Sentara Health Plans Pharmacy Changes

Effective: January 1, 2025

(For plans with pharmacy benefits administered by Sentara Health Plans)

DRUG NAME: Acthar® Gel (repository corticotropin injection) Single-Dose Pre-filled SelfJect™ Injector, all strengths		**INDICATION:** For use in adults to treat a range of chronic and acute inflammatory and autoimmune conditions
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICARE): cortrophin gel (*requires prior authorization)		

October 21, 2024 (January– March 2025)
Should changes to this list occur, a Changed document will be posted with the above date modified. Please continue to visit our website www.sentarahealthplans.com for the most current version. Always refer to your Summary of Benefits for verification of coverage.

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2025

(For plans with pharmacy benefits administered by Sentara Health Plans)

<table>
<tr><td colspan="2">DRUG NAME: adalimumab-aacf (CF) syringe 40 mg</td><td>INDICATION: Humira Biosimilar FDA approved to treat seven inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older and moderate-to-severe ulcerative colitis in adults</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL): 2 syringes per 28 days
(MEDICAID): 2 syringes per 28 days
(MEDICARE): N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]</td></tr>
</table>

DRUG NAME: adalimumab-ryvk CF 40 mg syringe	**INDICATION:** Low WAC Humira Biosimilar FDA approved to treat eight inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults and moderate-to-severe hidradenitis suppurativa in adult patients

REASON FOR CHANGE: New Drug

FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A

QUANTITY LIMIT:

- (COMMERCIAL): 2 auto-injectors per 28 days
- (MEDICAID): 2 auto-injectors per 28 days
- (MEDICARE): N/A

FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]

DRUG NAME: Adbry® (tralokinumab-ldrm) 300 mg/2 mL auto-injector for subcutaneous use		**INDICATION:** For the treatment of moderate-to-severe atopic dermatitis in adults and pediatric patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 auto-injectors (4 mL) per 28 days • (MEDICAID): 2 auto-injectors (4 mL) per 28 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICARE): Dupixent® (dupilumab) *requires prior authorization		

DRUG NAME: aliskiren (Tekturna®) tablets, all strengths		**INDICATION:** For the management of hypertension in adults and pediatric patients ≥50 kg and ≥6 years of age
REASON FOR CHANGE: Add Utilization Management Requirements & Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Step-Edit, Quantity Limit
STANDARD FORMULARY	Tier 2	Step-Edit, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Step-Edit, Quantity Limit
FAMIS FORMULARY	Formulary	Step-Edit, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day (both strengths) • (MEDICAID): 1 tablet per day (both strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID) Cartia XT®, diltiazem IR/ER q12hr/24hr, Taztia XT®, verapamil tab IR & ER		

DRUG NAME: Anktiva® (nogapendekin alfa inbakicept-pmln) solution, for intravesical use		**INDICATION:** An interleukin-15 (IL-15) receptor agonist indicated with Bacillus Calmette-Guérin (BCG) for the treatment of adult patients with BCG-unresponsive nonmuscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Austedo® (deutetrabenazine) XR 6, 12 & 24 mg		**INDICATION:** For the treatment of chorea associated with Huntington disease in adults; For the treatment of tardive dyskinesia in adults
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day (all strengths) • (MEDICAID): 1 tablet per day (all strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Austedo® (deutetrabenazine) XR 18 mg, 30, 36, 42 & 48 mg tablets		**INDICATION:** For the treatment of chorea associated with Huntington disease in adults; For the treatment of tardive dyskinesia in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day (all strengths) • (MEDICAID): 1 tablet per day (all strengths) • (MEDICARE): 30 tablets per 30 days (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Austedo® (deutetrabenazine) XR Titration pack 12-18-24-30 mg		**INDICATION:** For the treatment of chorea associated with Huntington disease in adults; For the treatment of tardive dyskinesia in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 28 tablets (1 pack) per 365 days • (MEDICAID): 28 tablets (1 pack) per 365 days • (MEDICARE): 28 tablets (1 pack) per 180 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Beqvez™ (fidanacogene elaparvovec-dzkt) injection, for intravenous infusion		**INDICATION:** For the treatment of adults with moderate to severe hemophilia B (congenital factor IX deficiency) who: currently use factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes, and, do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Chenodal® (chenodiol) 250 mg tablets		**INDICATION:** For the dissolution of radiolucent cholesterol gallstones in select patients as an alternative to surgery
REASON FOR CHANGE: Add Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: • (COMMERCIAL): 7 tablets per day • (MEDICAID): 7 tablets per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): ursodiol capsules/tablets		

DRUG NAME: Clobetasol Propionate Ophthalmic Suspension 0.05%		**INDICATION:** For the treatment of post-operative inflammation and pain following ocular surgery
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 3.5 mL (1 bottle) per 30 days • (MEDICAID): 3.5 mL (1 bottle) per 30 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): dexamethasone 0.1%, prednisolone AC %; (MEDICAID) Durezol®, fluorometholone, prednisolone acetate; (MEDICARE): dexamethasone 0.1%, prednisolone AC %		

<table>
<tr><td colspan="2">DRUG NAME: carbinoxamine ER 4 mg/5 mL 12-hour suspension</td><td>INDICATION: For the symptomatic treatment of seasonal and perennial allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis caused by inhalant allergens and foods; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; dermatographism; as therapy for anaphylactic reactions adjunctive to epinephrine and other standard measures after the acute manifestations have been controlled; amelioration of the severity of allergic reactions to blood or plasma.</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL): 40 mL per day
(MEDICAID): 40 mL per day
(MEDICARE): N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): carbinoxamine IR tablets; (MEDICAID): carbinoxamine IR tablets; (MEDICARE): cetirizine solution, levocetirizine solution</td></tr>
</table>

DRUG NAME: carbinoxamine 4 mg/5 mL solution		**INDICATION:** For the symptomatic treatment of seasonal and perennial allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis caused by inhalant allergens and foods; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; dermatographism; as therapy for anaphylactic reactions adjunctive to epinephrine and other standard measures after the acute manifestations have been controlled; amelioration of the severity of allergic reactions to blood or plasma.
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL): 40 mL per day • (MEDICAID): 40 mL per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): carbinoxamine IR tablets; (MEDICAID): carbinoxamine IR tablets; (MEDICARE): cetirizine solution, levocetirizine solution		

DRUG NAME: Capvaxive™ (pneumococcal 21-valent conjugate vaccine)		**INDICATION:** Active immunization for the prevention of invasive disease and pneumonia caused by Streptococcus pneumoniae serotypes 3, 6A, 7F, 8, 9N, 10A, 11A, 12F, 15A, 15B, 15C, 16F, 17F, 19A, 20A, 22F, 23A, 23B, 24F, 31, 33F and 35B in adults individuals 18 years of age and older; Active immunization for the prevention of pneumonia caused by S. pneumoniae serotypes 3, 6A, 7F, 8, 9N, 10A, 11A, 12F, 15A, 15C, 16F, 17F, 19A, 20A, 22F, 23A, 23B, 24F, 31, 33F and 35B in individuals 18 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9 (ACA)	N/A
STANDARD FORMULARY	Tier 9 (ACA)	N/A
EXCHANGE FORMULARY	Tier 9 (ACA)	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Duvyzat™ (givinostat)		**INDICATION:** For the treatment of Duchenne muscular dystrophy in patients ≥6 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 12 mL per day • (MEDICAID): 12 mL per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Entresto® Sprinkle (sacubitril and valsartan) oral pellets, all strengths		**INDICATION:** For the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients aged one year and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Entresto tablets; (MEDICARE): Entresto tablets		

DRUG NAME: Fasenra® (benralizumab) 10 mg/0.5 mL single- dose prefilled syringe		**INDICATION:** For use as add-on maintenance treatment of patients aged 6 years and older with severe asthma, and with an eosinophilic phenotype
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 syringe (0.5 mL) per 56 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Firdapse® (amifampridine) 10 mg tablets		**INDICATION:** For the treatment of Lambert-Eaton myasthenic syndrome in adults and pediatric patients ≥6 years of age
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: • (COMMERCIAL): 10 tablet per day • (MEDICAID): 10 tablets per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: glimepiride 3 mg tablets		**INDICATION:** For use as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day • (MEDICAID): 1 tablet per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: glimepiride 1, 2 & 4 mg tablets		

DRUG NAME: hydrocortisone 2% lotion		**INDICATION:** For use to treat a variety of skin conditions (such as insect bites, poison oak/ivy, eczema, dermatitis, allergies, rash, itching of the outer female genitals, anal itching)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: hydrocortisone 2.5% lotion		

DRUG NAME: Iqirvo® (elafibranor)		**INDICATION:** For the treatment of primary biliary cholangitis, in combination with ursodeoxycholic acid (UDCA), in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Imdelltra™ (tarlatamab-dlle) for injection, for intravenous use		**INDICATION:** A bispecific delta-like ligand 3 (DLL3)-directed CD3 T-cell engager indicated for the treatment of adult patients with extensive stage small cell lung cancer (ES-SCLC) with disease progression on or after platinum-based chemotherapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ingrezza® (valbenazine) sprinkle capsules, all strengths		**INDICATION:** For the treatment of adults with chorea associated with Huntington disease; For the treatment of adults with tardive dyskinesia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL): 1 capsule per day • (MEDICAID): 1 capsule per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICARE): tetrabenazine tablets, Austedo® (deutetrabenazine) IR/XR tablets (*both require prior authorization		

DRUG NAME: Jynarque® (tolvaptan) tablets		**INDICATION:** For use to slow kidney function decline in adults at risk of rapidly progressing autosomal dominant polycystic kidney disease (ADPKD)
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A

QUANTITY LIMIT:
• (COMMERCIAL):
  • 15 tablet – 2 tablets per day
  • 30 mg tablet – 1 tablet per day
• (MEDICAID):
  • 15 tablet per day – 2 tablets per day
• (MEDICARE): N/A		

FORMULARY ALTERNATIVES: (MEDICAID): tolvaptan tablets (*requires prior authorization)		

DRUG NAME: Kisunla™ (donanemab-azbt) injection for IV infusion 350 mg/20 mL		**INDICATION:** For the treatment of Alzheimer disease; to be initiated in patients with mild cognitive impairment or mild dementia stage of disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lazcluze™ (lazertinib) tablets, all strengths		**INDICATION:** For the first-line treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations, as detected by an FDA-approved test
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 80 mg - 2 tablets per day • 240 mg – 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: L-glutamine (Endari®) 5 gram powder packet		**INDICATION:** For use to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Age Edit = Prior authorization for members < 5 years of age
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 6 packets per day • (MEDICAID): N/A • (MEDICARE): 900 grams per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Libervant™ (diazepam) buccal film, all strengths		**INDICATION:** For the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 2 to 5 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 10 films per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID): clonazepam tab, Diastat® rectal, Diastat® AcuDial™ rectal, diazepam rectal & Device, Nayzilam®, Valtoco® Nasal		

DRUG NAME: Liraglutide 18 mg/3 mL injection		**INDICATION:** For use as an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients aged 10 years and older with type 2 diabetes mellitus; For use to reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL): 9 mL per 28 days • (MEDICAID): 9 mL per 28 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Ozempic, Rybelsus, Trulicity; (MEDICAID): Byetta, Trulicity, Victoza; (MEDICARE): Ozempic, Rybelsus, Trulicity		

