Sentara Health Plans Pharmacy Changes

Effective: October 1, 2024

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

<table>
<tr><td colspan="2">DRUG NAME: Adalimumab-aaty CF prefilled syringe/auto-injectors, all strengths</td><td>INDICATION: Low WAC Humira Biosimilar FDA approved to treat eight inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults and moderate-to-severe hidradenitis suppurativa in adult patients</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
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<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL): 2 injections per 28 days
(MEDICAID): 2 injections per 28 days
(MEDICARE): N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID) Humira pen/syringe (Abbvie mfg only); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]</td></tr>
</table>

DRUG NAME: Adalimumab-adbm CF prefilled syringe/auto-injectors, all strengths & formulations		**INDICATION:** High concentration, Low WAC Humira Biosimilar FDA approved to treat eight inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults and moderate-to-severe hidradenitis suppurativa in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 injections per 28 days • (MEDICAID): 2 injections per 28 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID) Humira pen/syringe (Abbvie mfg only); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]		

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

DRUG NAME: Alvaiz™ (eltrombopag) tablets, all strengths		**INDICATION:** For the treatment of thrombocytopenia in adult and pediatric patients 6 years and older with persistent or chronic immune thrombocytopenia who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy; thrombocytopenia in adult patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy; and adult patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 9 mg, 18 mg – 1 tablet per day • 36 mg, 54 mg – 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Alyglo™ (immune globulin intravenous, human-stwk) 10% liquid		**INDICATION:** For the treatment of primary humoral immunodeficiency (PI) in adults
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: Amtagvi™ (lifileucel) single IV infusion containing 7.5 x 10^9 to 72 x 10^9 viable cells		**INDICATION:** For use to treat adults who have unresectable or metastatic melanoma previously treated with a PD-1 blocking antibody, and if BRAF V600 mutation positive, a BRAF inhibitor with or without a MEK inhibitor
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Austedo® (deutetrabenazine) IR tablets, all strengths		**INDICATION:** For the treatment of chorea associated with Huntington disease in adults; For the treatment of tardive dyskinesia in adults.
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (COMMERCIAL): 4 tablets per day		
FORMULARY ALTERNATIVES: N/A		

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

DRUG NAME: baclofen 15 mg tablets		**INDICATION:** For the management of reversible spasticity associated with multiple sclerosis or spinal cord lesions.
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	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL): 8 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) baclofen 10 mg tablets; (MEDICAID) baclofen 10 mg tablets; (MEDICARE) baclofen 5 & 10 mg		

DRUG NAME: candesartan (Atacand®) tablets, all strengths		**INDICATION:** For the treatment of heart failure (NYHA class II to IV) in adults with left ventricular systolic dysfunction (ejection fraction ≤40%) to reduce cardiovascular death and heart failure hospitalization; For the management of hypertension in adults and children ≥1 year of age; Treatment for episodic migraine prevention in adults
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Step-Edit, Quantity Limit
STANDARD FORMULARY	Tier 2	Step-Edit, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Step-Edit, Quantity Limit
FAMIS FORMULARY	Formulary	Step-Edit, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 2	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day (all strengths) • (MEDICAID): 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Cyltezo® (dalimumab-adbm) CF prefilled syringe/auto-injectors, all strengths & formulations		**INDICATION:** High concentration, High WAC Humira Biosimilar FDA approved to treat eight inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults and moderate-to-severe hidradenitis suppurativa in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 injections per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID) Humira pen/syringe (Abbvie mfg only)		

DRUG NAME: Eohilia™ (budesonide) 2 mg/10 mL oral suspension (in single dose stick packs)		**INDICATION:** For the treatment of adult and pediatric patients ≥11 years of age with eosinophilic esophagitis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 60 stick packs (1 carton) per 30 days; Maximum QL is 180 stick packs (3 cartons) per 180 days • (MEDICAID): 60 stick packs (1 carton) per 30 days; Maximum QL is 180 stick packs (3 cartons) per 180 days • (MEDICARE): N/A 60 stick packs (1 carton) per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Filsuvez® (birch triterpenes) 10% topical gel		**INDICATION:** For the treatment of wounds associated with dystrophic and junctional epidermolysis bullosa in adults and pediatric patients ≥6 months 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
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Focinvez™ (fosaprepitant) injection		**INDICATION:** For use in combination with other antiemetic agents, in adults and pediatric patients 6 months of age and older for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin; Delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC)
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: Hepzato Kit™ (melphalan/hepatic delivery system)		**INDICATION:** For use as a liver-directed treatment for adult patients with uveal melanoma with unresectable hepatic metastases affecting less than 50% of the liver and no extrahepatic disease or extrahepatic disease limited to the bone, lymph nodes, subcutaneous tissues, or lung that is amenable to resection or 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		

