Sentara Health Plans Pharmacy Changes

Effective: January 1, 2026

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

DRUG NAME: aliskiren (generic Tekturna®) tablets, all strengths		**INDICATION:** For the management of hypertension in adults and pediatric patients ≥50 kg and ≥6 years of age
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Tier 2	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	Tier 4	N/A
QUANTITY LIMIT: 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): lisinopril, valsartan, hydrochlorothiazide, amlodipine, metoprolol; (MEDICAID): lisinopril, valsartan, hydrochlorothiazide, amlodipine, metoprolol		

DRUG NAME: amphetamine ER ODT (Adzenys XR – ODT® ABA)		**INDICATION:** For the treatment of attention-deficit/hyperactivity disorder (ADHD)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): amphetamine salts combo tablets (generic for Adderall IR), amphetamine salts combo XR capsules (generic for Adderall XR), dextroamphetamine tablets (generic for Dexedrine), dextroamphetamine SR capsules (generic for Dexedrine Spansule), lisdexamfetamine caspules (generic for Vyvanse®); (MEDICAID): amphetamine salts combo (generic for Adderall IR), amphetamine salts combo XR (generic for Adderall XR), dextroamphetamine tab (generic for Dexedrine), dextroamphetamine cap SR (generic for Dexdrine Spansule), Vyvanse® capsule (lisdexamfetamine); (MEDICARE): amphetamine salts combo tablets (generic for Adderall IR), amphetamine salts combo XR capsules (generic for Adderall XR)		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2026

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

DRUG NAME: Andembry® (garadacimab-gxii) 200 mg/1.2 mL auto-injector and prefilled syringe injection, for subcutaneous use		**INDICATION:** For the prevention of attacks of hereditary angioedema (HAE) in adult and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Non-Formulary **(PHARMACY BENEFIT)**	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICARE): Haegarda® (*requires prior authorization)		

DRUG NAME: Andembry® (garadacimab-gxii) 200 mg/1.2 mL auto-injector and prefilled syringe injection, for subcutaneous use		**INDICATION:** For the prevention of attacks of hereditary angioedema (HAE) in adult and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1.2 mL (1 injections) per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID): Cinryze™; (MEDICARE): Haegarda® (*requires prior authorization)		

December 12, 2025 (January – March 2026)

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

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2026

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

DRUG NAME: Anzupgo® (delgocitinib) cream, for topical use		**INDICATION:** For the topical treatment of moderate to severe chronic hand eczema (CHE) in adults who have had an inadequate response to, or for whom topical corticosteroids are not advisable
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 60 grams (2 tubes) per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): tacrolimus ointment, azathioprine, cyclosporine, methotrexate, prednisone, topical corticosteroids (e.g., triamcinolone); (MEDICARE): tacrolimus ointment, azathioprine, cyclosporine, methotrexate, prednisone, topical corticosteroids (e.g., triamcinolone)		

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

DRUG NAME: Arbli (losartan) 10 mg/mL oral suspension		**INDICATION:** For the management of hypertension in adults and children ≥6 years of age; For the treatment of diabetic nephropathy with an elevated serum creatinine and proteinuria (urinary albumin to creatinine ratio ≥300 mg/g) in patients with type 2 diabetes and a history of hypertension
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: 5 mL per day		
FORMULARY ALTERNATIVES: generic losartan tablets		

DRUG NAME: Averi (desogestrel/ethinyl estradiol/ferrous bisglycinate) 0.15-0.03-36.5 mg tablets		**INDICATION:** For the prevention of pregnancy
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: Apri, Cyred, Enskyce, Isibloom, Juleber, Kalliga, Reclipsen		

DRUG NAME: Avmapki™ Fakzynja™ Co-Pack (avutometinib 0.8 mg capsules; defactinib 200 mg tablets), co-packaged for oral use		**INDICATION:** For the treatment of KRAS-mutated recurrent low-grade serous ovarian cancer in adults who have received 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: 66 units (1 pack) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Avonex® (interferon beta-1a) 30 mcg/0.5 mL pen/syringe		**INDICATION:** For the treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
REASON FOR CHANGE: Add Utilization Management Requirements		
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	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: azelastine-fluticasone 137-50 mcg nasal spray (generic Dymista®)		**INDICATION:** For the relief of symptoms of seasonal allergic rhinitis in adults and pediatric patients ≥6 years of age
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic azelastine nasal spray & generic fluticasone nasal spray, (MEDICAID): Brand Dymista®, fluticasone nasal spray (RX);(MEDICARE): generic azelastine nasal spray & generic fluticasone nasal spray		

DRUG NAME: Betaseron® (interferon beta-1b) 0.3 mg kit		**INDICATION:** From the treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease in adults
REASON FOR CHANGE: Add Utilization Management Requirements		
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	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2026

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

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

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

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

DRUG NAME: Bonsity® (teriparatide) 560 mcg/2.24 mL prefilled pen injection, for subcutaneous use		**INDICATION:** Treatment of osteoporosis in postmenopausal females who are at high risk for fracture (defined as history of osteoporotic fracture or multiple risk factors for fracture); treatment to increase bone mass in males with primary or hypogonadal osteoporosis who are high risk for fracture; treatment of glucocorticoid-induced osteoporosis in patients taking a prednisone dosage of ≥5 mg/day (or equivalent) at a high risk for fracture. May also be used in patients who are intolerant to other available osteoporosis therapy or in whom these therapies have failed
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: 1 pen per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): alendronate & ibandronate tablets; (MEDICARE): teriparatide (recombinant) injection *requires prior authorization*		

DRUG NAME: Brinsupri™ (brensocatib) tablets, all strengths		**INDICATION:** For the treatment of non-cystic fibrosis bronchiectasis in adult and pediatric patients 12 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	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: 1 tablet per day (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Briviact® (brivaracetam) 10 mg/mL oral solution		**INDICATION:** For the treatment of partial-onset seizures in patients 1 month of age and older
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 12 mL per day		
FORMULARY ALTERNATIVES: (MEDICAID): lacosamide soln/tab (generic 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: Brukinsa® (Zanubrutinib) 160 mg tablets		**INDICATION:** For the treatment of: chronic lymphocytic leukemia or small lymphocytic lymphoma in adults; Treatment (in combination with obinutuzumab) of relapsed or refractory follicular lymphoma in adults after ≥2 lines of systemic therapy; Treatment of mantle cell lymphoma in adults who have received at least 1 prior therapy; Treatment of relapsed or refractory marginal zone lymphoma in adults who have received at least 1 anti–CD20-based regimen; Treatment of Waldenström macroglobulinemia 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: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Brynovin™ (sitagliptin HCl) 25 mg/mL solution		**INDICATION:** For use as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 4 mL per day		
FORMULARY ALTERNATIVES: Brand Januvia®		

DRUG NAME: Bucapsol™ (buspirone) 7.5,10 & 15 mg capsules		**INDICATION:** For the management of generalized anxiety disorder or the short-term relief of the symptoms of anxiety
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 2 capsules per day (all strengths)		
FORMULARY ALTERNATIVES: generic buspirone tablets		

DRUG NAME: butalbital-acetaminophen-caffeine 50-325-40 mg/15 mL solution		**INDICATION:** For the relief of tension-type headache symptoms.
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: 90 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): butalbital-acetaminophen-caffeine 50-325-40 mg tablets; (MEDICAID): butalbital-acetaminophen-caffeine 50-325-40 mg tablets; (MEDICARE) butalbital-acetaminophen-caffeine 50-325-40 mg tablets		

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

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

DRUG NAME: Dicylcomine 40 mg tablets		**INDICATION:** For the treatment of irritable bowel syndrome (IBS)–associated abdominal pain
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 tablets per day		
FORMULARY ALTERNATIVES: dicyclomine 10 mg capsules, dicyclomine 10 mg/5 mL solution, dicyclomine 20 mg tablets		

DRUG NAME: DycloPro (dyclonine HCL) 0.5% solution		**INDICATION:** For anesthetizing accessible mucous membranes (e.g., the mouth, pharynx, larynx, trachea, esophagus, and urethra) prior to various endoscopic procedures
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: viscous lidocaine 2% solution		

DRUG NAME: Brand Dymista® (azelastine-fluticasone) 137-50 mcg nasal spray		**INDICATION:** For the relief of symptoms of seasonal allergic rhinitis in adults and pediatric patients ≥6 years of age
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic azelastine nasal spray & generic fluticasone nasal spray; (MEDICARE): generic azelastine nasal spray & generic fluticasone nasal spray		

DRUG NAME: Brand Dyrenium® (triamterene) capsules, all strengths		**INDICATION:** For the management of edema
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	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 capsule per day (all strengths)		
FORMULARY ALTERNATIVES: amiloride hcl, eplerenone, spironolactone		

DRUG NAME: Egrifta SV® (tesamorelin) for injection, for subcutaneous use		**INDICATION:** For the reduction of excess abdominal fat in HIV-infected adult patients with lipodystrophy
REASON FOR CHANGE: Add 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: 1 vial per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Egrifta WR™ (tesamorelin) for injection, for subcutaneous use		**INDICATION:** For the reduction of excess abdominal fat in HIV-infected adult patients with lipodystrophy
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: 4 vial kits per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ekterly® (sebetralstat) 300 mg tablets		**INDICATION:** For the treatment of acute attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: (MEDICAID): Berinert®, Cinryze™, icatibant (generic Firazyr®), Kalbitor®, Sajazir™; (MEDICARE): icatibant (generic Firazyr®) , Sajazir™ (*both require prior authorization)		

DRUG NAME: Emblaveo™ (aztreonam and avibactam) for injection, for intravenous use		**INDICATION:** For the treatment of complicated intra-abdominal infection (in combination with metronidazole) in patients ≥18 years of age with limited or no alternative options, caused by the following susceptible organisms: Escherichia coli, Klebsiella pneumoniae, Klebsiella oxytoca, Enterobacter cloacae complex, Citrobacter freundii complex, or Serratia marcescens
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: Empaveli® (pegcetacoplan) 1,080 mg/20 mL in a single-dose vial for injection, for subcutaneous use		**INDICATION:** For the treatment of adult patients with paroxysmal nocturnal hemoglobinuria and for the treatment of adult and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria
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: 8 vials per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Emrelis™ (telisotuzumab vedotin-tllv) 20 mg and 100 mg lyophilized powder in a single-dose vial for injection, for intravenous use		**INDICATION:** For the treatment of locally advanced or metastatic, nonsquamous non–small cell lung cancer (NSCLC) in adults with high c-MET protein overexpression (≥50% of tumor cells with strong [3+] staining), as determined by an approved test, who have received a 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	Medicare Part B	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Enflonsia™ (clesrovimab-cfor) 105 mg/0.7 mL prefilled syringe injection, for intramuscular use		**INDICATION:** For the prevention of respiratory syncytial virus (RSV) lower respiratory tract disease in neonates and infants who are born during or entering their first RSV season
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: eprosartan mesylate 600 mg tablets		**INDICATION:** For the management of hypertension
REASON FOR CHANGE: Add Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): irbesartan, losartan, olmesartan, valsartan ; (MEDICAD): irbesartan, losartan, olmesartan, valsartan; (MEDICARE): irbesartan, losartan, olmesartan, valsartan		

DRUG NAME: Fanapt® (iloperidone) Titration Pack B (1-2-6-8 mg) & Pack C (1-2-6 mg)		**INDICATION:** For the acute treatment of manic or mixed episodes in bipolar I disorder in adults; For the treatment of adults with schizophrenia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit

QUANTITY LIMIT:

- (COMMERCIAL & MEDICAID):
  - Titration Pack B – 12 tablets (1 pack) per 365 days
  - Titration Pack C – 8 tablets (1 pack) per 365 days
- (MEDICARE):
  - Titration Pack B – 12 tablets (1 pack) per 180 days
  - Titration Pack C – 8 tablets (1 pack) per 180 days

FORMULARY ALTERNATIVES: (COMMERCIAL): aripiprazole tablets, olanzapine tablets, quetiapine IR/ER tablets, risperidone 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: Feiba® (anti-inhibitor coagulant complex) lyophilized powder for solution, for intravenous use **J7918**		**INDICATION:** For use in hemophilia A and B patients with inhibitors for control and prevention of bleeding episodes, perioperative management, and routine prophylaxis to prevent or reduce the frequency of bleeding episodes.
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	N/A	N/A
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Flarex® (fluorometholone acetate) 0.1% ophthalmic suspension		**INDICATION:** For the treatment of steroid-responsive inflammation of the palpebral and bulbar conjunctiva, cornea, and anterior segment of the eye
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	Tier 3	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: fluorometholone 0.1% ophthalmic solution		

DRUG NAME: fluticasone Ellipta inhalation powder (Arnuity Ellipta ABA), all strengths		**INDICATION:** For the maintenance treatment of asthma in adult and pediatric patients aged 5 years and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: Brand Arnuity Ellipta		

DRUG NAME: Galzin® (zinc acetate) 25 & 50 mg capsules		**INDICATION:** For the maintenance treatment of Wilson disease following chelation therapy
REASON FOR CHANGE: Change Drug Tier and Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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: generic trientine hcl & penicillamine (*both require prior authorization)		

DRUG NAME: Glassia® [alpha1 – proteinase inhibitor {human)] 4 gm/200 mL & 5 gm/250 mL vial		**INDICATION:** For chronic augmentation and maintenance therapy in adults with clinically evident emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin 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: Harliku™ (nitisinone) 2 mg tablets		**INDICATION:** For the reduction of urine homogentisic acid (HGA) in adult patients with alkaptonuria (AKU)
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: N/A		

DRUG NAME: Hernexeos® (zongertinib) 60 mg tablets		**INDICATION:** For the treatment of adult patients with unresectable or metastatic non-squamous non-small cell lung cancer (NSCLC) whose tumors have HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test, and who have received 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: 3 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Hylenex® recombinant (hyaluronidase) 150 unit/mL solution in a single-dose vial for injection		**INDICATION:** For use as an adjuvant to increase the dispersion and absorption of other injected drugs; As an adjuvant in subcutaneous fluid administration (hypodermoclysis) for achieving hydration; As an adjunct in subcutaneous urography for improving resorption of radiopaque agents
REASON FOR CHANGE: Remove Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ibtrozi™ (taletrectinib) 200 mg capsules		**INDICATION:** For the treatment of locally advanced or metastatic ROS1-positive non–small cell lung cancer (NSCLC) 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: 3 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: ibuprofen 300 mg tablets		**INDICATION:** For the management of inflammatory diseases and rheumatoid disorders, mild to moderate pain, fever, dysmenorrhea, and osteoarthritis
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: generic ibuprofen 600 mg tablets		

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

DRUG NAME: Imuldosa™ (ustekinumab-srlf) injection 45 mg/0.5 mL or 90 mg/mL solution in a single-dose prefilled syringe		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 90 mg/mL syringe – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*		

<table>
<tr><td colspan="2">DRUG NAME: Imuldosa™ (ustekinumab-srlf) 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
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<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Jaythari (deflazacort) tablets, all strengths		**INDICATION:** For the treatment of Duchenne muscular dystrophy (DMD) in patients ≥2 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Brand Emflaza		

DRUG NAME: Jobevne® (bevacizumab-nwgd) injection, for intravenous use		**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: Journavx™ (suzetrigine) 50 mg tablets		**INDICATION:** For the treatment of moderate to severe acute pain in adult
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 30 tablets per 90 days • (MEDICAID): 30 tablets per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): diclofenac sodium 1% gel, lidocaine 5% patch, preferred oral NSAIDs; (MEDICAID): diclofenac sodium 1% gel, lidocaine 5% patch, preferred oral NSAIDs (e.g., ibuprofen, meloxicam, naproxen), acetaminophen 500 mg tablets; (MEDICARE): diclofenac sodium 1% gel, lidocaine 5% patch, preferred oral NSAIDs (e.g., ibuprofen, meloxicam, naproxen)		

