Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

<table>
<tr><td colspan="2">DRUG NAME: adalimumab-aaty</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: Change Drug Tier</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Formulary</td><td>Prior Authorization, 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 & MEDICAID)
20 mg/0.2 mL syringe – 2 injections per 28 days
40 mg/0.4 mL auto-injector/syringe – 2 injections per 28 days
80 mg/0.8 mL auto-injector – 2 injections per 28 days
80 mg Crohn’s starter kit – 3 injections (1 kit) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): adalimumab-adbm (unbranded version of Cyltezo made by Boehringer Ingelheim), Hadlima™; (MEDICARE): Hadlima, Simlandi *both require prior authorization*</td></tr>
</table>

October 28, 2026 (January – March 2027)

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.

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

DRUG NAME: albuterol HFA 90 mcg inhaler (Ventolin ABA)		**INDICATION:** For the treatment or prevention of bronchospasm in patients 4 years of age and older with reversible obstructive airway disease; For the prevention of exercise-induced bronchospasm in patients 4 years of age and older
REASON FOR CHANGE: Change Drug Tier		
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	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic albuterol HFA inhaler; (MEDICARE): albuterol HFA (Proair authorized generic), albuterol HFA (Proventil authorized generic)		

DRUG NAME: Armlupeg™ (pegfilgrastim-unne) 6 mg/0.6 mL injection for subcutaneous use in a single-dose prefilled syringe **– MEDICAL BENEFIT**		**INDICATION:** Biosimilar to Neulasta®, indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia; Increase survival in patients acutely exposed to myelosuppressive doses of radiation
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		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

DRUG NAME: Armlupeg™ (pegfilgrastim-unne) 6 mg/0.6 mL injection for subcutaneous use in a single-dose prefilled syringe **– PHARMACY BENEFIT**		**INDICATION:** Biosimilar to Neulasta®. For use to increase survival in patients acutely exposed to myelosuppressive doses of radiation. To decrease the incidence of infection (as manifested by febrile neutropenia), in patients with nonmyeloid malignancies receiving myelosuppressive cancer chemotherapy associated with a clinically significant incidence of febrile neutropenia
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	Non-Formulary	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): Fulphila, Neupogen vial/syringe; (MEDICARE): Nivestym *require prior authorization*		

DRUG NAME: atomoxetine 4 mg/mL oral solution		**INDICATION:** For the treatment of attention-deficit/hyperactivity disorder (ADHD) in adult and 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 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 & MEDICAID): 25 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): generic atomoxetine oral capsule; (MEDICAID): atomoxetine (generic for Strattera®), clonidine ER, guanfacine ER		

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DRUG NAME: Atoncy™ (atomoxetine) 4 mg/mL oral solution		**INDICATION:** For the treatment of attention-deficit/hyperactivity disorder (ADHD) in adult and 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 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 & MEDICAID): 25 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): generic atomoxetine oral capsule; (MEDICAID): atomoxetine (generic for Strattera®), clonidine ER, guanfacine ER		

DRUG NAME: Auvelity (dextromethorphan and bupropion) ER tablet - 30-105 mg and 45-105 mg titration pack		**INDICATION:** For the treatment of agitation associated with dementia due to Alzheimer's disease
REASON FOR CHANGE: New Drug		
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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 51 tablets (1 pack) per 365 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): Rexulti *requires prior authorization*		

DRUG NAME: Avopef™ (etoposide) 100 mg/5 mL (20 mg/mL) multiple-dose vial		**INDICATION:** For use in combination with chemotherapy for the treatment of refractory testicular cancer in adult patients and in combination with chemotherapy and immunotherapy for the first-line treatment of small cell lung cancer (SCLC) in adult patients
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: Awiqli® (insulin icodec-abae) 700 unit/mL (U-700) solution in FlexTouch prefilled pen		**INDICATION:** For use as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (T2DM)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization
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: (COMMERCIAL): insulin glargine-yfgn pen and vial (Biocon mfg only), Lantus Solostar/vial, Toujeo Solostar, Toujeo Max Solostar; (MEDICAID): Lantus Solostar® & vial, Toujeo Solostar® pen (requires prior authorization); (MEDICARE): Lantus Solostar/vial, Toujeo Solostar, Toujeo Max Solostar		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

DRUG NAME: Baxdela® (delafloxacin) 300 mg vial for injection by intravenous infusion		**INDICATION:** For the treatment of adults with the following infections caused by designated susceptible bacteria: Acute Bacterial Skin and Skin Structure Infections (ABSSSI) and Community-Acquired Bacterial Pneumonia (CABP)
REASON FOR CHANGE: Add Utilization Management		
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: Baxdela® (delafloxacin) 450 mg tablets		**INDICATION:** For the treatment of adults with the following infections caused by designated susceptible bacteria: Acute Bacterial Skin and Skin Structure Infections (ABSSSI) and Community-Acquired Bacterial Pneumonia (CABP)
REASON FOR CHANGE: Add Utilization Management & 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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (MEDICAID): 28 tablets per 30 days		
FORMULARY ALTERNATIVES: levofloxacin & moxifloxacin tablets		

DRUG NAME: Baxfendy™ (baxdrostat) oral tablet – 1 and 2 mg		**INDICATION:** For use in combination with other antihypertensive drugs, for the treatment of hypertension, to lower blood pressure in adults who are not adequately controlled on other agents
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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERICAL & MEDICAID): 1 tablet per day (both strengths)		
FORMULARY ALTERNATIVES: amiloride tablet, eplerenone tablet, spironolactone tablet		