DRUG NAME: Livmarli® (maralixibat) oral solution 9.5 mg/mL		**INDICATION:** For the treatment of cholestatic pruritus in patients 3 months of age and older with Alagille syndrome (ALGS)
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 3 mL per day • (MEDICAID): 3 mL per day • (MEDICARE): 90 mL per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Livmarli® (maralixibat) oral solution 19 mg/mL		**INDICATION:** For the treatment of cholestatic pruritus in patients 12 months of age and older with progressive familial intrahepatic cholestasis (PFIC). Livmarli was previously approved for this indication in patients 5 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • COMMERCIAL): 2 mL per day • (MEDICAID): 2 mL per day • (MEDICARE): 60 mL per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: metyrosine (Demser) 250 mg capsules		**INDICATION:** For the short-term management of pheochromocytoma before surgery; long-term management of pheochromocytoma when surgery is contraindicated or when chronic malignant pheochromocytoma exists
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization
STANDARD FORMULARY	Tier 2	Prior Authorization
EXCHANGE FORMULARY	Tier 2	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: mRESVIA™ (respiratory syncytial virus vaccine)		**INDICATION:** A vaccine indicated for active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9	Age Edit = ≤ 59 years of age
STANDARD FORMULARY	Tier 9	Age Edit = ≤ 59 years of age
EXCHANGE FORMULARY	Tier 9	Age Edit = ≤ 59 years of age
FAMIS FORMULARY	Formulary	Age Edit = ≤ 59 years of age
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Age Edit = ≤ 59 years of age
MEDICARE FORMULARY	Tier 3	Age Edit = ≤ 59 years of age
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: MydCombi™ (tropicamide and phenylephrine HCl ophthalmic spray) 1%/2.5%		**INDICATION:** For use to induce mydriasis for diagnostic procedures and conditions where short-term pupil dilation is desired
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Myhibbin™ (mycophenolate mofetil) 200 mg/mL oral suspension		**INDICATION:** For the prophylaxis of organ rejection, in adult and pediatric recipients 3 months of age and older of allogeneic kidney, heart or liver transplants, in combination with other immunosuppressants
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization (Age-Edit = > 8 years old), Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization (Age-Edit = > 8 years old), Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization (Age-Edit = > 8 years old), Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization (Age-Edit = > 8 years old), Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (Age-Edit = > 8 years old), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL): 2 bottles per 30 days • (MEDICAID): 2 bottles per 30 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): mycophenolate mofetil 200 mg/mL oral suspension (Cellcept®); (MEDICARE): mycophenolate mofetil 200 mg/mL oral suspension (Cellcept®)		

DRUG NAME: naloxone 0.4 mg/mL syringe		**INDICATION:** For the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or CNS depression. Intended for immediate administration as emergency therapy in settings where opioids may be present. Not a substitute for emergency medical care
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 1	N/A
STANDARD FORMULARY	Tier 1	N/A
EXCHANGE FORMULARY	Tier 1	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Tier 2	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Norvir® (ritonavir) 100 mg softgel capsules		**INDICATION:** For use in combination with other antiretroviral agents for the treatment of HIV-1 infection
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Specialty (Tier 5)	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Norvir® powder pack/solution, ritonavir tablets; (MEDICAID): Norvir® powder pack, ritonavir tablets/solution		

DRUG NAME: Nourianz® (istradefylline), all strengths		**INDICATION:** For the treatment of Parkinson disease, in combination with levodopa/carbidopa, in adult patients experiencing "off" episodes
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): N/A • (MEDICAID): 1 tablet per day (both strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICARE): carbidopa/levodopa tablets		

DRUG NAME: Ohtuvayre™ (ensifentrine) inhalation suspension 3 mg/2.5 mL		**INDICATION:** For the maintenance treatment of chronic obstructive pulmonary disease in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 ampules per day • (MEDICAID): 2 ampules per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): rolumilast (requires prior authorization); (MEDICARE): albuterol/ipratropium nebulizer solution, roflumilast tablets (*requires prior authorization)		

DRUG NAME: Ojemda (tovorafenib), all strengths & formulations		**INDICATION:** For the treatment of patients 6 months of age and older with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 400 mg dose – 16 tablets per 28 days • 500 mg dose – 20 tablets per 28 days • 600 mg dose – 24 tablets per 28 days • 25 mg/mL suspension – 96 mL per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Omvoh (mirikizumab-mrkz) 100 mg/mL prefilled syringe		**INDICATION:** For the treatment of treatment of moderately to severely active ulcerative colitis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 syringes (2 mL) per 28 days • (MEDICAID): 2 syringes (2 mL) per 28 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®); (MEDICARE): Humira, Cyltezo, Hyrimoz, Stelara (*all require prior authorization)		

DRUG NAME: ondansetron ODT 16 mg tablet		**INDICATION:** For the prevention of nausea and vomiting associated with highly emetogenic cancer chemotherapy; Prevention of nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy; Prevention of postoperative nausea and/or vomiting (PONV); Prevention of nausea and vomiting associated with radiotherapy in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: ondansetron 4 & 8 mg ODT tablets		

DRUG NAME: Onyda™ XR (clonidine HCl) extended-release oral suspension 0.1 mg/mL		**INDICATION:** For the treatment of attention deficit hyperactivity disorder (ADHD) as monotherapy or as adjunctive therapy to central nervous system (CNS) stimulant medications in pediatric patients 6 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limits
STANDARD FORMULARY	Non-Formulary	Quantity Limits
EXCHANGE FORMULARY	Non-Formulary	Quantity Limits
FAMIS FORMULARY	Non-Formulary	Quantity Limits
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limits
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 4 mL per day • (MEDICAID): 4 mL per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): clonidine 0.1 mg extended-release tablets; (MEDICAID): atomoxetine (generic Strattera®), clonidine ER & guanfacine ER tablets; (MEDICARE): clonidine 0.1 mg extended-release tablets		

DRUG NAME: Opsynvi® (macitentan/tadalafil) tablets, all strengths		**INDICATION:** For chronic treatment of pulmonary arterial hypertension (PAH, WHO Group I) in adult patients of WHO functional class (FC) II-III
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day (both strengths) • (MEDICAID): 1 tablet per day (both strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Alyq (tadalafil), sildenafil tab/susp, tadalafil (generic Adcirca®); (MEDICARE): sildenafil tablets (generic Revatio), tadalafil tablets (generic Adcirca)		

DRUG NAME: Otezla® (apremilast) 20 mg tablets		**INDICATION:** For the treatment of pediatric patients 6 years of age and older and weighing at least 20 kg with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe, infliximab (generic Remicade®)		

DRUG NAME: Otezla® (apremilast) 10-20 mg tablet starter pack		**INDICATION:** For the treatment of pediatric patients 6 years of age and older and weighing at least 20 kg with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 55 tablets (1 pack) per 365 days		
FORMULARY ALTERNATIVES: (MEDICAID) Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe, infliximab (generic Remicade®)		

DRUG NAME: phenoxybenzamine (Dibenzyline) 10 mg capsules		**INDICATION:** For the treatment of sweating and hypertension associated with pheochromocytoma
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization
STANDARD FORMULARY	Tier 2	Prior Authorization
EXCHANGE FORMULARY	Tier 2	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICARE): doxazosin tablets		

DRUG NAME: PiaSky® (crovalimab) 340 mg/2 mL injection for intravenous or subcutaneous use		**INDICATION:** For the treatment of paroxysmal nocturnal hemoglobinuria in adult and pediatric patients ≥13 years of age and ≥40 kg
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Potassium Chloride ER 15 mEq tablets		**INDICATION:** For the treatment of hypokalemia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic potassium chloride; (MEDICAID): generic potassium chloride 15 mEq tablet extended-release particles/crystals; (MEDICARE): generic potassium chloride 15 mEq tablet extended-release particles/crystals		

DRUG NAME: Qbrexza® (glycopyrronium) 2.4 % cloth		**INDICATION:** For the topical treatment of primary axillary hyperhidrosis in adults and pediatric patients 9 years of age and older
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 box (30 pouches) per 30 days • (MEDICAID): 1 box (30 pouches) per 30 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): DrySol solution, glycopyrrolate tablets; (MEDICARE): glycopyrrolate tablets		

DRUG NAME: Retevmo® (selpercatinib) tablets, all strengths	**INDICATION:** For the treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with a rearranged during transfection (RET) gene fusion, as detected by an FDA-approved test; Adult and pediatric patients 2 years of age and older with advanced or metastatic medullary thyroid cancer (MTC) with a RET mutation, as detected by an FDA-approved test, who require systemic therapy; Adult and pediatric patients 2 years of age and older with advanced or metastatic thyroid cancer with a RET gene fusion, as detected by an FDA-approved test, who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate); Adult and pediatric patients 2 years of age and older with locally advanced or metastatic solid tumors with a RET gene fusion, as detected by an FDA-approved test, that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options

REASON FOR CHANGE: New Drug

FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit

QUANTITY LIMIT: N/A
- 80, 120 & 160 mg – 2 tablets per day
- 40 mg – 3 tablets per day

FORMULARY ALTERNATIVES: N/A

DRUG NAME: Rextovy™ (naloxone) Nasal Spray, 4 mg		**INDICATION:** For emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression, for adult and pediatric patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Quantity Limit
STANDARD FORMULARY	Tier 3	Quantity Limit
EXCHANGE FORMULARY	Tier 3	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL): 2 unit-dose devices (1 carton) per fill		
FORMULARY ALTERNATIVES: (MEDICAID): Kloxxado™ Spray, naloxone syringe & vial, naloxone nasal spray, naloxone nasal spray OTC, Naloxone Carpuject, naltrexone tab, Narcan® Nasal Spray, Vivitrol®, Zimhi™; (MEDICARE): generic naloxone 4 mg nasal spray		

DRUG NAME: Rinvoq® LQ (Upadacitinib) 1 mg/mL oral solution		**INDICATION:** For the treatment of adults and pediatric patients 2 years of age and older with active psoriatic arthritis (PsA) who have had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers. Treatment of patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (pJIA) who have had an inadequate response or intolerance to one or more TNF blockers
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 12 mL per day		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®)		

DRUG NAME: generic roflumilast (Daliresp®) tablets		**INDICATION:** For use to reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations
REASON FOR CHANGE: Add Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: RSV vaccines: Abrysvo®, Arexvy & mRESVIA™ (respiratory syncytial virus vaccine)	**INDICATION:** For active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older. Abrysvo® is also indicated for active immunization of pregnant individuals at 32 through 36 weeks gestational age for the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV) in infants from birth through 6 months of age

REASON FOR CHANGE: Add Quantity Limit

FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9	Age Edit = ≤ 59 years of age, Quantity Limit
STANDARD FORMULARY	Tier 9	Age Edit = ≤ 59 years of age, Quantity Limit
EXCHANGE FORMULARY	Tier 9	Age Edit = ≤ 59 years of age, Quantity Limit
FAMIS FORMULARY	Formulary	Age Edit = ≤ 59 years of age, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Age Edit = ≤ 59 years of age, Quantity Limit
MEDICARE FORMULARY	Tier 3	Age Edit = ≤ 59 years of age

QUANTITY LIMIT:

- (COMMERCIAL): 1 injection per lifetime
- (MEDICAID): 1 injection per lifetime
- (MEDICARE): N/A

FORMULARY ALTERNATIVES: N/A

DRUG NAME: Rystiggo® (rozanolixizumab-noli) 420 mg/3 mL, 560 mg/4 mL & 840 mg/6 mL vial		**INDICATION:** For the treatment of generalized myasthenia gravis as chronic immunosuppressive therapy in adults who are anti-acetylcholine receptor (AChR) antibody positive or anti-muscle-specific tyrosine kinase (MuSK) antibody positive
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rytelo™ (imetelstat) for injection for intravenous use, all strengths		**INDICATION:** For the treatment of low- to intermediate-1 risk myelodysplastic syndromes in adults with transfusion-dependent anemia requiring ≥4 RBC units over 8 weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agent
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Scemblix (asciminib) 100 mg tablets		**INDICATION:** For the treatment of adult patients with Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) with the T315I mutation
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: sitagliptin-metformin IR, all strengths		**INDICATION:** For use as adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 tablet per day (both strengths) • (MEDICAID): 2 tablet per day (both strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: Janumet®		

