Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

DRUG NAME: adalimumab-bwwd (CF) 40 mg/0.4 mL prefilled syringe/auto-injector		**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
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& MEDICIAD) 2 injections per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): adalimumab-adbm, Simlandi® (adalimumab-ryvk); (MEDICAID): adalimumab-adbm, Hadlima™; (MEDICARE): Simlandi®, Hadlima™		

DRUG NAME: Aqvesme™ (mitapivat) 100 mg tablets		**INDICATION:** For the treatment of anemia in adults with alpha- or beta-thalassemia
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): 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

June 2, 2026 (July – September 2026)
Should changes to this list occur, a Changed document will be posted with the above date modified. Please continue to visit our website www.sentarahealthplans.com for the most current version. Always refer to your Summary of Benefits for verification of coverage.

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

<table>
<tr><td colspan="2">DRUG NAME: Aukelso™ (denosumab-bnht) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial and in a single-dose prefilled syringe</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Aukelso 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>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</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>(PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

DRUG NAME: Avtozma® (tocilizumab-anoh) 162 mg/0.9 mL single-dose prefilled syringes and auto-injector for subcutaneous use	**INDICATION:** Biosimilar to Actemra® indicated for the treatment of: Adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs);Adult patients with giant cell arteritis; Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis; Patients 2 years of age and older with active systemic juvenile idiopathic arthritis; Adults and pediatric patients 2 years of age and older with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome, and; Hospitalized adult patients with coronavirus disease 2019 (COVID-19) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO)

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): 3.6 mL (4 injections) per 28 days

FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): Tyenne *requires prior authorization*; (MEDICAID): adalimumab-adbm, Enbrel® pen/sureclick, Hadlima™, Pyzchiva syringe/vial

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

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: 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): bacitracin/polymyxin b sulfate oint, ciprofloxacin drops, erythromycin, gentamicin drops/oint, moxifloxacin drops (generic Vigamox), ofloxacin drops, polymyxin/trimethoprim, tobramycin; (MEDICARE): Brand Besivance®		

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

<table>
<tr><td colspan="2">DRUG NAME: Bildyos® (denosumab-nxxp) 60 mg/mL in a single-dose prefilled syringe/vial</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Bildyos 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: Change Drug Tier and Utilization Management Requirements</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>N/A (MEDICAL)</td></tr>
<tr><td>Formulary</td><td>Prior Authorization (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>(PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

<table>
<tr><td colspan="2">DRUG NAME: Bilprevda® (denosumab-nxxp) 120 mg/1.7 mL solution in a single-dose vial</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Bilprevda 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: Change Drug Tier and Utilization Management Requirements</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>N/A (MEDICAL)</td></tr>
<tr><td>Formulary</td><td>Prior Authorization (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>(PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

DRUG NAME: Blenrep (belantamab mafodotin-blmf) 70 mg as a lyophilized powder in single-use vial for reconstitution & further dilution for injection, for intravenous use		**INDICATION:** For use in combination with bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Bosaya™ (denosumab-kyqq) 60 mg/mL in a single-dose prefilled syringe/vial</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Bosaya 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 (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>(PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: cefixime 400 mg tablets</td><td>INDICATION: For the treatment of uncomplicated urinary tract infections (due to Escherichia coli and Proteus mirabilis), otitis media (due to Haemophilus influenzae, Moraxella catarrhalis, and Streptococcus pyogenes), pharyngitis and tonsillitis (due to S. pyogenes), acute exacerbations of chronic bronchitis (due to Streptococcus pneumoniae and H. influenzae); uncomplicated cervical/urethral gonorrhea (due to Neisseria gonorrhoeae [penicillinase- and nonpenicillinase-producing])</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED)</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>N/A</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: (COMMERCIAL & MEDICARE): cefixime 400 mg capsules; (MEDICAID): cephalexin capsules/suspension, cefaclor 250 mg capsules, cefuroxime tablets</td></tr>
</table>

