CareSource Planning for Healthy Babies (P4HB) Family Planning

7/1/2024

INTRODUCTION

This is the 2024 **CareSource Medicaid Formulary or Preferred Drug List (PDL)**. This list can help providers in picking clinically appropriate and lower priced products. All Georgia Medicaid drugs are covered by CareSource. This is just a list of preferred drugs.

These drugs have been reviewed by the CareSource Pharmacy and Therapeutics (P&T) Committee. The list is up to date at the time of review.

We do not promise the accuracy of the data. It is also not meant to be a full list. It does not substitute for the provider's knowledge, skill and judgment. All the data in the list is a guide. Providers are fully responsible for all drug choices.

The list is subject to state-specific laws and rules. This can be, but is not limited **to:**

- those about generic option
- controlled substance schedules
- brand preference
- mandatory generics (when it applies)

We take no responsibility for the actions or gaps of any provider. They should review the drug maker's product data or standard references.

PREFACE

The list is set up in sections. Each section is split up by therapeutic drug class by method of action. Products are listed by generic name. The brand name is also listed. This is for information only. Unless the drug is an injection or special case, the dosage, forms and strengths are listed.

P&T COMMITTEE

A national P&T Committee are used to approve safe and useful drug therapies. It is made up of:

- the plan's medical directors
- pharmacy staff
- those in the medical community

DRUG COVERAGE DETAILS

Only a strength, dosage or other formulation may be covered if listed. Other strengths/dosages/formulations are not covered. For example: injectable forms of the product. Extended- and delayed-release products have their own listing.

metformin Glucophage
The immediate-release product listing would not have the extended-release product.

metformin ext-rel Glucophage XR
A second listing shows the extended-release product.

Dosage forms will be part of the section where listed.

Neomycin/polymyxin B/hydrocortisone Cortisporin

Cortisporin is only in the OTIC list. It is limited to the solution and suspension. The cream cannot be assumed to be on the list. It would need to be part of the DERMATOLOGY. section.

Prior Authorizations (PA)

CareSource may need providers to send us why a drug or amount is needed. This is called a PA. CareSource must approve this before a member can get the drug. “PA” means that a PA is needed. Here are some reasons for a PA:

- A generic or alternative drug is available.
- The drug can be misused or abused.
- The drug needs special handling, monitoring or has limited shipping.
- There are other drugs that must be tried first.

PA Requests

Health partners may ask for a PA online or by fax. Find out more on the Providers page at **CareSource.com**. We may not approve a PA ask for a drug. If we don't, we will tell the member how to appeal.

Quantity Limits

Some drugs have limits on how much can be given at a time. “QL” is used to show there is a quantity limit. QLs are based on the drug makers’ suggested dosing. Patient safety is also kept in mind. Therapy with opioid analgesics may have quantity limits. These are based on drug makers' recommended dosing and/or state regulations.

The quantity limits are in the list below.

Step Therapy

Members may need to try one drug before taking another. This is called Step Therapy. One drug must be tried before another will be approved for use. CareSource will cover some drugs only if the Step Therapy protocol is followed. “ST” is used in the list when it is needed.

Generic Substitution and Therapeutic Interchange

Generic substitution is a pharmacy action. A generic version is given instead of a brand-name product. Italic type means there is a generic. Not all strengths or dosage forms of

the generic may be generically on hand. A brand-name drug that has a generic product will become non-formulary. The generic product will be covered in place of the brand-name product. The list is subject to state-specific regulations and rules about generic substitution.

Generic drugs are often priced lower than the brand-name. They should be prescribed first if the standards are followed. Prescription generic drugs are:

- Approved by the U.S. FDA. This is for safety and effectiveness. They are made under the same strict standards as brand-name products.
- Tested in humans. The generic must be absorbed at the same rate as the brand-name product. They may differ from the brand in size, color, and inactive ingredients. This does not alter their use.
- Made in the same strength and dosage form as the brand-name products.

A generic drug will have the same effect and safety as the brand name.

PLAN DESIGN

The list shows a closed formulary plan design. The drugs listed are covered by the plan as listed. Certain drugs are covered if utilization management standards are met. This can be ST, PA, and/or QL. Asks for drugs outside of the listed standards will be reviewed. If a drug is not listed, a formulary exception may be asked for coverage. Medical need or formulary exception asks will be reviewed. This is based on PA measures or standard non-formulary prescription criteria. A member or a provider can ask for a formulary exception. Fill out the form found on the PDL page at **CareSource.com**.

NOTICE

This list has brand-name prescription drugs that are trademarks or registered trademarks.

CareSource does not operate the organizations listed here. CareSource is not responsible for the reliability of the content. These listings are not a recommendation by CareSource.

Note: this list is updated regularly. Changes may show before their effective date.

List of Abbreviations

1: Preferred generic product

2: Preferred brand product

ACA: Affordable Care Act

AR: Age Restriction. For certain drugs, the drug may be covered for members in a certain age range without a prior authorization.

OTC: Over-the-Counter. An OTC drug is a non-prescription drug.