DRUG NAME: Sofdra™ (sofpironium) topical gel, 12.45%		**INDICATION:** For the treatment of primary axillary hyperhidrosis in adults and pediatric patients 9 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 bottle (40.2 mL) per 30 days • (MEDICAID): 1 bottle (40.2 mL) per 30 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Drysol solution, glycopyrrolate tablets; (MEDICAID): Drysol solution, Xerac AC 6.25% solution, glycopyrrolate tablets; (MEDICARE): glycopyrrolate tablets		

DRUG NAME: Spevigo® (spesolimab-sbzo) 150 mg/mL solution single-dose prefilled syringe for subcutaneous (SC) administration		**INDICATION:** For the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 mL (2 syringes) per 28 days • (MEDICAID): 2 mL (2 syringes) per 28 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Taltz® (ixekizumab) 20 mg/0.25 mL & 40 mg/0.5 mL syringe		**INDICATION:** For the treatment of patients aged 6 years or older with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 syringe per 28 days (both strengths) • (MEDICAID): 1 syringe per 2 days (both strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe, infliximab (generic Remicade®); (MEDICARE): Humira, Cosentyx, Otezla & Stelara		

DRUG NAME: Tevimbra® (tislelizumab-jsgr) injection, for intravenous use		**INDICATION:** For the treatment of adult patients with unresectable or metastatic esophageal squamous cell carcinoma (ESCC) after prior systemic chemotherapy that did not include a PD-(L)1 inhibitor
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vabysmo® (faricimab-svoa) 6 mg/0.05 mL syringe injection, for intravitreal use		**INDICATION:** For the treatment of neovascular (wet) age-related macular degeneration; diabetic macular edema; and macular edema following retinal vein occlusion
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vafseo® (vadadustat) tablets, all strengths		**INDICATION:** For the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for ≥3 months
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vigafyde™ (vigabatrin) solution 100 mg/mL		**INDICATION:** For the treatment of pediatric patients 1 month to 2 years of age with infantile spasms (IS), where the potential benefits outweigh the potential risk of vision loss
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Gabitril®, lacosamide soln/tab (gen Vimpat®), Lamictal® ODT dose pk, lamotrigine ODT, lamotrigine tab, lamotrigine chew tab, lamotrigine XR, levetiracetam soln/tab, levetiracetam ER, roweepra (generic levetiracetam), subvenite tab (generic); (MEDICARE): vigabatrin packets/tablets, Vigadrone® packets, Vigpoder® packets (*all require prior authorization)		

DRUG NAME: Vijoice® (alpelisib) 50 mg oral granules		**INDICATION:** For the treatment of adult and pediatric patients 2 years of age and older with severe manifestations of PIK3CA Related Overgrowth Spectrum (PROS) who require systemic therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 packet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Voranigo® (vorasidenib) tablets, all strengths		**INDICATION:** For the treatment of adult and pediatric patients 12 years and older with Grade 2 astrocytoma or oligodendroglioma with a susceptible IDH1 or IDH2 mutation following surgery including biopsy, sub-total resection, or gross total resection
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 10 mg – 2 tablets per day • 40 mg – 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Voydeya™ (danicopan) tablets, all strengths		**INDICATION:** For the treatment of extravascular hemolysis (EVH) in adults with paroxysmal nocturnal hemoglobinuria (PNH)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 180 tablets per 30 days (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Winrevair™ (sotatercept-csrk) for injection, for subcutaneous use, all strengths		**INDICATION:** For the treatment of adults with pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class (FC) and reduce the risk of clinical worsening event
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 kit per 21 days (both strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): Alyq (tadalafil), sildenafil tab/susp, tadalafil (generic Adcirca®); (MEDICARE): sildenafil tablets (generic Revatio), tadalafil tablets (generic Adcirca)		

DRUG NAME: Xolremdi™ (mavorixafor) capsules, all strengths		**INDICATION:** A CXC chemokine receptor 4 antagonist indicated in patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zepbound™ (tirzepatide) vials for injection, 2.5 mg/0.5 mL & 5 mg/0.5 mL		**INDICATION:** For use as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of: 30 kg/m2 or greater (obesity) or 27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes mellitus, obstructive sleep apnea or cardiovascular disease)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3 – **GROUP SPECIFIC BENEFIT**	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3 – **GROUP SPECIFIC BENEFIT**	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 mL (4 vials) per 28 days (both strengths) • (MEDICAID): 2 mL (4 vials) per 28 days (both strengths) • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): orlistat Xenical, phendimetrazine IR and ER, phentermine, benzphetamine, diethylpropion IR and ER		

DRUG NAME: Zoryve® (roflumilast) 0.15% cream		**INDICATION:** For the topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 6 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 tube (60 grams) per 30 days • (MEDICAID): 1 tube (60 grams) per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID): *Elidel®, **Eucrisa™, & *tacrolimus (all require prior authorization); (MEDICARE): pimecrolimus 1% cream & tacrolimus 0.03% & 0.1% ointment (*both require prior authorization)		

DRUG NAME: Ztalmy® (ganaxolone) oral suspension 50 mg/mL		**INDICATION:** For the treatment of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) in patients 2 years of age and older
REASON FOR CHANGE: Change Drug Tier and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 10 bottles per 30 days • (MEDICAID): 10 bottles per 30 days • (MEDICARE): 1100 mL (10 bottles) per 30 days		
FORMULARY ALTERNATIVES: (MEDICARE): N/A		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2025

(For plans with pharmacy benefits administered by Sentara Health Plans)

1/1/2025 Commercial Formulary Updates

Coverage Changes

APPLICABLE FORMULARIES	Label Name	SI	Drug Class	Current Drug Coverage Status	Proposed Drug Coverage Status			
ALL COMM FORMULARIES	HYDROCORTISONE 1% CREAM	Y	F	YES	NO			
ALL COMM FORMULARIES	LIDOCAINE-HC 3-0.5% CREAM	Y	F	YES	NO			
ALL COMM FORMULARIES	LIDOCORT 3-0.5% CREAM	Y	F	YES	NO			
ALL COMM FORMULARIES	LIDOCAINE-HC 3-0.5% CREAM	Y	F	YES	NO			
ALL COMM FORMULARIES	UREA 40% CREAM	Y	F	YES	NO			

Formulary Changes

APPLICABLE FORMULARIES	Label Name	SI	Drug Class	Current Formulary Status	Current Tier	Proposed Formulary Status	Proposed Tier	Preferred Alternatives for Clinically Equivalent Drugs (CED) & Non-Formulary (NF) Drugs
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 12.5 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAM 12.5 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL XR 5 MG CAPSULE	X	F	Y	2	N	11	DEXTROAMP-AMPHET ER 5 MG CAP
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL XR 10 MG CAPSULE	X	F	Y	2	N	11	DEXTROAMP-AMPHET ER 10 MG CAP
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL XR 15 MG CAPSULE	X	F	Y	2	N	11	DEXTROAMP-AMPHET ER 15 MG CAP
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL XR 20 MG CAPSULE	X	F	Y	2	N	11	DEXTROAMP-AMPHET ER 20 MG CAP
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL XR 25 MG CAPSULE	X	F	Y	2	N	11	DEXTROAMP-AMPHET ER 25 MG CAP
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL XR 30 MG CAPSULE	X	F	Y	2	N	11	DEXTROAMP-AMPHET ER 30 MG CAP
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 5 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAMINE 5 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 10 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAMIN 10 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 15 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAMIN 15 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 7.5 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAM 7.5 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 20 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAMIN 20 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	ADDERALL 30 MG TABLET	X	F	Y	2	N	11	DEXTROAMP-AMPHETAMIN 30 MG TAB
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 10 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 20 MG CAPSULE
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 20 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 30 MG CAPSULE
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 30 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 40 MG CAPSULE
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 40 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 50 MG CAPSULE
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 50 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 60 MG CAPSULE
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 60 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 70 MG CAPSULE
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 70 MG CAPSULE	X	F	Y	2	N	11	LISDEXAMFETAMINE 10 MG CAPSULE

MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 10 MG CHEWABLE TABLET	W	F	Y	2	N	11	LISDEXAMFETAMINE 10 MG TB CHEW
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 20 MG CHEWABLE TABLET	W	F	Y	2	N	11	LISDEXAMFETAMINE 20 MG TB CHEW
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 30 MG CHEWABLE TABLET	W	F	Y	2	N	11	LISDEXAMFETAMINE 30 MG TB CHEW
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 40 MG CHEWABLE TABLET	W	F	Y	2	N	11	LISDEXAMFETAMINE 40 MG TB CHEW
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 50 MG CHEWABLE TABLET	W	F	Y	2	N	11	LISDEXAMFETAMINE 50 MG TB CHEW
MOVE TO N11 ON ALL FORMULARIES EXCEPT OPEN & VCUHS	VYVANSE 60 MG CHEWABLE TABLET	W	F	Y	2	N	11	LISDEXAMFETAMINE 60 MG TB CHEW
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 20 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 30 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 40 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 50 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 60 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 70 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 10 MG TB CHEW	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 20 MG TB CHEW	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 30 MG TB CHEW	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 40 MG TB CHEW	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 50 MG TB CHEW	Y	F	Y	1	Y	2	N/A
MOVE TO T2 ON ALL COMM FORMULARIES	LISDEXAMFETAMINE 60 MG TB CHEW	Y	F	Y	1	Y	2	N/A
(CED) ALL COMM EXCEPT SG2024	ADAPALENE 0.3% GEL PUMP	Y	F	Y	1	N	10	ADAPALENE 0.3% GEL
(CED) ALL COMM EXCEPT SG2024	ALTRENO 0.05% LOTION	W	F	Y	3	N	11	TRETINOIN 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	BETAMETHASONE DP AUG 0.05% GEL	Y	F	Y	1	N	10	BETAMETHASONE DP 0.05% CRM
(CED) ALL COMM EXCEPT SG2024	BETAMETHASONE DP AUG 0.05% LOT	Y	F	Y	1	N	10	BETAMETHASONE DP 0.05% LOT
(CED) ALL COMM EXCEPT SG2024	CALCIPOTRIENE-BETAMETH DP OINT	Y	F	Y	2	N	10	CALCIPOTRIENE 0.005% CREAM, BETAMETHASONE DP AUG 0.05% CRM
(CED) ALL COMM EXCEPT SG2024	CARBAMAZEPINE 200 MG/10 ML CUP	Y	F	Y	1	N	10	CARBAMAZEPINE 100 MG/5 ML SUSP
(CED) ALL COMM EXCEPT SG2024	CLIND PH-BENZOYL PERO 1.2-2.5%	Y	F	Y	2	N	10	CLIND PH-BENZOYL PEROX 1.2-5%
(CED) ALL COMM EXCEPT SG2024	CLINDAMYCIN PHOSPHATE 1% GEL	Y	F	Y	2	N	10	CLINDAMYCIN PHOSP 1% LOTION
(CED) ALL COMM EXCEPT SG2024	CLINDAMYCIN-BENZOYL PEROX 1-5%	Y	F	Y	2	N	10	CLIND PH-BENZOYL PEROX 1.2-5%
(CED) ALL COMM EXCEPT SG2024	CLINDAMYCIN-BNZ PEROX 1-5% PMP	Y	F	Y	2	N	10	CLIND PH-BENZOYL PEROX 1.2-5%
(CED) ALL COMM EXCEPT SG2024	CLOBETASOL 0.05% TOPICAL LOTN	Y	F	Y	2	N	10	CLOBETASOL 0.05% GEL