<table>
<tr><td colspan="2">DRUG NAME: Jubbonti® (denosumab-bbdz) 60 mg/mL in a single-dose prefilled syringe</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Jubbonti is approved for the following treatment indications, which are also currently approved for Prolia: postmenopausal women with osteoporosis at high risk for fracture; increasing bone mass in men with osteoporosis at high risk for fracture; glucocorticoid-induced osteoporosis in men and women at high risk for fracture; increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer; and increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer</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 Specialty</td><td>N/A</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Formulary</td><td>N/A (PHARMACY)</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Tier 1</td><td>Prior Authorization, Quantity Limit (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICARE): 1 injection per 180 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Kerendia® (finerenone) 40 mg tablets		**INDICATION:** For use to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, nonfatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease associated with type 2 diabetes; For use to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visits in adult patients with heart failure with left ventricular ejection fraction ≥40%
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 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Khindivi™ (hydrocortisone) 1 mg/mL oral solution		**INDICATION:** For use as replacement therapy in pediatric patients 5 years of age and older with adrenocortical insufficiency
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 & MEDICARE): hydrocortisone tablets, prednisone oral solution, prednisolone oral solution; (MEDICAID): dexamethasone solution/tablets, hydrocortisone tablets, prednisolone oral solution		

DRUG NAME: Kirsty™ (insulin aspart-xjhz) 100 unit/mL vial & pen		**INDICATION:** Interchangeable biosimilar to Novo Nordisk's Novolog® (insulin aspart). For use to improve glycemic control in adults and pediatric patients with diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Brand Humalog®; (MEDICAID): insulin aspart cartridge/pen/vial; (MEDICARE): Brand Humalog®		

DRUG NAME: Kyzatrex® (testosterone undecanoate) capsules, all strengths		**INDICATION:** For testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: testosterone cypionate injection, testosterone gel (generic Androgel) *both require prior authorization*		

DRUG NAME: Leqselvi™ (deuruxolitinib) 8 mg tablets		**INDICATION:** For the treatment of severe alopecia areata 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	Excluded Benefit	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: (MEDICARE): azathioprine, cyclosporine, oral corticosteroids, methotrexate		

DRUG NAME: Livmarli® (maralixibat) 10, 15, 20 & 30 mg tablets		**INDICATION:** For the treatment of cholestatic pruritus in patients with Alagille syndrome ≥3 months of age; For the treatment of cholestatic pruritus in patients ≥12 months of age with progressive familial intrahepatic cholestasis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit

QUANTITY LIMIT:
• (COMMERCIAL & MEDICAID):
  • 10 mg tablets – 2 tablets per day
  • 15 mg tablets – 2 tablets per day
  • 20 mg tablets – 2 tablets per day
  • 30 mg tablets – 1 tablet per day
• (MEDICARE):
  • 10 mg tablets – 2 tablets per day
  • 15 mg tablets – 2 tablets per day
  • 20 mg tablets – 2 tablets per day
  • 30 mg tablets – 2 tablets per day		

FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lopressor® (metoprolol tartrate) 10 mg/mL oral solution		**INDICATION:** For the treatment of hypertension, to lower blood pressure and in the long-term treatment of angina pectoris in adult patients, to reduce angina attacks and to improve exercise tolerance; and in the treatment of hemodynamically stable patients with definite or suspected myocardial infarction, to reduce the risk of cardiovascular mortality when used alone or in conjunction with intravenous metoprolol therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	N/A
QUANTITY LIMIT: 20 mL per day		
FORMULARY ALTERNATIVES: generic metoprolol tartrate tablets		

DRUG NAME: Lynozyfic™ (linvoseltamab-gcpt) injection, for intravenous use		**INDICATION:** For the treatment of relapsed or refractory multiple myeloma in adults who have received at least 4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody
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: Merilog™ (insulin aspart-szjj) 100 unit/mL vial & 100 unit/mL solostar pen		**INDICATION:** Biosimilar to Novo Nordisk's Novolog® (insulin aspart). For use to improve glycemic control in adults and pediatric patients with diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): Brand Humalog®, (MEDICAID): insulin aspart cartridge/pen/vial		

DRUG NAME: Micort HC (hydrocortisone) 2.5% rectal cream		**INDICATION:** For the relief of the 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	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: hydrocortisone 2.5% cream with perineal applicator		

DRUG NAME: Miudella® (copper intrauterine system)		**INDICATION:** For the prevention of pregnancy in females of reproductive potential for up to 3 years
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 **(MEDICAL)**
	Non-Formulary	Prior Authorization (PDL Criteria), **(PHARMACY)**
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Depo-Provera® 104 mg, Kyleena™, Liletta®, medroxyprogesterone 150 mg, Mirena®, Nexplanon®, Paragard®, Skyla®; (MEDICARE): Liletta®		

DRUG NAME: mRESVIA™ (respiratory syncytial virus vaccine)		**INDICATION:** For active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in adults 18 through 59 years of age who are at increased risk of severe respiratory syncytial virus (RSV) disease. ACIP recommends expanded use in adults 50 – 59 years of age who are at increased risk of severe respiratory syncytial virus (RSV) disease with a single dose of RSV vaccine.
REASON FOR CHANGE: Change Age Edit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9	Age Edit = ≤ 49 years of age, Quantity Limit
STANDARD FORMULARY	Tier 9	Age Edit = ≤ 49 years of age, Quantity Limit
EXCHANGE FORMULARY	Tier 9	Age Edit = ≤ 49 years of age, Quantity Limit
FAMIS FORMULARY	Formulary	Age Edit = ≤ 49 years of age, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Age Edit = ≤ 49 years of age, Quantity Limit
MEDICARE FORMULARY	Tier 3	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Modeyso™ (dordaviprone) 125 mg capsules		**INDICATION:** For the treatment of adult and pediatric patients 1 year of age and older with diffuse midline glioma harboring an H3 K27M mutation with progressive disease following prior 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: 20 capsules per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: nilotinib tartrate 50, 150 & 200 mg capsules		**INDICATION:** For the treatment of newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase in adults and pediatric patients ≥1 year of age; For the treatment of chronic and accelerated phase Ph+ CML in adults with resistance or intolerance to prior tyrosine kinase therapy that included imatinib; For the treatment of chronic and accelerated phase Ph+ CML in pediatric patients ≥1 year of age with resistance or intolerance to prior tyrosine kinase therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 4 capsules per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): generic nilotinib hcl (Tasigna), (MEDICARE): Brand Tasigna capsules (*requires prior authorization)		

DRUG NAME: Orlynvah™ (sulopenem etzadroxil and probenecid) 500/500 mg tablets		**INDICATION:** For the treatment of uncomplicated urinary tract infections caused by the designated microorganisms Escherichia coli, Klebsiella pneumoniae, or Proteus mirabilis in adult women with limited or no alternative oral antibacterial treatment options
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 10 tablets per 30 days		
FORMULARY ALTERNATIVES: generic nitrofurantoin capsules, cephalexin capsules, trimethoprim-sulfamethoxazole tablets		

<table>
<tr><td colspan="2">DRUG NAME: Osenvelt® (denosumab-bmwo) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Osenvelt is approved for the following treatment indications, which are also currently approved for Xgeva: prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors; treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity; and treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy</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 Specialty</td><td>N/A</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Tier 1</td><td>Prior Authorization (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Ospomyv™ (denosumab-dssb) 60 mg/mL in a single-dose prefilled syringe</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Ospomyv is approved for the following treatment indications, which are also currently approved for Prolia: postmenopausal women with osteoporosis at high risk for fracture; increasing bone mass in men with osteoporosis at high risk for fracture; glucocorticoid-induced osteoporosis in men and women at high risk for fracture; increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer; and increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td></td><td></td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Tier 1</td><td>Prior Authorization (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Otulfi (ustekinumab-aauz) injection, for subcutaneous use - 45 mg/0.5 mL and 90 mg/mL solution in a single-dose prefilled syringe	**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)

REASON FOR CHANGE: New Drug

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

QUANTITY LIMIT:

- 45 mg/0.5 mL vial – 1 vial per 84 days
- 45 mg/0.5 mL syringe – 1 syringe per 84 days
- 90 mg/mL syringes – 1 syringe per 56 days

FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*

<table>
<tr><td colspan="2">DRUG NAME: Otulfi (ustekinumab-aauz) injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen’s Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn’s disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Penmenvy (meningococcal Groups A, B, C, W, and Y Vaccine) for injectable suspension, for intramuscular use		**INDICATION:** For active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y in individuals 10 through 25 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 9 – **Group specific Benefit**	N/A
STANDARD FORMULARY	Tier 9 – **Group specific Benefit**	N/A
EXCHANGE FORMULARY	Tier 9 – **Group specific Benefit**	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Tier 3	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Plegridy® (peginterferon beta-1a) 125 mcg/0.5 mL pen/syringe/starter pack		**INDICATION:** For the treatment of patients with relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
REASON FOR CHANGE: Add Utilization Management Requirements		
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	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Prezcobix® (darunavir/cobicistat) 675/150 mg tablets		**INDICATION:** For the treatment of HIV-1 in treatment-naïve and treatment-experienced pediatric patients weighing at least 25 kg with no darunavir resistance-associated substitutions (V11I, V32I, L33F, I47V, I50V, I54L, I54M, T74P, L76V, I84V, L89V)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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	Specialty (Tier 5)	N/A
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: generic darunavir (Prezista) & generic ritnoavir (Norvir)		

<table>
<tr><td colspan="2">DRUG NAME: Prolia® (denosumab) 60 mg/mL in a single-dose prefilled syringe</td><td>INDICATION: FDA approved for the following indications: postmenopausal women with osteoporosis at high risk for fracture; increasing bone mass in men with osteoporosis at high risk for fracture; glucocorticoid-induced osteoporosis in men and women at high risk for fracture; increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer; and increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Add Utilization Management Requirements</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit Specialty</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit Specialty</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit Specialty</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PHARMACY)</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>N/A (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Pyzchiva® (ustekinumab-ttwe) injection, for subcutaneous use - 45 mg/0.5 mL single-dose vial, 45 mg/0.5 mL and 90 mg/mL solution in a single-dose prefilled syringe (Sandoz) & autoinjector (Cordavis)	**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)

REASON FOR CHANGE: New Drug

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

QUANTITY LIMIT:

- 45 mg/0.5 mL vial – 1 vial per 84 days
- 45 mg/0.5 mL auto-injector/syringe – 1 injection per 84 days
- 90 mg/mL auto-injector/syringe – 1 injection per 56 days

FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*

DRUG NAME: Pyzchiva® (ustekinumab-ttwe) injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization **(MEDICAL)**
	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rebif® (interferon beta-1a) 22 mcg/0.5 mL & 44/0.5 mL syringe/ titration pack; Rebif Rebidose (interferon beta-1a) 22 mcg/0.5 mL & 44/0.5 mL pen/titration pack subcutaneous injection		**INDICATION:** For the treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
REASON FOR CHANGE: Add Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: RyVent® (carbinoxamine maleate) 6 mg tablets		**INDICATION:** For the symptomatic treatment of seasonal and perennial allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis caused by inhalant allergens and foods; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; dermatographism; as therapy for anaphylactic reactions adjunctive to epinephrine and other standard measures after the acute manifestations have been controlled; amelioration of the severity of allergic reactions to blood or plasma.
REASON FOR CHANGE: Change Drug Tier 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	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 4 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): carbinoxamine maleate 4 mg immediate-release tablets; (MEDICARE): cetirizine tablets, levocetirizine tablets		

DRUG NAME: Selarsdi™ (ustekinumab-aekn) injection, for subcutaneous use - 45 mg/0.5 mL and 90 mg/mL solution in a single-dose prefilled syringe	**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)

REASON FOR CHANGE: New Drug

FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	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:
- 45 mg/0.5 mL syringe – 1 syringe per 84 days
- 90 mg/mL syringe – 1 syringe per 56 days

FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva

DRUG NAME: Selarsdi® (ustekinumab-aekn injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization **(MEDICAL)**
	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Sephience™ (sepiapterin) oral powder, all strengths		**INDICATION:** For the treatment of hyperphenylalaninemia (HPA) in adult and pediatric patients 1 month of age and older with sepiapterin-responsive phenylketonuria (PKU)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A

QUANTITY LIMIT:
• (COMMERCIAL& MEDICAID):
  • 250 mg – 3 packets per day
  • 1000 mg – 6 packets per day
• (MEDICARE): 30 tablets per 30 days		

FORMULARY ALTERNATIVES: (MEDICARE): generic sapropterin poweder (*requires prior authorization)		

DRUG NAME: sitagliptin-metformin extended-release tablets, all strengths (100-1000 mg, 50-1000 mg & 50-500 mg)		**INDICATION:** For use as adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
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: Janumet XR®		

DRUG NAME: Spevigo® (spesolimab-sbzo) 300 mg/2 mL syringe injection		**INDICATION:** For the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 mL per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Steqeyma™ (ustekinumab-stba) injection, for subcutaneous use - 45 mg/0.5 mL or 90 mg/mL solution in a single-dose prefilled syringe		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 45 mg/0.5 mL vial – 1 vial per 84 days • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 90 mg/mL syringes – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva		

DRUG NAME: Stelara® (ustekinumab) 45 mg/0.5 mL single-dose vial injection/prefilled syringe & 90 mg/1 mL prefilled syringe for subcutaneous use		**INDICATION:** For the treatment of moderately to severely active Crohn disease in adults; Treatment of moderate to severe plaque psoriasis in adult and pediatric patients ≥6 years of age who are candidates for phototherapy or systemic therapy; Treatment of active psoriatic arthritis in adult and pediatric patients ≥6 years of age; and treatment of moderately to severely active ulcerative colitis in adults.
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary Specialty	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary Specialty	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary Specialty	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary ***CLOSED CLASS***	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek *both require prior authorization*		

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2026

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

<table>
<tr><td colspan="2">DRUG NAME: Steqeyma (ustekinumab-stba) injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen’s Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn’s disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Stoboclo® (denosumab-bmwo) 60 mg/mL in a single-dose prefilled syringe		**INDICATION:** An interchangeable biosimilar to U.S.-licensed Prolia® (denosumab). Stoboclo is approved for the following treatment indications, which are also currently approved for Prolia: postmenopausal women with osteoporosis at high risk for fracture; increasing bone mass in men with osteoporosis at high risk for fracture; glucocorticoid-induced osteoporosis in men and women at high risk for fracture; increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer; and increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit Specialty	N/A
STANDARD FORMULARY	Medical Benefit Specialty	N/A
EXCHANGE FORMULARY	Medical Benefit Specialty	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A **(MEDICAL)**
	Formulary	N/A **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	N/A **(MEDICAL)**
	Tier 1	Prior Authorization, Quantity Limit **(PHARMACY)**
QUANTITY LIMIT: (MEDICARE): 1 syringe per 180 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Symbravo® (meloxicam/rizatriptan) 20-10 mg tablets		**INDICATION:** For the acute treatment of migraine with or without aura in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 9 tablets per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): generic meloxicam tablets & generic rizatriptan tablets/ODT; (MEDICAID): sumatriptan succinate tablets/cartridge/vial/pen, Imitrex® nasal, rizatriptan tab/MLT		