DRUG NAME: iDose® TR (travoprost intracameral implant) 75 mcg		**INDICATION:** For the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ingrezza® (valbenazine) capsules, all strengths		**INDICATION:** For the treatment of adults with chorea associated with Huntington disease; For the treatment of adults with tardive dyskinesia
REASON FOR CHANGE: 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 (PDL Criteria); Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization; Quantity Limit
QUANTITY LIMIT: 1 capsule per day (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lenmeldy™ (atidarsagene autotemcel) suspension for intravenous infusion		**INDICATION:** For the treatment of children with pre-symptomatic late infantile (PSLI), pre-symptomatic early juvenile (PSEJ) or early symptomatic early juvenile (ESEJ) metachromatic leukodystrophy (MLD)
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: Livmarli® (maralixibat) oral solution		**INDICATION:** For the treatment of cholestatic pruritus in patients with Alagille syndrome ≥3 months; For the treatment of cholestatic pruritus in patients ≥5 years of age with progressive familial intrahepatic cholestasis
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 4 mL per day • (MEDICAID): 4 mL per day • (MEDICARE): 120 mL per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: mirabegron ER (Myrbetriq®) tablets		**INDICATION:** For the treatment of neurogenic detrusor overactivity in pediatric patients ≥3 years of age (granules) and weighing ≥35 kg (tablets); For the treatment of overactive bladder in adults with symptoms of urinary frequency, urgency, or urge urinary incontinence as monotherapy or in combination with an antimuscarinic agent
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Step- Edit
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Tier 2	Step- Edit
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: (MEDICAID) oxybutynin tab/syrup, oxybutynin ER, solifenacin, Toviaz		

DRUG NAME: Ogsiveo™ (nirogacestat) 100 & 150 mg tablets		**INDICATION:** For progressing desmoid tumors in adults who require systemic treatment
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: 2 tablets per day (both strengths) • MEDICAID: 2 tablets per day (both strengths) • MEDICARE: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ormalvi (dichlorphenamide) 50 mg tablets		**INDICATION:** For the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants
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: 4 tablet per day • MEDICAID: 4 tablet per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) generic dichlorphenamide (requires prior authorization); (MEDICAID) generic dichlorphenamide (requires prior authorization); (MEDICARE) acetazolamide capsules/tablets		

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

DRUG NAME: Pemgarda™ (pemivibart)		**INDICATION:** For the preexposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents (12 years of age and older weighing at least 40 kg): who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual infected with SARS-CoV-2; and who have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments and are unlikely to mount an adequate response to COVID-19 vaccination
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: RevivaSil™ (silicone) gel-pad kit		**INDICATION:** For the management of hypertrophic, hyperpigmented, and keloid scar tissue
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Excluded Benefit	N/A
STANDARD FORMULARY	Excluded Benefit	N/A
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: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rezdiffra™ (resmetirom) tablets, all strengths		**INDICATION:** For the treatment of noncirrhotic metabolic dysfunction–associated steatotic liver disease (formerly termed nonalcoholic steatohepatitis) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis), in conjunction with diet and exercise, in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 60 mg – 1 tablet per day • 80 mg – 1 tablet per day • 100 mg – 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: RiVive™ (naloxone) 3 mg nasal spray		**INDICATION:** To revive someone during an overdose from many prescription pain medications or street drugs such as heroin
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Excluded Benefit	N/A
STANDARD FORMULARY	Excluded Benefit	N/A
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID) Kloxxado™ Spray, naloxone syringe & vial, naloxone nasal spray, naloxone nasal spray OTC, Naloxone Carpuject, naltrexone tab, Narcan® Nasal Spray, Vivitrol®, Zimhi™		

DRUG NAME: Ryzneuta® (efbemalenograstim alfa-vuxw) SC injection 20 mg/mL solution in a single-dose prefilled syringe		**INDICATION:** For use to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs 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	Specialty (Tier 4)	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICARE) Nyvepria®, Ziextenzo® *both require prior authorization*		

