whose current treatment includes a medication removed from the PDL. Please provide these members a prescription for a preferred alternative. There are multiple ways to prescribe an alternative:

- Call or fax the pharmacy.
- Use e-script.
- Write a new prescription and give it directly to the member.

If a preferred alternative is not appropriate, please call 800-310-6826 for prior authorization.

Changes will be effective Jan. 1, 2017

PDL Additions

Brand Name	Generic Name	Comments
Cabometyx	Cabozantinib	Indicated for treating advanced renal cell carcinoma. Prior authorization required. Available through specialty pharmacy.
Cetylev	Acetylcysteine	Indicated as an antidote for acetaminophen overdose indicated to prevent or lessen hepatic injury after ingestion of a potentially hepatotoxic quantity of acetaminophen in patients with acute ingestion or from repeated supratherapeutic ingestion.
Delzicol	Mesalamine	Indicated for treating ulcerative colitis.
Dificid	Fidaxomicin	Indicated for the treatment of Clostridium difficile-associated diarrhea. Prior authorization required.
Impavido	Miltefosine	Indicated for treating visceral leishmaniasis, mucosal leishmaniasis, and cutaneous leishmaniasis. Prior authorization required.
Odefsey	Emtricitabine/Rilpivirine/Tenofovir alefenamide	Indicated for treating HIV.
Plegridy	Peginteferon beta-1a	Indicated for treating multiple sclerosis. Prior authorization required. Available through specialty pharmacy.
Varubi	Rolapitant	Indicated for treating chemotherapy-induced nausea/vomiting prophylaxis, in combination with other antiemetic agents.
Veltassa	Patiromer	Indicated for treating hyperkalemia. Prior authorization required.
Venclexta	Venetoclax	Indicated for treating chronic lymphocytic leukemia (CLL). Prior authorization required. Available through specialty pharmacy.
Urea 10% cream Urea 20% cream Urea 10% lotion	Urea topical	Indicated for dry skin conditions (e.g., psoriasis).

*Only generics are covered.

PDL Modifications

Brand Name	Generic Name	Comments
Opana Extended Release (ER)*	Oxymorphone ER tablet	Prior authorization required. Current users will be grandfathered.
Zohydro ER	Hydrocodone ER capsule	Prior authorization required. Current users will be grandfathered.

*Only generics are covered.

PDL Deletions

Brand Name	Generic Name	Comments
Duetact*	Pioglitazone/ glimepiride*	Alternative agents are available including pioglitazone and glimepiride. Current users will not be grandfathered.
Lialda	Mesalamine	Alternative agents are available including Apriso and Delzicol. Current users will not be grandfathered.

*Only generics are covered.

If you have any questions, please call the UnitedHealthcare Community Plan Pharmacy Department at 800-310-6826.