DRUG NAME: Besremi (ropeginterferon alfa-2b) 500 mcg/0.5 mL solution in a single-dose prefilled pen injector for subcutaneous use		**INDICATION:** For the treatment of adults with polycythemia vera
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	Non-Formulary	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	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 mL (2 pens) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: besifloxacin 0.6% eye drops (Besivance® ABA)		**INDICATION:** For the treatment of bacterial conjunctivitis caused by susceptible isolates of the following bacteria: Aerococcus viridans, CDC coryneform group G, Haemophilus influenzae, Staphylococcus aureus, Staphylococcus epidermidis, Streptococcus mitis group, Streptococcus oralis, Streptococcus pneumoniae, Corynebacterium pseudodiphtheriticum, Corynebacterium striatum, Moraxella lacunata, Moraxella catarrhalis, Pseudomonas aeruginosa, Staphylococcus hominis, Staphylococcus lugdunensis, Staphylococcus warneri, Streptococcus salivarius
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	N/A
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	Tier 3	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): bacitracin/polymyxin b sulfate oint, ciprofloxacin drops, erythromycin, gentamicin drops/oint, moxifloxacin drops (generic Vigamox), ofloxacin drops, polymyxin/trimethoprim, tobramycin		

DRUG NAME: Besivance® (besifloxacin) 0.6% eye drops		**INDICATION:** For the treatment of bacterial conjunctivitis caused by susceptible isolates of the following bacteria: Aerococcus viridans, CDC coryneform group G, Haemophilus influenzae, Staphylococcus aureus, Staphylococcus epidermidis, Streptococcus mitis group, Streptococcus oralis, Streptococcus pneumoniae, Corynebacterium pseudodiphtheriticum, Corynebacterium striatum, Moraxella lacunata, Moraxella catarrhalis, Pseudomonas aeruginosa, Staphylococcus hominis, Staphylococcus lugdunensis, Staphylococcus warneri, Streptococcus salivarius
REASON FOR CHANGE: Change Drug Tier		
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: (COMMERCIAL & MEDICAID): bacitracin/polymyxin b sulfate oint, ciprofloxacin drops, erythromycin, gentamicin drops/oint, moxifloxacin drops (generic Vigamox), ofloxacin drops, polymyxin/trimethoprim, tobramycin		

DRUG NAME: Breztri Aerosphere® (budesonide/glycopyrrolate/formoterol fumarate) for oral inhalation - 160 mcg/18 mcg/ 4.8 mcg		**INDICATION:** For the maintenance treatment of asthma in adult and pediatric patients 12 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, 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)
MEDICARE FORMULARY	Tier 3	Quantity Limit
QUANTITY LIMIT: (COMMERCIAL & MEDICARE): 1 inhaler per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): Stiolto Respimat, Anoro Ellipta, Trelegy Ellipta; (MEDICAID): Advair® Diskus, Advair® HFA, Dulera®, Symbicort®, Trelegy® Ellipta		

DRUG NAME: Bucapsol (buspirone) 5 mg capsule		**INDICATION:** For the management of generalized anxiety disorder or the short-term relief of the symptoms of anxiety
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	Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 2 capsules per day		
FORMULARY ALTERNATIVES: generic buspirone tablets		

DRUG NAME: generic budesonide-formoterol inhalation aerosol (generic Symbicort), generic Breyna & Brand Symbicort, all strengths		**INDICATION:** For the treatment of asthma in patients 6 years of age and older and for the maintenance treatment of airflow obstruction and reducing exacerbations in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2 (Generic); Tier 3 (Brand)	Quantity Limit
STANDARD FORMULARY	Tier 2 (Generic); Non-Formulary (Brand)	Quantity Limit
EXCHANGE FORMULARY	Tier 2 (Generic); Non-Formulary (Brand)	Quantity Limit
FAMIS FORMULARY	Formulary (Generic); Non-Formulary (Brand)	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: (COMMERCIAL): 2 inhalers per 30 days (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: buspirone HCl oral tablet – 2.5 and 12.5 mg strengths		**INDICATION:** For the management of generalized anxiety disorder or the short-term relief of the symptoms of anxiety
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 & MEDICARE): 2 tablets per day		
FORMULARY ALTERNATIVES: generic buspirone tablets		

DRUG NAME: Bysanti™ (milsaperidone) (all strengths) – titration packs A, B, & C and 1, 2, 4, 6, 8, 10, & 12 mg tablets		**INDICATION:** For the treatment of schizophrenia in adults and acute treatment of manic or mixed episodes associated with bipolar I disorder in adults
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	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): • 1, 2, 4, 6, 8, 10, & 12 mg – 2 tablets per day • Titration pack A & C – 8 tablets (1 pack) per 365 days • Titration pack B – 12 tablets (1 pack) per 365 days (MEDICARE): • 1, 2, 4, 6, 8, 10, & 12 mg – 2 tablets per day • Titration pack A & C – 8 tablets (1 pack) per 180 days • Titration pack B – 12 tablets (1 pack) per 180 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): aripiprazole tablet, lurasidone tablet, olanzapine tablet, quetiapine IR/ER tablet, risperidone tablet, ziprasidone tablet; (MEDICAID): aripiprazole tab, clozapine tab, lurasidone, olanzapine ODT/tab/IM, paliperidone ER, quetiapine fumarate ER, quetiapine tab, risperidone ODT/soln/tab, Vraylar (requires prior authorization), ziprasidone cap/vial		

DRUG NAME: Cavhanza (nilotinib) orally disintegrating tablet – 60 and 80 mg		**INDICATION:** For the treatment of newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase in adults; For the treatment of chronic and accelerated phase Ph+ CML in adults with resistance or intolerance to prior tyrosine kinase therapy that included imatinib
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	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): generic nilotinib capsules (50, 150, or 200 mg)		