DRUG NAME: Corphena (dexchlorpheniramine) 2 mg/5 mL solution		**INDICATION:** For the treatment of perennial and seasonal allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; amelioration of allergic reactions to blood or plasma; dermatographism; adjunctive therapy for the management of anaphylactic reactions
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic desloratadine 5 mg tablets, levocetirizine tablets/solution; (MEDICAID): cetirizine liquid 1mg/1mL (RX/OTC), cetirizine tabs, OTC, levocetirizine tab, loratadine tab/syrup OTC; (MEDICARE): cetirizine liquid 1mg/1mL, levocetirizine tablets		

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

<table>
<tr><td colspan="2">DRUG NAME: Cyltezo® (adalimumab-adbm) injection, for subcutaneous use

*Change applicable for self-funded groups. Self-Funded Groups Include: Atlantic Orthopaedic, CBBT, City of Suffolk, City of Newport News, City of Virginia Beach, Hampton City Schools, HRSD, James City County, Lyon Shipyard Inc., Marine Hydraulics, Portsmouth Public Schools, Regent University, Seaward Marine Corporation, Sentara Health, St Mary's Home, Tidewater Physicians, VCU Health System, and Virginia Beach Schools</td><td>INDICATION: Humira Biosimilar FDA approved to treat several inflammatory diseases including: moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults, moderate-to-severe hidradenitis suppurativa in adult patients, and non-infectious intermediate, posterior, and panuveitis in adult patients</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: 2 injections per 28 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): adalimumab-adbm, Simlandi® (adalimumab-ryvk); (MEDICAID): adalimumab-adbm, Hadlima™; (MEDICARE): Simlandi®, Hadlima™</td></tr>
</table>

DRUG NAME: Daybue® Stix (trofinetide) for oral solution, all strengths – 5000, 6000 & 8000 mg packets		**INDICATION:** For the treatment of Rett syndrome in adults and pediatric patients ≥2 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): • 5,000 mg – 4 packets per day • 6,000 mg – 4 packets per day • 8,000 mg – 2 packets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Desloratadine 0.5 mg/mL solution		**INDICATION:** For the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis in adults and pediatric patients ≥2 years of age and perennial allergic rhinitis in adults and pediatric patients ≥6 months of age; For symptomatic relief of pruritus, reduction in number of hives, and reduction in size of hives associated with chronic spontaneous urticaria in adults and pediatric patients ≥6 months 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): 10 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic desloratadine 5 mg tablets; (MEDICAID): cetirizine liquid 1mg/1mL (RX/OTC), cetirizine tabs, OTC, levocetirizine tab, loratadine tab/syrup OTC; (MEDICARE): cetirizine liquid 1mg/1mL, levocetirizine tablets/solution		

DRUG NAME: generic dihydroergotamine 4 mg/mL nasal spray		**INDICATION:** For the acute treatment of migraine with or without aura in adults
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 8 mL per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: generic dihydroergotamine 1 mg/mL ampule		**INDICATION:** For the acute treatment of migraine with or without aura and the acute treatment of cluster headaches in adults
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 24 mL per 28 days; (MEDICARE): 8 mL per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Duratuss AC (dexbrompheniramine/codeine) 10 mg-1 mg/5 mL liquid		**INDICATION:** To temporarily relieve symptoms due to the common cold, hay fever (allergic rhinitis) or other upper respiratory allergies
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	Age-Edit < 18 years of age
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic guaifenesin-codeine liquid, guaifenesin AC cough syrup, benzonatate capsules; (MEDICAID): generic guaifenesin-codeine liquid, guaifenesin AC cough syrup, benzonatate capsules		

DRUG NAME: Enoby™ (denosumab-qbde) 60 mg/mL in a single-dose prefilled syringe/vial		**INDICATION:** An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Enoby 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
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 **(MEDICAL)**
	Non-Formulary	Prior Authorization **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	Prior Authorization **(MEDICAL)**
	Non-Formulary	**(PHARMACY)**
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Exdensur® (depemokimab-ulaa) 100 mg/mL in a single dose, prefilled pen/syringe, for subcutaneous use		**INDICATION:** For the add-on maintenance treatment of severe asthma in adults and pediatric patients ≥12 years of age with an eosinophilic phenotype
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: Ferabright™ (ferumoxytol injection), for intravenous use, all strengths		**INDICATION:** For magnetic resonance imaging (MRI) of the brain in adults with known or suspected malignant neoplasms in the brain to visualize lesions with a disrupted blood-brain barrier
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: Forzinity™ (elamipretide) 280 mg/3.5 mL solution for injection in single-patient use vials		**INDICATION:** For use to improve muscle strength in adult and pediatric patients with Barth syndrome weighing at least 30 kg
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID) 4 vials per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Furoscix® (furosemide) 80 mg/10 mL injection for subcutaneous use		**INDICATION:** For the treatment of congestion due to fluid overload in adult patients with chronic heart failure
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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 6 kits per 90 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): furosemide tablets		

