Sentara Health Plans Pharmacy Changes

Effective: July 1, 2025

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

DRUG NAME: abiraterone 500 mg tablets (generic Zytiga®)		**INDICATION:** For the treatment of metastatic, castration-resistant prostate cancer (in combination with prednisone; For the treatment of metastatic, high-risk castration-sensitive prostate cancer (in combination with prednisone
REASON FOR CHANGE: Add Quantity Limit		
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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): abiraterone 250 mg tablets (generic Zytiga®)		

DRUG NAME: Abirtega (abiraterone) 250 mg tablets		**INDICATION:** For the treatment of metastatic, castration-resistant prostate cancer (in combination with prednisone; For the treatment of metastatic, high-risk castration-sensitive prostate cancer (in combination with prednisone
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2025

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

<table>
<tr><td colspan="2">DRUG NAME: adalimumab-adaz (CF) 20 mg/0.2 mL prefilled syringe & 80 mg pen</td><td>INDICATION: Humira Biosimilar FDA approved to treat seven inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older and moderate-to-severe ulcerative colitis in adults</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: 2 syringes per 28 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); HIX/SG 2024 & 25 – Simlandi (adalimumab-ryvk) and adalimumab-adbm; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)</td></tr>
</table>

DRUG NAME: Adasuve® (loxapine aerosol powder breath activated)		**INDICATION:** For the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
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: Aqneursa™ (levacetylleucine) for oral suspension: 1-gram levacetylleucine in a unit-dose packet		**INDICATION:** Treatment of neurological manifestations of Niemann-Pick disease type C (NPC) in adults and pediatric patients weighing ≥15 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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 packets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Alhemo (concizumab-mtci) injection, for subcutaneous use, all strengths		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients ≥12 years of age with hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors and for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients ≥12 years of age with hemophilia B (congenital factor IX deficiency) with factor IX inhibitors
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	Formulary	N/A
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Alhemo (concizumab-mtci) injection, for subcutaneous use, all strengths		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients ≥12 years of age with hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors and for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients ≥12 years of age with hemophilia B (congenital factor IX deficiency) with factor IX inhibitors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary **[Pharmacy Benefit]**	N/A
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Alyftrek (vanzacaftor, tezacaftor, and deutivacaftor) tablets		**INDICATION:** For the treatment of cystic fibrosis (CF) in patients ≥6 years of age who have at least one F508del mutation or another responsive mutation in the CF transmembrane conductance regulator (CFTR) gene
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	Non-Formulary	N/A
QUANTITY LIMIT: • 4-20-50 mg – 3 tablets per day • 10-50-125mg – 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Attruby™ (acoramidis) 356 mg tablets		**INDICATION:** For the treatment of the cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis in adults to reduce cardiovascular death and cardiovascular-related hospitalization
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Aucatzyl® (obecabtagene autoleucel) suspension for intravenous infusion		**INDICATION:** For the treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)
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: Auranofin 3 mg capsules		**INDICATION:** For the management of adult patients with active stage classic or definite rheumatoid arthritis who do not respond to or tolerate an adequate trial of full doses of one or more nonsteroidal anti-inflammatory drugs
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	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: 3 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): ibuprofen tablets, meloxicam tablets, naproxen tablets; (MEDICAID): ibuprofen tablets, meloxicam tablets, naproxen tablets; (MEDICARE): Ridaura (auranofin) capsules		

DRUG NAME: Avzivi® (bevacizumab-tnjn) injection ***Commercial availability pending***		**INDICATION:** A vascular endothelial growth factor inhibitor biosimilar to Avastin used for the treatment of colorectal cancer, non-small cell lung cancer, glioblastoma, renal cell carcinoma, cervical cancer, and epithelial ovarian, fallopian tube, or primary peritoneal 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
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Axtle (pemetrexed dipotassium) vials, all strengths		**INDICATION:** For use in combination with cisplatin for the initial treatment of patients with locally advanced or metastatic, non-squamous NSCLC; For use as a single agent for the maintenance treatment of patients with locally advanced or metastatic, non-squamous NSCLC whose disease has not progressed after four cycles of platinum-based first-line chemotherapy; For use as a single agent for the treatment of patients with recurrent, metastatic non-squamous, NSCLC after prior chemotherapy. For use in combination with cisplatin, for the initial treatment of patients with malignant pleural mesothelioma whose disease is unresectable or who are otherwise not candidates for curative surgery
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: Azmiro (testosterone cypionate) 200 mg/mL syringe</td><td>INDICATION: For the treatment of testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter syndrome, chemotherapy, or toxic damage from alcohol or heavy metals; gonadotropin or luteinizing hormone-releasing hormone deficiency; or pituitary-hypothalamic injury from tumors, trauma, or radiation</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>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</td></tr>
<tr><td>Non-Formulary
[Pharmacy Benefit]</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL) generic testosterone cypionate (*requires prior authorization), (MEDICIAD) generic testosterone cypionate; (MEDICARE) generic testosterone cypionate (*requires prior authorization)</td></tr>
</table>

DRUG NAME: Bimzelx® (bimekizumab-bkzx) 160 mg/mL subcutaneous solution prefilled syringe/auto-injector		**INDICATION:** For the treatment of all the following in adults: active ankylosing spondylitis, active nonradiographic axial spondyloarthritis with objective signs of inflammation, moderate to severe hidradenitis suppurativa, moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy, and active psoriatic arthritis
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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 mL (1 injection) per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® Pen/Sureclick/Syringe/Vial, Humira® Pen/Syringe, infliximab (generic Remicade®); (MEDICARE): Cimzia®, Cyltezo®, Enbrel®, Humira®, Otezla®, Skyrizi®, Stelara®, Taltz®		

DRUG NAME: Bimzelx® (bimekizumab-bkzx) 320 mg/mL subcutaneous solution prefilled syringe/auto-injector		**INDICATION:** For the treatment of all the following in adults: active ankylosing spondylitis, active nonradiographic axial spondyloarthritis with objective signs of inflammation, moderate to severe hidradenitis suppurativa, moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy, and active psoriatic arthritis
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: 2 mL (1 injection) per 56 days		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® Pen/Sureclick/Syringe/Vial, Humira® Pen/Syringe, infliximab (generic Remicade®); (MEDICARE): Cimzia®, Cyltezo®, Enbrel®, Humira®, Otezla®, Skyrizi®, Stelara®, Taltz®		