DRUG NAME: triamterene capsules (generic Dyrenium®), all strengths		**INDICATION:** For the management of edema
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	Tier 1	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 (all strengths)		
FORMULARY ALTERNATIVES: amiloride hcl, eplerenone, spironolactone		

DRUG NAME: Tryptyr® (acoltremon ophthalmic solution) 0.003%, for topical ophthalmic use		**INDICATION:** For the treatment of the signs and symptoms of dry eye disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 60 vials (1 carton) per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic cyclosporine emulsion (Restasis®), Xiidra; (MEDICAID): Restasis®, Xiidra; (MEDICARE): generic cyclosporine emulsion (Restasis®), Xiidra		

DRUG NAME: Unloxcyt™ (cosibelimab-ipdl) injection		**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 S	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: Ustekinumab injection, for subcutaneous use - 45 mg/0.5 mL vial and prefilled syringe, 90 mg/mL prefilled syringe		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 45 mg/0.5 mL vial – 1 vial per 84 days • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 90 mg/mL syringes – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*		

<table>
<tr><td colspan="2">DRUG NAME: Ustekinumab injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen’s Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn’s disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Ustekinumab-aekn injection, for subcutaneous use - 45 mg/0.5 mL and 90 mg/mL prefilled syringe</td><td>INDICATION: Biosimilar and interchangeable to Janssen’s Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn’s disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>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:
45 mg/0.5 mL syringe – 1 syringe per 84 days
90 mg/mL syringe – 1 syringe per 56 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*</td></tr>
</table>

DRUG NAME: Ustekinumab-ttwe injection, for subcutaneous use - 45 mg/0.5 mL and 90 mg/mL solution in a single-dose prefilled syringe		**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 45 mg/0.5 mL syringe – 1 syringe per 84 days • 90 mg/mL syringe – 1 syringe per 56 days		
FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*		

<table>
<tr><td colspan="2">DRUG NAME: Ustekinumab-ttwe injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen’s Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn’s disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Vabrinty (leuprolide acetate) 22.5 mg & 45 mg injectable suspension in a kit with prefilled dual chamber syringe for subcutaneous administration		**INDICATION:** For the treatment of advanced prostate 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: Vabrinty (leuprolide acetate) 22.5 mg & 45 mg injectable suspension in a kit with prefilled dual chamber syringe for subcutaneous administration		**INDICATION:** For the treatment of advanced prostate cancer
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: • 22.5 mg – 1 kit per 84 days • 45 mg – 1 kit per 180 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): Eligard (*requires prior authorization); (MEDICAID): Eligard (*requires prior authorization); (MEDICARE): Lupron Depot (*requires prior authorization)		

DRUG NAME: valsartan (generic Diovan®) 40 mg & 320 mg tablets		**INDICATION:** For the treatment of heart failure (NYHA class II to IV) in adults; For the management of hypertension in adults and pediatric patients ≥1 year of age; For the reduction of cardiovascular mortality in patients with left ventricular dysfunction or failure following myocardial infarction (MI) (eg, acute coronary syndromes such as ST-elevation MI or non–ST-elevation MI) in adults
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 1	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vizz™ (aceclidine) 1.44% 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: pilocarpine 1, 2 & 4% ophthalmic drops		

DRUG NAME: Wezlana™ (ustekinumab-auub) injection, for subcutaneous use - 45 mg/0.5 mL or 90 mg/mL solution in a single-dose prefilled syringe; 45 mg/0.5 mL solution in a single-dose vial	**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)

REASON FOR CHANGE: New Drug

FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	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:
- 45 mg/0.5 mL vial – 1 vial per 84 days
- 45 mg/0.5 mL syringe – 1 syringe per 84 days
- 90 mg/mL syringes – 1 syringe per 56 days

FORMULARY ALTERNATIVES: (COMMERCIAL); Selarsdi & Yesintek *both require prior authorization*; (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva; (MEDICARE): Selarsdi & Yesintek® *both require prior authorization*

<table>
<tr><td colspan="2">DRUG NAME: Wezlana™ (ustekinumab-auub) injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen’s Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn’s disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Wyost® (denosumab-bbdz) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial</td><td>INDICATION: An interchangeable biosimilar to U.S.-licensed Xgeva® (denosumab). Wyost is approved for the following treatment indications, which are also currently approved for Xgeva: prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors; treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity; and treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: 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 Specialty</td><td>N/A</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit Specialty</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>N/A</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Tier 1</td><td>Prior Authorization (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Xgeva® (denosumab) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial</td><td>INDICATION: FDA approved for the following indications: prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors; treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity; and treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit Specialty</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit Specialty</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit Specialty</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>N/A (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Yesintek™ (ustekinumab-kfce injection, for subcutaneous use - 45 mg/0.5 mL and 90 mg/mL solution in a single-dose prefilled syringe; 45 mg/0.5 mL solution in a single-dose vial	**INDICATION:** Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)

REASON FOR CHANGE: New Drug

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

QUANTITY LIMIT:

- 45 mg/0.5 mL vial – 1 vial per 84 days
- 45 mg/0.5 mL syringe – 1 syringe per 84 days
- 90 mg/mL syringes – 1 syringe per 56 days

FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, adalimumab-adbm, Pyzchiva

<table>
<tr><td colspan="2">DRUG NAME: Yesintek™ (ustekinumab-kfce) injection, for intravenous use - 130 mg/26 mL (5 mg/mL) solution in a single-dose vial</td><td>INDICATION: Biosimilar and interchangeable to Janssen's Stelara® (ustekinumab), indicated for the treatment of adult patients with moderate to severe plaque psoriasis (Ps) who are candidates for phototherapy or systemic therapy; active psoriatic arthritis (PsA); moderately to severely active Crohn's disease (CD); moderately to severely active ulcerative colitis; Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy; Pediatric patients 6 years and older with active psoriatic arthritis (PsA)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td rowspan="2">SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization (MEDICAL)</td></tr>
<tr><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit (PHARMACY)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: (MEDICAID): 1 vial (26 mL) per 365 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: January 1, 2026

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

DRUG NAME: Yeztugo® (lenacapavir) 300 mg tablets		**INDICATION:** For use as preexposure prophylaxis (PrEP) in adults and adolescents weighing ≥35 kg to reduce the risk of sexually acquired HIV-1
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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	Medicare Part B	N/A
QUANTITY LIMIT: 300 mg tablets – 4 tablets per 365 days		
FORMULARY ALTERNATIVES: (MEDICAID): Apretude, Descovy®, emtricitabine-tenofovir		

DRUG NAME: Yeztugo® (lenacapavir) 463.5 mg/1.5 mL in single-dose vial for subcutaneous injection		**INDICATION:** For use as preexposure prophylaxis (PrEP) in adults and adolescents weighing ≥35 kg to reduce the risk of sexually acquired HIV-1
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 (**MEDICAL**)
	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit (**PHARMACY**)
MEDICARE FORMULARY	Medicare Part B	N/A
QUANTITY LIMIT: 463.5 mg/ 1.5 mL vial – 3 mL (2 vials) per 180 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Yutrepia™ (treprostinil) inhalation powder contained in capsule is available in 4 strengths: 26.5 mcg, 53 mcg, 79.5 mcg, 106 mcg		**INDICATION:** For the treatment of PAH (WHO Group I) in patients with NYHA Class III symptoms to improve exercise ability and for the treatment of pulmonary hypertension associated with interstitial lung disease (WHO Group 3) to improve exercise ability
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 112 capsules (4 cartons) per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): Ventavis®; (MEDICARE): generic ambrisentan tablets, generic bosentan tablets (*both require prior authorization)		

DRUG NAME: Zelsuvmi™ (berdazimer) 10.3% topical gel		**INDICATION:** For the treatment of molluscum contagiosum in adults and pediatric patients ≥1 year of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 carton per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zevaskyn™ (prademagene zamikeracel), gene-modified cellular sheets, for topical use		**INDICATION:** For the treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa
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: Zilxi® (minocycline) 1.5% topical foam		**INDICATION:** For the treatment of inflammatory lesions of rosacea in adults
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)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic minocycline 50, 75 & 100 mg immediate-release capsules; (MEDICAID): metronidazole cream/gel; (MEDICARE): generic minocycline 50, 75 & 100 mg immediate-release capsules		

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DRUG NAME: Zusduri™ (mitomycin) for intravesical solution		**INDICATION:** For the treatment of recurrent, low-grade, intermediate-risk, non–muscle invasive bladder cancer (LG-IR-NMIBC) 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		

Quantity Limits

Drug Name	SI-indicator	Recommended QL
Tegretol 200 mg	X-MSB	8 tablets per day
carbamazepine 200 mg tablet	Y-generic	8 tablets per day
Epitol 200 mg tablets	Y-generic	8 tablets per day
carbamazepine 100 mg chewable tablets	Y-generic	10 tablets per day
carbamazepine 200 mg chewable tablets	W-SSB	8 tablets per day
Carbatrol ER 200 mg capsule	X-MSB	2 capsules per day
carbamazepine er 200 mg capsule	Y-generic	2 capsules per day
Carbatrol ER 300 mg capsule	X-MSB	5 capsules per day
carbamazepine er 300 mg capsule	Y-generic	5 capsules per day
Carbatrol ER 100 mg capsule	X-MSB	2 capsules per day
carbamazepine er 100 mg capsule	Y-generic	2 capsules per day
carbamazepine 200 mg/10 ml cup	Y-generic	50 ml per day
Tegretol XR 100 mg tablet	X-MSB	2 tablets per day
carbamazepine er 100 mg tablet	Y-generic	2 tablets per day
Tegretol XR 200 mg tablet	X-MSB	2 tablets per day
carbamazepine er 200 mg tablet	Y-generic	2 tablets per day
Tegretol XR 400 mg tablet	X-MSB	4 tablets per day
carbamazepine er 400 mg tablet	Y-generic	4 tablets per day
Tegretol 100 mg/5 ml susp	X-MSB	50 ml per day
carbamazepine 100 mg/5 ml susp	Y-generic	50 ml per day
Onfi 20 mg tablet	X-MSB	2 tablets per day
clobazam 20 mg tablet	Y-generic	2 tablets per day
Onfi 10 mg tablet	X-MSB	2 tablets per day
clobazam 10 mg tablet	Y-generic	2 tablets per day
Onfi 2.5 mg/ml suspension	X-MSB	16 ml per day
clobazam 2.5 mg/ml suspension	Y-generic	16 ml per day
Sympazan 5 mg film	W-SSB	1 film strip per day
Sympazan 10 mg film	W-SSB	2 film strips per day
Sympazan 20 mg film	W-SSB	2 film strips per day

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Drug Name	SI-indicator	Recommended QL
Depakote DR 250 mg tablet	X-MSB	2 tablets per day
divalproex sod dr 250 mg tab	Y-generic	2 tablets per day
Depakote DR 500 mg tablet	X-MSB	7 tablets per day
divalproex sod dr 500 mg tab	Y-generic	7 tablets per day
Depakote DR 125 mg tablet	X-MSB	2 tablets per day
divalproex sod dr 125 mg tab	Y-generic	2 tablets per day
Depakote DR 125 mg sprinkle cp	X-MSB	8 capsules per day
divalproex dr 125 mg cap sprinkle	Y-generic	8 capsules per day
Depakote ER 500 mg tablet	X-MSB	7 tablets per day
divalproex sod er 500 mg tab	Y-generic	7 tablets per day
Depakote ER 250 mg tablet	X-MSB	2 tablets per day
divalproex sod er 250 mg tab	Y-generic	2 tablets per day
Zarontin 250 mg capsule	X-MSB	6 capsules per day
ethosuximide 250 mg capsule	Y-generic	6 capsules per day
Zarontin 250 mg/5 ml solution	X-MSB	30 ml per day
ethosuximide 250 mg/5 ml soln	Y-generic	30ml per day
felbamate 600 mg/5 ml susp	Y-generic	30ml per day
felbamate 600 mg/5 ml susp cup	Y-generic	30ml per day
Felbatol 400 mg tablet	X-MSB	6 tablets per day
felbamate 400 mg tablet	Y-generic	6 tablets per day
Felbatol 600 mg tablet	X-MSB	6 tablets per day
felbamate 600 mg tablet	Y-generic	6 tablets per day
Neurontin 100 mg capsule	X-MSB	6 capsules per day
gabapentin 100 mg capsule	Y-generic	6 capsules per day
Neurontin 300 mg capsule	X-MSB	9 capsules per day
gabapentin 300 mg capsule	Y-generic	9 capsules per day
Neurontin 400 mg capsule	X-MSB	6 capsules per day
gabapentin 400 mg capsule	Y-generic	6 capsules per day
Neurontin 250 mg/5 ml solution	X-MSB	72 ml per day
gabapentin 250 mg/5 ml soln	Y-generic	72 ml per day
gabapentin 250 mg/5ml soln cup	Y-generic	72 ml per day

Drug Name	SI-indicator	Recommended QL
gabapentin 300 mg/6 ml soln	Y-generic	72 ml per day
gabapentin 300 mg/6ml soln cup	Y-generic	72 ml per day
Neurontin 800 mg tablet	X-MSB	4 tablets per day
gabapentin 800 mg tablet	Y-generic	4 tablets per day
Neurontin 600 mg tablet	X-MSB	6 tablets per day
gabapentin 600 mg tablet	Y-generic	6 tablets per day
Vimpat 50 mg tablet	X-MSB	2 tablets per day
lacosamide 50 mg tablet	Y-generic	2 tablets per day
Vimpat 100 mg tablet	X-MSB	2 tablets per day
lacosamide 100 mg tablet	Y-generic	2 tablets per day
Vimpat 150 mg tablet	X-MSB	2 tablets per day
lacosamide 150 mg tablet	Y-generic	2 tablets per day
Vimpat 200 mg tablet	X-MSB	2 tablets per day
lacosamide 200 mg tab	Y-generic	2 tablets per day
Vimpat 10 mg/ml solution	X-MSB	40 ml per day
lacosamide 10 mg/ml solution	Y-generic	40 ml per day
lacosamide 150 mg/15 ml cup	Y-generic	40 ml per day
lacosamide 200 mg/20 ml cup	Y-generic	40 ml per day
Motpoly XR 100 mg capsule	W-SSB	1 capsule per day
Motpoly XR 150 mg capsule	W-SSB	2 capsules per day
Motpoly XR 200 mg capsule	W-SSB	2 capsules per day
Lamictal ODT 50 mg tablet	X-MSB	3 tablets per day
lamotrigine odt 50 mg tablet	Y-generic	3 tablets per day
Lamictal ODT 25 mg tablet	X-MSB	3 tablets per day
lamotrigine odt 25 mg tablet	Y-generic	3 tablets per day
Lamictal ODT 100 mg tablet	X-MSB	2 tablets per day
lamotrigine odt 100 mg tablet	Y-generic	2 tablets per day
Lamictal ODT 200 mg tablet	X-MSB	2 tablets per day
lamotrigine odt 200 mg tablet	Y-generic	2 tablets per day
Lamictal ODT start kt (orange)	X-MSB	1 kit per 35 days
lamotrigine odt kit (orange)	Y-generic	1 kit per 35 days