DRUG NAME: Clotic (clotrimazole) 1% otic drop		**INDICATION:** For the treatment of fungal otitis externa (otomycosis) due to Aspergillus species and Candida species in patients ≥18 years of age with intact tympanic membranes
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 & MEDICAID): clotrimazole 1% topical solution (OTC)		

DRUG NAME: Decnupaz™ (pivekimab sunirine-pvzy) 2 mg lyophilized cake in a single-dose vial		**INDICATION:** For the treatment of adult patients with blastic plasmacytoid dendritic cell neoplasm (BPDCN)
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: Dexlyt (dexamethasone) 0.25 mg oral tablet		**INDICATION:** For use as an anti-inflammatory or immunosuppressant agent in the treatment of a variety of diseases, including those of allergic, hematologic (e.g., immune thrombocytopenia), dermatologic, neoplastic (leukemias, lymphomas, and multiple myeloma), rheumatic, autoimmune, nervous system, renal, and respiratory origin; Primary or secondary adrenocorticoid deficiency (not first line), congenital adrenal hyperplasia; Management of shock, cerebral edema, and as a diagnostic agent
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	Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): generic dexamethasone 0.5, 0.75, 1, 1.5, 2, 4, and 6 mg oral tablet; (MEDICAID): generic dexamethasone solution/tablet		

DRUG NAME: doxycycline hyclate 75 mg capsule		**INDICATION:** For the treatment of Rickettsial infections; Sexually transmitted infections; Respiratory tract infections; Specific bacterial infections; Ophthalmic infections; Anthrax, including inhalational anthrax (post-exposure); Alternative treatment for selected infections when penicillin is contraindicated; Adjunctive therapy for acute intestinal amebiasis and severe acne; Prophylaxis of malaria
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: generic doxycycline hyclate 50 and 100 mg capsules		

DRUG NAME: dronabinol 5 mg/mL oral solution		**INDICATION:** For the treatment of anorexia associated with weight loss in patients with AIDS; Treatment of nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments
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	Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: generic dronabinol capsule (For Medicaid: *requires prior authorization)		

DRUG NAME: duloxetine HCl DR capsules – 80, 90, and 120 mg		**INDICATION:** For the management of fibromyalgia in adult (all formulations) and pediatric patients ≥13 years of age; For the treatment of generalized anxiety disorder in adult and pediatric patients ≥7 years of age; For the treatment of unipolar major depressive disorder in adults; For the management of chronic musculoskeletal pain including osteoarthritis of the knee and low back pain in adults; For the management of pain associated with diabetic peripheral neuropathy in adults
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	Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 capsule per day (all strengths)		
FORMULARY ALTERNATIVES: generic duloxetine 20, 30 & 60 mg		

DRUG NAME: Evesse™ (hydrocortisone butyrate) 0.1% lotion		**INDICATION:** For the topical treatment of mild to moderate atopic dermatitis in patients 3 months of age and older
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: (COMMERCIAL): hydrocortisone butyrate 0.1% solution/cream/ointment; (MEDICAID): fluticasone propionate cream/ointment, mometasone furoate cream/ointment/solution; (MEDICARE): betamethasone dipropionate topical lotion 0.05%, triamcinolone topical lotion 0.1%		

DRUG NAME: Evdi (trabectedin) 1 mg/20 mL solution in a single-dose vial		**INDICATION:** For the treatment of adult patients with unresectable or metastatic liposarcoma or leiomyosarcoma who received a prior anthracycline-containing regimen
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: Favlyxa™ (fluorouracil) 250 mg/10 mL single-dose vial		**INDICATION:** For the treatment of adult patients with unresectable or metastatic liposarcoma or leiomyosarcoma who received a prior anthracycline-containing regimen
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		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

DRUG NAME: FC2 female condom		**INDICATION:** For the prevention of sexually transmitted infections (STIs) and unintended pregnancy
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9	Quantity Limit
STANDARD FORMULARY	Tier 9	Quantity Limit
EXCHANGE FORMULARY	Tier 9	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 12 condoms (1 box) per fill		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Filkri® (filgrastim-laha) injection in single-dose prefilled syringes – 300 mcg/0.5 mL and 480 mcg/0.8 mL – **MEDICAL BENEFIT**		**INDICATION:** To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; For reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia; To reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation; For chronic administration to reduce the incidence and duration of sequelae of neutropenia in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia; To increase survival in patients acutely exposed to myelosuppressive doses of radiation
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		

<table>
<tr><td colspan="2">DRUG NAME: Filkri® (filgrastim-laha) injection in single-dose prefilled syringes – 300 mcg/0.5 mL and 480 mcg/0.8 mL – PHARMACY BENEFIT</td><td>INDICATION: To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; For reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia; To reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation; For chronic administration to reduce the incidence and duration of sequelae of neutropenia in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia; To increase survival in patients acutely exposed to myelosuppressive doses of radiation</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>Specialty (Tier 4)</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Formulary</td><td>Prior Authorization</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): Fulphila, Neupogen vial/syringe; (MEDICARE): Zarxio, Nivestym</td></tr>
</table>

DRUG NAME: Furoscix® ReadyFlow™ (furosemide) 80 mg/mL solution in a single-dose prefilled autoinjector		**INDICATION:** For the treatment of edema in adult patients with chronic heart failure (CHF) or chronic kidney disease (CKD), including the nephrotic syndrome
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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 6 injections per 90 days		
FORMULARY ALTERNATIVES: furosemide tablets		

DRUG NAME: Gammagard liquid® ERC [immune globulin infusion (human)] 10% solution for intravenous, or subcutaneous use		**INDICATION:** For primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age and older
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: glipizide 15 mg tablet		**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	Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day		
FORMULARY ALTERNATIVES: glipizide 5 mg and 10 mg tablets		