DRUG NAME: Bizengri® (zenocutuzumab-zbco) injection 375 mg/18.75 mL (20 mg/mL) in a single-dose vial for intravenous use		**INDICATION:** For the treatment of adults with advanced, unresectable or metastatic non-small cell lung cancer (NSCLC) harboring a neuregulin 1 (NRG1) gene fusion with disease progression on or after prior systemic therapy; and adults with advanced, unresectable or metastatic pancreatic adenocarcinoma harboring a neuregulin 1 (NRG1) gene fusion with disease progression on or after 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: Boruzu™ (bortezomib) injection		**INDICATION:** For the treatment of multiple myeloma and mantle cell lymphoma
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: bupropion XL 450 mg tablets (generic Forfivo XL)		**INDICATION:** For the treatment of unipolar major depressive disorder (MDD); For the prevention of seasonal major depressive episodes in patients with a diagnosis of seasonal affective disorder (SAD)
REASON FOR CHANGE: Change Drug Tier and Quantity Limit		
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: 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) bupropion XL 150 & 300 mg tablets; (MEDICAID) bupropion XL 150 & 300 mg tablets; (MEDICARE) bupropion XL 150 & 300 mg tablets		

DRUG NAME: Caplyta® (lumateperone) 10.5 & 21 mg capsules		**INDICATION:** For use as monotherapy or as an adjunct to lithium or valproate for treatment of depressive episodes associated with bipolar disorder I or II in adults; For the treatment of schizophrenia in adults
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (MEDICAID): 1 capsule per day (both strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): aripiprazole tablets, olanzapine tablets, quetiapine IR/ER tablets, risperidone solution/tablets, ziprasidone capsules; (MEDICAID): aripiprazole tab, clozapine tab, lurasidone, olanzapine ODT/tab/IM, quetiapine fumarate ER, quetiapine tab, risperidone ODT/soln/tab, Vraylar™, ziprasidone cap		

DRUG NAME: carbidopa 25 mg tablets (generic Lodosyn)		**INDICATION:** Given with carbidopa/levodopa in the treatment of idiopathic Parkinson disease, postencephalitic parkinsonism, and symptomatic parkinsonism, which may follow injury to the nervous system by carbon monoxide and/or manganese intoxication
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	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: 8 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Clobetasol 0.025% cream		**INDICATION:** For the short-term relief of inflammation and pruritic manifestations of moderate to severe corticosteroid-responsive dermatoses
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic clobetasol 0.05% cream; (MEDICAID): generic clobetasol 0.05% cream; (MEDICARE): generic clobetasol 0.05% cream		

DRUG NAME: Crexont® (carbidopa-levodopa ER) capsules, all strengths		**INDICATION:** For the treatment of Parkinson disease, postencephalitic parkinsonism, and symptomatic parkinsonism that may follow carbon monoxide and/or manganese intoxication; treatment of motor fluctuations in advanced Parkinson disease
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
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: 6 capsules per day (all strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): carbidopa-levodopa ER 25-100 & 50-200 mg tablets; (MEDICARE): carbidopa-levodopa ER 25-100 & 50-200 mg tablets		

DRUG NAME: Purified cortrophin® gel (repository corticotropin injection USP), 40 units/0.5 mL & 80 units/mL prefilled syringes		**INDICATION:** For the treatment of acute exacerbations of multiple sclerosis; Short-term administration as an adjunctive therapy during an acute episode or exacerbation in rheumatoid arthritis, including juvenile rheumatoid arthritis; psoriatic arthritis; ankylosing spondylitis; and acute gouty arthritis; Exacerbations or as maintenance therapy in select cases of systemic lupus erythematosus and systemic dermatomyositis (polymyositis); Severe erythema multiforme (Stevens-Johnson syndrome) and severe psoriasis; Atopic dermatitis and serum sickness; Severe acute and chronic allergic and inflammatory conditions affecting the eye and its adnexa, such as allergic conjunctivitis, keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, and anterior segment inflammation; Symptomatic sarcoidosis; Inducing a diuresis or remission of proteinuria due to nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus
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	Formulary	Prior Authorization
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Danziten™ (nilotinib) tablets, all strengths		**INDICATION:** For the treatment of: Adult patients with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase; and adult patients with chronic phase (CP) and accelerated phase (AP) Ph+ CML resistant to or intolerant to prior therapy that included imatinib
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 71 mg – 2 tablets per day • 95 mg – 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Datroway® (datopotamab deruxtecan-dlnk) 100 mg lyophilized powder in a single-dose vial for injection, for intravenous use		**INDICATION:** For the treatment of unresectable or metastatic, hormone receptor (HR)–positive, human epidermal growth factor receptor 2 (HER2)–negative (IHC 0, IHC 1+ or IHC 2+/ISH-) breast cancer in adults who have received prior endocrine-based therapy and chemotherapy for unresectable or metastatic disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Duopa™(carbidopa-levodopa) enteral suspension		**INDICATION:** For the treatment of Parkinson disease, postencephalitic parkinsonism, and symptomatic parkinsonism that may follow carbon monoxide and/or manganese intoxication; treatment of motor fluctuations in advanced Parkinson disease
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary **[Pharmacy Benefit]**	Prior Authorization, Quantity Limit
	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medicare Part B Benefit	Prior Authorization
QUANTITY LIMIT: 4 cartons per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): carbidopa-levodopa IR/ER/ODT tablets		