Drug Name	SI-indicator	Recommended QL
Lamictal ODT start kit (blue)	X-MSB	1 kit per 28 days
lamotrigine odt kit (blue)	Y-generic	1 kit per 28 days
Lamictal ODT start kit (green)	X-MSB	1 kit per 35 days
lamotrigine odt kit (green)	Y-generic	1 kit per 35 days
Lamictal tab start kit (blue)	X-MSB	1 kit per 28 days
lamotrigine tab start kit-blue	Y-generic	1 kit per 28 days
subvenite tab start kit (blue)	Y-generic	1 kit per 28 days
Lamictal tab start kit (green)	X-MSB	1 kit per 35 days
lamotrigine tab start kit-green	Y-generic	1 kit per 35 days
subvenite tab start kit(green)	Y-generic	1 kit per 35 days
Lamictal tab start kit (orange)	X-MSB	1 kit per 35 days
lamotrigine tab start kit-orange	Y-generic	1 kit per 35 days
subvenite tab start kit(orange)	Y-generic	1 kit per 35 days
Lamictal XR 25 mg tablet	X-MSB	3 tablets per day
lamotrigine er 25 mg tablet	Y-generic	3 tablets per day
Lamictal XR 50 mg tablet	X-MSB	3 tablets per day
lamotrigine er 50 mg tablet	Y-generic	3 tablets per day
Lamictal XR 100 mg tablet	X-MSB	3 tablets per day
lamotrigine er 100 mg tablet	Y-generic	3 tablets per day
Lamictal XR 200 mg tablet	X-MSB	3 tablets per day
lamotrigine er 200 mg tablet	Y-generic	3 tablets per day
Lamictal XR start kit (blue)	W-SSB	28 tablets per 28 days
Lamictal XR start kit (green)	W-SSB	35 tablets per 35 days
Lamictal XR start kit (orange)	W-SSB	35 tablets per 35 days
Lamictal XR 300 mg tablet	X-MSB	2 tablets per day
lamotrigine er 300 mg tablet	Y-generic	2 tablets per day
Lamictal XR 250 mg tablet	X-MSB	2 tablets per day
Lamictal 100 mg tablet	X-MSB	3 tablets per day
lamotrigine 100 mg tablet	Y-generic	3 tablets per day
subvenite 100 mg tablet	Y-generic	3 tablets per day
Lamictal 25 mg tablet	X-MSB	6 tablets per day

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Drug Name	SI-indicator	Recommended QL
lamotrigine 25 mg tablet	Y-generic	6 tablets per day
subvenite 25 mg tablet	Y-generic	6 tablets per day
Lamictal 25 mg disper tablet	X-MSB	2 tablets per day
lamotrigine 25 mg disper tab	Y-generic	2 tablets per day
Lamictal 5 mg disper tablet	X-MSB	4 tablets per day
lamotrigine 5 mg disper tablet	Y-generic	4 tablets per day
Lamictal 150 mg tablet	X-MSB	3 tablets per day
lamotrigine 150 mg tablet	Y-generic	3 tablets per day
subvenite 150 mg tablet	Y-generic	3 tablets per day
Lamictal 200 mg tablet	X-MSB	3 tablets per day
lamotrigine 200 mg tablet	Y-generic	3 tablets per day
subvenite 200 mg tablet	Y-generic	3 tablets per day
Keppra XR 500 mg tablet	X-MSB	6 tablets per day
levetiracetam er 500 mg tablet	Y-generic	6 tablets per day
roweepra xr 500 mg tablet	Y-generic	6 tablets per day
levetiracetam 500 mg/5 ml cup	Y-generic	30 ml per day
levetiracetam 500 mg/5 ml soln	Y-generic	30 ml per day
levetiracetam 100 mg/ml soln	Y-generic	30 ml per day
Keppra 100 mg/ml oral soln	X-MSB	30 ml per day
levetiracetam 1,000mg/10ml cup	Y-generic	30 ml per day
Keppra XR 750 mg tablet	X-MSB	4 tablets per day
levetiracetam er 750 mg tablet	Y-generic	4 tablets per day
roweepra xr 750 mg tablet	Y-generic	4 tablets per day
Spritam 250 mg tablet	W-SSB	2 tablets per day
Spritam 500 mg tablet	W-SSB	2 tablets per day
Spritam 750 mg tablet	W-SSB	4 tablets per day
Spritam 1,000 mg tablet	W-SSB	2 tablets per day
Elepsia XR 1,000 mg tablet	W-SSB	2 tablets per day
Elepsia XR 1,500 mg tablet	W-SSB	2 tablets per day
Keppra 750 mg tablet	X-MSB	4 tablets per day
levetiracetam 750 mg tablet	Y-generic	4 tablets per day

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Drug Name	SI-indicator	Recommended QL
roweepra 750 mg tablet	Y-generic	4 tablets per day
Keppra 250 mg tablet	X-MSB	2 tablets per day
levetiracetam 250 mg tablet	Y-generic	2 tablets per day
Keppra 500 mg tablet	X-MSB	6 tablets per day
levetiracetam 500 mg tablet	Y-generic	6 tablets per day
roweepra 500 mg tablet	Y-generic	6 tablets per day
Keppra 1,000 mg tablet	X-MSB	3 tablets per day
levetiracetam 1,000 mg tablet	Y-generic	3 tablets per day
roweepra 1,000 mg tablet	Y-generic	3 tablets per day
Celontin 300 mg capsule	X-MSB	4 capsules per day
methsuximide 300 mg capsule	Y-generic	4 capsules per day
Trileptal 300 mg tablet	X-MSB	2 tablets per day
oxcarbazepine 300 mg tablet	Y-generic	2 tablets per day
Trileptal 600 mg tablet	X-MSB	4 tablets per day
oxcarbazepine 600 mg tablet	Y-generic	4 tablets per day
Trileptal 300 mg/5 ml susp	X-MSB	40 ml per day
oxcarbazepine 300 mg/5 ml susp	Y-generic	40 ml per day
Trileptal 150 mg tablet	X-MSB	2 tablets per day
oxcarbazepine 150 mg tablet	Y-generic	2 tablets per day
Mysoline 250 mg tablet	X-MSB	8 tablets per day
primidone 250 mg tablet	Y-generic	8 tablets per day
Mysoline 50 mg tablet	X-MSB	4 tablets per day
primidone 50 mg tablet	Y-generic	4 tablets per day
primidone 125 mg tablet	Y-generic	3 tablets per day
Banzel 40 mg/ml suspension	X-MSB	80 ml per day
rufinamide 40 mg/ml suspension	Y-generic	80 ml per day
Banzel 200 mg tablet	X-MSB	6 tablets per day
rufinamide 200 mg tablet	Y-generic	6 tablets per day
Banzel 400 mg tablet	X-MSB	8 tablets per day
rufinamide 400 mg tablet	Y-generic	8 tablets per day
tiagabine hcl 2 mg tablet	Y-generic	2 tablets per day

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Drug Name	SI-indicator	Recommended QL
tiagabine hcl 4 mg tablet	Y-generic	2 tablets per day
tiagabine hcl 12 mg tablet	Y-generic	2 tablets per day
tiagabine hcl 16 mg tablet	Y-generic	2 tablets per day
Topamax 50 mg tablet	X-MSB	3 tablets per day
Topamax 100 mg tablet	X-MSB	3 tablets per day
topiramate 100 mg tablet	Y-generic	3 tablets per day
Topamax 200 mg tablet	X-MSB	2 tablets per day
topiramate 200 mg tablet	Y-generic	2 tablets per day
Topamax 25 mg tablet	X-MSB	3 tablets per day
topiramate 25 mg tablet	Y-generic	3 tablets per day
Topamax 15 mg sprinkle cap	X-MSB	2 capsules per day
topiramate 15 mg sprinkle cap	Y-generic	2 capsules per day
Topamax 25 mg sprinkle cap	X-MSB	2 capsules per day
topiramate 25 mg sprinkle cap	Y-generic	2 capsules per day
Eprontia 25 mg/ml solution	W-SSB	16 ml per day
valproic acid 250 mg capsule	Y-generic	4 capsules per day
valproic acid 500 mg/10 ml cup	Y-generic	120 ml per day
Zonegran 25 mg capsule	X-MSB	6 capsules per day
zonisamide 25 mg capsule	Y-generic	6 capsules per day
zonisamide 50 mg capsule	Y-generic	6 capsules per day
Zonegran 100 mg capsule	X-MSB	6 capsules per day
zonisamide 100 mg capsule	Y-generic	6 capsules per day
Zonisade 100 mg/5 ml oral susp	W-SSB	6 bottles per day

Quantity Limit Table

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
ACIPHEX SPRINKLE DR 5 MG CAP	RABEPRAZOLE SODIUM	W	1 CAPSULE PER DAY	30	ORAL
ACTONEL 150 MG TABLET	RISEDRONATE SODIUM	X	1 TABLET PER 28 DAYS	1	ORAL
ACTONEL 35 MG TABLET	RISEDRONATE SODIUM	X	4 TABLETS PER 28 DAYS	4	ORAL
ACTOPLUS MET 15 MG-500 MG TAB	PIOGLITAZONE HCL/METFORMIN HCL	X	2 TABLETS PER DAY	60	ORAL
ACTOPLUS MET 15 MG-850 MG TAB	PIOGLITAZONE HCL/METFORMIN HCL	X	3 TABLETS PER DAY	60	ORAL
ACTOS 15 MG TABLET	PIOGLITAZONE HCL	X	1 TABLET PER DAY	30	ORAL
ACTOS 30 MG TABLET	PIOGLITAZONE HCL	X	1 TABLET PER DAY	30	ORAL
ACTOS 45 MG TABLET	PIOGLITAZONE HCL	X	1 TABLET PER DAY	30	ORAL
ADIPEX-P 37.5 MG CAPSULE	PHENTERMINE HCL	X	1 CAPSULE PER DAY	100	ORAL
ADIPEX-P 37.5 MG TABLET	PHENTERMINE HCL	X	1 TABLET PER DAY	100	ORAL
ADVAIR 100-50 DISKUS	FLUTICASONE PROPION/SALMETEROL	X	1 PACKAGE PER 30 DAYS	60	INHALATION
ADVAIR 250-50 DISKUS	FLUTICASONE PROPION/SALMETEROL	X	1 PACKAGE PER 30 DAYS	60	INHALATION
ADVAIR 500-50 DISKUS	FLUTICASONE PROPION/SALMETEROL	X	1 PACKAGE PER 30 DAYS	60	INHALATION
ADVAIR HFA 115-21 MCG INHALER	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	12	INHALATION
ADVAIR HFA 230-21 MCG INHALER	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	12	INHALATION

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
ADVAIR HFA 45-21 MCG INHALER	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	12	INHALATION
AIRDUO RESPICLICK 113-14 MCG	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	1	INHALATION
AIRDUO RESPICLICK 232-14 MCG	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	1	INHALATION
AIRDUO RESPICLICK 55-14 MCG	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	1	INHALATION
ALENDRONATE SOD 70 MG/75 ML	ALENDRONATE SODIUM	Y	300 ML PER 30 DAYS	75	ORAL
ALENDRONATE SODIUM 10 MG TAB	ALENDRONATE SODIUM	Y	1 TABLET PER DAY	30	ORAL
ALENDRONATE SODIUM 35 MG TAB	ALENDRONATE SODIUM	Y	4 TABLETS PER 28 DAYS	12	ORAL
ALENDRONATE SODIUM 5 MG TABLET	ALENDRONATE SODIUM	Y	1 TABLET PER DAY	30	ORAL
ALENDRONATE SODIUM 70 MG TAB	ALENDRONATE SODIUM	Y	4 TABLETS PER 28 DAYS	12	ORAL
ALOGLIPTIN 12.5 MG TABLET	ALOGLIPTIN BENZOATE	W	1 TABLET PER DAY	30	ORAL
ALOGLIPTIN 25 MG TABLET	ALOGLIPTIN BENZOATE	W	1 TABLET PER DAY	30	ORAL
ALOGLIPTIN 6.25 MG TABLET	ALOGLIPTIN BENZOATE	W	1 TABLET PER DAY	30	ORAL
ALOGLIPTIN-METFORMIN 12.5-1000	ALOGLIPTIN BENZ/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
ALOGLIPTIN-METFORMIN 12.5-500	ALOGLIPTIN BENZ/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
ALOGLIPTIN-PIOGLIT 12.5-30 MG	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
ALOGLIPTIN-PIOGLIT 25-15 MG TB	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
ALOGLIPTIN-PIOGLIT 25-30 MG TB	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
ALOGLIPTIN-PIOGLIT 25-45 MG TB	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
ALTOPREV 20 MG TABLET	LOVASTATIN	W	1 TABLET PER DAY	30	ORAL
ALTOPREV 40 MG TABLET	LOVASTATIN	W	1 TABLET PER DAY	30	ORAL
ALTOPREV 60 MG TABLET	LOVASTATIN	W	1 TABLET PER DAY	30	ORAL
ALVESCO 160 MCG INHALER	CICLESONIDE	W	2 INHALERS PER 30 DAYS	6.1	INHALATION
ALVESCO 80 MCG INHALER	CICLESONIDE	W	1 INHALER PER 30 DAYS	6.1	INHALATION
AMLODIPINE-ATORVAST 10-10 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 10-20 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 10-40 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 10-80 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 2.5-10 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 2.5-20 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 2.5-40 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 5-10 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 5-20 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
AMLODIPINE-ATORVAST 5-40 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
AMLODIPINE-ATORVAST 5-80 MG	AMLODIPINE/ATORVASTATIN	Y	1 TABLET PER DAY	30	ORAL
ANDROGEL 1% (25 MG/2.5 G) PKT	TESTOSTERONE	X	2 PACKETS PER DAY	2.5	TRANSDERMAL
ANDROGEL 1% (50 MG/5 G) PKT	TESTOSTERONE	X	1 PACKET PER DAY	5	TRANSDERMAL
ANDROGEL 1.62% GEL PUMP	TESTOSTERONE	X	2 BOTTLES PER 30 DAYS	75	TRANSDERMAL
ANDROGEL 1.62%(1.25G) GEL PCKT	TESTOSTERONE	X	1 PACKET PER DAY	1.25	TRANSDERMAL
ANDROGEL 1.62%(2.5G) GEL PCKT	TESTOSTERONE	X	2 PACKETS PER DAY	2.5	TRANSDERMAL
ANORO ELLIPTA 62.5-25 MCG INH	UMECLIDINIUM BRM/VILANTEROL TR	W	1 INHALER PER 30 DAYS	14	INHALATION
APLENZIN ER 174 MG TABLET	BUPROPION HBR	W	1 TABLET PER DAY	30	ORAL
APLENZIN ER 348 MG TABLET	BUPROPION HBR	W	1 TABLET PER DAY	30	ORAL
APLENZIN ER 522 MG TABLET	BUPROPION HBR	W	1 TABLET PER DAY	30	ORAL
ARAVA 10 MG TABLET	LEFLUNOMIDE	X	1 TABLET PER DAY	30	ORAL
ARAVA 20 MG TABLET	LEFLUNOMIDE	X	1 TABLET PER DAY	30	ORAL
ARFORMOTEROL 15 MCG/2 ML SOLN	ARFORMOTEROL TARTRATE	Y	60 VIALS PER 30 DAYS	2	INHALATION
ARNUITY ELLIPTA 100 MCG INH	FLUTICASONE FUROATE	W	1 INHALER PER 30 DAYS	30	INHALATION
ARNUITY ELLIPTA 200 MCG INH	FLUTICASONE FUROATE	W	1 INHALER PER 30 DAYS	30	INHALATION