DRUG NAME: Gwyn Lo (norelgestromin and ethinyl estradiol) 220-20 mcg/day patch		**INDICATION:** For the prevention of pregnancy in women with a BMI < 30 kg/m for whom a combined hormonal contraceptive is appropriate
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: Xulane patch, Zafemy patch, generic norelgestromin and ethinyl estradiol patch		

DRUG NAME: Hepcludex® (bulevirtide-gmod) 8.5 mg lyophilized powder or cake, in a single-dose vial		**INDICATION:** For the treatment of chronic hepatitis delta virus (HDV) infection in adults without cirrhosis or with compensated cirrhosis
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	Non-Formulary	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: (COMMERICAL & MEDICAID): 1 vial per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Hympavzi® (marstacimab-hncq) 75 mg/0.5 mL single-dose prefilled pen **– MEDICAL BENEFIT**		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients 6 years of age and older with hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors, or hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors
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: Hympavzi® (marstacimab-hncq) 75 mg/0.5 mL single-dose prefilled pen **– PHARMACY BENEFIT**		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients 6 years of age and older with hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors, or hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors
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	Medical Benefit	Prior Authorization
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 4 pens per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: generic icatibant, generic Sajazir & Brand Firazyr 30 mg/3 mL prefilled syringe for subcutaneous injection		**INDICATION:** For the treatment of acute attacks of hereditary angioedema
REASON FOR CHANGE: Change Benefit Type		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty Tier 4 (Generic); Specialty Tier 4 (Brand)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty Tier 4 (Generic); Non-Formulary (Brand)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty Tier 4 (Generic); Non-Formulary (Brand)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary (Generic); Non-Formulary (Brand)	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Icotyde™ (icotrokinra) 200 mg tablet		**INDICATION:** For the treatment of moderate to severe plaque psoriasis in adults and pediatric patients ≥12 years of age who weigh ≥40 kg 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	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& MEDICAID) 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): Skyrizi, Tremfya, Yesintek; (MEDICAID): adalimumab-adbm (unbranded version of Cyltezo made by Boehringer Ingelheim), Enbrel® pen/sureclick, Hadlima™, Pyzchiva® syringe/vial, Starjemza™; (MEDICARE): Hadlima, Simlandi, Otezla/Otezla XR, Yesintek		

DRUG NAME: Idvynso™ (doravirine-islatravir) 100 mg-0.25 mg oral tablet		**INDICATION:** For the treatment of HIV-1 infection in adults to replace current antiretroviral regimen in those who are virologically-suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of virologic treatment failure and no known substitutions associated with resistance to doravirine
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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	Tier 4	N/A
QUANTITY LIMIT: (COMMERICAL & MEDICAID): 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERICAL & MEDICAID): Biktarvy, Dovato, Juluca		

DRUG NAME: Imuldosa® (ustekinumab-srlf) injection – 45 mg/0.5 mL syringe/vial or 90 mg/mL syringe		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: Change Drug Tier		
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 & MEDICAID) • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 90 mg/mL syringe – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (MEDICAID): Pyzchiva® syringe/vial, Starjemza™; (MEDICARE): Yesintek *requires prior authorization*		

DRUG NAME: Jakafi XR™ (ruxolitinib) oral tablet – 11, 22, 33, 44, and 55 mg		**INDICATION:** For the treatment of intermediate or high-risk myelofibrosis (MF), including primary MF, post-polycythemia vera MF, and post-essential thrombocythemia MF in adults; Polycythemia vera in adults who have had an inadequate response to or are intolerant of hydroxyurea; Steroid-refractory acute graft-versus-host disease (GVHD) in adult and pediatric patients 12 years and older; Chronic GVHD after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years 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	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Jideytro™ (zidesamtinib) oral tablet – 25 and 100 mg		**INDICATION:** For the treatment of adult patients with locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC) who received a prior ROS1 kinase inhibitor
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	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 25 mg – 3 tablets per day • 100 mg – 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Jubereq® (denosumab-desu) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Jubereq is approved for the following treatment indications, which are also currently approved for Xgeva: prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors; treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity; and treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy</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>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria) (PHARMACY)</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>N/A (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): (PHARMACY) Enoby, Xtrenbo; (MEDICARE): (PHARMACY) Wyost (require prior authorization)</td></tr>
</table>

DRUG NAME: Juxtapid (lomitapide) oral capsule – 2, 5, 10, 20, and 30 mg		**INDICATION:** For use as an adjunct to a low-fat diet and exercise and other low-density lipoprotein cholesterol (LDL-C) therapies to reduce LDL-C, in adults and pediatric patients ≥2 years of age with homozygous familial hypercholesterolemia (HoFH)
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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: • 2, 5, and 10 mg: 1 capsule per day • 20 and 30 mg: 2 capsules per day		
FORMULARY ALTERNATIVES: generic atorvastatin, lovastatin, pravastatin, simvastatin, or rosuvastatin tablets		

DRUG NAME: Kresladi™ (marnetegragene autotemcel) suspension for intravenous infusion		**INDICATION:** For the treatment of pediatric patients with severe leukocyte adhesion deficiency- I (LAD-I) due to biallelic variants in ITGB2 without an available human leukocyte antigen (HLA)-matched sibling donor for allogeneic hematopoietic stem cell transplant (HSCT)
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: Kymbee (deflazacort) 22.75 mg/mL oral suspension		**INDICATION:** For the treatment of Duchenne muscular dystrophy (DMD) in patients ≥2 years of age
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): Emflaza; (MEDICARE): generic oral corticosteroids		