(CED) ALL COMM EXCEPT SG2024	CYCLOBENZAPRINE 7.5 MG TABLET	Y	F	Y	1	N	10	CYCLOBENZAPRINE 5 MG TABLET, CYCLOBENZAPRINE 10 MG TABLET
(CED) ALL COMM EXCEPT SG2024	DESOXIMETASONE 0.05% CREAM	Y	F	Y	2	N	10	DESOXIMETASONE 0.25% CREAM
(CED) ALL COMM EXCEPT SG2024	DESOXIMETASONE 0.05% GEL	Y	F	Y	2	N	10	DESOXIMETASONE 0.25% CREAM, DESOXIMETASONE 0.25% OINTMENT
(CED) ALL COMM EXCEPT SG2024	DESOXIMETASONE 0.05% OINTMENT	Y	F	Y	2	N	10	DESOXIMETASONE 0.25% OINTMENT
(CED) ALL COMM EXCEPT SG2024	DESOXIMETASONE 0.25% SPRAY	Y	F	Y	2	N	10	DESOXIMETASONE 0.25% CREAM, DESOXIMETASONE 0.25% OINTMEN
(CED) ALL COMM EXCEPT SG2024	DEXTROAMPHETAMINE 15 MG TAB	Y	F	Y	1	N	10	DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE 10 MG TAB
(CED) ALL COMM EXCEPT SG2024	DEXTROAMPHETAMINE 20 MG TAB	Y	F	Y	1	N	10	DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE 10 MG TAB
(CED) ALL COMM EXCEPT SG2024	DEXTROAMPHETAMINE 30 MG TAB	Y	F	Y	1	N	10	DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE 10 MG TAB
(CED) ALL COMM EXCEPT SG2024	DICLOFENAC 1.5% TOPICAL SOLN	Y	F	Y	1	N	10	DICLOFENAC SODIUM 1% GEL
(CED) ALL COMM EXCEPT SG2024	DILTIAZEM 12HR ER 120 MG CAP	Y	F	Y	1	N	10	DILTIAZEM 60 MG TABLET, DILTIAZEM 24HR ER 120 MG CAP
(CED) ALL COMM EXCEPT SG2024	DILTIAZEM 12HR ER 60 MG CAP	Y	F	Y	1	N	10	DILTIAZEM 60 MG TABLET, DILTIAZEM 24HR ER 120 MG CAP
(CED) ALL COMM EXCEPT SG2024	DILTIAZEM 12HR ER 90 MG CAP	Y	F	Y	1	N	10	DILTIAZEM 90 MG TABLET, DILTIAZEM 24HR ER 180 MG CAP
(CED) ALL COMM EXCEPT SG2024	FLUOCINONIDE 0.05% GEL	Y	F	Y	1	N	10	FLUOCINONIDE 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	FLUOCINONIDE 0.1% CREAM	Y	F	Y	2	N	10	FLUOCINONIDE 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	FLUOCINONIDE-E 0.05% CREAM	Y	F	Y	1	N	10	FLUOCINONIDE 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	HALOBETASOL PROP 0.05% OINTMNT	Y	F	Y	1	N	10	HALOBETASOL PROP 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	HYDROCORTISONE VAL 0.2% OINTMT	Y	F	Y	2	N	10	HYDROCORTISONE VAL 0.2% CREAM
(CED) ALL COMM EXCEPT SG2024	ISOTRETINOIN 10 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 10 MG CAPSULE, CLARAVIS 10 MG CAPSULE, MYORISAN 10 MG CAPSULE, ZENATANE 10 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	ISOTRETINOIN 20 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 20 MG CAPSULE, CLARAVIS 20 MG CAPSULE, MYORISAN 20 MG CAPSULE, ZENATANE 20 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	ISOTRETINOIN 30 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 30 MG CAPSULE, CLARAVIS 30 MG CAPSULE, MYORISAN 30 MG CAPSULE, ZENATANE 30 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	ISOTRETINOIN 40 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 40 MG CAPSULE, CLARAVIS 40 MG CAPSULE, MYORISAN 40 MG CAPSULE, ZENATANE 40 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	LAMOTRIGINE ER 100 MG TABLET	Y	F	Y	2	N	10	LAMOTRIGINE 100 MG TABLET
(CED) ALL COMM EXCEPT SG2024	LAMOTRIGINE ER 200 MG TABLET	Y	F	Y	2	N	10	LAMOTRIGINE 200 MG TABLET
(CED) ALL COMM EXCEPT SG2024	LAMOTRIGINE ER 25 MG TABLET	Y	F	Y	2	N	10	LAMOTRIGINE 25 MG DISPER TAB, LAMOTRIGINE 25 MG TABLET
(CED) ALL COMM EXCEPT SG2024	LAMOTRIGINE ER 250 MG TABLET	Y	F	Y	2	N	10	LAMOTRIGINE 100 MG TABLET, LAMOTRIGINE 150 MG TABLET
(CED) ALL COMM EXCEPT SG2024	LAMOTRIGINE ER 300 MG TABLET	Y	F	Y	2	N	10	LAMOTRIGINE 150 MG TABLET

(CED) ALL COMM EXCEPT SG2024	LAMOTRIGINE ER 50 MG TABLET	Y	F	Y	2	N	10	LAMOTRIGINE 25 MG TABLET, LAMOTRIGINE 100 MG TABLET
(CED) ALL COMM EXCEPT SG2024	LIDOCAINE 3% CREAM	Y	F	Y	1	N	10	LIDOCAINE 5% OINTMENT
(CED) ALL COMM EXCEPT SG2024	LIDOCAINE HCL 2% JELLY	Y	F	Y	2	N	10	LIDOCAINE 5% OINTMENT
(CED) ALL COMM EXCEPT SG2024	MATZIM LA 420 MG TABLET	Y	F	Y	2	N	10	TIADYLT ER 420 MG CAPSULE, TIAZAC ER 420 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	METHAMPHETAMINE 5 MG TABLET	Y	F	Y	2	N	10	DEXTROAMP-AMPHETAMINE 5 MG TAB
(CED) ALL COMM EXCEPT SG2024	TRETINOIN 0.01% GEL	Y	F	Y	1	N	10	TRETINOIN 0.025% CREAM
(CED) ALL COMM EXCEPT SG2024	TRETINOIN 0.025% GEL	Y	F	Y	1	N	10	TRETINOIN 0.025% CREAM
(CED) ALL COMM EXCEPT SG2024	TRETINOIN 0.05% GEL	Y	F	Y	2	N	10	TRETINOIN 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	TRETINOIN GEL MICRO 0.04% TUBE	Y	F	Y	2	N	10	TRETINOIN 0.05% CREAM
(CED) ALL COMM EXCEPT SG2024	TRETINOIN GEL MICRO 0.1% TUBE	Y	F	Y	2	N	10	TRETINOIN 0.1% CREAM
(CED) ALL COMM EXCEPT SG2024	VERAPAMIL ER PM 100 MG CAPSULE	Y	F	Y	2	N	10	VERAPAMIL ER 120 MG CAPSULE, VERAPAMIL ER 120 MG TABLET, VERAPAMIL SR 120 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	VERAPAMIL ER PM 200 MG CAPSULE	Y	F	Y	2	N	10	VERAPAMIL ER 180 MG CAPSULE, VERAPAMIL ER 180 MG TABLET, VERAPAMIL SR 180 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	VERAPAMIL ER PM 300 MG CAPSULE	Y	F	Y	2	N	10	VERAPAMIL ER 240 MG CAPSULE, VERAPAMIL ER 240 MG TABLET, VERAPAMIL SR 240 MG CAPSULE
(CED) ALL COMM EXCEPT SG2024	VERAPAMIL SR 360 MG CAPSULE	Y	F	Y	2	N	10	VERAPAMIL ER 180 MG CAPSULE, VERAPAMIL ER 180 MG TABLET, VERAPAMIL SR 180 MG CAPSULE
(CED) ALL COMM FORMULARIES (CODE AT TRADE ID)	ROWEEPRA 500 MG TABLET	Y	F	Y	1	N	10	LEVETIRACETAM 500 MG TABLET
(NF) ALL COMM EXCEPT OPEN AND SG2024	NITRO-DUR 0.3 MG/HR PATCH	W	F	Y	3	N	11	NITROGLYCERIN 0.1 MG/HR PATCH, NITROGLYCERIN 0.3 MG/HR PATCH
NF) ALL COMM EXCEPT OPEN AND SG2024	NITRO-DUR 0.8 MG/HR PATCH	W	F	Y	3	N	11	NITROGLYCERIN 0.4 MG/HR PATCH, NITROGLYCERIN 0.6 MG/HR PATCH
NF) ALL COMM EXCEPT OPEN AND SG2024	NICARDIPINE 20 MG CAPSULE	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
NF) ALL COMM EXCEPT OPEN AND SG2024	NICARDIPINE 30 MG CAPSULE	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
NF) ALL COMM EXCEPT OPEN AND SG2024	RHOFADE 1% CREAM	W	F	Y	3	N	11	AZELAIC ACID 15% GEL, METRONIDAZOLE 0.75% CREAM, METRONIDAZOLE TOPICAL 1% GEL
NF) ALL COMM EXCEPT OPEN AND SG2024	PROPAFENONE HCL ER 225 MG CAP	Y	F	Y	2	N	10	FLECAINIDE ACETATE TABS
NF) ALL COMM EXCEPT OPEN AND SG2024	PROPAFENONE HCL ER 325 MG CAP	Y	F	Y	2	N	10	FLECAINIDE ACETATE TABS
NF) ALL COMM EXCEPT OPEN AND SG2024	PROPAFENONE HCL ER 425 MG CAP	Y	F	Y	2	N	10	FLECAINIDE ACETATE TABS
(NF-BE) ALL COMM FORMULARIES	UREA 40% CREAM	Y	F	Y	1	N	10	BENEFIT EXCLUSION. NO ALT REQUIRED

(NF-BE) ALL COMM FORMULARIES	HYDROCORTISONE 1% CREAM	Y	F	Y	1	N	10	BENEFIT EXCLUSION. NO ALT REQUIRED
(NF-BE) ALL COMM FORMULARIES	LIDOCAINE-HC 3-0.5% CREAM	Y	F	Y	1	N	10	BENEFIT EXCLUSION. NO ALT REQUIRED
(NF-BE) ALL COMM FORMULARIES	LIDOCORT 3-0.5% CREAM	Y	F	Y	1	N	10	BENEFIT EXCLUSION. NO ALT REQUIRED
(NF-BE) ALL COMM FORMULARIES	LIDOCAINE-HC 3-0.5% CREAM	Y	F	Y	1	N	10	BENEFIT EXCLUSION. NO ALT REQUIRED
(T1) ALL COMM FORMULARIES: (+) change	PACERONE 200 MG TABLET	Y	F	Y	2	Y	1	N/A
(T1) ALL COMM FORMULARIES: (+) change	DRYSOL DAB-O-MATIC SOLUTION	W	F	Y	2	Y	1	N/A
(T1) ALL COMM FORMULARIES: (+) change	ACNE MEDICATION 5% GEL	X	O	Y	2	Y	1	N/A
(T1) ALL COMM FORMULARIES: (+) change	CICLODAN 0.77% CREAM	Y	F	N	10	Y	1	N/A
(T1) ALL COMM FORMULARIES: (+) change	METRONIDAZOLE TOPICAL 0.75% GL	Y	F	Y	2	Y	1	N/A
(T1) ALL COMM FORMULARIES: (+) change	CLIND PH-BENZOYL PEROX 1.2-5%	Y	F	Y	2	Y	1	N/A
(T1) ALL COMM FORMULARIES: (+) change	TRUE VITAMIN B-6 10 MG TABLET	W	O	N	11	Y	1	N/A
(T1) VCUHS AND COS; (T2) ALL OTHER COMM: (+) change	CLOBETASOL 0.05% SHAMPOO	Y	F	N	10	Y	2	N/A
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 17 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 20 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 25.5 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 30 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 34 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 40 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T10) ALL COMM FORMULARIES EXCEPT OPEN AND SG2024	NISOLDIPINE ER 8.5 MG TABLET	Y	F	Y	2	N	10	AMLODIPINE BESYLATE TABS, FELODIPINE ER TABLETS, ISRADIPINE CAPSULES, NIFEDIPINE CAPSULES/ER TABLETS
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DANTROLENE SODIUM 25 MG CAP	Y	F	Y	1	Y	2	N/A