DRUG NAME: Duopa™(carbidopa-levodopa) enteral suspension		**INDICATION:** For the treatment of Parkinson disease, postencephalitic parkinsonism, and symptomatic parkinsonism that may follow carbon monoxide and/or manganese intoxication; treatment of motor fluctuations in advanced Parkinson disease
REASON FOR CHANGE: Add Utilization Management Requirements		
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	Non-Formulary **[Pharmacy Benefit]**	Prior Authorization, Quantity Limit
	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medicare Part B Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: edaravone infusion bottle, all strengths		**INDICATION:** For the treatment of amyotrophic lateral sclerosis (ALS)
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: Emrosi™ (minocycline hydrochloride) extended-release capsules, 40 mg		**INDICATION:** For use to treat inflammatory lesions (papules and pustules) of rosacea in adult
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: 1 capsule per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) minocycline 50 mg capsules; (MEDICAID) minocycline 50 mg capsules; (MEDICARE) minocycline 50 mg capsules/tablets		

DRUG NAME: Ensacove™ (ensartinib) 25 & 100 mg capsules ***Commercial availability pending***		**INDICATION:** For the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced or metastatic non-small cell lung cancer (NSCLC) who have not previously received an ALK-inhibitor
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 capsules per day (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Esperoct® [antihemophilic factor (recombinant), glycopegylated-exei] vial of lyophilized powder for solution, for intravenous use, 4000 units		**INDICATION:** For surgical prophylaxis in adults and children with hemophilia A; For on-demand treatment and control of bleeding episodes in adults and children with hemophilia A; For routine prophylaxis to reduce the frequency of bleeding episodes in adults and children with hemophilia A
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	Formulary **[Pharmacy Benefit]**	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Erzofri® (paliperidone palmitate) extended-release injectable suspension, for intramuscular use (all strengths: 39 mg/0.25 mL, 78 mg/0.5 mL, 117 mg/0.75 mL, 156 mg/mL, 234 mg/1.5 mL, 351 mg/2.25 mL)		**INDICATION:** For treatment of schizophrenia in adults and treatment of schizoaffective disorder in adults as monotherapy and as an adjunct to mood stabilizers or antidepressants
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Age-Edit <18 years old, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Age-Edit <18 years old, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Age-Edit <18 years old, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Age-Edit <18 years old, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Age-Edit <18 years old, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 39 mg/0.25 mL, 78 mg/0.5 mL, 117 mg/0.75 mL, 156 mg/mL, 234 mg/1.5 mL – 1 injection per 28 days • 351 mg/2.25 mL – 1 injection per 365 days		
FORMULARY ALTERNATIVES: (COMMERCIAL) Invega Hafyera™, Sustenna® & Trinza®; (MEDICIAD) Abilify Invega Hafyera™, Sustenna® & Trinza®; (MEDICARE) Invega Hafyera™, Sustenna® & Trinza®		

DRUG NAME: Evrysdi® (risdiplam) 5 mg tablets		**INDICATION:** For the treatment of spinal muscular atrophy in pediatric and 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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: (MEDICARE): Evrysdi® (risdiplam) oral solution (*requires prior authorization)		

DRUG NAME: Fenopron (fenoprofen) 300 mg capsules		**INDICATION:** For the relief of the signs and symptoms of osteoarthritis; For relief of mild to moderate pain in adults; For relief of the signs and symptoms of RA
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: 4 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): ibuprofen, flurbiprofen & oxaprozin tablets; (MEDICAID): Children's Motrin® susp (OTC), diclofenac sodium ibuprofen cap, ibuprofen tab (OTC & Rx), Infant's ibuprofen drops, meloxicam tab, naproxen tab, naproxen sodium (OTC), naproxen EC (Rx), sulindac; (MEDICARE): ibuprofen, flurbiprofen & oxaprozin tablets		

DRUG NAME: fesoterodine ER tablets (generic Toviaz®), all strengths		**INDICATION:** For the treatment of neurogenic detrusor overactivity in pediatric patients ≥6 years of age and weighing >25 kg; For the treatment of overactive bladder in adults with symptoms of urinary frequency, urgency, or urge incontinence
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Tier 2	Step-Edit, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day (both strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL) oxybutynin tablets, solifenacin tablets; (MEDICARE): oxybutynin tablets, solifenacin tablets		

DRUG NAME: Frindovyx™ (cyclophosphamide) injection, for intravenous use, all strengths		**INDICATION:** For the treatment of acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myeloid leukemia, Hodgkin lymphoma, mycosis fungoides, multiple myeloma, neuroblastoma, non-Hodgkin lymphomas (including Burkitt lymphoma and other malignant lymphomas), ovarian adenocarcinoma, and retinoblastoma
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Fulvicin P-G (griseofulvin) 165 mg tablets</td><td>INDICATION: For the treatment of the following dermatophyte infections of the skin, hair, and nails not adequately treated by topical therapy: Tinea corporis, tinea pedis, tinea cruris, tinea barbae, tinea capitis, tinea unguium (onychomycosis) when caused by one or more of the following species of fungi: Trichophyton rubrum, Trichophyton tonsurans, Trichophyton mentagrophytes, Trichophyton interdigitalis, Trichophyton verrucosum, Trichophyton megnini, Trichophyton gallinae, Trichophyton crateriform, Trichophyton sulphureum, Trichophyton schoenleini, Microsporum audouini, Microsporum canis, Microsporum gypseum, and Epidermophyton floccosum</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: 4 tablets per day</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): generic griseofulvin ultramicrosize 125 & 250 mg tablets, (MEDICAID): generic griseofulvin suspension; (MEDICARE): generic griseofulvin ultramicrosize 125 & 250 mg tablets</td></tr>
</table>

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 Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 6 kits per 90 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): furosemide tablets; (MEDICARE): furosemide tablets		

DRUG NAME: Gabarone (gabapentin) 100 & 400 mg tablets		**INDICATION:** For the management of postherpetic neuralgia (PHN) in adults; For use as adjunctive therapy in the treatment of focal (partial) seizures with and without secondary generalization in adults and pediatric patients 3 years of age and older with epilepsy
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: 3 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic gabapentin capsules/tablets/solution; (MEDICAID): generic gabapentin capsules/tablets/solution; (MEDICARE): generic gabapentin capsules/tablets/solution		

DRUG NAME: Gemtesa® (vibegron) 75 mg tablets		**INDICATION:** For the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in adults and adult males on pharmacological therapy for benign prostatic hyperplasia
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) generic mirabegron tablets (*requires step-edit); (MEDICAID) Brand Myrbetriq granules/tablets & generic mirabegron tablets; (MEDICARE) Brand Myrbetriq tablets		

