Steward
Health Care Network
HEALTH CHOICE
UTAH

2019 Formulary Changes – Year to Date

Health Choice Utah may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, and/or move a drug at a higher cost-sharing tier, we will notify you of the change at least 60 days before the date that the change becomes effective. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary.

This table shows drugs that have been removed from the 2019 Steward Health Choice Utah Formulary.

Name of Drug	Description of Change	Alternative Drug	Effective Date
Brand Avodart	Removed from formulary	Generic Dutasteride	5/1/2019
Butalbital/Caffeine/Codine/APAP 300mg	Removed from formulary	Butalbital/Caffeine/Codine/APAP 325mg	6/1/2019
Erythromycin/Benzoyl Peroxide Gel	Removed from formulary	Erythromycin, Benzoyl Peroxide products	5/1/2019
Invokamet	Removed from Formulary	Segluromet	5/1/2019
Invokana	Removed from Formulary	Steglatro	5/1/2019
Loestrin FE	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019
Ortho-Tri-Cyclen	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019
Ortho-Tri-Cyclen LO	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019

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This table shows drugs that have been removed from the 2019 Steward Health Choice Utah Formulary.

Name of Drug	Description of Change	Alternative Drug	Effective Date
Plan B	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019
Ranexa	Removed from formulary	Ranolazine Tablet	2/28/2019
Seasonique	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019
Tazarotene Cream	Removed from formulary	Differin gel	5/1/2019
Tazarotene Gel	Removed from formulary	Differin gel	5/1/2019
Yasmin	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019
Yaz	Removed from formulary	Generic product on formulary, removing Brand	5/1/2019

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This table outlines the positive changes to our formulary that may impact you.

Name of Drug	Description of Change	Drug Coverage	Previous Coverage	Effective Date
Dakins Solution	Addition to the Formulary		NA	3/1/2019
Eucrisa	Addition to the Formulary	PA	NA	1/1/2019
Nuedexta	Addition to the Formulary	PA	NA	1/1/2019
Povidone-Iodine Solution	Addition to the Formulary		NA	3/1/2019
Rosuvastatin	Addition to the Formulary	QL 30/30	NA	3/1/2019
Segluromet	Addition to the Formulary	PA	NA	5/1/2019
Steglatro	Addition to the Formulary	PA	NA	5/1/2019
Sucraid	Addition to the Formulary	PA	NA	1/1/2019
Sucraid	Addition to the Formulary	PA	NA	1/1/2019
Xarelto	Addition to the Formulary	QL 60/30	NA	1/1/2019
Orilissa Tab	Addition to the Formulary		NA	10/1/2019

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This table outlines the changes to Prior Authorization Criteria that may impact you.

Name of Drug	Description of Change	Effective Date
Actimmune	PA criteria change	1/1/2019
Aimovig	PA criteria change	1/1/2019
Amitiza	PA criteria change	5/1/2019
Anzemet	PA criteria change	5/1/2019
Aranesp/Epogen/Procrit	PA criteria change	5/1/2019
Azopt	PA criteria change	5/1/2019
Baraclude	PA criteria change	1/1/2019
Celecoxib	PA criteria change	5/1/2019
Cosopt	PA criteria change	5/1/2019
DDAVP	PA criteria change	5/1/2019
Diclofenac Gel 1%	PA criteria change	5/1/2019
Dificid	PA criteria change	5/1/2019
Donepezil	PA criteria change	5/1/2019
DPPI4 Inhibitors (Januvia, Janumet, Janumet XR, Tradjenta, Jentadueto, Kombiglyze XR, Onglyza)	PA criteria change	5/1/2019
Dupixent	PA criteria change	1/1/2019
Dutasteride	PA criteria change	5/1/2019

Name of Drug	Description of Change	Effective Date
Elidel 1% Cream	PA criteria change	5/1/2019
Elmiron	PA requirement Added	1/1/2019
Elmiron	PA criteria change	5/1/2019
Entresto	PA criteria change	5/1/2019
Eucrisa	PA criteria change	5/1/2019
Ezetimibe	PA requirement Added	3/1/2019
Fuzeon	PA criteria change	5/1/2019
Galantamine	PA criteria change	5/1/2019
Glyxambi	PA criteria change	5/1/2019
Hemlibra	PA criteria change	5/1/2019
Hepsera	PA criteria change	1/1/2019
Ivermectin	PA removed	1/1/2019
Linzess	PA criteria change	5/1/2019
Mavyret	PA criteria change	1/1/2019
Natroba	PA requirement Added	5/1/2019
Non-Form Hep C	PA criteria change	1/1/2019
Spinosad	PA requirement Added	5/1/2019
Step Therapy	PA criteria change	5/1/2019
Tretinoin Cream	Added age limit (<26)	5/1/2019

Tretinoin Gel	Added age limit (<26)	5/1/2019

This table outlines the changes to Prior Authorization Criteria that may impact you.

Name of Drug	Description of Change	Effective Date
Truvada	PA removed	3/1/2019
Tyzeka	PA criteria change	1/1/2019
Uloric	PA requirement Added	1/1/2019