(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DANTROLENE SODIUM 50 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DANTROLENE SODIUM 100 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DISOPYRAMIDE 100 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DISOPYRAMIDE 150 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	AMIODARONE HCL 400 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MEXILETINE 150 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MEXILETINE 200 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MEXILETINE 250 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ADAPALENE 0.1% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ADAPALENE 0.1% GEL	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ADAPALENE 0.3% GEL	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ADAPALENE-BNZYL PEROX 0.1-2.5%	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ALCLOMETASONE DIPR 0.05% OINT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ALCLOMETASONE DIPRO 0.05% CRM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ALPRAZOLAM ODT 0.25 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ALPRAZOLAM ODT 0.5 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ALPRAZOLAM ODT 1 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ALPRAZOLAM ODT 2 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	AMOXAPINE 100 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	AMOXAPINE 150 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	BETAMETHASONE DP 0.05% CRM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	BETAMETHASONE DP 0.05% LOT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	BETAMETHASONE VA 0.1% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	BETAMETHASONE VA 0.1% LOTION	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	BETAMETHASONE VALER 0.1% OINTM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	AMOXAPINE 25 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	AMOXAPINE 50 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	BACLOFEN 5 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CALCIPOTRIENE 0.005% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CALCIPOTRIENE 0.005% SOLUTION	Y	F	Y	1	Y	2	N/A

(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE 100 MG/5 ML SUSP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE ER 100 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE ER 100 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE ER 200 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE ER 200 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE ER 300 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CARBAMAZEPINE ER 400 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CICLOPIROX 0.77% GEL	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CICLOPIROX 0.77% TOPICAL SUSP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CICLOPIROX 1% SHAMPOO	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	HYDROCORTISONE VAL 0.2% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLINDAMYCIN PHOSP 1% LOTION	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLOBETASOL 0.05% GEL	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLOBETASOL EMOLLIENT 0.05% CRM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLORAZEPATE 15 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLORAZEPATE 3.75 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLORAZEPATE 7.5 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLOZAPINE 100 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLOZAPINE 200 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLOZAPINE 25 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	CLOZAPINE 50 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DESONIDE 0.05% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DESONIDE 0.05% LOTION	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DESONIDE 0.05% OINTMENT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DESOXIMETASONE 0.25% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DESOXIMETASONE 0.25% OINTMENT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DIAZEPAM 10 MG RECTAL GEL SYST	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DIAZEPAM 2.5 MG RECTAL GEL SYS	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DIAZEPAM 20 MG RECTAL GEL SYST	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DILTIAZEM 24H ER(CD) 360 MG CP	Y	F	Y	1	Y	2	N/A

(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DIVALPROEX DR 125 MG CAP SPRNK	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DIVALPROEX SOD ER 250 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	DIVALPROEX SOD ER 500 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ECONAZOLE NITRATE 1% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ERYTHROMYCIN 2% GEL	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.025 MG PATCH(1/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.025 MG PATCH(2/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.0375MG PATCH(1/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.0375MG PATCH(2/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.05 MG PATCH (1/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.05 MG PATCH (2/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.06 MG PATCH (1/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.075 MG PATCH(1/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.075 MG PATCH(2/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.1 MG PATCH (1/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL 0.1 MG PATCH (2/WK)	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ESTRADIOL-NORETH 0.5-0.1 MG TB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ETHOSUXIMIDE 250 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ETHOSUXIMIDE 250 MG/5 ML SOLN	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUOCINOLONE 0.01% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUOCINOLONE 0.025% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUOCINOLONE 0.025% OINTMENT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUOCINONIDE 0.05% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUOCINONIDE 0.05% OINTMENT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUOCINONIDE 0.05% SOLUTION	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUVOXAMINE MALEATE 100 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUVOXAMINE MALEATE 25 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	FLUVOXAMINE MALEATE 50 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	GABAPENTIN 250 MG/5 ML SOLN	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	GABAPENTIN 250 MG/5ML SOLN CUP	Y	F	Y	1	Y	2	N/A

(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	GABAPENTIN 300 MG/6ML SOLN CUP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	HALOBETASOL PROP 0.05% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ISRADIPINE 2.5 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ISRADIPINE 5 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	LOXAPINE 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	LOXAPINE 25 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	LOXAPINE 5 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	LOXAPINE 50 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MIMVEY 1-0.5 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MIRTAZAPINE 15 MG ODT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MIRTAZAPINE 30 MG ODT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MIRTAZAPINE 45 MG ODT	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	MIRTAZAPINE 7.5 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	NIMODIPINE 30 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	OXAZEPAM 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	OXAZEPAM 15 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	OXAZEPAM 30 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	OXCARBAZEPINE 300 MG/5 ML SUSP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PERPHENAZINE 16 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PERPHENAZINE 2 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PERPHENAZINE 4 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PERPHENAZINE 8 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PHENYTOIN SOD EXT 200 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PHENYTOIN SOD EXT 300 MG CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PIMOZIDE 1 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	PIMOZIDE 2 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	SELENIUM SULFIDE 2.25% SHAMPOO	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	SERTRALINE 20 MG/ML ORAL CONC	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	SULFACETAMIDE SOD 10% TOP SUSP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	THIORIDAZINE 10 MG TABLET	Y	F	Y	1	Y	2	N/A

(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	THIORIDAZINE 100 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	THIORIDAZINE 25 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	THIORIDAZINE 50 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TOPIRAMATE 15 MG SPRINKLE CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TOPIRAMATE 25 MG SPRINKLE CAP	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TRETINOIN 0.1% CREAM	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TRIFLUOPERAZINE 1 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TRIFLUOPERAZINE 10 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TRIFLUOPERAZINE 2 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	TRIFLUOPERAZINE 5 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ZIPRASIDONE HCL 20 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ZIPRASIDONE HCL 40 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ZIPRASIDONE HCL 60 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, AND COS	ZIPRASIDONE HCL 80 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) OPEN; (NF) ALL OTHER COMM EXCEPT SG2024 (T1)	QUINIDINE GLUC ER 324 MG TAB	Y	F	Y	1	N	10	DISOPYRAMIDE CAPSULES
(T2) OPEN; (NF) ALL OTHER COMM EXCEPT SG2024 (T1)	QUINIDINE SULFATE 300 MG TAB	Y	F	Y	1	N	10	DISOPYRAMIDE CAPSULES
(T2) OPEN; (NF) ALL OTHER COMM EXCEPT SG2024 (T1)	QUINIDINE SULFATE 200 MG TAB	Y	F	Y	1	N	10	DISOPYRAMIDE CAPSULES

UM Changes – Quantity Limit

APPLICABLE FORMULARIES	Label Name	SI	Drug Class	Current Quantity Limit	Proposed Quantity Limit			
ADD TO ALL COMM FORMULARIES	APTIOM 200 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	APTIOM 400 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	APTIOM 600 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	APTIOM 800 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	BACLOFEN 5 MG TABLET	Y	F		ADD QL - 3 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	BRIVIACT 10 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	BRIVIACT 10 MG/ML ORAL SOLN	W	F		ADD QL - 20 ML PER DAY			

ADD TO ALL COMM FORMULARIES	BRIVIACT 100 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	BRIVIACT 25 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	BRIVIACT 50 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	BRIVIACT 75 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	CARISOPRODOL 250 MG TABLET	Y	F		ADD QL - 3 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	DANTROLENE SODIUM 100 MG CAP	Y	F		ADD QL - 4 CAPSULE S PER DAY			
ADD TO ALL COMM FORMULARIES	DANTROLENE SODIUM 25 MG CAP	Y	F		ADD QL - 3 CAPSULE S PER DAY			
ADD TO ALL COMM FORMULARIES	DANTROLENE SODIUM 50 MG CAP	Y	F		ADD QL - 3 CAPSULE SPER DAY			
ADD TO ALL COMM FORMULARIES	DILANTIN 30 MG CAPSULE	W	F		ADD QL - 3 CAPSULE S PER DAY			
ADD TO ALL COMM FORMULARIES	DOFETILIDE 125 MCG CAPSULE	Y	F		ADD QL - 2 CAPSULE S PER DAY			
ADD TO ALL COMM FORMULARIES	DOFETILIDE 250 MCG CAPSULE	Y	F		ADD QL - 2 CAPSULE S PER DAY			
ADD TO ALL COMM FORMULARIES	DOFETILIDE 500 MCG CAPSULE	Y	F		ADD QL - 2 CAPSULE S PER DAY			
ADD TO ALL COMM FORMULARIES	FYCOMPA 0.5 MG/ML ORAL SUSP	W	F		ADD QL - 24 ML PER DAY			
ADD TO ALL COMM FORMULARIES	FYCOMPA 10 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	FYCOMPA 12 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	FYCOMPA 2 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	FYCOMPA 4 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	FYCOMPA 6 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			

ADD TO ALL COMM FORMULARIES	FYCOMPA 8 MG TABLET	W	F		ADD QL - 1 TABLET PER DAY			
ADD TO ALL COMM FORMULARIES	LOREEV XR 1.5 MG CAPSULE	W	F		ADD QL - 1 CAPSULE PER DAY			
ADD TO ALL COMM FORMULARIES	METAXALONE 800 MG TABLET	Y	F		ADD QL - 4 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	OXTELLAR XR 150 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	OXTELLAR XR 300 MG TABLET	W	F		ADD QL - 2 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	OXTELLAR XR 600 MG TABLET	W	F		ADD QL - 4 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	SKELAXIN 800 MG TABLET	X	F		ADD QL - 4 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	SOMA 250 MG TABLET	X	F		ADD QL - 3 TABLETS PER DAY			
ADD TO ALL COMM FORMULARIES	TIKOSYN 125 MCG CAPSULE	X	F		ADD QL - 2 CAPSULES PER DAY			
ADD TO ALL COMM FORMULARIES	TIKOSYN 250 MCG CAPSULE	X	F		ADD QL - 2 CAPSULES PER DAY			
ADD TO ALL COMM FORMULARIES	TIKOSYN 500 MCG CAPSULE	X	F		ADD QL - 2 CAPSULES PER DAY			

UM Changes - Prior Authorization (PA) or Step Therapy (ST)

APPLICABLE FORMULARIES	Label Name	SI	Drug Class	Current UM Rule Category (MPA)	Current UM Rule Category (ST1)	Proposed UM		
ADD TO ALL COMM FORMULARIES	CUTAQUIG 16.5% (1 G/6 ML) VIAL	W	F			ADD UM		
ADD TO ALL COMM FORMULARIES	METAXALONE 800 MG TABLET	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	METAXALL 800 MG TABLET	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	SKELAXIN 800 MG TABLET	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	FELBATOL 400 MG TABLET	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	FELBATOL 600 MG TABLET	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	FELBATOL 600 MG/5 ML SUSP	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	FELBAMATE 600 MG/5 ML SUSP CUP	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	FELBAMATE 400 MG TABLET	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	FELBAMATE 600 MG TABLET	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	TIAGABINE HCL 4 MG TABLET	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	TIAGABINE HCL 12 MG TABLET	Y	F			ADD UM		