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

<table>
<tr><td colspan="2">DRUG NAME: Hemlibra® (emicizumab-kxwh) injection, for subcutaneous use, all strengths</td><td>INDICATION: For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients ages newborn and older with hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Add Utilization Management Requirements</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>Formulary</td><td>N/A (PHARMACY)</td></tr>
<tr><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

DRUG NAME: Brand Humira® (adalimumab) injection, for subcutaneous use ***Change applicable for self-funded groups.** Self-Funded Groups Include: Atlantic Orthopaedic, CBBT, City of Suffolk, City of Newport News, City of Virginia Beach, Hampton City Schools, HRSD, James City County, Lyon Shipyard Inc., Marine Hydraulics, Portsmouth Public Schools, Regent University, Seaward Marine Corporation, Sentara Health, St Mary's Home, Tidewater Physicians, VCU Health System, and Virginia Beach Schools		**INDICATION:** FDA approved to treat several inflammatory diseases including: moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults, moderate-to-severe hidradenitis suppurativa in adult patients, and non-infectious intermediate, posterior, and panuveitis in adult patients.
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
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: 2 injections per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): adalimumab-adbm, Simlandi® (adalimumab-ryvk); (MEDICAID): adalimumab-adbm, Hadlima™; (MEDICARE): Simlandi®, Hadlima™		

DRUG NAME: Hymovis® One 32 mg/4 mL syringe injection		**INDICATION:** For use to temporarily relieve knee pain caused by osteoarthritis
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: Hyrnuo® (sevabertinib) 10 mg tablets		**INDICATION:** For the treatment (as a single agent) of locally advanced or metastatic non squamous non–small cell lung cancer whose tumors have HER2 (ERBB2) tyrosine kinase domain activating mutations (as detected by an approved test), in adults, who have received a prior systemic therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Imaavy™ (nipocalimab-aahu) 300 mg/1.26 mL vial		**INDICATION:** For the treatment of generalized myasthenia gravis in adult and pediatric patients ≥12 years of age who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Itvisma® (onasemnogene abeparvovec-brve) suspension, for intrathecal injection		**INDICATION:** For the treatment of spinal muscular atrophy (SMA) in adult and pediatric patients 2 years of age and older with confirmed mutation in SMN1 gene
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: Javadin™ (clonidine HCl) 0.02 mg/mL solution		**INDICATION:** For the treatment of hypertension in adult patients to lower blood pressure
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, MEDICAID & MEDICARE): 30 mL per day		
FORMULARY ALTERNATIVES: generic clonidine tablets/patches		

DRUG NAME: Jaythari (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): Brand Emflaza; (MEDICARE): generic oral corticosteroids		

DRUG NAME: Jubbonti® (denosumab-bbdz) 60 mg/mL in a single-dose prefilled syringe		**INDICATION:** An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Jubbonti 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
REASON FOR CHANGE: Change Utilization Management Requirements		
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 **(MEDICAL)**
	Formulary	Prior Authorization **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	N/A **(MEDICAL)**
	Formulary	Prior Authorization, Quantity Limit **(PHARMACY)**
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Komzifti™ (ziftomenib) 200 mg capsules		**INDICATION:** For the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation who have no satisfactory alternative treatment options
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 3 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Kymbee (deflazacort) tablets, all strengths		**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): Brand Emflaza; (MEDICARE): generic oral corticosteroids		

DRUG NAME: Lasix® ONYU (furosemide injection) 80 mg per 2.67 mL in a single-dose prefilled cartridge co-packaged with a single-use Disposable Unit of the Infusor		**INDICATION:** For the treatment of edema in adult patients with chronic heart failure
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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 6 kits per 90 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): furosemide tablets		