DRUG NAME: Leqembi® Iqlik (lecanemab-irmb) 250 mg/1.5 mL single-dose prefilled autoinjector		**INDICATION:** For the treatment of Alzheimer's disease
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 & MEDICAID): 8 auto-injectors per 28 days		
FORMULARY ALTERNATIVES: (MEDICARE): donepezil ODT and tablet, rivastigmine patch and capsule, memantine tablet and ER capsule		

DRUG NAME: levalbuterol tartrate HFA 45 mcg inhaler (Xopenex ABA)		**INDICATION:** For the treatment or prevention of bronchospasm in patients 4 years of age and older with reversible obstructive airway disease
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization
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: (COMMERCIAL): generic albuterol HFA inhaler; (MEDICAID): albuterol HFA (Proair Authorized Generic), albuterol HFA (Proventil Authorized Generic), Ventolin® HFA; (MEDICARE): albuterol HFA (Proair authorized generic), albuterol HFA (Proventil authorized generic)		

DRUG NAME: Lipfendra® (enlicitide) 20 mg tablet		**INDICATION:** For use as an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDL-C) in adults with hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH)
REASON FOR CHANGE: New Drug		
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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): Repatha (requires prior authorization); (MEDICAID): atorvastatin, rosuvastatin, ezetimibe		

DRUG NAME: Lynavoy (linerixibat) 40 mg tablet		**INDICATION:** For the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients
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	Non-Formulary	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: (COMMERICAL & MEICAID): 2 tablets per day		
FORMULARY ALTERNATIVES: (COMMERICAL): generic ursodiol 300 mg; (MEDICAID): generic ursodiol capsule/tablet; (MEDICARE): generic ursodiol 300 mg capsule, generic ursodiol 250 and 500 mg tablet		

DRUG NAME: methylphenidate ER orally disintegrating tablet – 8.6, 17.3, and 25.9 mg (Cotempla XR ABA)		**INDICATION:** For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in pediatric patients 6 to 17 years of age
REASON FOR CHANGE: New Drug		
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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL, MEDICAID) • 2 tablets per day – 17.3 & 25.9 mg • 1 tablet per day – 8.6 mg		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic methylphenidate CD capsule, generic methylphenidate ER tablet, generic methylphenidate ER(LA) capsule, generic methylphenidate ER (Concerta); (MEDICAID): methylphenidate IR generic, methylphenidate solution, methylphenidate ER tab (Metadate ER tab), methylphenidate ER (Concerta), dexmethylphenidate IR, dexmethylphenidate XR; (MEDICARE): generic methylphenidate ER tablets (10 and 20 mg)		

DRUG NAME: mFLUSIVA (influenza vaccine, mRNA) injectable suspension, for intramuscular use		**INDICATION:** For active immunization for the prevention of influenza disease caused by influenza virus subtypes A and type B represented in the vaccine. FDA approved for use in persons 50 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9	N/A
STANDARD FORMULARY	Tier 9	N/A
EXCHANGE FORMULARY	Tier 9	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Tier 1	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Nereus™ (tradipitant) 85 mg capsule		**INDICATION:** For the prevention of vomiting induced by motion in adults
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: (COMMERICAL & MEDICAID): 14 capsules per 30 days		
FORMULARY ALTERNATIVES: (COMMERICAL & MEDICARE): generic meclizine 25 mg tablets, generic promethazine solution/suppository/tablets, generic scopolamine patch; (MEDICAID): meclizine (OTC, Rx), generic promethazine solution/suppository/tablets		

DRUG NAME: Niktimvo (axatilimab-csfr) single-dose vial for intravenous infusion – 9 mg/0.9mL and 22 mg/2.2 mL vials		**INDICATION:** For the treatment of chronic graft-versus-host disease (cGVHD) after failure of at least 2 prior lines of systemic therapy in adult and pediatric patients weighing ≥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: Nufymco (ranibizumab-leyk) single-dose glass vial for intravitreal injection – 0.3 mg/0.05 mL and 5 mg/0.05 mL		**INDICATION:** For the treatment of diabetic macular edema; For the treatment of diabetic retinopathy; For the treatment of neovascular (wet) age-related macular degeneration (AMD)
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: Opsynvi® (macitentan/tadalafil) tablets, all strengths		**INDICATION:** For the treatment of pulmonary arterial hypertension (World Health Organization [WHO] Group 1 and WHO functional class [FC] II or III) to reduce the risk of clinical worsening events and hospitalization and improve exercise ability
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	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic macitentan tablets, generic tadalafil tablets ;(MEDICAID): ambrisentan (generic Letairis) 5 & 10mg, Tracleer® tab, Alyq (tadalafil), sildenafil tab/susp, tadalafil (generic Adcirca®); (MEDICARE): ambrisentan oral tablet, bosentan 62.5 mg and 125 mg tablet (*both require prior authorization)		

<table>
<tr><td colspan="2">DRUG NAME: Osvyrti™ (denosumab-desu) 60 mg/mL in a single-dose prefilled syringe</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Osvyrti is approved for the following treatment indications, which are also currently approved for Prolia: postmenopausal women with osteoporosis at high risk for fracture; increasing bone mass in men with osteoporosis at high risk for fracture; glucocorticoid-induced osteoporosis in men and women at high risk for fracture; increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer; and increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer</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>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria) (PHARMACY)</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>N/A (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): (PHARMACY) Enoby (require prior authorization); (MEDICARE): (PHARMACY) Jubbonti (require prior authorization)</td></tr>
</table>