ADD TO ALL COMM FORMULARIES	TIAGABINE HCL 16 MG TABLET	Y	F			ADD UM		
ADD TO ALL COMM FORMULARIES	GABITRIL 4 MG TABLET	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	GABITRIL 12 MG TABLET	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	GABITRIL 16 MG TABLET	X	F			ADD UM		
ADD TO ALL COMM FORMULARIES	ERYTHROMYCIN-BENZOYL GEL	Y	F			ADD UM		
REMOVE FROM ALL COMM FORMULARIES	ALTRENO 0.05% LOTION	W	F	MPA	ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES	DESOXIMETASONE 0.05% GEL	Y	F		ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES	DESOXIMETASONE 0.05% CREAM	Y	F		ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES	DESOXIMETASONE 0.05% OINTMENT	Y	F		ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES	FLUOCINONIDE 0.1% CREAM	Y	F		ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES: (+) change	CLOBETASOL PROP 0.05% SPRAY	Y	F		ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES: (+) change	TAZAROTENE 0.1% CREAM	Y	F		ST1	REMOVE ST		
REMOVE FROM ALL COMM FORMULARIES	CALCIPOTRIENE-BETAMETH DP OINT	Y	F		ST1	REMOVE ST		

1/1/2025 Medical Benefit Oncology Therapy Updates

HCPCS	Drug Brand Name	Drug Generic Name	Commercial UM Change	Medicaid UM Change	Medicare UM Change	Notes on Changes
J9305	Alimta	Pemetrexed	Auth Added	Auth Added	Auth Added	(-) All LOB
J9261	Arranon	Nelarabine	Auth Added	Auth Added	Auth Added	(-) All LOB
J2783	Elitek	Rasburicase	Auth Added	Auth Added	Auth Added	(-) All LOB
J9155	Firmagon	Degarelix	Auth Added	Auth Added	Auth Added	(-) All LOB
J9198	Infugem	Gemcitabine HCl	Auth Added	Auth Added	Auth Added	(-) All LOB
J9314	N/A	Pemetrexed (Teva)	Auth Added	Auth Added	Auth Added	(-) All LOB
J0208	Pedmark	Sodium Thiosulfate	Auth Added	Auth Added	Auth Added	(-) All LOB
J9304	Pemfexy	Pemetrexed	Auth Added	Auth Added	Auth Added	(-) All LOB
J9324	Pemrydi RTU	Pemetrexed	Auth Added	Auth Added	Auth Added	(-) All LOB
J9600	Photofrin	Porfimer Sodium	Auth Added	Auth Added	Auth Added	(-) All LOB
J9295	Portrazza	Necitumumab	Auth Added	Auth Added	Auth Added	(-) All LOB
J9015	Proleukin	Aldesleukin	Auth Added	Auth Added	Auth Added	(-) All LOB
J9262	Synribo	Omacetaxine Mepesuccinate	Auth Added	Auth Added	Auth Added	(-) All LOB
J9328	Temodar	Temozolomide IV	Auth Added	Auth Added	Auth Added	(-) All LOB
J9400	Zaltrap	Zib-aflibercept	Auth Added	Auth Added	Auth Added	(-) All LOB
Q2017	Vumon	Teniposide	Auth Added	Auth Added	Auth Added	(-) All LOB
J9032	Beleodaq	Belinostat	Auth Added	No change	No change	(-) Commercial
J9269	Elzonris	Tagraxofusp-erzs	Auth Added	No change	No change	(-) Commercial
J9307	Folotyn	Pralatrexate	Auth Added	No change	No change	(-) Commercial
J9319	Istodax	Romidepsin, lyophilized	Auth Added	No change	No change	(-) Commercial

J9313	Lumoxiti	Moxetumomab pasudotox-tdfk	Auth Added	No change	No change	(-) Commercial
J9203	Mylotarg	Gemtuzumab ozogamicin	Auth Added	No change	No change	(-) Commercial
J9318	Romidepsin	Romidepsin, non-lyophilized	Auth Added	No change	No change	(-) Commercial
J2860	Sylvant	Siltuximab	Auth Added	No change	No change	(-) Commercial
J9357	Valstar	Valrubicin	Auth Added	No change	No change	(-) Commercial
J9153	Vyxeos	Daunorubicin/Cytarabine Liposome	Auth Added	No change	No change	(-) Commercial
J9352	Yondelis	Trabectedin	Auth Added	No change	No change	(-) Commercial
A9590	Azedra	Iobenguane I 131	No change	No change	Auth Added	(-) Medicare
A9513	Lutathera	Lutetium Lu 177 Dotatate	No change	No change	Auth Added	(-) Medicare
Q5107	Mvasi	Bevacizumab-awwb	No change	Auth Added	No change	(-) Medicare
J2796	Nplate	Romiplostim	No change	No change	Auth Added	(-) Medicare
HCPCS	**Drug Brand Name**	**Drug Generic Name**	**Commercial UM Change**	**Medicaid UM Change**	**Medicare UM Change**	**Notes on Changes**
Q5108	Fulphila	Pegfilgrastim-jmdb	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5130	Fylneta	Pegfilgratim-pbbk	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J1447	Granix	Tbo-filgrastim	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J2820	Leukine	Sargramostim	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J2506	Neulasta	Pegfilgrastim	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J1442	Neupogen	Filgrastim	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5110	Nivestym	Filgrastim-aafi	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5122	Nyvepria	Pegfilgrastim-apgf	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5125	Releuko	Filgrastim-ayow	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J1449	Rolvedon	eflapegrastim-xnstm	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J9361	Ryzneuta	Efbemalenograstim Alfa	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5127	Stimufend	Pegfilgrastim-fpgk	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5111	Udenyca	Pegfilgrastim-cbqv	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5101	Zarxio	Filgrastim-sndz	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
Q5120	Ziextenzo	Pegfilgrastim-bmez	Auth Removed	Auth Removed	Auth Removed	(+) All LOB
J8655	Akynzeo	Netupitant/Palonosetron **PO**	No change	Auth Removed	No change	(+) Medicaid
J2469	Aloxi IV	Palonosetron	No change	Auth Removed	No change	(+) Medicaid
J0881	Aranesp	Darbepoetin	No change	No change	Auth Removed	(+) Medicaid
J8501	Emend **PO**	Aprepitant	No change	Auth Removed	No change	(+) Medicaid
J0885	Procrit/Epogen	Epoetin alfa	No change	No change	Auth Removed	(+) Medicaid
Q5106	Retacrit	Epoetin alfa-epbx	No change	No change	Auth Removed	(+) Medicaid
J8670	Varubi	Rolapitant	No change	Auth Removed	No change	(+) Medicaid
J1627	Sustol	Granisetron SC	Auth Removed	Auth Removed	Auth Removed	(+) Medicaid & Medicare

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2025

(For plans with pharmacy benefits administered by Sentara Health Plans)

1/1/2025 Pharmacy Benefit Oncology Therapy Updates

Drug Brand Name	Drug Generic Name	Commercial UM Change	Medicaid UM Change	Medicare UM Change	Notes on Changes
Eulexin	Flutamide	Auth Added	Auth Added	**Out-of-Scope Pharmacy Benefit (Part D Formulary): Express Scripts Review**	(-) Commercial & Medicaid
Thalomid	Thalidomide	Auth Added	Auth Added		(-) Commercial & Medicaid
Xermelo	Telotristat	Auth Added	Auth Added		(-) Commercial & Medicaid
Fareston	Toremifene	Auth Added	Auth Added		(-) Commercial: **Add PA** (-) Medicaid: **Add QL**
Alkeran	Melphalan oral tablet	No change	Auth Added		(-) Medicaid
Nilandron	Nilutamide	No change	Auth Added		(-) Medicaid

1/1/2025 Safe Harbor Drug List Updates

PRODUCT SERVICE ID	LABEL TXT	STRENGTH	Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)
65702010110	ACCU-CHEK AVIVA PLUS METER	N/A	ADD
65702073110	ACCU-CHEK GUIDE ME GLUCOSE MTR	N/A	ADD
65702072910	ACCU-CHEK GUIDE MONITOR SYSTEM	N/A	ADD
64764051030	ACTOPLUS MET XR 15-1,000 MG TB	15-1000 MG	ADD
00597000160	AGGRENOX 25 MG-200 MG CAPSULE	25MG-200MG	ADD
00378412201	ALBUTEROL SULFATE ER 4 MG TAB	4 MG	ADD
00378412401	ALBUTEROL SULFATE ER 8 MG TAB	8 MG	ADD
08373074000	ASTHMA CHECK PEAK FLOW MTR	N/A	ADD
46287003001	ATORVALIQ 20 MG/5 ML SUSP	20 MG/5 ML	ADD
00173086118	AVANDIA 2 MG TABLET	2 MG	ADD
00173086313	AVANDIA 4 MG TABLET	4 MG	ADD
08290511252	BD YALE REGULAR BEVEL NEEDLE	30GX1/2"	ADD
51407082630	BEXAGLIFLOZIN 20 MG TABLET	20 MG	ADD
51407082690	BEXAGLIFLOZIN 20 MG TABLET	20 MG	ADD
82381217401	BRENZAVVY 20 MG TABLET	20 MG	ADD
82381217402	BRENZAVVY 20 MG TABLET	20 MG	ADD
00173091610	BREO ELLIPTA 50-25 MCG INHALER	50-25 MCG	ADD
00310653001	BYDUREON 2 MG PEN INJECT	2MG/0.65ML	ADD
00310653004	BYDUREON 2 MG PEN INJECT	2MG/0.65ML	ADD
00378008101	CAPTOPRIL-HCTZ 25-15 MG TABLET	25 MG-15MG	ADD
16571082709	CAPTOPRIL-HCTZ 25-15 MG TABLET	25 MG-15MG	ADD
00378008301	CAPTOPRIL-HCTZ 25-25 MG TABLET	25 MG-25MG	ADD