<table>
<tr><td colspan="2">DRUG NAME: griseofulvin ultramicronize 165 mg tablets</td><td>INDICATION: For the treatment of the following dermatophyte infections of the skin, hair, and nails not adequately treated by topical therapy: Tinea corporis, tinea pedis, tinea cruris, tinea barbae, tinea capitis, tinea unguium (onychomycosis) when caused by one or more of the following species of fungi: Trichophyton rubrum, Trichophyton tonsurans, Trichophyton mentagrophytes, Trichophyton interdigitalis, Trichophyton verrucosum, Trichophyton megnini, Trichophyton gallinae, Trichophyton crateriform, Trichophyton sulphureum, Trichophyton schoenleini, Microsporum audouini, Microsporum canis, Microsporum gypseum, and Epidermophyton floccosum</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: 4 tablets per day</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): generic griseofulvin ultramicrosize 125 & 250 mg tablets; (MEDICAID): generic griseofulvin ultramicrosize 125 & 250 mg tablets; (MEDICARE): generic griseofulvin ultramicrosize 125 & 250 mg tablets</td></tr>
</table>

DRUG NAME: Gomekli™ (mirdametinib) 1&2 mg capsules, 1 mg tablet for suspension		**INDICATION:** For the treatment of adult and pediatric patients 2 years of age and older with neurofibromatosis type 1 (NF1) who have symptomatic plexiform neurofibromas (PN) not amenable to complete resection
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: N/A • 1 mg – 126 capsules per day 28 days • 2 mg – 84 capsules per 28 days • 1 mg tablet for oral suspension – 168 tablets per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Brand Humalog® (insulin lispro) all products vials/pens/cartridge		**INDICATION:** For use to improve glycemic control in pediatric patients and adults with type 1 diabetes mellitus; to improve glycemic control in adults with type 2 diabetes mellitus
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	N/A
STANDARD FORMULARY	Tier 2	N/A
EXCHANGE FORMULARY	Tier 1	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	N/A (No Change)	N/A
MEDICARE FORMULARY	N/A (No Change)	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Hercessi™ (trastuzumab-strf) for injection, for intravenous use, all strengths		**INDICATION:** Biosimilar to Heceptin, for the treatment of adults with HER2-overexpressing breast cancer and HER2-overexpressing metastatic gastric or gastroesophageal junction 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: hydrocodone-acetaminophen 2.5/325 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	Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Tier 4	Quantity Limit
QUANTITY LIMIT: 360 tablets per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL) hydrocodone-acetaminophen 5/325 mg tablets		

DRUG NAME: hydrocortisone 2.5% solution		**INDICATION:** For the topical relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) hydrocortisone 2.5% cream/lotion/ointment; (MEDICIAD) hydrocortisone 2.5% cream/lotion/ointment; (MEDICARE) hydrocortisone 2.5% cream/lotion/ointment		

DRUG NAME: Hympavzi (marstacimab-hncq) injection, for subcutaneous use 150 mg/mL in single-dose prefilled syringe/pen		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients 12 years of age and older with: hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors, or hemophilia B (congenital factor IX deficiency) without factor IX inhibitors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 injections per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Hympavzi (marstacimab-hncq) injection, for subcutaneous use 150 mg/mL in single-dose prefilled syringe/pen		**INDICATION:** For the treatment of schizophrenia in adultsFor routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients 12 years of age and older with: hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors, or hemophilia B (congenital factor IX deficiency) without factor IX inhibitors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary **[Pharmacy Benefit]**	N/A
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Imkeldi (imatinib) 80 mg/mL oral solution	**INDICATION:** For the treatment of relapsed or refractory Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL) in adults; Treatment of newly diagnosed Ph+ ALL in children (in combination with chemotherapy); Treatment of aggressive systemic mastocytosis in adults without D816V mutation or with c-kit mutational status unknown. c-kit; Treatment of newly diagnosed Ph+ chronic myeloid leukemia (CML) in chronic phase in adults and children; Treatment of Ph+ CML in blast crisis, accelerated phase, or chronic phase after failure of interferon-alfa therapy; Treatment of unresectable, recurrent, and/or metastatic dermatofibrosarcoma protuberans in adults; Treatment of Kit (CD117)-positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST); Adjuvant treatment of Kit (CD117)–positive GIST following complete gross resection in adults; Treatment of hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) in adult patients who have the FIP1L1–platelet-derived growth factor receptor (PDGFR) alpha fusion kinase (mutational analysis or fluorescent in situ hybridization [FISH] demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFR alpha fusion kinase negative or unknown; and Treatment of myelodysplastic /myeloproliferative diseases associated with PDGFR gene rearrangements 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	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit

QUANTITY LIMIT: 280 ml (2 bottles) per 28 days

FORMULARY ALTERNATIVES: N/A

DRUG NAME: Inzirqo (hydrochlorothiazide) 10 mg/mL oral suspension		**INDICATION:** For the treatment of hypertension in adult and pediatric patients alone or in combination with other antihypertensive agents, to lower blood pressure; For the treatment of edema associated with congestive heart failure, hepatic cirrhosis and renal disease including the nephrotic syndrome in adult and pediatric 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	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 4 bottles per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic hydrochlorothiazide tablets; (MEDICAID): generic hydrochlorothiazide tablets; (MEDICARE): generic hydrochlorothiazide tablets		

DRUG NAME: Ivra (melphalan) 90 mg/mL vial for injection, for intravenous use		**INDICATION:** For palliative treatment of patients with multiple myeloma for whom oral therapy is not appropriate
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: Jivi® [antihemophilic factor (recombinant), PEGylated-aucl] vial of lyophilized powder for solution, for intravenous use, 4000 units		**INDICATION:** For surgical prophylaxis in adults and children with hemophilia A; For on-demand treatment and control of bleeding episodes in adults and children with hemophilia A; For routine prophylaxis to reduce the frequency of bleeding episodes in adults and children with hemophilia A
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	Formulary **[Pharmacy Benefit]**	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Kebilidi (eladocagene exuparvovec-tneq) suspension, for intraputaminal infusion		**INDICATION:** For the treatment of adult and pediatric patients with aromatic 13 L-amino acid decarboxylase (AADC) deficiency
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: labetolol 400 mg tablets		**INDICATION:** For the management of hypertension
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) labetolol 100, 200 & 300 mg tablets; (MEDICARE) labetolol 100, 200 & 300 mg tablets		