DRUG NAME: levetiracetam 500 mg tablets for suspension		**INDICATION:** For the treatment of focal (partial) onset seizures in adults and children ≥4 years of age and >20 kg; For adjunctive therapy in the treatment of myoclonic seizures in adults and adolescents 12 years and older with juvenile myoclonic epilepsy; and for adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in adults and children 6 years and older with idiopathic generalized epilepsy
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: generic levetiracetam IR tablets/solution/ER tablets		

DRUG NAME: Lodoco® (colchicine) tablets		**INDICATION:** For use to reduce the risk of myocardial infarction, stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular 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	Tier 3	Prior Authorization, 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: 1 tablet per day		
FORMULARY ALTERNATIVES: atorvastatin, rosuvastatin, ezetimibe		

DRUG NAME: Lopressor (metoprolol tartrate) 12.5 mg tablets		**INDICATION:** For the long-term treatment of angina pectoris; Management of hypertension; and for the treatment of hemodynamically stable acute myocardial infarction to reduce cardiovascular mortality (injection to be used in combination with metoprolol oral maintenance therapy)
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): 2 tablets per day		
FORMULARY ALTERNATIVES: generic metoprolol tartrate 25, 50 & 100 mg tablets		

DRUG NAME: Lunsumio Velo™ (mosunetuzumab-axgb) 45 mg/mL solution in a single-dose vial for injection, for subcutaneous use		**INDICATION:** For the treatment of relapsed or refractory follicular lymphoma in adults after ≥2 lines of systemic therapy
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: Lymphir™ (denileukin diftitox-cxd) 300 mcg lyophilized cake in a single-dose vial for injection, for intravenous use		**INDICATION:** For the treatment of relapsed or refractory stage I to III cutaneous T-cell lymphoma in adults after at least one prior systemic therapy
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: Lynkuet® (elinzanetant) 60 mg capsules		**INDICATION:** For the treatment of moderate to severe vasomotor symptoms associated with menopause
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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID) 2 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL& MEDICAID): oral estrogen tablets, transdermal estrogen patches, SNRI's, SSRI's, gabapentin, clonidine, oxybutynin; (MEDICARE): oral estrogen tablets, transdermal estrogen patches, SNRI's, SSRI's,		

DRUG NAME: meloxicam 7.5 mg/5 mL suspension		**INDICATION:** For the relief of the signs and symptoms of osteoarthritis; management of osteoarthritis pain; and for the relief of signs and symptoms of rheumatoid arthritis (RA); relief of the signs and symptoms of pauciarticular or polyarticular course juvenile RA in patients ≥2 years of age (suspension) and in patients weighing ≥60 kg (tablet)
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: 10 mL per day		
FORMULARY ALTERNATIVES: generic meloxicam tablets		

DRUG NAME: Metoprolol tartrate 12.5 mg tablets		**INDICATION:** For the long-term treatment of angina pectoris; Management of hypertension; and for the treatment of hemodynamically stable acute myocardial infarction to reduce cardiovascular mortality (injection to be used in combination with metoprolol oral maintenance therapy)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 2 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): generic metoprolol tartrate 25, 50 & 100 mg tablets		

DRUG NAME: midazolam 10 mg/0.7 mL auto-injector		**INDICATION:** For the treatment of status epilepticus in adults
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: generic mycophenolate 200 mg/mL suspension (CellCept®)		**INDICATION:** For the prophylaxis of organ rejection, in adult and pediatric recipients 3 months of age and older of allogeneic kidney, heart or liver transplants, in combination with other immunosuppressants
REASON FOR CHANGE: Add Age Edit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization (Age- Edit = > 8 years old)
STANDARD FORMULARY	Tier 2	Prior Authorization (Age- Edit = > 8 years old)
EXCHANGE FORMULARY	Tier 2	Prior Authorization (Age- Edit = > 8 years old)
FAMIS FORMULARY	Formulary	Prior Authorization (Age- Edit = > 8 years old)
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (Age- Edit = > 8 years old)
MEDICARE FORMULARY	Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Myqorzo™ (aficamten) tablets, all strengths – 5, 10, 15 & 20 mg		**INDICATION:** For the treatment of symptomatic obstructive hypertrophic cardiomyopathy in adults to improve functional capacity and symptoms
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): 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: atenolol, metoprolol, verapamil, diltiazem, disopyramide		