16571082809	CAPTOPRIL-HCTZ 25-25 MG TABLET	25 MG-25MG	ADD
00378008401	CAPTOPRIL-HCTZ 50-15 MG TABLET	50 MG-15MG	ADD
16571082909	CAPTOPRIL-HCTZ 50-15 MG TABLET	50 MG-15MG	ADD
00378008601	CAPTOPRIL-HCTZ 50-25 MG TABLET	50 MG-25MG	ADD
16571083009	CAPTOPRIL-HCTZ 50-25 MG TABLET	50 MG-25MG	ADD
00009037003	COLESTID FLAVORED GRANULES	7.5 G	ADD
50002086072	COMFORT EZ PRO PEN NDL 31G 4MM	31G X5/32"	ADD
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
66993036230	DAPAGLIFLOZIN-METFO ER 10-1000	10-1000 MG	ADD
66993036160	DAPAGLIFLOZIN-METFOR ER 5-1000	5MG-1000MG	ADD
68682070430	DILTIAZEM 24H ER(LA) 120 MG TB	120 MG	ADD
68682070490	DILTIAZEM 24H ER(LA) 120 MG TB	120 MG	ADD
69097099202	DILTIAZEM 24H ER(LA) 120 MG TB	120 MG	ADD
69097099205	DILTIAZEM 24H ER(LA) 120 MG TB	120 MG	ADD
70436019504	DILTIAZEM 24H ER(LA) 120 MG TB	120 MG	ADD
70436019506	DILTIAZEM 24H ER(LA) 120 MG TB	120 MG	ADD
03999060071	DROPSAFE INS SYR 0.5ML 31G 8MM	31 GX5/16"	ADD
03999060079	DROPSAFE INSUL SYR 1ML 31G 6MM	31GX15/64"	ADD
59212009730	DUTOPROL 100-12.5 MG TABLET	100-12.5MG	ADD
59212008730	DUTOPROL 25-12.5 MG TABLET	25-12.5 MG	ADD
60006037786	EASY CMFT SFTY PEN NDL 32G 4MM	32GX 5/32"	ADD
50027049466	EASY COMFORT 0.3 ML 31G 1/2"	31GX1/2"	ADD
08496016401	EASY TOUCH LUER LOK INSUL 1 ML	N/A	ADD
08496015401	EASY TOUCH UNI-SLIP SYR 1 ML	N/A	ADD
00378662993	EPROSARTAN MESYLATE 600 MG TAB	600 MG	ADD
70661005030	EZETIMIBE-ATORVASTATIN 10-10MG	10 MG-10MG	ADD
70661005090	EZETIMIBE-ATORVASTATIN 10-10MG	10 MG-10MG	ADD
70661005130	EZETIMIBE-ATORVASTATIN 10-20MG	10 MG-20MG	ADD
70661005190	EZETIMIBE-ATORVASTATIN 10-20MG	10 MG-20MG	ADD
70661005230	EZETIMIBE-ATORVASTATIN 10-40MG	10 MG-40MG	ADD
70661005290	EZETIMIBE-ATORVASTATIN 10-40MG	10 MG-40MG	ADD
70661005330	EZETIMIBE-ATORVASTATIN 10-80MG	10 MG-80MG	ADD
70661005390	EZETIMIBE-ATORVASTATIN 10-80MG	10 MG-80MG	ADD
00169320611	FIASP PUMPCART 100 UNIT/ML	100/ML	ADD
00169320615	FIASP PUMPCART 100 UNIT/ML	100/ML	ADD
66993008796	FLUTICASONE-SALMETEROL 115-21	115-21MCG	ADD
66993008896	FLUTICASONE-SALMETEROL 230-21	230-21MCG	ADD
66993008696	FLUTICASONE-SALMETEROL 45-21	45-21 MCG	ADD

66993013597	FLUTICASONE-VILANTEROL 100-25	100-25MCG	ADD
66993013697	FLUTICASONE-VILANTEROL 200-25	200-25 MCG	ADD
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
59630057560	FORTAMET ER 1,000 MG TABLET	1000 MG	ADD
59630057460	FORTAMET ER 500 MG TABLET	500 MG	ADD
52817038510	GLIPIZIDE 2.5 MG TABLET	2.5 MG	ADD
00009501401	GLYSET 100 MG TABLET	100 MG	ADD
00009501201	GLYSET 25 MG TABLET	25 MG	ADD
00009501301	GLYSET 50 MG TABLET	50 MG	ADD
38396044664	GNP ULTRA COMFORT 0.5 ML SYR	30 GAUGE	ADD
00054062127	ICOSAPENT ETHYL 0.5 GM CAPSULE	0.5 GRAM	ADD
43598074672	ICOSAPENT ETHYL 0.5 GM CAPSULE	0.5 GRAM	ADD
69238259707	ICOSAPENT ETHYL 0.5 GM CAPSULE	0.5 GRAM	ADD
00480012649	ICOSAPENT ETHYL 500 MG CAPSULE	0.5 GRAM	ADD
08462109751	IN-CHECK NASAL WITH MASK	N/A	ADD
08462109750	IN-CHECK ORAL FLOW METER	N/A	ADD
61058025352	INSULIN CARTRIDGE 3 ML	N/A	ADD
73070040011	INSULIN DEGLUDEC 100 UNIT/ML	100/ML	ADD
73070040315	INSULIN DEGLUDEC PEN (U-100)	100/ML (3)	ADD
73070050315	INSULIN DEGLUDEC PEN (U-200)	200/ML (3)	ADD
00078038405	LOTREL 5-40 MG CAPSULE	5 MG-40 MG	ADD
00002823501	LYUMJEV TEMPO PEN 100 UNIT/ML	100/ML	ADD
00002823505	LYUMJEV TEMPO PEN 100 UNIT/ML	100/ML	ADD
62135068130	METFORMIN HCL 625 MG TABLET	625 MG	ADD
72336006430	METFORMIN HCL 625 MG TABLET	625 MG	ADD
00002147101	MOUNJARO 10 MG/0.5 ML PEN	10MG/0.5ML	ADD
00002147180	MOUNJARO 10 MG/0.5 ML PEN	10MG/0.5ML	ADD
00002146001	MOUNJARO 12.5 MG/0.5 ML PEN	12.5MG/0.5	ADD
00002146080	MOUNJARO 12.5 MG/0.5 ML PEN	12.5MG/0.5	ADD
00002145701	MOUNJARO 15 MG/0.5 ML PEN	15MG/0.5ML	ADD
00002145780	MOUNJARO 15 MG/0.5 ML PEN	15MG/0.5ML	ADD
00002150601	MOUNJARO 2.5 MG/0.5 ML PEN	2.5 MG/0.5	ADD
00002150680	MOUNJARO 2.5 MG/0.5 ML PEN	2.5 MG/0.5	ADD
00002149501	MOUNJARO 5 MG/0.5 ML PEN	5 MG/0.5ML	ADD
00002149580	MOUNJARO 5 MG/0.5 ML PEN	5 MG/0.5ML	ADD
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**

00002148401	MOUNJARO 7.5 MG/0.5 ML PEN	7.5 MG/0.5	ADD
00002148480	MOUNJARO 7.5 MG/0.5 ML PEN	7.5 MG/0.5	ADD
53885001185	ONETOUCH ULTRA2 GLUCOSE SYST	N/A	ADD
53885004601	ONETOUCH ULTRA2 GLUCOSE SYST	N/A	ADD
53885001183	ONETOUCH VERIO FLEX METER	N/A	ADD
53885004401	ONETOUCH VERIO FLEX METER	N/A	ADD
53885065701	ONETOUCH VERIO METER	N/A	ADD
53885001169	ONETOUCH VERIO REFLECT METER	N/A	ADD
53885092701	ONETOUCH VERIO REFLECT METER	N/A	ADD
00378505577	PITAVASTATIN 1 MG TABLET	1 MG	ADD
00480363198	PITAVASTATIN 1 MG TABLET	1 MG	ADD
00832604890	PITAVASTATIN 1 MG TABLET	1 MG	ADD
42291090590	PITAVASTATIN 1 MG TABLET	1 MG	ADD
65862081290	PITAVASTATIN 1 MG TABLET	1 MG	ADD
68382048116	PITAVASTATIN 1 MG TABLET	1 MG	ADD
00378505677	PITAVASTATIN 2 MG TABLET	2 MG	ADD
00480363298	PITAVASTATIN 2 MG TABLET	2 MG	ADD
00832604990	PITAVASTATIN 2 MG TABLET	2 MG	ADD
42291090690	PITAVASTATIN 2 MG TABLET	2 MG	ADD
65862081390	PITAVASTATIN 2 MG TABLET	2 MG	ADD
68382048216	PITAVASTATIN 2 MG TABLET	2 MG	ADD
00378505777	PITAVASTATIN 4 MG TABLET	4 MG	ADD
00480363398	PITAVASTATIN 4 MG TABLET	4 MG	ADD
00832605090	PITAVASTATIN 4 MG TABLET	4 MG	ADD
42291090790	PITAVASTATIN 4 MG TABLET	4 MG	ADD
65862081490	PITAVASTATIN 4 MG TABLET	4 MG	ADD
68382048316	PITAVASTATIN 4 MG TABLET	4 MG	ADD
00597044587	PRADAXA 110 MG PELLET PACK	110 MG	ADD
00597045016	PRADAXA 150 MG PELLET PACK	150 MG	ADD
00597042578	PRADAXA 20 MG PELLET PACK	20 MG	ADD
00597043018	PRADAXA 30 MG PELLET PACK	30 MG	ADD
00597043596	PRADAXA 40 MG PELLET PACK	40 MG	ADD
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
00597044053	PRADAXA 50 MG PELLET PACK	50 MG	ADD
00378073101	PROPRANOLOL-HCTZ 40-25 MG TAB	40 MG-25MG	ADD
00378034701	PROPRANOLOL-HCTZ 80-25 MG TAB	80 MG-25MG	ADD
50632000789	PURE CMFT SFTY PEN NDL 32G 4MM	32GX 5/32"	ADD
82098000510	RAYA SURE PEN NEEDLE 29G 12MM	29GX15/32"	ADD

82098000210	RAYA SURE PEN NEEDLE 31G 5MM	31GX13/64"	ADD
68180049001	REPAGLINIDE-METFORMIN 1-500 MG	1MG-500MG	ADD
68180049101	REPAGLINIDE-METFORMIN 2-500 MG	2 MG-500MG	ADD
00002898005	REZVOGLAR 100 UNIT/ML KWIKPEN	100/ML (3)	ADD
10631001917	RIOMET ER 500 MG/5 ML SUSP	500 MG/5ML	ADD
08595013001	SAFESNAP INSUL SYRINGE 0.3 ML	30 GX5/16"	ADD
08595013010	SAFESNAP INSUL SYRINGE 0.3 ML	30 GX5/16"	ADD
08595022901	SAFESNAP INSUL SYRINGE 0.5 ML	29 G X1/2"	ADD
08595022910	SAFESNAP INSUL SYRINGE 0.5 ML	29 G X1/2"	ADD
08595023001	SAFESNAP INSUL SYRINGE 0.5 ML	30 GX5/16"	ADD
08595023010	SAFESNAP INSUL SYRINGE 0.5 ML	30 GX5/16"	ADD
08595032801	SAFESNAP INSULIN SYRINGE 1 ML	28GX1/2"	ADD
08595032810	SAFESNAP INSULIN SYRINGE 1 ML	28GX1/2"	ADD
08595032901	SAFESNAP INSULIN SYRINGE 1 ML	29 G X1/2"	ADD
08595032910	SAFESNAP INSULIN SYRINGE 1 ML	29 G X1/2"	ADD
73317778904	SAFETY PEN NEEDLE 31G 4MM	31G X5/32"	ADD
00378470577	SAXAGLIPTIN HCL 2.5 MG TABLET	2.5 MG	ADD
00378470593	SAXAGLIPTIN HCL 2.5 MG TABLET	2.5 MG	ADD
65862082530	SAXAGLIPTIN HCL 2.5 MG TABLET	2.5 MG	ADD
68462072630	SAXAGLIPTIN HCL 2.5 MG TABLET	2.5 MG	ADD
68462072690	SAXAGLIPTIN HCL 2.5 MG TABLET	2.5 MG	ADD
00378470677	SAXAGLIPTIN HCL 5 MG TABLET	5 MG	ADD
00378470693	SAXAGLIPTIN HCL 5 MG TABLET	5 MG	ADD
65862082630	SAXAGLIPTIN HCL 5 MG TABLET	5 MG	ADD
68462072730	SAXAGLIPTIN HCL 5 MG TABLET	5 MG	ADD
68462072790	SAXAGLIPTIN HCL 5 MG TABLET	5 MG	ADD
00378817593	SAXAGLIPTIN-METFORMIN ER 5-500	5 MG-500MG	ADD
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
43598062030	SAXAGLIPTIN-METFORMIN ER 5-500	5 MG-500MG	ADD
00378817793	SAXAGLIPTIN-METFORMN ER 5-1000	5MG-1000MG	ADD
43598061930	SAXAGLIPTIN-METFORMN ER 5-1000	5MG-1000MG	ADD
00378817691	SAXAGLIPTN-METFORM ER 2.5-1000	2.5-1000MG	ADD
43598061860	SAXAGLIPTN-METFORM ER 2.5-1000	2.5-1000MG	ADD
04351096610	STRIVE PEAK FLOW METER	N/A	ADD
86227074015	SURE CMFT SFTY PEN NDL 32G 4MM	32GX 5/32"	ADD
00074328713	TARKA ER 2-180 MG TABLET	2 MG-180MG	ADD
00074328913	TARKA ER 2-240 MG TABLET	2MG-240 MG	ADD
00074329013	TARKA ER 4-240 MG TABLET	4MG-240 MG	ADD