DRUG NAME: Lithium 8 mEq/5 mL solution		**INDICATION:** For the treatment of acute mania, acute episodes with mixed features, and maintenance treatment in patients ≥7 years of age with a diagnosis of bipolar disorder
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 1	Quantity Limit
STANDARD FORMULARY	Tier 1	Quantity Limit
EXCHANGE FORMULARY	Tier 1	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: 30 mL per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lumakras® (sotorasib) 120 mg tablets		**INDICATION:** For the treatment of adult patients with KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, who have received at least one prior systemic therapy
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	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lumakras® (sotorasib) 240 mg tablets		**INDICATION:** For the treatment of adult patients with KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, who have received at least one 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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lymphir™ (denileukin diftitox-cxd) 300 mcg lyophilized cake in a single-dose vial for injection, for intravenous use ***Commercial availability pending***	**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: Metaxalone 640 mg tablets	**INDICATION:** For the relief of discomforts associated with acute, painful musculoskeletal conditions as an adjunct to rest, physical therapy, and other measures in adults and pediatric patients ≥ 13 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: 4 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic metaxalone 800 mg tablets; (MEDICAID): baclofen, chlorzoxazone, cyclobenzaprine HCL, dantrolene sodium, methocarbamol, tizanidine tabs; (MEDICARE): generic cyclobenzaprine, baclofen, chlorzoxazone tablets		

DRUG NAME: Metformin immediate-release 750 mg tablets		**INDICATION:** For the management of type 2 diabetes mellitus when hyperglycemia cannot be managed with diet and exercise alone
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: 2 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic metformin 500, 850 & 1000 mg tablets; (MEDICAID): generic metformin 500, 850 & 1000 mg tablets; (MEDICARE): generic metformin 500, 850 & 1000 mg tablets		

DRUG NAME: Metronidazole 125 mg tablets		**INDICATION:** For the treatment of symptomatic trichomoniasis in adults that has been confirmed by culture or wet smear test; Asymptomatic trichomoniasis in females when associated with cervical changes, and in asymptomatic sexual partners; Amebiasis (an infection caused by a parasite) in adults and children; Anaerobic bacterial infections (infections caused by bacteria that do not need oxygen to survive
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic metronidazole 250 mg tablets; (MEDICAID): generic metronidazole 250 mg tablets; (MEDICARE): generic metronidazole 250 mg tablets		

DRUG NAME: metyrosine (Demser) 250 mg capsules		**INDICATION:** For the short-term management of pheochromocytoma before surgery; long-term management of pheochromocytoma when surgery is contraindicated or when chronic malignant pheochromocytoma exists
REASON FOR CHANGE: Add 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	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: 16 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Miebo (perfluorohexyloctane ophthalmic solution)		**INDICATION:** For the treatment of the signs and symptoms of dry eye disease
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 3 mL (1 bottle) per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic cyclosporine emulsion (Restasis®), Xiidra®; (MEDICAID): Restasis®, Restasis Multidose®, Xiidra®; (MEDICARE): generic cyclosporine emulsion (Restasis®), Xiidra®		

DRUG NAME: mirabegron (Myrbetriq®) tablets, all strengths		**INDICATION:** 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; Treatment of neurogenic detrusor overactivity in pediatric patients ≥3 years of age (granules) and weighing ≥35 kg (tablets)
REASON FOR CHANGE: Change Drug Tier and 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	Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day (both strengths for brand & generic)		
FORMULARY ALTERNATIVES: (MEDICARE) Brand Myrbetriq® tablets		

DRUG NAME: Miplyffa™ (arimoclomol) capsules, all strengths		**INDICATION:** For use in combination with miglustat for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) in adult 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, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 3 capsules per day (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Neupro® (rotigotine) transdermal system, all strengths		**INDICATION:** For the treatment of Parkinson disease and for the treatment of moderate to severe primary restless legs syndrome
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	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: 30 patches per 30 days (all strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): ropinirole ER tablets; (MEDICARE): ropinirole ER tablets		

DRUG NAME: Niktimvo™ (axatilimab-csfr) 50 mg/mL for injection, for intravenous use, all strengths		**INDICATION:** For the treatment of chronic graft-versus-host disease (cGVHD) after failure of at least 2 prior lines of systemic therapy in adult and pediatric patients weighing ≥40 kg
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: nimodipine 60 mg/20 mL solution		**INDICATION:** For the improvement of neurological outcome by reducing the incidence and severity of ischemic deficits in adult patients with subarachnoid hemorrhage from ruptured intracranial aneurysms regardless of post-ictus neurological condition
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) nimodipine 30 mg capsules; (MEDICIAD) nimodipine 30 mg capsules; (MEDICARE) nimodipine 30 mg capsules		

DRUG NAME: Nypozi™ (filgrastim-txid) prefilled syringes (all strengths)		**INDICATION:** Biosimilar to Amgen's Neupogen (filgrastim). Nypozi is the fourth FDA-approved biosimilar to Neupogen. Zarxio® (filgrastim-sndz), Nivestym® (filgrastim-aafi) and Releuko® (filgrastim-ayow) have all previously launched. Nypozi, Zarxio, Nivestym, Releuko and Neupogen share the following indications: Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML); Reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT); Reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic 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		

DRUG NAME: Nypozi™ (filgrastim-txid) prefilled syringes (all strengths)		**INDICATION:** Biosimilar to Amgen's Neupogen (filgrastim). Nypozi is the fourth FDA-approved biosimilar to Neupogen. Zarxio® (filgrastim-sndz), Nivestym® (filgrastim-aafi) and Releuko® (filgrastim-ayow) have all previously launched. Nypozi, Zarxio, Nivestym, Releuko and Neupogen share the following indications: Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML); Reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT); Reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia
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: 3 syringes per day (both strengths)		
FORMULARY ALTERNATIVES: (MEDICAID) Neupogen®		