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

QL: Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.

ST: Step Therapy. In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

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CURRENT AS OF 7/1/2024

Drug Name	Tier	Restrictions / Limits
ANESTHETICS		
phenazopyridine oral tablet 100 mg, 200 mg	1	
ANTIARTHRITICS		
EC-NAPROXEN	1	
naproxen oral tablet,delayed release (dr/ec)	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
ANTIBIOTICS		
amoxicillin oral capsule	1	
amoxicillin oral suspension for reconstitution	1	
amoxicillin oral tablet	1	
amoxicillin oral tablet,chewable 125 mg	1	
amoxicillin-pot clavulanate oral suspension for reconstitution	1	
amoxicillin-pot clavulanate oral tablet	1	
amoxicillin-pot clavulanate oral tablet,chewable	1	
ampicillin	1	
AVIDOXY	1	
azithromycin oral	1	
cefadroxil	1	
cefdinir	1	
cefpodoxime	1	
cefprozil	1	
cefuroxime axetil	1	
cephalexin oral capsule 250 mg, 500 mg	1	
cephalexin oral suspension for reconstitution	1	
ciprofloxacin hcl oral	1	
ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml	1	
clarithromycin	1	
clindamycin hcl	1	
CLINDAMYCIN PEDIATRIC	1	
clindamycin phosphate vaginal	1	
dicloxacillin	1	
E.E.S. 400	1	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	1	
ERYTHROCIN (AS STEARATE)	1	
erythromycin ethylsuccinate	1	
erythromycin oral capsule,delayed release(dr/ec)	1	
erythromycin oral tablet	1	
erythromycin oral tablet,delayed release (dr/ec) 250 mg	1	
levofloxacin oral	1	
metronidazole oral	1	
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	1	QL (99 GM per 99 days)
minocycline oral capsule	1	
minocycline oral tablet	1	
MONDOXYNE NL	1	
MORGIDOX	1	
neomycin	1	
nitrofurantoin macrocrystal	1	
nitrofurantoin monohyd/m-cryst	1	
nitrofurantoin oral suspension 25 mg/5 ml	1	
penicillin v potassium	1	

Drug Name	Tier	Restrictions / Limits
sulfamethoxazole-trimethoprim oral	1	
SULFATRIM	1	
trimethoprim	1	
URELLE	2	
URETRON D-S	1	
URO-458	1	
VANDAZOLE	1	QL (99 GM per 99 days)
ANTIFUNGALS		
clotrimazole mucous membrane	1	
fluconazole	1	
griseofulvin microsize	1	
griseofulvin ultramicrosize	1	
ketoconazole oral	1	
nystatin oral tablet	1	
terbinafine hcl oral	1	QL (99 EA per 99 days)
terconazole	1	
ANTINEOPLASTICS		
VOTRIENT	2	
ANTIVIRALS		
valacyclovir	1	
BIOLOGICALS		
ADACEL(TDAP ADOLESN/ADULT)(PF)	2	
BOOSTRIX TDAP	2	
ENGERIX-B (PF)	2	
ENGERIX-B PEDIATRIC (PF)	2	
HEPLISAV-B (PF)	2	
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 40 MCG/ML, 5 MCG/0.5 ML	2	
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	2	
TDVAX	2	

Drug Name	Tier	Restrictions / Limits
TENIVAC (PF)	2	
CONTRACEPTIVES		
AFIRMELLE	1	
ALTAVERA (28)	1	
ALYACEN 1/35 (28)	1	
ALYACEN 7/7/7 (28)	1	
AMETHIA	1	QL (99 EA per 99 days)
AMETHYST (28)	1	QL (99 EA per 99 days)
APRI	1	
ARANELLE (28)	1	
ASHLYNA	1	QL (99 EA per 99 days)
AUBRA	1	
AUBRA EQ	1	
AUROVELA 1.5/30 (21)	1	
AUROVELA 1/20 (21)	1	
AUROVELA 24 FE	1	
AUROVELA FE 1.5/30 (28)	1	
AUROVELA FE 1-20 (28)	1	
AVIANE	1	
AYUNA	1	
AZURETTE (28)	1	
BALZIVA (28)	1	
BLISOVI 24 FE	1	
BLISOVI FE 1.5/30 (28)	1	
BLISOVI FE 1/20 (28)	1	
BRIELLYN	1	
CAMILA	1	
CAMRESE	1	QL (99 EA per 99 days)
CAMRESE LO	1	QL (99 EA per 99 days)
CAZIANT (28)	1	
CHATEAL (28)	1	
CHATEAL EQ (28)	1	
CRYSELLE (28)	1	