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
ARNUITY ELLIPTA 50 MCG INH	FLUTICASONE FUROATE	W	1 INHALER PER 30 DAYS	30	INHALATION
ASMANEX HFA 100 MCG INHALER	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	13	INHALATION
ASMANEX HFA 200 MCG INHALER	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	13	INHALATION
ASMANEX HFA 50 MCG INHALER	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	13	INHALATION
ASMANEX TWISTHALER 110 MCG #30	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	1	INHALATION
ASMANEX TWISTHALER 220 MCG #14	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	1	INHALATION
ASMANEX TWISTHALER 220 MCG #30	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	1	INHALATION
ASMANEX TWISTHALER 220 MCG #60	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	1	INHALATION
ASMANEX TWISTHALR 220 MCG #120	MOMETASONE FUROATE	W	1 INHALER PER 30 DAYS	1	INHALATION
ATELVIA DR 35 MG TABLET	RISEDRONATE SODIUM	X	4 TABLETS PER 28 DAYS	4	ORAL
ATORVALIQ 20 MG/5 ML SUSP	ATORVASTATIN CALCIUM	W	20 ML PER DAY	150	ORAL
ATORVASTATIN 10 MG TABLET	ATORVASTATIN CALCIUM	Y	1 TABLET PER DAY	1000	ORAL
ATORVASTATIN 20 MG TABLET	ATORVASTATIN CALCIUM	Y	1 TABLET PER DAY	1000	ORAL
ATORVASTATIN 40 MG TABLET	ATORVASTATIN CALCIUM	Y	1 TABLET PER DAY	1000	ORAL
ATORVASTATIN 80 MG TABLET	ATORVASTATIN CALCIUM	Y	1 TABLET PER DAY	500	ORAL

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
ATROVENT 17 MCG HFA INHALER	IPRATROPIUM BROMIDE	W	2 INHALERS PER 30 DAYS	12.9	INHALATION
AUBAGIO 14 MG TABLET	TERIFLUNOMIDE	X	1 TABLET PER DAY	28	ORAL
AUBAGIO 7 MG TABLET	TERIFLUNOMIDE	X	1 TABLET PER DAY	28	ORAL
AVONEX 30 MCG/0.5 ML SYRINGE	INTERFERON BETA-1A	W	2 ML (4 SYRINGES) PER 28 DAYS	0.5	INTRAMUSCULAR
AVONEX PEN 30 MCG/0.5 ML KIT	INTERFERON BETA-1A	W	4 KITS PER 28 DAYS	1	INTRAMUSCULAR
AVONEX PREFILLED SYR 30 MCG KT	INTERFERON BETA-1A	W	4 KITS PER 28 DAYS	1	INTRAMUSCULAR
AZELASTIN-FLUTIC 137-50MCG SPR	AZELASTINE/FLUTICASONE	Y	1 BOTTLE PER 30 DAYS	23	NASAL
BAXDELA 450 MG TABLET	DELAFLOXACIN MEGLUMINE	W	28 TABLETS PER 30 DAYS	20	ORAL
BENZPHETAMINE HCL 50 MG TABLET	BENZPHETAMINE HCL	Y	3 TABLETS PER DAY	100	ORAL
BETASERON 0.3 MG KIT	INTERFERON BETA-1B	W	1 KIT PER 28 DAYS	1	SUBCUTANEOUS
BETHKIS 300 MG/4 ML AMPULE	TOBRAMYCIN	X	224 ML PER 28 DAYS	4	INHALATION
BEVESPI AEROSPHERE INHALER	GLYCOPYRROLATE/FORMOTEROL FUM	W	1 INHALER PER 30 DAYS	10.7	INHALATION
BINOSTO 70 MG EFFERVESCENT TAB	ALENDRONATE SODIUM	W	4 TABLETS PER 28 DAYS	1	ORAL
BONIVA 150 MG TABLET	IBANDRONATE SODIUM	X	1 TABLET PER 28 DAYS	3	ORAL
BONJESTA ER 20-20 MG TABLET	DOXYLAMINE SUCCINATE/VIT B6	W	2 TABLETS PER DAY	60	ORAL
BREO ELLIPTA 100-25 MCG INHALR	FLUTICASONE/VILANTEROL	W	1 INHALER PER 30 DAYS	60	INHALATION

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
BREO ELLIPTA 200-25 MCG INHALR	FLUTICASONE/VILANTEROL	W	1 INHALER PER 30 DAYS	60	INHALATION
BREO ELLIPTA 50-25 MCG INHALER	FLUTICASONE/VILANTEROL	W	1 INHALER PER 30 DAYS	60	INHALATION
BREXAFEMME 150 MG TABLET	IBREXAFUNGERP CITRATE	W	4 TABLETS PER 30 DAYS	4	ORAL
BREYNA 160-4.5 MCG INHALER	BUDESONIDE/FORMOTEROL FUMARATE	Y	1 INHALER PER 30 DAYS	10.3	INHALATION
BREYNA 80-4.5 MCG INHALER	BUDESONIDE/FORMOTEROL FUMARATE	Y	1 INHALER PER 30 DAYS	10.3	INHALATION
BROVANA 15 MCG/2 ML SOLUTION	ARFORMOTEROL TARTRATE	X	60 VIALS PER 30 DAYS	2	INHALATION
BUDESONIDE 0.25 MG/2 ML SUSP	BUDESONIDE	Y	120 ML PER 30 DAYS	2	INHALATION
BUDESONIDE 0.5 MG/2 ML SUSP	BUDESONIDE	Y	120 ML PER 30 DAYS	2	INHALATION
BUDESONIDE 1 MG/2 ML INH SUSP	BUDESONIDE	Y	60 ML PER 30 DAYS	2	INHALATION
BUDESONIDE-FORMOTEROL 160-4.5	BUDESONIDE/FORMOTEROL FUMARATE	Y	1 INHALER PER 30 DAYS	10.2	INHALATION
BUDESONIDE-FORMOTEROL 80-4.5	BUDESONIDE/FORMOTEROL FUMARATE	Y	1 INHALER PER 30 DAYS	10.2	INHALATION
CADUET 10 MG-10 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CADUET 10 MG-20 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CADUET 10 MG-40 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CADUET 10 MG-80 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
CADUET 5 MG-10 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CADUET 5 MG-20 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CADUET 5 MG-40 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CADUET 5 MG-80 MG TABLET	AMLODIPINE/ATORVASTATIN	X	1 TABLET PER DAY	30	ORAL
CARDURA 1 MG TABLET	DOXAZOSIN MESYLATE	X	1 TABLET PER DAY	100	ORAL
CARDURA 2 MG TABLET	DOXAZOSIN MESYLATE	X	1 TABLET PER DAY	100	ORAL
CARDURA 4 MG TABLET	DOXAZOSIN MESYLATE	X	1 TABLET PER DAY	100	ORAL
CARDURA 8 MG TABLET	DOXAZOSIN MESYLATE	X	2 TABLETS PER DAY	100	ORAL
CARDURA XL 4 MG TABLET	DOXAZOSIN MESYLATE	W	1 TABLET PER DAY	30	ORAL
CARDURA XL 8 MG TABLET	DOXAZOSIN MESYLATE	W	1 TABLET PER DAY	30	ORAL
CATAPRES-TTS 1 PATCH	CLONIDINE	X	4 PATCHES PER 28 DAYS	4	TRANSDERMAL
CATAPRES-TTS 2 PATCH	CLONIDINE	X	4 PATCHES PER 28 DAYS	4	TRANSDERMAL
CATAPRES-TTS 3 PATCH	CLONIDINE	X	4 PATCHES PER 28 DAYS	4	TRANSDERMAL
CAYSTON 75 MG INHAL SOLUTION	AZTREONAM LYSINE	W	3 VIALS PER DAY	1	INHALATION
CEQUA 0.09% SOLUTION	CYCLOSPORINE	W	2 VIALS PER DAY	60	OPHTHALMIC (EYE)
CLARINEX 5 MG TABLET	DESLORATADINE	X	1 TABLET PER DAY	100	ORAL
CLARINEX-D 12 HR 2.5-120 MG TB	DESLORATADINE/PSEUDOEPHEDRINE	W	2 TABLETS PER DAY	100	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
CLIMARA 0.025 MG/DAY PATCH	ESTRADIOL	X	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLIMARA 0.0375 MG/DAY PATCH	ESTRADIOL	X	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLIMARA 0.05 MG/DAY PATCH	ESTRADIOL	X	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLIMARA 0.06 MG/DAY PATCH	ESTRADIOL	X	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLIMARA 0.075 MG/DAY PATCH	ESTRADIOL	X	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLIMARA 0.1 MG/DAY PATCH	ESTRADIOL	X	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLIMARA PRO PATCH	ESTRADIOL/LEVONORGESTREL	W	4 PATCHES PER 28 DAYS	4	TRANSDERMAL
CLONIDINE 0.1 MG/DAY PATCH	CLONIDINE	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLONIDINE 0.2 MG/DAY PATCH	CLONIDINE	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
CLONIDINE 0.3 MG/DAY PATCH	CLONIDINE	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
COARTEM TABLETS	ARTEMETHER/LUMEFANTRINE	W	24 TABLETS PER 365 DAYS	24	ORAL
COMBIVENT RESPIMAT 20-100 MCG	IPRATROPIUM/ALBUTEROL SULFATE	W	2 INHALERS PER 30 DAYS	4	INHALATION
CONTRAVE ER 8-90 MG TABLET	NALTREXONE HCL/BUPROPION HCL	W	4 TABLETS PER DAY	70	ORAL
COPAXONE 20 MG/ML SYRINGE	GLATIRAMER ACETATE	X	1 ML (1 SYRINGE) PER DAY	1	SUBCUTANEOUS
COPAXONE 40 MG/ML SYRINGE	GLATIRAMER ACETATE	X	12 ML (12 SYRINGES) PER 28 DAYS	1	SUBCUTANEOUS
CRESTOR 10 MG TABLET	ROSUVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
CRESTOR 20 MG TABLET	ROSUVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
CRESTOR 40 MG TABLET	ROSUVASTATIN CALCIUM	X	1 TABLET PER DAY	30	ORAL
CRESTOR 5 MG TABLET	ROSUVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
DEPO-PROVERA 150 MG/ML SYRINGE	MEDROXYPROGESTERONE ACETATE	X	1 ML PER 84 DAYS	1	INTRAMUSCULAR
DEPO-PROVERA 150 MG/ML VIAL	MEDROXYPROGESTERONE ACETATE	X	1 ML PER 84 DAYS	1	INTRAMUSCULAR
DESLORATADINE 2.5 MG ODT	DESLORATADINE	Y	1 TABLET PER DAY	1	ORAL
DESLORATADINE 5 MG ODT	DESLORATADINE	Y	1 TABLET PER DAY	1	ORAL
DESLORATADINE 5 MG TABLET	DESLORATADINE	Y	1 TABLET PER DAY	90	ORAL
DIAZEPAM 10 MG TABLET	DIAZEPAM	Y	4 TABLETS PER DAY	100	ORAL
DIAZEPAM 2 MG TABLET	DIAZEPAM	Y	4 TABLETS PER DAY	100	ORAL
DIAZEPAM 25 MG/5 ML ORAL CONC	DIAZEPAM	Y	8 ML PER DAY	30	ORAL
DIAZEPAM 5 MG TABLET	DIAZEPAM	Y	4 TABLETS PER DAY	100	ORAL
DIAZEPAM 5 MG/5 ML ORAL CUP	DIAZEPAM	Y	40 ML PER DAY	5	ORAL
DIAZEPAM 5 MG/5 ML SOLUTION	DIAZEPAM	Y	40 ML PER DAY	500	ORAL
DIAZEPAM 5 MG/ML ORAL CONC	DIAZEPAM	Y	8 ML PER DAY	30	ORAL
DIETHYLPROPION 25 MG TABLET	DIETHYLPROPION HCL	Y	3 TABLETS PER DAY	100	ORAL
DIETHYLPROPION ER 75 MG TABLET	DIETHYLPROPION HCL	Y	1 TABLET PER DAY	100	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
DIVIGEL 0.25 MG GEL PACKET	ESTRADIOL	X	1 PACKET PER DAY	30	TRANSDERMAL
DIVIGEL 0.5 MG GEL PACKET	ESTRADIOL	X	1 PACKET PER DAY	30	TRANSDERMAL
DIVIGEL 0.75 MG GEL PACKET	ESTRADIOL	X	1 PACKET PER DAY	30	TRANSDERMAL
DIVIGEL 1 MG GEL PACKET	ESTRADIOL	X	1 PACKET PER DAY	1	TRANSDERMAL
DIVIGEL 1.25 MG GEL PACKET	ESTRADIOL	X	1 PACKET PER DAY	1.25	TRANSDERMAL
DORAL 15 MG TABLET	QUAZEPAM	W	1 TABLET PER DAY	100	ORAL
DOTTI 0.025 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
DOTTI 0.0375 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
DOTTI 0.05 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
DOTTI 0.075 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
DOTTI 0.1 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
DOXAZOSIN MESYLATE 1 MG TAB	DOXAZOSIN MESYLATE	Y	1 TABLET PER DAY	100	ORAL
DOXAZOSIN MESYLATE 2 MG TAB	DOXAZOSIN MESYLATE	Y	1 TABLET PER DAY	100	ORAL
DOXAZOSIN MESYLATE 4 MG TAB	DOXAZOSIN MESYLATE	Y	1 TABLET PER DAY	100	ORAL
DOXAZOSIN MESYLATE 8 MG TAB	DOXAZOSIN MESYLATE	Y	2 TABLETS PER DAY	100	ORAL
DOXEPIN HCL 3 MG TABLET	DOXEPIN HCL	Y	1 TABLET PER DAY	30	ORAL

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DOXEPIN HCL 6 MG TABLET	DOXEPIN HCL	Y	1 TABLET PER DAY	30	ORAL
DRIZALMA SPRINKLE DR 20 MG CAP	DULOXETINE HCL	W	2 CAPSULES PER DAY	30	ORAL
DRIZALMA SPRINKLE DR 30 MG CAP	DULOXETINE HCL	W	1 CAPSULE PER DAY	30	ORAL
DRIZALMA SPRINKLE DR 40 MG CAP	DULOXETINE HCL	W	2 CAPSULE PER DAY	30	ORAL
DRIZALMA SPRINKLE DR 60 MG CAP	DULOXETINE HCL	W	2 CAPSULES PER DAY	30	ORAL
DUETACT 30-2 MG TABLET	PIOGLITAZONE HCL/GLIMEPIRIDE	X	1 TABLET PER DAY	30	ORAL
DUETACT 30-4 MG TABLET	PIOGLITAZONE HCL/GLIMEPIRIDE	X	1 TABLET PER DAY	30	ORAL
DULERA 100 MCG-5 MCG INHALER	MOMETASONE/FORMOTEROL	W	1 INHALER PER 30 DAYS	13	INHALATION
DULERA 200 MCG-5 MCG INHALER	MOMETASONE/FORMOTEROL	W	1 INHALER PER 30 DAYS	13	INHALATION
DULERA 50 MCG-5 MCG INHALER	MOMETASONE/FORMOTEROL	W	1 INHALER PER 30 DAYS	13	INHALATION
DYMISTA NASAL SPRAY	AZELASTINE/FLUTICASONE	X	1 BOTTLE PER 30 DAYS	23	NASAL
EBGLYSS 250 MG/2 ML PEN	LEBRIKIZUMAB-LBKZ	W	2 PENS/SYRINGES PER 28 DAYS	2	SUBCUTANEOUS
EDLUAR 10 MG SL TABLET	ZOLPIDEM TARTRATE	W	1 TABLET PER DAY	30	SUBLINGUAL
EDLUAR 5 MG SL TABLET	ZOLPIDEM TARTRATE	W	1 TABLET PER DAY	30	SUBLINGUAL
ELESTRIN 0.06% GEL	ESTRADIOL	W	52 GRAMS (2 BOTTLES) PER 30 DAYS	26	TRANSDERMAL
ENTRESTO 24 MG-26 MG TABLET	SACUBITRIL/VALSARTAN	W	2 TABLETS PER DAY	60	ORAL