DRUG NAME: Qivigy (immune globulin intravenous, human-kthm) 10% solution – 5g/50 mL & 10 g/100 mL single dose vial		**INDICATION:** For the treatment of adults with primary humoral immunodeficiency
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: generic ranitidine 150 mg & 300 mg tablets		**INDICATION:** For use to treat and prevent ulcers in the stomach and intestines. It is also used to treat conditions in which the stomach produces too much acid, such as Zollinger-Ellison syndrome. Ranitidine is also used to treat gastroesophageal reflux disease (GERD) and other conditions in which acid backs up from the stomach into the esophagus, causing heartburn.
REASON FOR CHANGE: Change Drug Tier		
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	Tier 2	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): cimetidine, famotidine, nizatidine; (MEDICAID): famotidine		

DRUG NAME: Proair Respiclick (albuterol sulfate) inhalation powder, for oral inhalation use		**INDICATION:** For the treatment or prevention of bronchospasm in patients 4 years of age and older with reversible obstructive airway disease; For the prevention of exercise-induced bronchospasm in patients 4 years of age and older
REASON FOR CHANGE: Change Drug Tier		
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: (COMMERCIAL): generic albuterol HFA inhaler; (MEDICAID): albuterol HFA (Proair Authorized Generic), albuterol HFA (Proventil Authorized Generic), Ventolin® HFA; (MEDICARE): albuterol HFA (Proair authorized generic), albuterol HFA (Proventil authorized generic		

DRUG NAME: Revtorpyk™ (gedatolisib) 180 mg lyophilized powder in a single-dose vial		**INDICATION:** For the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer without a PIK3CA mutation detected following progression on or after treatment with at least one line of endocrine therapy in the metastatic setting
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: RizaFilm (rizatriptan) oral film – 5 and 10 mg		**INDICATION:** For the acute treatment of migraine with or without aura in adults and pediatric patients ≥6 years of age
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 & MEDICAID): 12 tablets per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): rizatriptan tablet/ODT; (MEDICAID): sumatriptan succinate tablet/cartridge/vial/pen, rizatriptan tablet/MLT		

DRUG NAME: Saphnelo® (anifrolumab-fnia) 120 mg/0.8 mL single-dose syringe for subcutaneous injection		**INDICATION:** For the treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE), who are receiving standard 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	Non-Formulary	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 & MEDICAID): 4 syringes per 28 days		
FORMULARY ALTERNATIVES: (MEDICARE): Benlysta injection *requires prior authorization*		

DRUG NAME: Sarclisa Escena™ (isatuximab-irfc) 1400 mg/10 mL solution in single-dose vial for subcutaneous use		**INDICATION:** For use in combination with pomalidomide and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least 1 prior line of therapy including lenalidomide and a proteasome inhibitor; In combination with carfilzomib and dexamethasone, for the treatment of adult patients with relapsed or refractory multiple myeloma who have received 1 to 3 prior lines of therapy; In combination with bortezomib, lenalidomide and dexamethasone, for the treatment of adult patients with newly diagnosed multiple myeloma who are not eligible for autologous stem cell transplant (ASCT)
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: Selarsdi™ (ustekinumab-aekn) injection – 45 mg/0.5 mL syringe/vial or 90 mg/mL syringe		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
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	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID) • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 45 mg/0.5 mL vial – 1 vial per 84 days • 90 mg/mL syringe – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): Imuldosa, Yesintek *both require prior authorization*; (MEDICAID): Pyzchiva® syringe/vial, Starjemza™; (MEDICARE): Yesintek *requires prior authorization*		

DRUG NAME: Skyrizi® (risankizumab-rzaa) 55 mg/0.37 mL single-dose prefilled syringe		**INDICATION:** For the treatment of moderate-to-severe plaque psoriasis in adults and pediatric patients 6 years of age and older who are candidates for systemic therapy or phototherapy. For the treatment of active psoriatic arthritis in adults and pediatric patients 6 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), Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 0.37 mL (1 syringe) per 84 days; (MEDICARE): 6 syringes per 365 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: tapentadol 20 mg/mL solution		**INDICATION:** For the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate in adults and pediatric patients ≥6 years of age and ≥40 kg
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)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 30 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): hydrocodone/APAP, hydromorphone, morphine sulfate, oxycodone, oxycodone/APAP, oxymorphone, tramadol; (MEDICAID): codeine/APAP, hydrocodone/APAP, hydrocodone/ibuprofen, hydromorphone, morphine IR, oxycodone IR, oxycodone/APAP, tramadol HCl 50mg, tramadol HCl/APAP; (MEDICARE): hydrocodone/APAP solution, oxycodone solution		

DRUG NAME: Tepadina (thiotepa) 400 mg/bag for intravenous injection		**INDICATION:** To reduce the risk of graft rejection when used in conjunction with high-dose busulfan and cyclophosphamide as a preparative regimen for allogeneic hematopoietic progenitor (stem) cell transplantation (HSCT) for pediatric patients with class 3 beta-thalassemia; For treatment of adenocarcinoma of the breast or ovary; For controlling intracavitary effusions secondary to diffuse or localized neoplastic diseases of various serosal cavities; for treatment of superficial papillary carcinoma of the urinary bladder
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: Tevimbra® (tislelizumab-jsgr) 150 mg/15 mL solution in a single-dose vial for intravenous use		**INDICATION:** For use in in combination with platinum-containing chemotherapy for the first-line treatment of adults with unresectable or metastatic esophageal squamous cell carcinoma (ESCC) whose tumors express PD-L1 (≥1); As a single agent in adults with unresectable or metastatic esophageal squamous cell carcinoma (ESCC) after prior systemic chemotherapy that did not include a PD-(L)1 inhibitor; In combination with platinum and fluoropyrimidine-based chemotherapy in adults for the first line treatment of unresectable or metastatic HER2-negative gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 (≥1)
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: Tregzi™ (allogeneic regulatory T cell immunotherapy with HSPC and T cells-vldq) suspension for intravenous infusion		**INDICATION:** For use in matched donor hematopoietic stem cell transplantation with myeloablative preparative regimen, for hematopoietic and immunologic reconstitution and to improve chronic graft-versus-host disease (cGVHD)-free survival, in the treatment of adults with hematological malignancies
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: Trilitas™ (tazarotene) 0.1% gel		**INDICATION:** For the topical treatment of plaque psoriasis of up to 20% body surface area involvement; For the topical treatment of mild to moderate facial acne vulgaris
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: (COMMERCIAL): generic tazarotene 0.1% cream; (MEDICAID): adapalene gel OTC, tretinoin cream (0.025, 0.05, and 0.1%); (MEDICARE): generic tazarotene 0.1% cream (requires prior authorization)		