DRUG NAME: nelarabine 375 mg/75 mL vial		**INDICATION:** For the treatment of relapsed or refractory T-cell acute lymphoblastic leukemia/lymphoma in adult and pediatric patients ≥1 year of age following treatment with at least 2 chemotherapy regimens
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: Omlonti® (omidenepag isopropyl ophthalmic solution) 0.002%		**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	Tier 3	Step Edit
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): bimatoprost 0.03%, latanoprost, Lumigan 0.01%; (MEDICAID): latanoprost, Travatan Z®; (MEDICARE): latanoprost, travaprost, Lumigan, Vyzulta		

DRUG NAME: Ontralfy (tizanidine) 2 mg/5 mL solution		**INDICATION:** For the treatment of spasticity 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	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 60 mL per day		
FORMULARY ALTERNATIVES: generic tizanidine tablets/capsules		

DRUG NAME: Opdivo Qvantig™ (nivolumab/hyaluronidase-nvhy) 300 mg nivolumab and 5,000 units hyaluronidase per 2.5 mL (120 mg/2,000 units per mL) in a single-dose vial		**INDICATION:** For the treatment of renal cell carcinoma, melanoma, non-small cell lung cancer, head and neck squamous cell carcinoma, urothelial carcinoma, colorectal cancer, hepatocellular carcinoma, esophageal carcinoma, gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma
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: Orladeyo® (berotralstat) – 72, 96, 108 & 132 mg pellet packets		**INDICATION:** For prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 2 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	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 packet per day (all strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): Cinryze™; (MEDICARE): Haegarda *requires prior authorization*		

DRUG NAME: Orudis (ketoprofen) 75 mg capsule		**INDICATION:** For the management of the signs and symptoms of osteoarthritis, management of pain, treatment of primary dysmenorrhea; and for the management of the signs and symptoms of rheumatoid arthritis
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): 4 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): ibuprofen tabs, naproxen tabs, meloxicam tabs; (MEDICAID): diclofenac sodium, ibuprofen cap, ibuprofen tab 100mg, 200mg, 400mg, 600mg, 800mg (OTC & Rx), meloxicam tab, naproxen tab, naproxen sodium (OTC), naproxen EC (Rx), sulindac		

DRUG NAME: Osenvelt® (denosumab-bmwo) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial		**INDICATION:** An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Osenvelt 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
REASON FOR CHANGE: Change Utilization Management Requirements		
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 **(MEDICAL)**
	Formulary	Prior Authorization **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	N/A **(MEDICAL)**
	Formulary	Prior Authorization **(PHARMACY)**
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Pazopanib HCl 400 mg tablet		**INDICATION:** For the treatment of advanced renal cell carcinoma in adults and advanced soft tissue sarcoma in adults who have received prior chemotherapy
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	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Pivya™ (pivmecillinam) 185 mg tablets		**INDICATION:** For the treatment of uncomplicated urinary tract infection caused by susceptible isolates of Escherichia coli, Proteus mirabilis, and Staphylococcus saprophyticus in female patients ≥18 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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 9 tablets (1 box) per 30 days		
FORMULARY ALTERNATIVES: generic nitrofurantoin capsules, cephalexin capsules, trimethoprim-sulfamethoxazole tablets		

DRUG NAME: Pokonza™ (potassium chloride) 15 mEq packet for oral solution		**INDICATION:** For the treatment and prophylaxis of hypokalemia with or without metabolic alkalosis, in patients for whom dietary management with potassium-rich foods or diuretic dose reduction is insufficient
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 & MEDICAID): 1 packet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): potassium chloride 10% solution, Klor-Con M15 tablet; (MEDICAID & MEDICARE): potassium chloride 10% solution, potassium chloride 20 mEq packet		