08970100827	TERUMO INS SYRINGE U100-1 ML	30 G X3/8"	ADD
08970100161	TERUMO INS SYRINGE U100-1/2 ML	30 G X3/8"	ADD
08970100652	TERUMO SURGUARD2 NEEDLE 30X1/2	30GX1 1/2"	ADD
08970605018	TERUMO SURGUARD2 NEEDLE 30X1/2	30GX1 1/2"	ADD
08970100861	THINPRO INS SYRIN U100-0.3 ML	31GX3/8"	ADD
08970100864	THINPRO INS SYRIN U100-0.5 ML	31GX3/8"	ADD
08970100875	THINPRO INS SYRIN U100-0.5 ML	30 G X3/8"	ADD
08970100863	THINPRO INS SYRIN U100-1 ML	31GX3/8"	ADD
08970100876	THINPRO INS SYRIN U100-1 ML	30 G X3/8"	ADD
50027049444	TRUE CMFT SFTY PEN NDL 32G 4MM	32GX 5/32"	ADD
08470784501	UNIFINE PROTECT 32G 4MM	32GX 5/32"	ADD
08470794001	UNIFINE SAFECONTROL 32G 4MM	32GX 5/32"	ADD
70710124203	ZITUVIO 100 MG TABLET	100 MG	ADD
70710124003	ZITUVIO 25 MG TABLET	25 MG	ADD
70710124103	ZITUVIO 50 MG TABLET	50 MG	ADD
71052065601	ACARBOSE POWDER	100 %	REMOVE
04351089510	AEROGEAR ASTHMA ACTION KIT	N/A	REMOVE
00597008717	ATROVENT 17 MCG HFA INHALER	17MCG	REMOVE
50090096100	ATROVENT 17 MCG HFA INHALER	17MCG	REMOVE
08470130001	AUTOJECT 2 INJECTION DEVICE	N/A	REMOVE
08470131001	AUTOJECT 2 INJECTION DEVICE	N/A	REMOVE
08470131101	AUTOJECT 2 INJECTION DEVICE	N/A	REMOVE
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
08470381001	AUTOPEN 1 TO 21 UNITS	N/A	REMOVE
08470380001	AUTOPEN 2 TO 42 UNITS	N/A	REMOVE
00310460012	BEVESPI AEROSPHERE INHALER	9-4.8 MCG	REMOVE
00310460039	BEVESPI AEROSPHERE INHALER	9-4.8 MCG	REMOVE
73108000001	CEQUR SIMPLICITY 2 UNIT PATCH	2 UNIT	REMOVE
73108000100	CEQUR SIMPLICITY INSERTER	N/A	REMOVE
59310061031	CINQAIR 100 MG/10 ML VIAL	10 MG/ML	REMOVE
00597002402	COMBIVENT RESPIMAT 20-100 MCG	20-100 MCG	REMOVE
69101051030	CONSENSI 10-200 MG TABLET	10MG-200MG	REMOVE
69101050230	CONSENSI 2.5-200 MG TABLET	2.5-200 MG	REMOVE
69101050530	CONSENSI 5-200 MG TABLET	5MG-200MG	REMOVE
00310008828	DALIRESP 250 MCG TABLET	250 MCG	REMOVE
00310008839	DALIRESP 250 MCG TABLET	250 MCG	REMOVE
00310009530	DALIRESP 500 MCG TABLET	500 MCG	REMOVE
00310009590	DALIRESP 500 MCG TABLET	500 MCG	REMOVE

00310090060	DUAKLIR PRESSAIR 400-12MCG INH	400-12 MCG	REMOVE
72124000101	DUAKLIR PRESSAIR 400-12MCG INH	400-12 MCG	REMOVE
70408064434	ELIXOPHYLLIN 80 MG/15 ML ELIX	80 MG/15ML	REMOVE
00310173030	FASENRA 30 MG/ML SYRINGE	30 MG/ML	REMOVE
00310183030	FASENRA PEN 30 MG/ML	30 MG/ML	REMOVE
00002840001	FORTEO 600 MCG/2.4 ML PEN INJ	20MCG/DOSE	REMOVE
00173087306	INCRUSE ELLIPTA 62.5 MCG INH	62.5 MCG	REMOVE
00173087310	INCRUSE ELLIPTA 62.5 MCG INH	62.5 MCG	REMOVE
62088000031	INPEN (FOR HUMALOG) BLUE	N/A	REMOVE
62088000032	INPEN (FOR HUMALOG) GREY	N/A	REMOVE
62088000033	INPEN (FOR HUMALOG) PINK	N/A	REMOVE
62088000034	INPEN (NOVOLOG OR FIASP) BLUE	N/A	REMOVE
62088000035	INPEN (NOVOLOG OR FIASP) GREY	N/A	REMOVE
62088000036	INPEN (NOVOLOG OR FIASP) PINK	N/A	REMOVE
63402030101	LONHALA MAGNAIR 25 MCG REFILL	25 MCG/ML	REMOVE
63402020100	LONHALA MAGNAIR 25 MCG STARTER	25 MCG/ML	REMOVE
11845058001	NIACIN (NIACINAMIDE) 500 MG TB	500 MG	REMOVE
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
00179802902	NIACIN 500 MG TABLET	500 MG	REMOVE
00536407810	NIACIN 500 MG TABLET	500 MG	REMOVE
00904227260	NIACIN 500 MG TABLET	500 MG	REMOVE
00904227280	NIACIN 500 MG TABLET	500 MG	REMOVE
11845074201	NIACIN 500 MG TABLET	500 MG	REMOVE
37864079201	NIACIN 500 MG TABLET	500 MG	REMOVE
37864079210	NIACIN 500 MG TABLET	500 MG	REMOVE
43292012356	NIACIN 500 MG TABLET	500 MG	REMOVE
43292055792	NIACIN 500 MG TABLET	500 MG	REMOVE
51645079201	NIACIN 500 MG TABLET	500 MG	REMOVE
51645079210	NIACIN 500 MG TABLET	500 MG	REMOVE
54629071201	NIACIN 500 MG TABLET	500 MG	REMOVE
55289062001	NIACIN 500 MG TABLET	500 MG	REMOVE
58487003021	NIACIN 500 MG TABLET	500 MG	REMOVE
79854020983	NIACIN 500 MG TABLET	500 MG	REMOVE
00169185459	NOVOPEN ECHO INSULIN DEVICE	N/A	REMOVE
00173089201	NUCALA 100 MG/ML AUTO-INJECTOR	100 MG/ML	REMOVE
00173088101	NUCALA 100 MG/ML POWDER VIAL	100 MG	REMOVE
00173089242	NUCALA 100 MG/ML SYRINGE	100 MG/ML	REMOVE
08508300001	OMNIPOD 5 G6 INTRO KIT (GEN 5)	N/A	REMOVE

08508300021	OMNIPOD 5 G6 PODS (GEN 5) 5PK	N/A	REMOVE
08508114002	OMNIPOD CLASSIC PDM KIT(GEN 3)	N/A	REMOVE
08508112005	OMNIPOD CLASSIC PODS(GEN3) 5PK	N/A	REMOVE
08508200032	OMNIPOD DASH INTRO KIT (GEN 4)	N/A	REMOVE
08508200005	OMNIPOD DASH PODS (GEN 4) 5PK	N/A	REMOVE
29135017001	PLAIN NIACIN 500 MG TABLET	500 MG	REMOVE
29135017006	PLAIN NIACIN 500 MG TABLET	500 MG	REMOVE
29135017013	PLAIN NIACIN 500 MG TABLET	500 MG	REMOVE
11822511160	RA NIACIN 500 MG TABLET	500 MG	REMOVE
11822517530	RA NIACIN 500 MG TABLET	500 MG	REMOVE
31722067631	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
31722067632	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
31722067635	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
31722067636	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
42571036983	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
68382062430	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
68382062483	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
72205020111	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
72205020113	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
72205020124	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
72205020132	ROFLUMILAST 250 MCG TABLET	250 MCG	REMOVE
00378190577	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
00378190593	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
00904739946	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
00904739989	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
31722062330	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
31722062390	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
42571025930	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
43547000503	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
43547000509	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
59651027530	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
59651027590	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
60687078611	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
60687078621	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
68382096906	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
68382096916	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
72205020030	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE

72205020090	ROFLUMILAST 500 MCG TABLET	500 MCG	REMOVE
00597015570	STIOLTO RESPIMAT INHALER (10)	2.5-2.5MCG	REMOVE
00597015561	STIOLTO RESPIMAT INHALER (60)	2.5-2.5MCG	REMOVE
00597019261	STRIVERDI RESPIMAT INHAL SPRAY	2.5 MCG	REMOVE
00093110616	TERIPARATIDE 600 MCG/2.4ML PEN	20MCG/DOSE	REMOVE
60505618800	TERIPARATIDE 600 MCG/2.4ML PEN	20MCG/DOSE	REMOVE
66993049528	TERIPARATIDE 600 MCG/2.4ML PEN	20MCG/DOSE	REMOVE
PRODUCT SERVICE ID	**LABEL TXT**	**STRENGTH**	**Recommendation (ADD or REMOVE) for Sentara Safe Harbor/IRS Preventative List (DL 626985)**
47781065289	TERIPARATIDE 620 MCG/2.48 ML	20MCG/DOSE	REMOVE
55513011201	TEZSPIRE 210 MG/1.91 ML SYRING	210MG/1.91	REMOVE
00310080039	TUDORZA PRESSAIR 400 MCG INHAL	400 MCG	REMOVE
00310080060	TUDORZA PRESSAIR 400 MCG INHAL	400 MCG	REMOVE
70515000201	TUDORZA PRESSAIR 400 MCG INHAL	400 MCG	REMOVE
70515000202	TUDORZA PRESSAIR 400 MCG INHAL	400 MCG	REMOVE
72124000201	TUDORZA PRESSAIR 400 MCG INHAL	400 MCG	REMOVE
72124000202	TUDORZA PRESSAIR 400 MCG INHAL	400 MCG	REMOVE
70539000101	TYMLOS 80 MCG DOSE PEN INJECTR	80MCG/DOSE	REMOVE
70539000102	TYMLOS 80 MCG DOSE PEN INJECTR	80MCG/DOSE	REMOVE
08560940003	V-GO 20 DISPOSABLE DEVICE	N/A	REMOVE
08560940002	V-GO 30 DISPOSABLE DEVICE	N/A	REMOVE
08560940001	V-GO 40 DISPOSABLE DEVICE	N/A	REMOVE
50242004062	XOLAIR 150 MG/1.2 ML POWDER VL	150 MG	REMOVE
50242021501	XOLAIR 150 MG/ML SYRINGE	150 MG/ML	REMOVE
50242021401	XOLAIR 75 MG/0.5 ML SYRINGE	75MG/0.5ML	REMOVE
49502080632	YUPELRI 175 MCG/3 ML SOLUTION	175MCG/3ML	REMOVE
49502080693	YUPELRI 175 MCG/3 ML SOLUTION	175MCG/3ML	REMOVE