DRUG NAME: Tryngolza® (olezarsen) 50 mg/0.8 mL subcutaneous single-dose autoinjector		**INDICATION:** To reduce TG and the risk of acute pancreatitis in adults with severe hypertriglyceridemia (sHTG: TG greater than or equal to 500 mg/dL)
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 & MEDICAID): 1 autoinjector (0.8 mL) per 30 days		
FORMULARY ALTERNATIVES: (MEDICARE): fenofibrate (generic Tricor® 48 mg and 145 mg), gemfibrozil, icosapent ethyl (gen Vascepa®), omega-3 acid ethyl esters (requires prior authrorization)		

DRUG NAME: Tyvaso DPI® (trepostinil) inhalation powder 48-80 mcg maintenance kit		**INDICATION:** For the treatment of PAH (WHO Group I) in patients with NYHA Class III symptoms to improve exercise ability; For the treatment of pulmonary hypertension associated with interstitial lung disease (WHO Group 3) to improve exercise ability
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 & MEDICAID): 1 kit (224 cartridges) per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): ambrisentan (generic Letairis) 5 & 10mg, Tracleer® tab, Alyq (tadalafil), sildenafil tab/susp, tadalafil (generic Adcirca®); (MEDICARE): ambrisentan oral tablet, bosentan 62.5 mg and 125 mg tablet (*both require prior authorization)		

DRUG NAME: Ubrelvy (ubrogepant) oral tablet – 50 and 100 mg		**INDICATION:** For the treatment of migraine with or without aura in adults
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: (COMMERCIAL): 16 tablets per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Uptravi® (selexipag) tablet – 100 and 150 mcg		**INDICATION:** For the treatment of pulmonary arterial hypertension (PAH, WHO Group I) in pediatric patients aged two years 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	Non-Formulary	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: 2 tablets per day (both strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): sildenafil tablet and suspension		

DRUG NAME: Ursolign (ursodiol) 150 mg capsule		**INDICATION:** For the treatment of patients with radiolucent, noncalcified gallbladder stones <20 mm in greatest diameter in whom elective cholecystectomy would be undertaken except for the presence of increased surgical risk caused by systemic disease, advanced age, idiosyncratic reaction to general anesthesia, or for those patients who refuse surgery; For the prevention of gallstone formation in obese patients experiencing rapid weight loss
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: (COMMERCIAL & MEDICAID): ursodiol tablet, ursodiol 300 mg capsule; (MEDICARE): ursodiol 300 mg capsule, ursodiol 250 mg and 500 mg tablets		

DRUG NAME: Veppanu (vepdegestrant) oral tablet – 100 and 200 mg		**INDICATION:** For the treatment of adults with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, estrogen receptor-1 (ESR1)-mutated advanced or metastatic breast cancer, as detected by an FDA-authorized test, with disease progression following at least one line of endocrine 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	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Waskyra (etuvetidigene autotemcel) suspension, for intravenous use		**INDICATION:** For the treatment of pediatric patients aged 6 months and older and adults with Wiskott-Aldrich Syndrome (WAS) who have a mutation in the WAS gene and for whom hematopoietic stem cell transplantation (HSCT) is appropriate and no suitable human leukocyte antigen (HLA)-matched related stem cell donor is available
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: Xocova® (ensitrelvir) 125 mg tablet		**INDICATION:** For postexposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents 12 years of age and older following contact with an individual who has COVID-19
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	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERICAL & MEDICAID): 7 tablets (1 treatment course) per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID & MEDICARE): Paxlovid		

DRUG NAME: Xtoro™ (finafloxacin) 0.3% ear drop		**INDICATION:** For the treatment of acute otitis externa (AOE) caused by susceptible strains of Pseudomonas aeruginosa and Staphylococcus aureus
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: (COMMERCIAL): ciprofloxacin 0.2% otic solution, ciprofloxacin/hydrocortisone 0.2-0.1% otic suspension, ofloxacin 0.3% ear drops; (MEDICAID): ciprofloxacin/dexamethasone (generic Ciprodex), ofloxacin, neomycin/polymyxin/hc soln/sus; (MEDICARE): ciprofloxacin 0.2% otic drops, ofloxacin 0.3% otic drops, ciprofloxacin-dexamethasone 0.3-0.1% otic drops		