DRUG NAME: Ryzneuta® (efbemalenograstim alfa-vuxw) SC injection 20 mg/mL solution in a single-dose prefilled syringe		**INDICATION:** For use to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia
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: Simlandi® (adalimumab-ryvk) 40 mg/0.4 mL auto-injector</td><td>INDICATION: Citrate-free, high concentration (100 mg/mL) injection, interchangeable and biosimilar to AbbVie’s Humira® (adalimumab). Simlandi is the fourth FDA-approved biosimilar to Humira in the high-concentration strength. Simlandi is the first high-concentration biosimilar to Humira to be granted interchangeable status. Simlandi and Humira share the following indications: rheumatoid arthritis (RA), juvenile idiopathic arthritis (JIA), psoriatic arthritis (PsA), ankylosing spondylitis (AS), adult and pediatric Crohn’s disease (CD), ulcerative colitis (UC), plaque psoriasis (PsO), hidradenitis suppurativa (HS) and uveitis (UV)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
COMMERCIAL: 2 auto-injectors (0.8 mL) per 28 days
MEDICAID: 2 auto-injectors (0.8 mL) per 28 days
MEDICARE: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]</td></tr>
</table>

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

DRUG NAME: Tofidence™ (tocilizumab-bavi)		**INDICATION:** Biogen's manufacturer's first FDA-approved biosimilar to IV Actemra. For use in adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs); Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (PJIA); Patients 2 years of age and older with active systemic juvenile idiopathic arthritis (SJIA)
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: Tyruko® (natalizumab-sztn)</td><td>INDICATION: The first biosimilar approved for Tysabri. For use as monotherapy for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease, in adults; For inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn’s disease (CD) with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of tumor necrosis factor-alpha (TNF-α)</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>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</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: Wezlana™ (ustekinumab-auub) injection, for subcutaneous use - 45 mg/0.5 mL or 90 mg/mL solution in a single-dose prefilled syringe; 45 mg/0.5 mL solution in a single-dose 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	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:
  - 45 mg /0.5 ml vial – 1 vial per 84 days
  - 45 mg/0.5 ml syringe – 1syringe per 84 days
  - 90 mg/ml syringe – 1 syringe per 56 days
- MEDICAID:
  - 45 mg /0.5 ml vial – 1 vial per 84 days
  - 45 mg/0.5 ml syringe – 1syringe per 84 days
  - 90 mg/ ml syringe –1 syringe per 56 days
- MEDICARE: N/A

FORMULARY ALTERNATIVES: (MEDICAID) Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (gen Remicade®); (MEDICARE) Stelara® (ustekinumab) *requires prior authorization*

DRUG NAME: Wezlana™ (ustekinumab-auub) injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose 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	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: Winrevair™ (sotatercept-csrk) for injection, for subcutaneous use, all strengths		**INDICATION:** For the treatment of adults with pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class (FC) and reduce the risk of clinical worsening event
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	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: Winrevair™ (sotatercept-csrk) for injection, for subcutaneous use, all strengths		**INDICATION:** For the treatment of adults with pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class (FC) and reduce the risk of clinical worsening event
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization
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: (MEDICARE): sildenafil (Revatio) tablets, tadalafil (Adcirca) tablets		

DRUG NAME: Xcopri® (cenobamate) 25 mg tablets		**INDICATION:** For the treatment of focal (partial) onset seizures in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Specialty (Tier 5)	Quantity Limit
QUANTITY LIMIT: • COMMERCIAL: 1 tablet per day • MEDICAID: N/A • MEDICARE: 60 tablets per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID): Gabitril®, lacosamide soln/tab (gen Vimpat®), Lamictal® ODT dose pk, lamotrigine ODT, lamotrigine tab, lamotrigine chew tab, lamotrigine XR, levetiracetam soln/tab, levetiracetam ER, roweepra (generic levetiracetam), subvenite tab (generic lamotrigine), tiagabine, topiramate tab/sprinkle cap, zonisamide cap		

DRUG NAME: Xyrem® (sodium oxybate) solution		**INDICATION:** For the treatment of cataplexy or excessive daytime sleepiness in adult patients with narcolepsy and pediatric patients ≥7 years of age with narcolepsy
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (MEDICAID): 18 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) sodium oxybate solution		

DRUG NAME: Zymfentra™ (infliximab-dyyb) 120 mg/mL single-dose prefilled syringe, single-dose pre-filled syringe with needle shield, and single-dose prefilled pen		**INDICATION:** For maintenance treatment in adults of: Moderately to severely active ulcerative colitis (UC) following treatment with an infliximab product administered intravenously (IV); Moderately to severely active Crohn's disease (CD) following treatment with an infliximab product administered IV
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 ml (2 injections) per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID) Humira® Pen, Syringe infliximab (gen Remicade®)		