FORMULARY UPDATES
Effective 4/01/2023

February 21, 2023

Dear Care1st Providers and Staff:

Effective April 1, 2023, Care1st will implement the AHCCCS formulary changes based on the recommendations from the January 25, 2023, AHCCCS Pharmacy & Therapeutics (P & T) Committee. To review the Care1st Preferred Drug Lists including the recent updates, visit our website at:

www.care1staz.com > Providers > Pharmacy > Preferred Drug Lists

Care1st encourages all prescribing clinicians to review the Care1st Preferred Drug Lists (PDL) for preferred formulary alternatives prior to prescribing. The table below highlights some of the upcoming Formulary changes.

Drug Class	Drug (s) Removed from Formulary	Preferred Alternative(s) on Formulary (NEW or current alternatives)	Utilization Management (PA, STEP, QL, AGE)**	*Grandfathering permitted (Y/N)
Androgenic Agents	N/A	1. Testosterone Gel Packet (AG) (Vogelxo) (Transdermal) NEW 2. Androderm (Transdermal) 3. Androgel Gel Pump (Transdermal) 4. Androgel packet (Transdermal)	PA	N
Antivirals-Topical	Acyclovir Ointment (Topical)	1. Zovirax Ointment (Topical) NEW 2. Zovirax Cream (Topical)	QL	N
Bronchodilators, Beta Agonists	Proair HFA	1. Albuterol HFA (AG) (Proventil) 2. Albuterol HFA (Proair) 3. Albuterol HFA (AG) (Ventolin) 4. Albuterol HFA (AG) (Proair) 5. Albuterol HFA (Proventil)	N/A	N
Colony Stimulating Factors	Fulphila (Subcutaneous) Neupogen Vial (Injection) Neupogen Syringe (Injection) Nyvepria (Subcutaneous) Udenyca (Subcutaneous)	1. Flynetra (Subcutaneous) NEW 2. Nivestym Vial (Injection) NEW 3. Nivestym Syringe (Subcutaneous) 4. Ziextenzo Syringe (Subcutaneous) NEW	PA	N
Enzyme Replacement Gaucher Disease	N/A	1. Miglustat (Oral) NEW 2. Miglustat (AG) (Oral) 3. Cerdelga (Oral) 4. Cerezyme 400 units (Intravenous) 5. Elelyso (intravenous) 6. Vpriv 400 units (intravenous)	PA	N

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Visit our website at www.care1staz.com
Looking for your assigned Provider Network Rep? On our website go to Providers > Provider Rep Contact Info

Drug Class	Drug (s) Removed from Formulary	Preferred Alternative(s) on Formulary (NEW or current alternatives)	Utilization Management (PA, STEP, QL, AGE)**	*Grandfathering permitted (Y/N)
Erythropoiesis Stimulating Proteins	N/A	1. Aranesp Syringe (Injection) NEW 2. Epogen 3. Retacrit (Injection)	PA	N
Immune Globulins	N/A	1. Bivigam (Intravenous) NEW 2. Octagam (Intravenous) NEW 3. Xembify (Subcutaneous) NEW 4. Flebogamma Dif (Intravenous) 5. Gammagard Liquid (Injection) 6. Gammagard S-D (Intravenous) 7. Gammaked (Intravenous) 8. Gamunex-C (Injection) 9. Hizentra Vial (Subcutaneous) 10. Hizentra Syringe (Subcutaneous) 11. Privigen (Intravenous)	PA	N
Pulmonary Atrial Hypertension (PAH) Agents	Letairis (Oral) Sildenafil Suspension (AG) (Oral) Tracleer tablet (Oral)	1. Ambrisentan (Oral) NEW 2. Bosentan tablet (AG) (Oral) NEW 3. Bosentan tablet (Oral) NEW 4. Adcirca (Oral) 5. Revatio Suspension (Oral) 6. Sildenafil Tablet (Oral) 7. Sildenafil Suspension (Oral)	PA	N

*AHCCCS P&T determines whether or not to permit grandfathering (continued use of a non-formulary medication). If grandfathering is not permitted, members will need to switch to the preferred formulary alternative and a new prescription may be required. (See AHCCCS Policy 310-V)

** Prior Authorization (PA), Step Therapy (STEP), Quantity Limit (QL), Age Restriction (AGE), Authorized Generic (AG)

If you have any questions, please contact the Pharmacy Prior Authorization at 602-778-1800 (Options 5, 5).

Thank you!