DRUG NAME: Omvoh® (mirikizumab-mrkz) 300 mg dose prefilled pens/syringes		**INDICATION:** For the treatment of moderately to severely active Crohn's disease (CD) in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 3 mL (2 injections) per 28 days		
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: Opipza™ (aripiprazole) oral films, all strengths		**INDICATION:** For treatment of schizophrenia in patients ages 13 years and older; adjunctive treatment of major depressive disorder (MDD) in adult; irritability associated with autistic disorder in pediatric patients 6 years and older; and treatment of Tourette's disorder in pediatric patients 6 years and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Age-Edit <18 years old, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Age-Edit <18 years old, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Age-Edit <18 years old, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Age-Edit <18 years old, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Age-Edit <18 years old, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) aripiprazole tablets; (MEDICIAD) aripiprazole tab, clozapine tab, lurasidone, olanzapine ODT/tab/IM, quetiapine fumarate ER, quetiapine tab, risperidone ODT/soln/tab, Vraylar™, ziprasidone cap; (MEDICARE) aripiprazole tablets/ODT/solution		

DRUG NAME: Opdivo Qvantig™ (nivolumab/hyaluronidase-nvhy)		**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: Palforzia® [Peanut (Arachis hypogaea) Allergen Powder-dnfp] Powder for oral administration, 1 mg capsule (Level 0) kit & Initial Dose Escalation (1-3 years) kit		**INDICATION:** Oral immunotherapy for mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanuts in patients with a confirmed diagnosis of peanut allergy. Initial dose escalation may be administered to patients 1 to 17 years of age. Up-dosing and maintenance may be continued in patients ≥1 year of age. Peanut allergen powder is to be used in conjunction with a peanut-avoidant diet
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)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 1 mg (Level 0) – 15 capsules per 365 days • Initial Dose Escalation (1-3 years) kit – 7 capsules per 365 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Pavblu™ (aflibercept-ayyh) injection		**INDICATION:** For the treatment of patients with: Neovascular (Wet) Age-Related Macular Degeneration (AMD); Macular Edema Following Retinal Vein Occlusion (RVO); Diabetic Macular Edema (DME); and Diabetic Retinopathy (DR)
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: phenoxybenzamine (Dibenzyline) 10 mg capsules		**INDICATION:** For the treatment of sweating and hypertension associated with pheochromocytoma
REASON FOR CHANGE: Add 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, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 24 capsules per day		
FORMULARY ALTERNATIVES: (MEDICARE): doxazosin tablets		

DRUG NAME: PiaSky™ (crovalimab-akkz) 340 mg/2 mL vial for injection for intravenous or subcutaneous use		**INDICATION:** For the treatment of paroxysmal nocturnal hemoglobinuria in adult and pediatric patients ≥13 years of age and ≥40 kg
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 6 ml (3 vials) per 28 days		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Prevymis® (letermovir) 20 & 120 mg pellet packets</td><td>INDICATION: For prophylaxis of cytomegalovirus (CMV) infection and disease in adult and pediatric patients ≥6 months of age and weighing ≥6 kg who are CMV-seropositive recipients [R+] of an allogeneic hematopoietic cell transplant</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Specialty (Tier 5)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL):
20 mg – 4 packets per day
120 mg – 2 packets per day
(MEDICAID):
20 mg – 4 packets per day
120 mg – 2 packets per day
(MEDICARE):
20 mg – 4 packets per day
120 mg – 4 packets per day</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Qlosi (pilocarpine) 0.4% ophthalmic solution		**INDICATION:** For the treatment of presbyopia in adults
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) pilocarpine 1% solution; (MEDICIAD) pilocarpine 1% solution; (MEDICARE) pilocarpine 1% solution		

DRUG NAME: Qutenza® (capsaicin 8% topical system)		**INDICATION:** For the management of neuropathic pain associated with postherpetic neuralgia and diabetic peripheral neuropathy of the feet in adults
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
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: Raldesy™ (trazodone) 10 mg/mL oral solution		**INDICATION:** For the treatment of major depressive disorder (MDD) 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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 60 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic trazodone tablets; (MEDICAID): generic trazodone tablets; (MEDICARE): generic trazodone tablets		

DRUG NAME: rasagiline (generic Azilect®) tablets		**INDICATION:** For the treatment of Parkinson disease
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 1	N/A
STANDARD FORMULARY	Tier 1	N/A
EXCHANGE FORMULARY	Tier 1	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Retin-A® (tretinoin) micro pump 0.04, 0.08 & 0.1% gel		**INDICATION:** For the treatment of acne vulgaris
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Age-Edit for members ≥ 18 years old
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): tretinoin 0.05% cream (*requires age-edit); (MEDICAID): tretinoin 0.05% cream/gel, tretinoin 0.1% cream (*both require age-edit); (MEDICARE): tretinoin 0.025%, 0.05%, 0.1% cream/gel		

DRUG NAME: Retin-A® (tretinoin) micro pump 0.06% gel		**INDICATION:** For the treatment of acne vulgaris
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Age-Edit for members ≥ 18 years old
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): tretinoin 0.05% cream (*requires age-edit); (MEDICAID): tretinoin 0.05% cream/gel (*both require age-edit); (MEDICARE): tretinoin 0.025%, 0.05%, 0.1% cream/gel		

DRUG NAME: Revuforj® (revumenib) tablets, all strengths		**INDICATION:** For the treatment of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation in adult and pediatric patients 1 year and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 110 mg – 4 tablets per day • 160 mg – 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ridaura (auranofin) 3 mg capsules		**INDICATION:** For the management of adult patients with active stage classic or definite rheumatoid arthritis who do not respond to or tolerate an adequate trial of full doses of one or more nonsteroidal anti-inflammatory drugs
REASON FOR CHANGE: Change Drug Tier and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Quantity limit
STANDARD FORMULARY	Non-Formulary	Quantity limit
EXCHANGE FORMULARY	Tier 3	Quantity limit
FAMIS FORMULARY	Non-Formulary	Quantity limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity limit
MEDICARE FORMULARY	Specialty (Tier 5)	N/A
QUANTITY LIMIT: 3 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): ibuprofen tablets, meloxicam tablets, naproxen tablets; (MEDICAID): ibuprofen tablets, meloxicam tablets, naproxen tablets		