Drug Name	Tier	Restrictions / Limits
CYRED	1	
CYRED EQ	1	
DASETTA 1/35 (28)	1	
DASETTA 7/7/7 (28)	1	
DAYSEE	1	QL (99 EA per 99 days)
DEBLITANE	1	
desog-e.estradiol/e.estradiol	1	
drospirenone-ethinyl estradiol	1	
ELINEST	1	
ELURYNG	1	
ENPRESSE	1	
ENSKYCE	1	
ERRIN	1	
ESTARYLLA	1	
ethynodiol diac-eth estradiol	1	
etonogestrel-ethinyl estradiol	1	
FALMINA (28)	1	
HAILEY	1	
HAILEY 24 FE	1	
HEATHER	1	
INCASSIA	1	
ISIBLOOM	1	
JASMIEL (28)	1	
JENCYCLA	1	
JOLESSA	1	QL (99 EA per 99 days)
JULEBER	1	
JUNEL 1.5/30 (21)	1	
JUNEL 1/20 (21)	1	
JUNEL FE 1.5/30 (28)	1	
JUNEL FE 1/20 (28)	1	
JUNEL FE 24	1	
KAITLIB FE	1	
KALLIGA	1	
KARIVA (28)	1	

Drug Name	Tier	Restrictions / Limits
KELNOR 1/35 (28)	1	
KELNOR 1-50 (28)	1	
KURVELO (28)	1	
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)	1	QL (99 EA per 99 days)
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg	1	
LARIN 1.5/30 (21)	1	
LARIN 1/20 (21)	1	
LARIN 24 FE	1	
LARIN FE 1.5/30 (28)	1	
LARIN FE 1/20 (28)	1	
LAYOLIS FE	1	
LEENA 28	1	
LESSINA	1	
LEVONEST (28)	1	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	1	
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg (28)	1	QL (99 EA per 99 days)
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	1	QL (99 EA per 99 days)
levonorg-eth estrad triphasic	1	
LEVORA-28	1	
LORYNA (28)	1	
LOW-OGESTREL (28)	1	
LO-ZUMANDIMINE (28)	1	
LUTERA (28)	1	
LYZA	1	
MARLISSA (28)	1	

Drug Name	Tier	Restrictions / Limits
medroxyprogesterone intramuscular	1	QL (99 ML per 99 days)
MICROGESTIN 1.5/30 (21)	1	
MICROGESTIN 1/20 (21)	1	
MICROGESTIN FE 1.5/30 (28)	1	
MICROGESTIN FE 1/20 (28)	1	
MILI	1	
MONO-LINYAH	1	
NECON 0.5/35 (28)	1	
NIKKI (28)	1	
NORA-BE	1	
noreth-ethinyl estradiol-iron	1	
norethindrone (contraceptive)	1	
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1.5 mg-30 mcg (21)/75 mg (7)	1	
norgestimate-ethinyl estradiol	1	
NORTREL 0.5/35 (28)	1	
NORTREL 1/35 (21)	1	
NORTREL 1/35 (28)	1	
NORTREL 7/7/7 (28)	1	
OCELLA	1	
PHILITH	1	
PIMTREA (28)	1	
PORTIA 28	1	
RECLIPSEN (28)	1	
SETLAKIN	1	QL (99 EA per 99 days)
SHAROBEL	1	
SIMLIYA (28)	1	
SIMPESSE	1	QL (99 EA per 99 days)
SPRINTEC (28)	1	
SRONYX	1	
SYEDA	1	
TARINA 24 FE	1	
TARINA FE 1/20 (28)	1	
TARINA FE 1-20 EQ (28)	1	
TILIA FE	1	
TRI-ESTARYLLA	1	
TRI-LEGEST FE	1	
TRI-LINYAH	1	
TRI-LO-ESTARYLLA	1	
TRI-LO-MARZIA	1	
TRI-LO-MILI	1	
TRI-LO-SPRINTEC	1	
TRI-MILI	1	
TRI-SPRINTEC (28)	1	
TRIVORA (28)	1	
TRI-VYLIBRA	1	
TRI-VYLIBRA LO	1	
TULANA	1	
VELIVET TRIPHASIC REGIMEN (28)	1	
VIENVA	1	
VIORELE (28)	1	
VYFEMLA (28)	1	
VYLIBRA	1	
WERA (28)	1	
WYMZYA FE	1	
XULANE	1	
ZAFEMY	1	
ZARAH	1	
ZUMANDIMINE (28)	1	

Drug Name	Tier	Restrictions / Limits
GASTRO-INTESTINAL		
esomeprazole magnesium oral granules dr for susp in packet	1	
omeprazole oral capsule,delayed release(dr/ec)	1	
pantoprazole oral tablet,delayed release (dr/ec)	1	
HORMONES		
medroxyprogesterone oral	1	
norethindrone acetate	1	
progesterone micronized	1	
PRE-NATAL VITAMINS		
KOSHER PRENATAL PLUS IRON	2	
M-NATAL PLUS	1	
PRENATABS FA	1	
PRENATABS RX	1	
PRENATAL 19 ORAL TABLET,CHEWABLE	2	
PRENATAL PLUS	1	
PRENATAL PLUS (CALCIUM CARB)	1	
PRENATAL VITAMIN PLUS LOW IRON	1	
SE-NATAL 19 CHEWABLE	1	
THRIVITE RX	2	
TRICARE	2	
TRINATAL RX 1	1	

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