DRUG NAME: Yulithira (everolimus) tablets – 10, 2.5, 5 & 7.5 mg		**INDICATION:** For the treatment of advanced hormone receptor-positive, HER2-negative breast cancer in postmenopausal patients (in combination with exemestane and after letrozole or anastrozole failure); For the treatment of locally advanced, metastatic or unresectable progressive pancreatic neuroendocrine tumors (PNET) in adults; treatment of progressive, well-differentiated, nonfunctional GI or lung origin neuroendocrine tumors in adults with unresectable, locally advanced or metastatic disease; For the treatment of advanced renal cell carcinoma (RCC) after sunitinib or sorafenib failure in adults; For the treatment of renal angiomyolipoma, associated with TSC, not requiring immediate surgery in adults; For the treatment of subependymal giant cell astrocytoma (SEGA) associated with TSC in adults and pediatric patients ≥1 year of age which requires therapeutic intervention, but cannot be curatively resected.
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	Tier 2	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zenbexus™ (iberdomide) oral capsule – 0.75 and 1 mg		**INDICATION:** For the treatment (in combination with daratumumab/hyaluronidase and dexamethasone) of multiple myeloma in adults who have received at least 1 prior line of therapy including a proteasome inhibitor and an immunomodulatory agent
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	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 21 capsules per 28 days (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zeposia (ozanimod) 0.92 mg capsule		**INDICATION:** For the treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults; For the treatment of moderately to severely active ulcerative colitis in adults
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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 & MEDICAID): 1 capsule per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): dimethyl fumarate, Glatopa, glatiramer acetate, fingolimod, teriflunomide, Vumerity (requires PA), Kesimpta (requires PA; (MEDICAID): Avonex®, Copaxone 20 mg syringe®, dimethyl fumarate, fingolimod, Kesimpta® (ST), teriflunomide (generic Aubagio®); (MEDICARE): dimethyl fumarate, Glatopa, glatiramer acetate, fingolimod, teriflunomide, Kesimpta (all require prior authorization)		

DRUG NAME: Zeposia (ozanimod) starter kits (7-, 28-, and 37-day)		**INDICATION:** For the treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults; For the treatment of moderately to severely active ulcerative colitis in adults
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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 & MEDICAID): • Starter Kit (7-day): 7 capsules in 365 days • Starter Kit (28-day): 28 capsules in 365 days • Starter Kit (37-day): 37 capsules in 365 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): dimethyl fumarate, Glatopa, glatiramer acetate, fingolimod, teriflunomide, Vumerity (requires PA), Kesimpta (requires PA);(MEDICAID): Avonex®, Copaxone 20 mg syringe®, dimethyl fumarate, fingolimod, Kesimpta® (ST), teriflunomide (generic Aubagio®); (MEDICARE): dimethyl fumarate, Glatopa, glatiramer acetate, fingolimod, teriflunomide, Kesimpta (all require prior authorization)		

DRUG NAME: Zolymbus™ (bimatoprost) 0.01% ophthalmic gel		**INDICATION:** For the reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension
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: (COMMERCIAL): latanoprost, bimatoprost 0.01% or 0.03% eye drops; (MEDICAID): latanoprost, Travatan Z®; (MEDICARE): latanoprost, bimatoprost 0.01% eye drops, travoprost		

2027 Oncology Biosimilar Strategies

Bevacizumab				
Line of Business	**Preferred Products**	**Non-Preferred Products**	**Effective Date**	**Expectation**
Commercial	Vegzelma, Mvasi, Zirabev	Avastin, Alymsys, Jobevne, Avzivi	2/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.
Medicaid	Vegzelma, Mvasi, Zirabev	Avastin, Alymsys, Jobevne, Avzivi	2/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.
Medicare	Vegzelma, Mvasi, Zirabev	Avastin, Alymsys, Jobevne, Avzivi	1/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.*

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

Filgrastim				
Line of Business	**Preferred Products**	**Non-Preferred / Change**	**Effective Date**	**Expectation**
Commercial	Zarxio, Granix	Neupogen, Nivestym, Releuko, Filkri, Nypozi	2/1/2027	Medical + Pharmacy: PA will be added to non-formulary drugs. Change current members to a preferred product at reauthorization. Double step through preferred alternatives.
Medicare	Zarxio, Granix	Neupogen, Nivestym, Releuko, Filkri, Nypozi	1/1/2027	Medical: PA will be added to non-formulary drugs. Change current members to a preferred product at reauthorization. Double step through preferred alternatives.

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

Pegfilgrastim				
Line of Business	**Preferred Products**	**Non-Preferred / Change**	**Effective Date**	**Expectation**
Commercial	Udenyca, Fulphila	Neulasta, Nyvepria, Ziextenzo, Stimufend, Fylnetra, Ennumo, Armlupeg	2/1/2027	Medical + Pharmacy: PA will be added to non-formulary drugs. Change current members to a preferred product at reauthorization. Double step through preferred alternatives.
Medicare	Udenyca, Fulphila	Neulasta, Nyvepria, Ziextenzo, Stimufend, Fylnetra, Ennumo, Armlupeg	1/1/2027	Medical: PA will be added to non-formulary drugs. Change current members to a preferred product at reauthorization. Double step through preferred alternatives.

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

Trastuzumab				
Line of Business	**Preferred Products**	**Non-Preferred Products**	**Effective Date**	**Expectation**
Commercial	Ogivri, Ontruzant, Trazimera	Herceptin, Herceptin Hylecta, Kanjinti, Herzuma, Hercessi	2/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.
Medicaid	Ogivri, Ontruzant, Trazimera	Herceptin, Herceptin Hylecta, Kanjinti, Herzuma, Hercessi	2/1/2027	Continue per Appendix B DMAS PDL criteria.
Medicare	Ogivri, Ontruzant, Trazimera	Herceptin, Herceptin Hylecta, Kanjinti, Herzuma, Hercessi	1/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2027

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

Rituximab				
Line of Business	**Preferred Products**	**Non-Preferred Products**	**Effective Date**	**Expectation**
Commercial	Truxima, Riabni, Ruxience	Rituxan, Zimrixby, Rituxan Hycela	2/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.
Medicaid	Truxima, Riabni, Ruxience	Rituxan, Zimrixby, Rituxan Hycela	2/1/2027	Continue per Appendix B DMAS PDL criteria.
Medicare	Truxima, Riabni, Ruxience	Rituxan, Zimrixby, Rituxan Hycela	1/1/2027	Change current members to a preferred product at reauthorization. Double step through preferred alternatives.