DRUG NAME: Pokonza (potassium chloride) 5% (10 mEq/15 mL) solution		**INDICATION:** For the treatment and prophylaxis of hypokalemia with or without metabolic alkalosis, in patients for whom dietary management with potassium-rich foods or diuretic dose reduction is insufficient
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): 60 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): potassium chloride 10% solution, Klor-Con M10 tablet; (MEDICAID & MEDICARE): potassium chloride 10% solution, potassium chloride 20 mEq packet		

DRUG NAME: Potassium chloride 40 mEq packet for oral solution		**INDICATION:** For the treatment and prophylaxis of hypokalemia with or without metabolic alkalosis, in patients for whom dietary management with potassium-rich foods or diuretic dose reduction is insufficient
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 & MEDICAID): 1 packet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): potassium chloride 10% solution, potassium chloride ER 20 mEq tablet; (MEDICAID & MEDICARE): potassium chloride 10% solution, potassium chloride 20 mEq packet		

DRUG NAME: Redemplo® (plozasiran) 25 mg/0.5 mL solution in a single-dose prefilled syringe		**INDICATION:** For use as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome
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) 0.5 mL (1 injection) per 90 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rybrevant Faspro™ (amivantamab and hyaluronidase-lpuj) 1600 mg, 2240 mg, 2400 mg & 3520 mg single-dose vial for injection, for subcutaneous use	**INDICATION:** Non–small cell lung cancer, locally advanced or metastatic, with EGFR exon 19 deletion or exon 21 L858R substitution mutation, first-line treatment: First-line treatment (in combination with lazertinib) of locally advanced or metastatic non–small cell lung cancer (NSCLC) in adults with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations (as detected by an approved test); Non–small cell lung cancer, locally advanced or metastatic, with EGFR exon 19 deletion or exon 21 L858R substitution mutation, previously treated: Treatment (in combination with pemetrexed and carboplatin) of locally advanced or metastatic NSCLC in adults with EGFR exon 19 deletions or exon 21 L858R substitution mutations, with disease progression on or after treatment with an EGFR tyrosine kinase inhibitor; Non–small cell lung cancer, locally advanced or metastatic, with EGFR exon 20 insertion mutation, first-line treatment: First-line treatment (in combination with pemetrexed and carboplatin) of locally advanced or metastatic NSCLC in adults with EGFR exon 20 insertion mutations (as detected by an approved test); Non–small cell lung cancer, locally advanced or metastatic, with EGFR exon 20 insertion mutation, previously treated: Treatment (as a single agent) of locally advanced or metastatic NSCLC in adults with EGFR exon 20 insertion mutations (as detected by an approved test) with disease progression on or after platinum-based chemotherapy.

REASON FOR CHANGE: New Drug

FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization

QUANTITY LIMIT: N/A

FORMULARY ALTERNATIVES: N/A

DRUG NAME: Sdamlo (amlodipine) powder for solution, all strengths – 10, 2.5 & 5 mg		**INDICATION:** For the treatment of symptomatic chronic stable angina; treatment of confirmed or suspected vasospastic angina (previously referred to as Prinzmetal or variant angina); and for the management of hypertension in adults and children ≥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): 1 bottle per day (all strengths)		
FORMULARY ALTERNATIVES: generic amlodipine tablets		

DRUG NAME: Shingrix (zoster vaccine recombinant, adjuvated) 50 mcg/0.5 mL single-dose, disposable, prefilled syringe		**INDICATION:** For the prevention of herpes zoster (shingles) in patients ≥50 years of age and in patients ≥18 years of age who are or will be at increased risk for herpes zoster due to immunodeficiency or immunosuppression caused by disease or therapy
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	Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Starjemza (ustekinumab-hmny) injection, for subcutaneous use - 45 mg/0.5 mL solution in a single-dose prefilled syringe/vial and 90 mg/mL solution in a single-dose prefilled 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: 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) • 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 & MEDICARE): Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Hadlima™, Pyzchiva syringe/vial		

<table>
<tr><td colspan="2">DRUG NAME: Starjemza (ustekinumab-hmny) injection, 130 mg/26 mL vial for intravenous administration</td><td>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)</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), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Hadlima™, Pyzchiva syringe/vial</td></tr>
</table>