DRUG NAME: Romvimza™ (vimseltinib) capsules, 14 mg, 20 mg & 30 mg		**INDICATION:** For treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) for which surgical resection will potentially cause worsening functional limitations or severe morbidity
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 8 capsules per 28 days (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rybelsus® (semaglutide) tablets, all strengths		**INDICATION:** For use as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity limit
MEDICARE FORMULARY	Tier 3	Prior Authorization, Quantity limit

QUANTITY LIMIT:
• (COMMERCIAL):
  • 1.5 mg – 30 tablets per 365 days
  • 4 & 9 mg – 1 tablet per day
• (MEDICAID):
  • 1.5 mg – 30 tablets per 365 days
  • 4 & 9 mg – 1 tablet per day
• (MEDICARE): 1.5, 4 & 9 mg – 1 tablet per day		

FORMULARY ALTERNATIVES: (MEDICAID): Byetta®, Trulicity™, Victoza®		

DRUG NAME: Rytary™ (carbidopa-levodopa ER) capsules		**INDICATION:** For the treatment of Parkinson disease, postencephalitic parkinsonism, and symptomatic parkinsonism that may follow carbon monoxide and/or manganese intoxication; treatment of motor fluctuations in advanced Parkinson disease
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 10 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): carbidopa-levodopa ER 25-100 & 50-200 mg tablets; (MEDICARE): carbidopa-levodopa ER 25-100 & 50-200 mg tablets		

DRUG NAME: Simlandi® (adalimumab-ryvk) 20 mg/0.2 mL & 80 mg/0.8 mL prefilled syringe		**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	Specialty (Tier 4)	Prior Authorization, 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 syringes per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): **COMM/FAMIS** - Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

DRUG NAME: Simlandi® (adalimumab-ryvk) 40 mg/0.4 mL prefilled syringe		**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	Specialty (Tier 4)	Prior Authorization, 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 syringes per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL) **COMM/FAMIS** - Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); (MEDICIAD) Humira pen/syringe (Abbvie mfg only); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

DRUG NAME: sulfacleanse 8-4% suspension		**INDICATION:** For the treatment of acne vulgaris, acne rosacea, and seborrheic dermatitis
REASON FOR CHANGE: Exclude 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), Age-Edit for members ≥ 18 years old, Quantity limit
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: 1 bottle (473 mL) per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): sodium sulfacetaminde-sulfur 10%-5% cleanser; (MEDICAID): Acne Medication gel/lotion, benzoyl peroxide wash/cream/gel/lotion (OTC), clindacin ETZ 1% pledget, clindamycin ph 1% solution/pledget/swab/gel, clindamycin/benzoyl peroxide (Duac®), erythromycin solution, Panoxyl 4 Acne Cr Wash (OTC), Panoxyl 10 cleansing bar, foaming wash (OTC)		

DRUG NAME: Topiramate 50 mg sprinkle capsules		**INDICATION:** For prophylaxis of migraine headache in patients ≥12 years of age; For monotherapy or adjunctive therapy in patients ≥2 years of age or ≥6 years of age with focal (partial) onset or primary generalized tonic-clonic seizures; adjunctive therapy in patients ≥2 years of age or ≥6 years of age (with seizures associated with Lennox-Gastaut syndrome
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity limit
STANDARD FORMULARY	Non-Formulary	Quantity limit
EXCHANGE FORMULARY	Non-Formulary	Quantity limit
FAMIS FORMULARY	Non-Formulary	Quantity limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 2 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic topiramate 25 mg sprinkle capsules; (MEDICARE): generic topiramate 25 mg sprinkle capsules		

DRUG NAME: Tramadol 75 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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 5 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) tramadol 50 mg tablets (*requires prior authorization); (MEDICIAD) tramadol 50 mg tablets (*requires prior authorization); (MEDICARE) tramadol 50 mg tablets		

DRUG NAME: tretinoin (generic Retin-A®) micro pump 0.04, 0.08 & 0.1% gel		**INDICATION:** For the treatment of acne vulgaris
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Age-Edit for members ≥ 18 years old
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): tretinoin 0.05% cream, tretinoin 0.1% cream (*both require age-edit); (MEDICAID): tretinoin 0.05% cream/gel, tretinoin 0.1% cream (*both require age-edit); (MEDICARE): tretinoin 0.025%, 0.05%, 0.1% cream/gel		

DRUG NAME: Tryngolza™ (olezarsen) 80 mg/0.8 mL subcutaneous single dose autoinjector		**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: 1 auto-injector (0.8 mL) per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Unloxcyt™ (cosibelimab-ipdl) injection ***Commercial availability pending***		**INDICATION:** For the treatment of adults with metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) who are not candidates for curative surgery or curative radiation
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: Valtya (ethynodiol d-ethinyl estradiol) 1 mg -50 mcg tablets		**INDICATION:** For the prevention of pregnancy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 1	N/A
STANDARD FORMULARY	Tier 1	N/A
EXCHANGE FORMULARY	Tier 1	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Tier 2	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICARE): Ethynodiol-Eth-Estra 1mg- 50 mcg		

DRUG NAME: Veltassa® (patiromer) 1 gram powder packets for oral suspension		**INDICATION:** For the treatment of hyperkalemia in adults and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Tier 3	N/A
QUANTITY LIMIT: 4 packets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Venxxiva (tiopronin) delayed release tablets, all strengths		**INDICATION:** For the prevention of cystine stone formation in adults and pediatric patients ≥20 kg with severe homozygous cystinuria who are resistant to treatment with high fluid intake, alkali, and diet modification
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) Cystagon (*requires prior authorization)		