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ENTRESTO 49 MG-51 MG TABLET	SACUBITRIL/VALSARTAN	W	2 TABLETS PER DAY	60	ORAL
ENTRESTO 97 MG-103 MG TABLET	SACUBITRIL/VALSARTAN	W	2 TABLETS PER DAY	60	ORAL
ESTAZOLAM 1 MG TABLET	ESTAZOLAM	Y	1 TABLET PER DAY	100	ORAL
ESTAZOLAM 2 MG TABLET	ESTAZOLAM	Y	1 TABLET PER DAY	100	ORAL
ESTRADIOL 0.025 MG PATCH(1/WK)	ESTRADIOL	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.025 MG PATCH(2/WK)	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.0375MG PATCH(1/WK)	ESTRADIOL	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.0375MG PATCH(2/WK)	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.05 MG PATCH (1/WK)	ESTRADIOL	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.05 MG PATCH (2/WK)	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.06 MG PATCH (1/WK)	ESTRADIOL	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.06% 1.25G GEL PUMP	ESTRADIOL	Y	37.5 GRAMS (1 PUMP) PER 30 DAYS	37.5	TRANSDERMAL
ESTRADIOL 0.075 MG PATCH(1/WK)	ESTRADIOL	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.075 MG PATCH(2/WK)	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.1 MG PATCH (1/WK)	ESTRADIOL	Y	4 PATCHES PER 28 DAYS	1	TRANSDERMAL
ESTRADIOL 0.1 MG PATCH (2/WK)	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL

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ESTRADIOL 0.1% (0.25MG) GEL PK	ESTRADIOL	Y	1 PACKET PER DAY	1	TRANSDERMAL
ESTRADIOL 0.1% (0.5MG) GEL PKT	ESTRADIOL	Y	1 PACKET PER DAY	1	TRANSDERMAL
ESTRADIOL 0.1% (0.75MG) GEL PK	ESTRADIOL	Y	1 PACKET PER DAY	1	TRANSDERMAL
ESTRADIOL 0.1% (1 MG) GEL PKT	ESTRADIOL	Y	1 PACKET PER DAY	1	TRANSDERMAL
ESTRADIOL 0.1% (1.25MG) GEL PK	ESTRADIOL	Y	1 PACKET PER DAY	1.25	TRANSDERMAL
ESTROGEL 0.06% GEL	ESTRADIOL	X	37.5 GRAMS (1 PUMP) PER 30 DAYS	37.5	TRANSDERMAL
EVAMIST 1.53 MG/SPRAY	ESTRADIOL	W	16.2 ML (2 PUMPS) PER 30 DAYS	8.1	TRANSDERMAL
EYSUVIS 0.25% EYE DROPS	LOTEPREDNOL ETABONATE	W	2 BOTTLES PER 30 DAYS	8.3	OPHTHALMIC (EYE)
EZALLOR SPRINKLE 10 MG CAPSULE	ROSUVASTATIN CALCIUM	W	3 CAPSULE PER DAY	30	ORAL
EZALLOR SPRINKLE 20 MG CAPSULE	ROSUVASTATIN CALCIUM	W	4 CAPSULE PER DAY	30	ORAL
EZALLOR SPRINKLE 40 MG CAPSULE	ROSUVASTATIN CALCIUM	W	1 CAPSULE PER DAY	30	ORAL
EZALLOR SPRINKLE 5 MG CAPSULE	ROSUVASTATIN CALCIUM	W	5 CAPSULE PER DAY	30	ORAL
EZETIMIBE-SIMVASTATIN 10-10 MG	EZETIMIBE/SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
EZETIMIBE-SIMVASTATIN 10-20 MG	EZETIMIBE/SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
EZETIMIBE-SIMVASTATIN 10-40 MG	EZETIMIBE/SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
EZETIMIBE-SIMVASTATIN 10-80 MG	EZETIMIBE/SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
FINGOLIMOD 0.5 MG CAPSULE	FINGOLIMOD HCL	Y	1 CAPSULE PER DAY	30	ORAL
FLOLIPID 20 MG/5 ML ORAL SUSP	SIMVASTATIN	W	5 ML PER DAY	150	ORAL
FLOLIPID 40 MG/5 ML ORAL SUSP	SIMVASTATIN	W	5 ML PER DAY	150	ORAL
FLOVENT 100 MCG DISKUS	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	60	INHALATION
FLOVENT 250 MCG DISKUS	FLUTICASONE PROPIONATE	W	4 INHALERS PER 30 DAYS	60	INHALATION
FLOVENT 50 MCG DISKUS	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	60	INHALATION
FLOVENT HFA 110 MCG INHALER	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	12	INHALATION
FLOVENT HFA 220 MCG INHALER	FLUTICASONE PROPIONATE	W	2 INHALERS PER 30 DAYS	12	INHALATION
FLOVENT HFA 44 MCG INHALER	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	10.6	INHALATION
FLUTICASONE PROP 100MCG DISKUS	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	60	INHALATION
FLUTICASONE PROP 250 MCG DISK	FLUTICASONE PROPIONATE	W	4 INHALERS PER 30 DAYS	60	INHALATION
FLUTICASONE PROP 50 MCG DISKUS	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	60	INHALATION
FLUTICASONE PROP 50 MCG SPRAY	FLUTICASONE PROPIONATE	Y	1 BOTTLE PER 30 DAYS	16	NASAL
FLUTICASONE PROP HFA 110 MCG	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	12	INHALATION

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
FLUTICASONE PROP HFA 220 MCG	FLUTICASONE PROPIONATE	W	2 INHALERS PER 30 DAYS	12	INHALATION
FLUTICASONE PROP HFA 44 MCG	FLUTICASONE PROPIONATE	W	1 INHALER PER 30 DAYS	10.6	INHALATION
FLUTICASONE-SALMETEROL 100-50	FLUTICASONE PROPION/SALMETEROL	Y	1 PACKAGE PER 30 DAYS	60	INHALATION
FLUTICASONE-SALMETEROL 113-14	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	1	INHALATION
FLUTICASONE-SALMETEROL 115-21	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	12	INHALATION
FLUTICASONE-SALMETEROL 230-21	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	12	INHALATION
FLUTICASONE-SALMETEROL 232-14	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	1	INHALATION
FLUTICASONE-SALMETEROL 250-50	FLUTICASONE PROPION/SALMETEROL	Y	1 PACKAGE PER 30 DAYS	60	INHALATION
FLUTICASONE-SALMETEROL 45-21	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	12	INHALATION
FLUTICASONE-SALMETEROL 500-50	FLUTICASONE PROPION/SALMETEROL	Y	1 PACKAGE PER 30 DAYS	60	INHALATION
FLUTICASONE-SALMETEROL 55-14	FLUTICASONE PROPION/SALMETEROL	W	1 INHALER PER 30 DAYS	1	INHALATION
FLUTICASONE-VILANTEROL 100-25	FLUTICASONE/VILANTEROL	W	1 INHALER PER 30 DAYS	60	INHALATION
FLUTICASONE-VILANTEROL 200-25	FLUTICASONE/VILANTEROL	W	1 INHALER PER 30 DAYS	60	INHALATION
FLUVASTATIN ER 80 MG TABLET	FLUVASTATIN SODIUM	Y	1 TABLET PER DAY	100	ORAL
FLUVASTATIN SODIUM 20 MG CAP	FLUVASTATIN SODIUM	Y	1 CAPSULE PER DAY	100	ORAL

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FLUVASTATIN SODIUM 40 MG CAP	FLUVASTATIN SODIUM	Y	2 CAPSULES PER DAY	100	ORAL
FORMOTEROL 20 MCG/2 ML NEB VL	FORMOTEROL FUMARATE	Y	120 ML PER 30 DAYS	2	INHALATION
FORMOTEROL 20MCG/2ML VL-PARILC	FORMOTEROL FUMARATE/NEBULIZER	W	120 ML PER 30 DAYS	2	INHALATION
FORTESTA 10 MG GEL PUMP	TESTOSTERONE	X	1 PUMP PER 30 DAYS	60	TRANSDERMAL
FOSAMAX 70 MG TABLET	ALENDRONATE SODIUM	X	4 TABLETS PER 28 DAYS	4	ORAL
FOSAMAX PLUS D 70 MG-2800 UNIT	ALENDRONATE SODIUM/VITAMIN D3	W	4 TABLETS PER 28 DAYS	4	ORAL
FOSAMAX PLUS D 70 MG-5600 UNIT	ALENDRONATE SODIUM/VITAMIN D3	W	4 TABLETS PER 28 DAYS	4	ORAL
FUZEON 90 MG VIAL	ENFUVIRTIDE	W	2 VIALS PER DAY	60	SUBCUTANEOUS
GABAPENTIN ER 300 MG TABLET	GABAPENTIN	Y	1 TABLET PER DAY	90	ORAL
GABAPENTIN ER 600 MG TABLET	GABAPENTIN	Y	3 TABLETS PER DAY	90	ORAL
GILENYA 0.25 MG CAPSULE	FINGOLIMOD HCL	W	1 CAPSULE PER DAY	7	ORAL
GILENYA 0.5 MG CAPSULE	FINGOLIMOD HCL	X	1 CAPSULE PER DAY	30	ORAL
GLATIRAMER 20 MG/ML SYRINGE	GLATIRAMER ACETATE	Y	1 ML (1 SYRINGE) PER DAY	1	SUBCUTANEOUS
GLATIRAMER 40 MG/ML SYRINGE	GLATIRAMER ACETATE	Y	12 ML (12 SYRINGES) PER 28 DAYS	1	SUBCUTANEOUS
GLATOPA 20 MG/ML SYRINGE	GLATIRAMER ACETATE	Y	1 ML (1 SYRINGE) PER DAY	1	SUBCUTANEOUS
GLATOPA 40 MG/ML SYRINGE	GLATIRAMER ACETATE	Y	12 ML (12 SYRINGES) PER 28 DAYS	1	SUBCUTANEOUS

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GLUMETZA ER 500 MG TABLET	METFORMIN HCL	X	4 TABLETS PER DAY	100	ORAL
GLYXAMBI 10 MG-5 MG TABLET	EMPAGLIFLOZIN/LINAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
GLYXAMBI 25 MG-5 MG TABLET	EMPAGLIFLOZIN/LINAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
GOCOVRI ER 137 MG CAPSULE	AMANTADINE HCL	W	2 CAPSULES PER DAY	60	ORAL
GOCOVRI ER 68.5 MG CAPSULE	AMANTADINE HCL	W	6 CAPSULE PER DAY	60	ORAL
GRALISE ER 300 MG TABLET	GABAPENTIN	X	1 TABLET PER DAY	90	ORAL
GRALISE ER 450 MG TABLET	GABAPENTIN	W	2 TABLETS PER DAY	60	ORAL
GRALISE ER 600 MG TABLET	GABAPENTIN	X	3 TABLETS PER DAY	90	ORAL
GRALISE ER 750 MG TABLET	GABAPENTIN	W	2 TABLETS PER DAY	60	ORAL
GRALISE ER 900 MG TABLET	GABAPENTIN	W	2 TABLETS PER DAY	60	ORAL
HETLIOZ LQ 4 MG/ML SUSPENSION	TASIMELTEON	W	5 ML PER DAY	48	ORAL
HORIZANT ER 300 MG TABLET	GABAPENTIN ENACARBIL	W	2 TABLETS PER DAY	30	ORAL
HORIZANT ER 600 MG TABLET	GABAPENTIN ENACARBIL	W	2 TABLETS PER DAY	30	ORAL
IBANDRONATE SODIUM 150 MG TAB	IBANDRONATE SODIUM	Y	1 TABLET PER 28 DAYS	1	ORAL
IMPAVIDO 50 MG CAPSULE	MILTEFOSINE	W	3 CAPSULES PER DAY	28	ORAL

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
IMVEXXY 10 MCG MAINTENANCE PAK	ESTRADIOL	W	8 TABLETS PER 28 DAYS	8	VAGINAL
IMVEXXY 10 MCG STARTER PACK	ESTRADIOL	W	18 PER 365 DAYS	18	VAGINAL
IMVEXXY 4 MCG MAINTENANCE PACK	ESTRADIOL	W	8 TABLETS PER 28 DAYS	8	VAGINAL
IMVEXXY 4 MCG STARTER PACK	ESTRADIOL	W	18 PER 365 DAYS	18	VAGINAL
INCRUSE ELLIPTA 62.5 MCG INH	UMECLIDINIUM BROMIDE	W	1 INHALER PER 30 DAYS	7	INHALATION
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	IPRATROPIUM/ALBUTEROL SULFATE	Y	540 ML PER 30 DAYS	3	INHALATION
IPRATROPIUM 0.03% SPRAY	IPRATROPIUM BROMIDE	Y	1 BOTTLE PER 30 DAYS	30	NASAL
IPRATROPIUM 0.06% SPRAY	IPRATROPIUM BROMIDE	Y	2 BOTTLES PER 30 DAYS	15	NASAL
JANUMET 50-1,000 MG TABLET	SITAGLIPTIN PHOS/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
JANUMET 50-500 MG TABLET	SITAGLIPTIN PHOS/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
JANUMET XR 100-1,000 MG TABLET	SITAGLIPTIN PHOS/METFORMIN HCL	W	1 TABLET PER DAY	30	ORAL
JANUMET XR 50-1,000 MG TABLET	SITAGLIPTIN PHOS/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
JANUMET XR 50-500 MG TABLET	SITAGLIPTIN PHOS/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
JANUVIA 100 MG TABLET	SITAGLIPTIN PHOSPHATE	W	1 TABLET PER DAY	1	ORAL
JANUVIA 25 MG TABLET	SITAGLIPTIN PHOSPHATE	W	1 TABLET PER DAY	1	ORAL
JANUVIA 50 MG TABLET	SITAGLIPTIN PHOSPHATE	W	1 TABLET PER DAY	1	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
JARDIANCE 10 MG TABLET	EMPAGLIFLOZIN	W	1 TABLET PER DAY	30	ORAL
JARDIANCE 25 MG TABLET	EMPAGLIFLOZIN	W	1 TABLET PER DAY	30	ORAL
JATENZO 158 MG CAPSULE	TESTOSTERONE UNDECANOATE	W	4 CAPSULES PER DAY	120	ORAL
JATENZO 198 MG CAPSULE	TESTOSTERONE UNDECANOATE	W	4 CAPSULES PER DAY	120	ORAL
JATENZO 237 MG CAPSULE	TESTOSTERONE UNDECANOATE	W	2 CAPSULES PER DAY	120	ORAL
JENTADUETO 2.5 MG-1000 MG TAB	LINAGLIPTIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
JENTADUETO 2.5 MG-500 MG TAB	LINAGLIPTIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
JENTADUETO 2.5 MG-850 MG TAB	LINAGLIPTIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
JENTADUETO XR 2.5 MG-1,000 MG	LINAGLIPTIN/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
JENTADUETO XR 5 MG-1,000 MG TB	LINAGLIPTIN/METFORMIN HCL	W	1 TABLET PER DAY	30	ORAL
KAZANO 12.5-1,000 MG TABLET	ALOGLIPTIN BENZ/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
KAZANO 12.5-500 MG TABLET	ALOGLIPTIN BENZ/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
KITABIS PAK 300 MG/5 ML	TOBRAMYCIN/NEBULIZER	W	10 ML PER DAY	5	INHALATION
KOMBIGLYZE XR 2.5-1,000 MG TAB	SAXAGLIPTIN HCL/METFORMIN HCL	X	2 TABLETS PER DAY	60	ORAL
KOMBIGLYZE XR 5-1,000 MG TAB	SAXAGLIPTIN HCL/METFORMIN HCL	X	1 TABLET PER DAY	30	ORAL
KOMBIGLYZE XR 5-500 MG TABLET	SAXAGLIPTIN HCL/METFORMIN HCL	X	1 TABLET PER DAY	30	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
KONVOMEP 2-84 MG/ML ORAL SUSP	OMEPRAZOLE/SODIUM BICARBONATE	W	20 ML PER DAY	300	ORAL
LEFLUNOMIDE 10 MG TABLET	LEFLUNOMIDE	Y	1 TABLET PER DAY	30	ORAL
LEFLUNOMIDE 20 MG TABLET	LEFLUNOMIDE	Y	1 TABLET PER DAY	30	ORAL
LESCOL XL 80 MG TABLET	FLUVASTATIN SODIUM	X	1 TABLET PER DAY	30	ORAL
LEVOCETIRIZINE 5 MG TABLET	LEVOCETIRIZINE DIHYDROCHLORIDE	Y	1 TABLET PER DAY	90	ORAL
LIPITOR 10 MG TABLET	ATORVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LIPITOR 20 MG TABLET	ATORVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LIPITOR 40 MG TABLET	ATORVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LIPITOR 80 MG TABLET	ATORVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LIVALO 1 MG TABLET	PITAVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LIVALO 2 MG TABLET	PITAVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LIVALO 4 MG TABLET	PITAVASTATIN CALCIUM	X	1 TABLET PER DAY	90	ORAL
LOFEXIDINE 0.18 MG TABLET	LOFEXIDINE HCL	Y	16 TABLETS PER DAY	36	ORAL
LOMAIRA 8 MG TABLET	PHENTERMINE HCL	W	3 TABLETS PER DAY	90	ORAL
LOVASTATIN 10 MG TABLET	LOVASTATIN	Y	1 TABLET PER DAY	60	ORAL
LOVASTATIN 20 MG TABLET	LOVASTATIN	Y	1 TABLET PER DAY	60	ORAL
LOVASTATIN 40 MG TABLET	LOVASTATIN	Y	2 TABLETS PER DAY	60	ORAL
LUCEMYRA 0.18 MG TABLET	LOFEXIDINE HCL	X	16 TABLETS PER DAY	36	ORAL