DRUG NAME: Stoboclo® (denosumab-bmwo) 60 mg/mL in a single-dose prefilled syringe		**INDICATION:** An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Stoboclo 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
REASON FOR CHANGE: Change Utilization Management Requirements		
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 **(MEDICAL)**
	Formulary	Prior Authorization **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	N/A **(MEDICAL)**
	Formulary	Prior Authorization, Quantity Limit **(PHARMACY)**
QUANTITY LIMIT: (MEDICARE): 1 syringe per 180 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Subvenite® (lamotrigine) 10 mg/mL suspension		**INDICATION:** For the maintenance treatment of bipolar disorder to delay the time to occurrence of mood episodes (depression, mania, hypomania, episodes with mixed features), as monotherapy or adjunctive therapy; For the treatment of Lennox-Gastaut syndrome (adjunctive therapy only), primary generalized tonic-clonic seizures (adjunctive therapy only), and focal onset seizures (monotherapy or adjunctive therapy)
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	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (MEDICARE): 1500 mL per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic lamotrigine tablets/chew tab; (MEDICAID): lamotrigine tabs/chew tab, lamotrigine XR, subvenite tab (generic lamotrigine)		

DRUG NAME: Tizanidine HCL 8 mg capsules		**INDICATION:** For the treatment of spasticity 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	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 3 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic tizanidine tablets/capsules; (MEDICAID & MEDICARE): generic tizanidine tablets		

DRUG NAME: Tyvaso DPI® (treprostinil) inhalation powder 80 mcg cartridge, 32-64 maintenance kit & 48-64 maintenance kit		**INDICATION:** For the treatment of pulmonary arterial hypertension (PAH; WHO Group 1) 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 pack per 30 days (all strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): Ventavis®; (MEDICARE): generic ambrisentan, generic bosentan		

DRUG NAME: Tyzavan (vancomycin injection) 1.25 gram/250 mL bag, 1.5 gram/300 mL bag, 1.75 gram/350 mL bag, 2 gram/400 mL bag, 500 mg/100 mL bag, & 750 mg/150 mL bag for intravenous use		**INDICATION:** For the treatment of the following infections in adult and pediatric patients (1 month and older) for whom appropriate dosing with this formulation can be achieved: septicemia, infective endocarditis, skin and skin structure infections, bone infections, & lower respiratory tract infections
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: Ustekinumab-aauz injection, for subcutaneous use - 45 mg/0.5 mL and 90 mg/mL solution in a single-dose prefilled 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: 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) • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 90 mg/mL syringe – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Hadlima™, Pyzchiva syringe/vial		

DRUG NAME: Ustekinumab-ttwe injection, for subcutaneous use - 45 mg/0.5 mL vial		**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: 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): 45 mg/0.5 mL vial – 1 vial per 84 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): adalimumab-adbm, Enbrel® pen/sureclick, Hadlima™, Pyzchiva syringe/vial		

DRUG NAME: Voyxact® (sibeprenlimab-szsi) 400 mg/2 mL in a single-dose prefilled syringe		**INDICATION:** For use to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression
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) 2 mL (1 injection) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vraylar® (cariprazine) 0.5 mg and 0.75 mg capsules		**INDICATION:** For treatment of schizophrenia in adult and pediatric patients 13 years of age and older and for acute treatment of manic or mixed episodes associated with bipolar I disorder in adult and pediatric patients 10 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 capsule per day (both strengths); (MEDICARE): 30 capsules per 30 days (both strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): aripiprazole, risperidone, quetiapine IR/ER		

DRUG NAME: Vybrique™ (sildenafil) – 25, 50, 75 & 100 mg films		**INDICATION:** For the treatment of erectile dysfunction
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary – **GROUP SPECIFIC BENEFIT**	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary – **GROUP SPECIFIC BENEFIT**	Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Excluded Benefit	N/A
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: (COMMERCIAL): 6 films per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic sildenafil (Viagra) tablets		

DRUG NAME: Vykoura™ (leucovorin calcium) injection, for intravenous or intramuscular use		**INDICATION:** For rescue after high-dose methotrexate therapy in adult and pediatric patients; Reducing the toxicity of methotrexate in adult and pediatric patients with impaired methotrexate elimination or folic acid antagonists or dihydrofolate reductase (DHFR) inhibitors following an overdose in adult and pediatric patients; Treatment of megaloblastic anemias due to folic acid deficiency in adult and pediatric patients when oral therapy is not feasible; Treatment of patients with metastatic colorectal cancer in combination with 5-fluorouracil
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		