DRUG NAME: vigadrone 500 mg tablets		**INDICATION:** For use as monotherapy for pediatric patients 1 month to 2 years of age with infantile spasms for whom the potential benefits outweigh the potential risk of vision loss; For use as adjunctive therapy for adults and pediatric patients ≥2 years of age with refractory complex partial seizures who have inadequately responded to several alternative treatments and for whom the potential benefits outweigh the risk of vision loss
REASON FOR CHANGE: Change Drug Tier		
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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 180 tablets per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID): lacosamide soln/tab (gen Vimpat®), lamotrigine tab, lamotrigine chew tab, lamotrigine XR, levetiracetam soln/tab, levetiracetam ER, roweepra (generic levetiracetam), subvenite tab (generic lamotrigine), topiramate tab/sprinkle cap, zonisamide cap		

DRUG NAME: Vimkunya™ (Chikungunya Vaccine, Recombinant) injectable suspension, for intramuscular use		**INDICATION:** For the prevention of disease caused by chikungunya virus (CHIKV) in persons ≥12 years of age
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	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Tier 3	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vyalev™ (foscarbiodpa and foslevodopa) injection for subcutaneous, injection contains 120 mg foscarbidopa and 2,400 mg foslevodopa per 10 mL (12 mg foscarbidopa and 240 mg foslevodopa per mL)		**INDICATION:** For the treatment of motor fluctuations in adults with advanced Parkinson's disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 6 cartons per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vyalev™ (foscarbiodpa and foslevodopa) injection for subcutaneous, injection contains 120 mg foscarbidopa and 2,400 mg foslevodopa per 10 mL (12 mg foscarbidopa and 240 mg foslevodopa per mL)		**INDICATION:** For the treatment of motor fluctuations in adults with advanced Parkinson's disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Xadago® (safinamide) tablets, all strengths		**INDICATION:** For use as adjunctive treatment to carbidopa/levodopa in patients with Parkinson disease experiencing "off" episodes
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	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 (all strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): rasagiline tablets, selegiline capsules/tablets; (MEDICARE): rasagiline tablets, selegiline capsules/tablets		

DRUG NAME: Xarah FE (norethindrone-ethinyl estradiol-iron) 1 mg/20-30-35 mcg tablets		**INDICATION:** For the prevention of pregnancy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 1	N/A
STANDARD FORMULARY	Tier 1	N/A
EXCHANGE FORMULARY	Tier 1	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): NORETH-EE-FE 1.5-0.03MG (21)-75, NORETH-EE-FE 1-0.02(21)-75 TAB, NORETH-EE-FE 1-0.02(24)-75 CHW; (MEDICARE): NORETH-EE-FE 1 MG/20-30-35 MCG		

DRUG NAME: Zepbound™ (tirzepatide) vials for injection, 10 mg/0.5 mL & 7.5 mg/0.5 mL		**INDICATION:** 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 (eg, cardiovascular disease, dyslipidemia, hypertension, obstructive sleep apnea, type 2 diabetes mellitus); For the treatment of moderate to severe obstructive sleep apnea in adults with obesity
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3 - **GROUP SPECIFIC BENEFIT**	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3 - **GROUP SPECIFIC BENEFIT**	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 mL (4 vials) per 28 days (both strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): orlistat, Xenical, phendimetrazine IR and ER, phentermine, benzphetamine, diethylpropion IR and ER		

DRUG NAME: Ziihera® (zanidatamab-hrii) for injection, for intravenous use		**INDICATION:** For the treatment of previously treated, unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive (IHC 3+ [as detected by an approved test]) biliary tract cancer 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		

Commercial Formulary Project Horizon Alignment

HCPCS	HCPCS Short Description Brand Name	Current Formulary Placement (COMMERCIAL)	Current Utilization Management (COMMERCIAL)	7/1/25 UM Change (COMMERCIAL)
J2062	Loxapine inhalation (Adasuve®)	CED/NF (Pharmacy Benefit)	N/A	Medical Benefit - Add Prior Authorization (Commercial & Medicare)
J0289	Amphotericin B liposome (Ambisome®)	Medical Benefit	N/A	Add Prior Authorization
J0875	Dalbavancin (Dalvance®)	Medical Benefit	N/A	Add Prior Authorization
J0699	Cefiderocol (Fetroja®)	Medical Benefit	N/A	Add Prior Authorization
Q0138	Ferumoxytol, non-esrd (Feraheme®)	Medical Benefit	N/A	Add Prior Authorization
J1324	Enfuvirtide (Fuzeon®)	Medical Benefit	N/A	Add Prior Authorization
J1439	Ferric carboxymaltos (Injectafer®)	Medical Benefit	N/A	Add Prior Authorization
J2425	Palifermin (Kepivance®)	Medical Benefit	N/A	Add Prior Authorization
J0121	Omadacycline (Nuzyra®)	Medical Benefit	N/A	Add Prior Authorization
J2407	Oritavancin (Orbactiv®)	Medical Benefit	N/A	Add Prior Authorization
J2406	Oritavancin (Kimyrsa™)	Medical Benefit	N/A	Add Prior Authorization
J1640	Hemin (Panhematin®)	Medical Benefit	N/A	Add Prior Authorization
J0743	Cilastatin, imipenem (Primaxin®)	Medical Benefit	N/A	Add Prior Authorization
J7336	Capsaicin 8% patch (Qutenza®	CED/NF (Pharmacy Benefit)	N/A	Medical Benefit - Add Prior Authorization
J0742	Imipenem, cilastatin & relebactam (Recarbrio™)	Medical Benefit	N/A	Add Prior Authorization
J0480	Basiliximab (Simulect®)	Medical Benefit	N/A	Add Prior Authorization
J3090	Tedizolid (Sivextro®)	Medical Benefit	N/A	Add Prior Authorization
J0712	Ceftaroline (Teflaro®)	Medical Benefit	N/A	Add Prior Authorization
J3243	Tigecycline (Tygacil®)	Medical Benefit	N/A	Add Prior Authorization
J2186	Meropenem (Vabomere®)	Medical Benefit	N/A	Add Prior Authorization
J3095	Telavancin (Vibativ®)	Medical Benefit	N/A	Add Prior Authorization
J0122	Eravacycline (Xerava™)	Medical Benefit	N/A	Add Prior Authorization
J0291	Plazomicin (Zemdri®)	Medical Benefit	N/A	Add Prior Authorization

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2025

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

April 30, 2025 (July– September 2025)

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