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LYLLANA 0.025 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
LYLLANA 0.0375 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
LYLLANA 0.05 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
LYLLANA 0.075 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
LYLLANA 0.1 MG PATCH	ESTRADIOL	Y	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
MEDROXYPROGESTERONE 150 MG/ML	MEDROXYPROGESTERONE ACETATE	Y	1 ML PER 84 DAYS	1	INTRAMUSCULAR
MELOXICAM 15 MG TABLET	MELOXICAM	Y	1 TABLET PER DAY	1000	ORAL
MELOXICAM 7.5 MG TABLET	MELOXICAM	Y	1 TABLET PER DAY	1000	ORAL
MELOXICAM 7.5 MG/5 ML SUSP	MELOXICAM	W	10 ML PER DAY	100	ORAL
MENOSTAR 14 MCG/DAY PATCH	ESTRADIOL	W	4 PATCHES PER 28 DAYS	4	TRANSDERMAL
METFORMIN ER 1,000 MG OSM-TAB	METFORMIN HCL	Y	2 TABLETS PER DAY	60	ORAL
METFORMIN ER 500 MG GASTRC-TB	METFORMIN HCL	Y	4 TABLETS PER DAY	100	ORAL
METFORMIN ER 500 MG OSMOTIC TB	METFORMIN HCL	Y	3 TABLETS PER DAY	60	ORAL
METFORMIN HCL ER 500 MG TABLET	METFORMIN HCL	Y	4 TABLETS PER DAY	120	ORAL
METFORMIN HCL ER 750 MG TABLET	METFORMIN HCL	Y	2 TABLETS PER DAY	30	ORAL
METHYLERGONOVINE 0.2 MG TABLET	METHYLERGONOVINE MALEATE	Y	8 TABLETS PER DAY	12	ORAL

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MINIVELLE 0.025 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
MINIVELLE 0.0375 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
MINIVELLE 0.05 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
MINIVELLE 0.075 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
MINIVELLE 0.1 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	1	TRANSDERMAL
MOBIC 15 MG TABLET	MELOXICAM	X	1 TABLET PER DAY	100	ORAL
MOBIC 7.5 MG TABLET	MELOXICAM	X	1 TABLET PER DAY	100	ORAL
MOMETASONE FUROATE 50 MCG SPRY	MOMETASONE FUROATE	Y	1 BOTTLE PER 30 DAYS	17	NASAL
NASONEX 50 MCG NASAL SPRAY	MOMETASONE FUROATE	X	1 BOTTLE PER 30 DAYS	17	NASAL
NATESTO NASAL 5.5 MG/0.122 GM	TESTOSTERONE	W	3 PUMP BOTTLES PER 30 DAYS	7.32	NASAL
NEBUPENT 300 MG INHAL POWDER	PENTAMIDINE ISETHIONATE	X	1 VIAL PER 28 DAYS	1	INHALATION
NESINA 12.5 MG TABLET	ALOGLIPTIN BENZOATE	W	1 TABLET PER DAY	30	ORAL
NESINA 25 MG TABLET	ALOGLIPTIN BENZOATE	W	1 TABLET PER DAY	30	ORAL
NESINA 6.25 MG TABLET	ALOGLIPTIN BENZOATE	W	1 TABLET PER DAY	30	ORAL
OCTREOTIDE ACET ER 20 MG IM VL	OCTREOTIDE ACETATE, MI-SPHERES	Y	2 KITS PER 28 DAYS	1	INTRAMUSCULAR
OCTREOTIDE ACET ER 30 MG IM VL	OCTREOTIDE ACETATE, MI-SPHERES	Y	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
OLOPATADINE 665 MCG NASAL SPRY	OLOPATADINE HCL	Y	1 BOTTLE PER 30 DAYS	30.5	NASAL

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OMECLAMOX-PAK COMBO PACK	OMEPRAZOLE/CLARITH/AMOXICILLIN	W	2 PACKS (160 TABLETS) PER 365 DAYS	80	ORAL
OMEPRAZOLE-BICARB 20-1,100 CAP	OMEPRAZOLE/SODIUM BICARBONATE	Y	1 CAPSULE PER DAY	30	ORAL
OMEPRAZOLE-BICARB 20-1,680 PKT	OMEPRAZOLE/SODIUM BICARBONATE	Y	1 PACKET PER DAY	30	ORAL
OMNARIS 50 MCG NASAL SPRAY	CICLESONIDE	W	1 BOTTLE PER 30 DAYS	12.5	NASAL
ONGLYZA 2.5 MG TABLET	SAXAGLIPTIN HCL	X	1 TABLET PER DAY	30	ORAL
ONGLYZA 5 MG TABLET	SAXAGLIPTIN HCL	X	1 TABLET PER DAY	30	ORAL
ORLISTAT 120 MG CAPSULE	ORLISTAT	W	3 CAPSULES PER DAY	90	ORAL
OSENI 12.5-30 MG TABLET	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
OSENI 25-15 MG TABLET	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
OSENI 25-30 MG TABLET	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
OSENI 25-45 MG TABLET	ALOGLIPTIN BENZ/PIOGLITAZONE	W	1 TABLET PER DAY	30	ORAL
OSMOLEX ER 129 MG TABLET	AMANTADINE HCL	W	1 TABLET PER DAY	30	ORAL
OSMOLEX ER 193 MG TABLET	AMANTADINE HCL	W	1 TABLET PER DAY	90	ORAL
OSMOLEX ER 258 MG TABLET	AMANTADINE HCL	W	1 TABLET PER DAY	30	ORAL
OSMOLEX ER 322 MG DAILY DOSE	AMANTADINE HCL	W	1 TABLET PER DAY	60	ORAL
OXYTROL 3.9 MG/24HR PATCH	OXYBUTYNIN	W	8 PATCHES PER 28 DAYS	1	TRANSDERMAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
PAROXETINE MESYLATE 7.5 MG CAP	PAROXETINE MESYLATE	Y	1 CAPSULE PER DAY	30	ORAL
PATANASE 665 MCG NASAL SPRAY	OLOPATADINE HCL	X	1 BOTTLE PER 30 DAYS	30.5	NASAL
PEGASYS 180 MCG/0.5 ML SYRINGE	PEGINTERFERON ALFA-2A	W	4 SYRINGES PER 28 DAYS	0.5	SUBCUTANEOUS
PEGASYS 180 MCG/ML VIAL	PEGINTERFERON ALFA-2A	W	4 VIALS PER 28 DAYS	1	SUBCUTANEOUS
PENTAMIDINE 300 MG INHAL POWDR	PENTAMIDINE ISETHIONATE	Y	1 VIAL PER 28 DAYS	1	INHALATION
PERFOROMIST 20 MCG/2 ML SOLN	FORMOTEROL FUMARATE	X	120 ML PER 30 DAYS	2	INHALATION
PHENDIMETRAZINE 35 MG TABLET	PHENDIMETRAZINE TARTRATE	Y	6 TABLETS PER DAY	1000	ORAL
PHENDIMETRAZINE ER 105 MG CAP	PHENDIMETRAZINE TARTRATE	Y	1 CAPSULE PER DAY	14	ORAL
PHENTERMINE 15 MG CAPSULE	PHENTERMINE HCL	Y	1 CAPSULE PER DAY	100	ORAL
PHENTERMINE 30 MG CAPSULE	PHENTERMINE HCL	Y	1 CAPSULE PER DAY	100	ORAL
PHENTERMINE 37.5 MG CAPSULE	PHENTERMINE HCL	Y	1 CAPSULE PER DAY	100	ORAL
PHENTERMINE 37.5 MG TABLET	PHENTERMINE HCL	Y	1 TABLET PER DAY	100	ORAL
PIOGLITAZONE HCL 15 MG TABLET	PIOGLITAZONE HCL	Y	1 TABLET PER DAY	500	ORAL
PIOGLITAZONE HCL 30 MG TABLET	PIOGLITAZONE HCL	Y	1 TABLET PER DAY	500	ORAL
PIOGLITAZONE HCL 45 MG TABLET	PIOGLITAZONE HCL	Y	1 TABLET PER DAY	500	ORAL

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PIOGLITAZONE-GLIMEPIRIDE 30-2	PIOGLITAZONE HCL/GLIMEPIRIDE	Y	1 TABLET PER DAY	30	ORAL
PIOGLITAZONE-GLIMEPIRIDE 30-4	PIOGLITAZONE HCL/GLIMEPIRIDE	Y	1 TABLET PER DAY	30	ORAL
PIOGLITAZONE-METFORMIN 15-500	PIOGLITAZONE HCL/METFORMIN HCL	Y	2 TABLETS PER DAY	180	ORAL
PIOGLITAZONE-METFORMIN 15-850	PIOGLITAZONE HCL/METFORMIN HCL	Y	3 TABLETS PER DAY	180	ORAL
PITAVASTATIN 1 MG TABLET	PITAVASTATIN CALCIUM	Y	1 TABLET PER DAY	90	ORAL
PITAVASTATIN 2 MG TABLET	PITAVASTATIN CALCIUM	Y	1 TABLET PER DAY	90	ORAL
PITAVASTATIN 4 MG TABLET	PITAVASTATIN CALCIUM	Y	1 TABLET PER DAY	90	ORAL
PRAVASTATIN SODIUM 10 MG TAB	PRAVASTATIN SODIUM	Y	1 TABLET PER DAY	1000	ORAL
PRAVASTATIN SODIUM 20 MG TAB	PRAVASTATIN SODIUM	Y	1 TABLET PER DAY	1000	ORAL
PRAVASTATIN SODIUM 40 MG TAB	PRAVASTATIN SODIUM	Y	1 TABLET PER DAY	1000	ORAL
PRAVASTATIN SODIUM 80 MG TAB	PRAVASTATIN SODIUM	Y	1 TABLET PER DAY	1000	ORAL
PRILOSEC DR 10 MG SUSPENSION	OMEPRAZOLE MAGNESIUM	W	1 PACKET PER DAY	30	ORAL
PRILOSEC DR 2.5 MG SUSPENSION	OMEPRAZOLE MAGNESIUM	W	1 PACKET PER DAY	30	ORAL
PULMICORT 0.25 MG/2 ML RESPUL	BUDESONIDE	X	120 ML PER 30 DAYS	2	INHALATION
PULMICORT 0.5 MG/2 ML RESPULE	BUDESONIDE	X	120 ML PER 30 DAYS	2	INHALATION

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
PULMICORT 1 MG/2 ML RESPULE	BUDESONIDE	X	60 ML PER 30 DAYS	2	INHALATION
PULMICORT 180 MCG FLEXHALER	BUDESONIDE	W	2 INHALERS PER 30 DAYS	1	INHALATION
PULMICORT 90 MCG FLEXHALER	BUDESONIDE	W	1 INHALER PER 30 DAYS	1	INHALATION
QNASL 80 MCG NASAL SPRAY	BECLOMETHASONE DIPROPIONATE	W	1 BOTTLE PER 30 DAYS	10.6	NASAL
QNASL CHILDREN'S 40 MCG SPRAY	BECLOMETHASONE DIPROPIONATE	W	1 BOTTLE PER 30 DAYS	6.8	NASAL
QSYMIA 11.25 MG-69 MG CAPSULE	PHENTERMINE/TOPIRAMATE	W	1 CAPSULE PER DAY	30	ORAL
QSYMIA 15 MG-92 MG CAPSULE	PHENTERMINE/TOPIRAMATE	W	1 CAPSULE PER DAY	30	ORAL
QSYMIA 3.75 MG-23 MG CAPSULE	PHENTERMINE/TOPIRAMATE	W	1 CAPSULE PER DAY	30	ORAL
QSYMIA 7.5 MG-46 MG CAPSULE	PHENTERMINE/TOPIRAMATE	W	1 CAPSULE PER DAY	30	ORAL
QUALAQUIN 324 MG CAPSULE	QUININE SULFATE	X	42 CAPSULES (1 TREATMENT COURSE) PER 180 DAYS	30	ORAL
QUAZEPAM 15 MG TABLET	QUAZEPAM	W	1 TABLET PER DAY	100	ORAL
QUININE SULFATE 324 MG CAPSULE	QUININE SULFATE	Y	42 CAPSULES (1 TREATMENT COURSE) PER 180 DAYS	30	ORAL
QUVIVIQ 25 MG TABLET	DARIDOREXANT HCL	W	1 TABLET PER DAY	30	ORAL
QUVIVIQ 50 MG TABLET	DARIDOREXANT HCL	W	1 TABLET PER DAY	30	ORAL