<table>
<tr><td colspan="2">DRUG NAME: Wyost® (denosumab-bbdz) 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). Wyost 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: Change Drug Tier and Utilization Management Requirements</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>N/A</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Formulary</td><td>Prior Authorization (PHARMACY)</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Formulary</td><td>Prior Authorization (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Xtrenbo™ (denosumab-bnht) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial and in a single-dose prefilled syringe</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Xtrenbo 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>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</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>(PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Xyvona (levorphanol) – 2 & 3 mg tablets		**INDICATION:** For the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (MEDICAID) • 2 mg – 4 tablets per day • 3 mg – 3 tablets per day		
FORMULARY ALTERNATIVES: codeine/APAP, hydrocodone/APAP, hydrocodone/ibuprofen, hydromorphone, morphine IR, oxycodone IR, oxycodone/APAP, tramadol HCl 50 mg, tramadol HCl/APAP		

DRUG NAME: Yartemlea (narsoplimab-wuug) 370 mg/2 mL (185 mg/mL) in a single-dose vial for injection, for intravenous use		**INDICATION:** For the treatment of hematopoietic cell transplant-associated thrombotic microangiopathy (TA-TMA) in adult and pediatric patients ≥ 2 years of age
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		

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2026

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

DRUG NAME: Yuflyma (adalimumab-aaty) injection, for subcutaneous use ***Change applicable for self-funded groups.** Self-Funded Groups Include: Atlantic Orthopaedic, CBBT, City of Suffolk, City of Newport News, City of Virginia Beach, Hampton City Schools, HRSD, James City County, Lyon Shipyard Inc., Marine Hydraulics, Portsmouth Public Schools, Regent University, Seaward Marine Corporation, Sentara Health, St Mary's Home, Tidewater Physicians, VCU Health System, and Virginia Beach Schools		**INDICATION:** Humira Biosimilar FDA approved to treat several inflammatory diseases including: moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults, moderate-to-severe hidradenitis suppurativa in adult patients, and non-infectious intermediate, posterior, and panuveitis in adult patients
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
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: 2 injections per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): adalimumab-adbm, Simlandi® (adalimumab-ryvk); (MEDICAID): adalimumab-adbm, Hadlima™; (MEDICARE): Simlandi®, Hadlima™		

DRUG NAME: Zepbound® (tirzepatide) KwikPen, all strengths		**INDICATION:** For the treatment of moderate to severe obstructive sleep apnea in adults with obesity; and for use as an adjunct to a reduced-calorie diet and increased physical activity to reduce excess body weight and maintain weight reduction long-term in adults with obesity, or in adults with overweight in the presence of ≥1 weight-related comorbid condition (e.g., cardiovascular disease, dyslipidemia, hypertension, obstructive sleep apnea, type 2 diabetes mellitus)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary – **GROUP SPECIFIC BENEFIT**	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary – **GROUP SPECIFIC BENEFIT**	Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Excluded Benefit	N/A
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 2 mL (4 pens) per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): Zepbound pen *requires prior authorization		

DRUG NAME: Zybic (meloxicam) 7.5 mg/5 mL suspension		**INDICATION:** For the relief of the signs and symptoms of osteoarthritis; management of osteoarthritis pain; and for the relief of signs and symptoms of rheumatoid arthritis (RA); relief of the signs and symptoms of pauciarticular or polyarticular course juvenile RA in patients ≥2 years of age (suspension) and in patients weighing ≥60 kg (tablet)
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): 10 mL per day		
FORMULARY ALTERNATIVES: generic meloxicam tablets		

DRUG NAME: Zycubo® (copper histidinate) 2.9 mg of copper histidinate (equivalent to 0.5 mg elemental copper) as a lyophilized powderor cake in a single-dose vial for reconstitution for injection, for subcutaneous use		**INDICATION:** For the treatment of Menkes disease in pediatric 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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 2 vials per day		
FORMULARY ALTERNATIVES: N/A		