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
QVAR REDIHALER 40 MCG	BECLOMETHASONE DIPROPIONATE	W	1 INHALER PER 30 DAYS	10.6	INHALATION
QVAR REDIHALER 80 MCG	BECLOMETHASONE DIPROPIONATE	W	2 INHALERS PER 30 DAYS	10.6	INHALATION
RISEDRONATE SOD DR 35 MG TAB	RISEDRONATE SODIUM	Y	4 TABLETS PER 28 DAYS	4	ORAL
RISEDRONATE SODIUM 150 MG TAB	RISEDRONATE SODIUM	Y	1 TABLET PER 28 DAYS	3	ORAL
RISEDRONATE SODIUM 30 MG TAB	RISEDRONATE SODIUM	Y	1 TABLET PER DAY	30	ORAL
RISEDRONATE SODIUM 35 MG TAB	RISEDRONATE SODIUM	Y	4 TABLETS PER 28 DAYS	1	ORAL
RISEDRONATE SODIUM 5 MG TABLET	RISEDRONATE SODIUM	Y	1 TABLET PER DAY	30	ORAL
ROSUVASTATIN CALCIUM 10 MG TAB	ROSUVASTATIN CALCIUM	Y	1 TABLET PER DAY	90	ORAL
ROSUVASTATIN CALCIUM 20 MG TAB	ROSUVASTATIN CALCIUM	Y	1 TABLET PER DAY	90	ORAL
ROSUVASTATIN CALCIUM 40 MG TAB	ROSUVASTATIN CALCIUM	Y	1 TABLET PER DAY	30	ORAL
ROSUVASTATIN CALCIUM 5 MG TAB	ROSUVASTATIN CALCIUM	Y	1 TABLET PER DAY	90	ORAL
ROSUVASTATIN-EZETIMIBE 10-10MG	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
ROSUVASTATIN-EZETIMIBE 20-10MG	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
ROSUVASTATIN-EZETIMIBE 40-10MG	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
ROSUVASTATIN-EZETIMIBE 5-10 MG	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
ROSZET 10-10 MG TABLET	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL

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ROSZET 20-10 MG TABLET	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
ROSZET 40-10 MG TABLET	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
ROSZET 5-10 MG TABLET	EZETIMIBE/ROSUVASTATIN CALCIUM	W	1 TABLET PER DAY	30	ORAL
SABRIL 500 MG POWDER PACKET	VIGABATRIN	X	6 PACKETS PER DAY	50	ORAL
SABRIL 500 MG TABLET	VIGABATRIN	X	6 TABLETS PER DAY	100	ORAL
SACUBITRIL-VALSARTAN 24-26 MG	SACUBITRIL/VALSARTAN	Y	2 TABLETS PER DAY	180	ORAL
SACUBITRIL-VALSARTAN 49-51 MG	SACUBITRIL/VALSARTAN	Y	2 TABLETS PER DAY	180	ORAL
SACUBITRIL-VALSARTAN 97-103 MG	SACUBITRIL/VALSARTAN	Y	2 TABLETS PER DAY	180	ORAL
SANDOSTATIN LAR DEPOT 10 MG KT	OCTREOTIDE ACETATE, MI-SPHERES	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SANDOSTATIN LAR DEPOT 10 MG VL	OCTREOTIDE ACETATE, MI-SPHERES	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SANDOSTATIN LAR DEPOT 20 MG KT	OCTREOTIDE ACETATE, MI-SPHERES	W	2 KITS PER 28 DAYS	1	INTRAMUSCULAR
SANDOSTATIN LAR DEPOT 20 MG VL	OCTREOTIDE ACETATE, MI-SPHERES	W	2 KITS PER 28 DAYS	1	INTRAMUSCULAR
SANDOSTATIN LAR DEPOT 30 MG KT	OCTREOTIDE ACETATE, MI-SPHERES	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SANDOSTATIN LAR DEPOT 30 MG VL	OCTREOTIDE ACETATE, MI-SPHERES	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SAVELLA 100 MG TABLET	MILNACIPRAN HCL	W	2 TABLETS PER DAY	60	ORAL
SAVELLA 12.5 MG TABLET	MILNACIPRAN HCL	W	2 TABLETS PER DAY	60	ORAL
SAVELLA 25 MG TABLET	MILNACIPRAN HCL	W	2 TABLETS PER DAY	60	ORAL
SAVELLA 50 MG TABLET	MILNACIPRAN HCL	W	2 TABLETS PER DAY	60	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
SAVELLA TITRATION PACK	MILNACIPRAN HCL	W	55 TABLETS PER 365 DAYS	55	ORAL
SAXAGLIPTIN HCL 2.5 MG TABLET	SAXAGLIPTIN HCL	Y	1 TABLET PER DAY	90	ORAL
SAXAGLIPTIN HCL 5 MG TABLET	SAXAGLIPTIN HCL	Y	1 TABLET PER DAY	90	ORAL
SAXAGLIPTIN-METFORMIN ER 5-500	SAXAGLIPTIN HCL/METFORMIN HCL	Y	1 TABLET PER DAY	30	ORAL
SAXAGLIPTIN-METFORMN ER 5-1000	SAXAGLIPTIN HCL/METFORMIN HCL	Y	1 TABLET PER DAY	30	ORAL
SAXAGLIPTN-METFORM ER 2.5-1000	SAXAGLIPTIN HCL/METFORMIN HCL	Y	2 TABLETS PER DAY	60	ORAL
SECUADO 3.8 MG/24 HR PATCH	ASENAPINE	W	1 PATCH PER DAY	1	TRANSDERMAL
SECUADO 5.7 MG/24 HR PATCH	ASENAPINE	W	1 PATCH PER DAY	1	TRANSDERMAL
SECUADO 7.6 MG/24 HR PATCH	ASENAPINE	W	1 PATCH PER DAY	1	TRANSDERMAL
SEGLUROMET 2.5-1,000 MG TABLET	ERTUGLIFLOZIN/METFORMIN	W	2 TABLETS PER DAY	60	ORAL
SEGLUROMET 2.5-500 MG TABLET	ERTUGLIFLOZIN/METFORMIN	W	2 TABLETS PER DAY	60	ORAL
SEGLUROMET 7.5-1,000 MG TABLET	ERTUGLIFLOZIN/METFORMIN	W	2 TABLETS PER DAY	60	ORAL
SEGLUROMET 7.5-500 MG TABLET	ERTUGLIFLOZIN/METFORMIN	W	2 TABLETS PER DAY	60	ORAL
SEREVENT DISKUS 50 MCG	SALMETEROL XINAFOATE	W	1 INHALER PER 30 DAYS	60	INHALATION
SIGNIFOR LAR 10 MG KIT	PASIREOTIDE PAMOATE	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SIGNIFOR LAR 20 MG KIT	PASIREOTIDE PAMOATE	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
SIGNIFOR LAR 30 MG KIT	PASIREOTIDE PAMOATE	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SIGNIFOR LAR 40 MG KIT	PASIREOTIDE PAMOATE	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SIGNIFOR LAR 60 MG KIT	PASIREOTIDE PAMOATE	W	1 KIT PER 28 DAYS	1	INTRAMUSCULAR
SILENOR 3 MG TABLET	DOXEPIN HCL	X	1 TABLET PER DAY	30	ORAL
SILENOR 6 MG TABLET	DOXEPIN HCL	X	1 TABLET PER DAY	30	ORAL
SIMVASTATIN 10 MG TABLET	SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
SIMVASTATIN 20 MG TABLET	SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
SIMVASTATIN 40 MG TABLET	SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
SIMVASTATIN 5 MG TABLET	SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
SIMVASTATIN 80 MG TABLET	SIMVASTATIN	Y	1 TABLET PER DAY	30	ORAL
SITAGLIPTIN 100 MG TABLET	SITAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
SITAGLIPTIN 25 MG TABLET	SITAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
SITAGLIPTIN 50 MG TABLET	SITAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
SITAVIG 50 MG BUCCAL TABLET	ACYCLOVIR	W	1 TABLET PER 30 DAYS	1	BUCCAL
SOLOSEC 2 GM GRANULE PACKET	SECNIDAZOLE	W	2 GRAMS PER 30 DAYS	1	ORAL
SPIRIVA HANDIHALER 18 MCG CAP	TIOTROPIUM BROMIDE	X	1 CAPSULE PER DAY	30	INHALATION
SPIRIVA RESPIMAT 1.25 MCG INH	TIOTROPIUM BROMIDE	W	1 INHALER PER 30 DAYS	4	INHALATION
SPIRIVA RESPIMAT 2.5 MCG INH	TIOTROPIUM BROMIDE	W	1 INHALER PER 30 DAYS	4	INHALATION

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
STEGLATRO 15 MG TABLET	ERTUGLIFLOZIN PIDOLATE	W	1 TABLET PER DAY	30	ORAL
STEGLATRO 5 MG TABLET	ERTUGLIFLOZIN PIDOLATE	W	1 TABLET PER DAY	30	ORAL
STEGLUJAN 15-100 MG TABLET	ERTUGLIFLOZIN/SITAGLIPTIN PHOS	W	1 TABLET PER DAY	30	ORAL
STEGLUJAN 5-100 MG TABLET	ERTUGLIFLOZIN/SITAGLIPTIN PHOS	W	1 TABLET PER DAY	30	ORAL
STIOLTO RESPIMAT INHALER (10)	TIOTROPIUM BR/OLODATEROL HCL	W	1 INHALER PER 30 DAYS	4	INHALATION
STIOLTO RESPIMAT INHALER (60)	TIOTROPIUM BR/OLODATEROL HCL	W	1 INHALER PER 30 DAYS	4	INHALATION
STRIVERDI RESPIMAT INHAL SPRAY	OLODATEROL HCL	W	1 INHALER PER 30 DAYS	4	INHALATION
SUMATRIPTAN 6 MG/0.5 ML SYRNG	SUMATRIPTAN SUCCINATE	Y	6 ML (12 SYRINGES) PER 30 DAYS	0.5	SUBCUTANEOUS
SUMATRIPTAN-NAPROXEN 85-500 MG	SUMATRIPTAN SUCC/NAPROXEN SOD	Y	9 TABLETS PER 30 DAYS	9	ORAL
SYMBICORT 160-4.5 MCG INHALER	BUDESONIDE/FORMOTEROL FUMARATE	X	1 INHALER PER 30 DAYS	6	INHALATION
SYMBICORT 80-4.5 MCG INHALER	BUDESONIDE/FORMOTEROL FUMARATE	X	1 INHALER PER 30 DAYS	10.2	INHALATION
SYNJARDY 12.5-1,000 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
SYNJARDY 12.5-500 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
SYNJARDY 5-1,000 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
SYNJARDY 5-500 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
SYNJARDY XR 10-1,000 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	1 TABLET PER DAY	30	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
SYNJARDY XR 12.5-1,000 MG TAB	EMPAGLIFLOZIN/METFORMIN HCL	W	2 TABLETS PER DAY	60	ORAL
SYNJARDY XR 25-1,000 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	1 TABLET PER DAY	90	ORAL
SYNJARDY XR 5-1,000 MG TABLET	EMPAGLIFLOZIN/METFORMIN HCL	W	2 TABLETS PER DAY	180	ORAL
TERAZOSIN 1 MG CAPSULE	TERAZOSIN HCL	Y	7 CAPSULE PER DAY	100	ORAL
TERAZOSIN 10 MG CAPSULE	TERAZOSIN HCL	Y	2 CAPSULES PER DAY	100	ORAL
TERAZOSIN 2 MG CAPSULE	TERAZOSIN HCL	Y	8 CAPSULE PER DAY	100	ORAL
TERAZOSIN 5 MG CAPSULE	TERAZOSIN HCL	Y	9 CAPSULE PER DAY	100	ORAL
TERIFLUNOMIDE 14 MG TABLET	TERIFLUNOMIDE	Y	1 TABLET PER DAY	30	ORAL
TERIFLUNOMIDE 7 MG TABLET	TERIFLUNOMIDE	Y	1 TABLET PER DAY	30	ORAL
TESTIM 1% (50MG) GEL	TESTOSTERONE	X	2 PACKETS PER DAY	5	TRANSDERMAL
TESTOSTERONE 1% (25MG/2.5G) PK	TESTOSTERONE	Y	2 PACKETS PER DAY	2.5	TRANSDERMAL
TESTOSTERONE 1% (50 MG/5 G) PK	TESTOSTERONE	Y	1 PACKET PER DAY	5	TRANSDERMAL
TESTOSTERONE 1.62% (2.5 G) PKT	TESTOSTERONE	Y	2 PACKETS PER DAY	2.5	TRANSDERMAL
TESTOSTERONE 1.62% GEL PUMP	TESTOSTERONE	Y	2 BOTTLES PER 30 DAYS	75	TRANSDERMAL
TESTOSTERONE 1.62% (1.25 G) PKT	TESTOSTERONE	Y	1 PACKET PER DAY	1.25	TRANSDERMAL
TESTOSTERONE 10 MG GEL PUMP	TESTOSTERONE	Y	1 PUMP PER 30 DAYS	60	TRANSDERMAL

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TESTOSTERONE 12.5 MG/1.25 GRAM	TESTOSTERONE	Y	300 GRAMS (4 BOTLLES) PER 30 DAYS	75	TRANSDERMAL
TESTOSTERONE 30 MG/1.5 ML PUMP	TESTOSTERONE	Y	2 BOTLLES (180 ML) PER 30 DAYS	90	TRANSDERMAL
TESTOSTERONE 50 MG/5 GRAM GEL	TESTOSTERONE	Y	2 TUBES PER DAY	5	TRANSDERMAL
TESTOSTERONE 50 MG/5 GRAM PKT	TESTOSTERONE	W	2 PACKETS PER DAY	5	TRANSDERMAL
TINIDAZOLE 250 MG TABLET	TINIDAZOLE	Y	40 TABLETS PER 30 DAYS	40	ORAL
TINIDAZOLE 500 MG TABLET	TINIDAZOLE	Y	20 TABLETS PER 30 DAYS	20	ORAL
TIOTROPIUM 18 MCG CAP-INHALER	TIOTROPIUM BROMIDE	Y	1 CAPSULE PER DAY	30	INHALATION
TLANDO 112.5 MG CAPSULE	TESTOSTERONE UNDECANOATE	W	4 CAPSULES PER DAY	120	ORAL
TOBI 300 MG/5 ML SOLUTION	TOBRAMYCIN IN 0.225% SOD CHLOR	X	10 ML PER DAY	5	INHALATION
TOBI PODHALER 28 MG INHALE CAP	TOBRAMYCIN	W	224 CAPSULES PER 28 DAYS	8	INHALATION
TOBRAMYCIN 300 MG/4 ML AMPULE	TOBRAMYCIN	Y	224 ML PER 28 DAYS	4	INHALATION
TOBRAMYCIN 300 MG/5 ML AMPULE	TOBRAMYCIN IN 0.225% SOD CHLOR	Y	10 ML PER DAY	5	INHALATION
TOBRAMYCIN PAK 300 MG/5 ML	TOBRAMYCIN/NEBULIZER	W	10 ML PER DAY	5	INHALATION
TRADJENTA 5 MG TABLET	LINAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
TRELEGY ELLIPTA 100-62.5-25	FLUTICASONE/UMECLIDIN/VILANTER	W	1 INHALER PER 30 DAYS	60	INHALATION

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TRELEGY ELLIPTA 200-62.5-25	FLUTICASONE/UMECLIDIN/VILANTER	W	1 INHALER PER 30 DAYS	60	INHALATION
TREXIMET 85-500 MG TABLET	SUMATRIPTAN SUCC/NAPROXEN SOD	X	9 TABLETS PER 30 DAYS	9	ORAL
TUDORZA PRESSAIR 400 MCG INHAL	ACLIDINIUM BROMIDE	W	1 INHLAER PER 30 DAYS	1	INHALATION
VALACYCLOVIR HCL 500 MG TABLET	VALACYCLOVIR HCL	Y	2 TABLETS PER DAY	90	ORAL
VALIUM 10 MG TABLET	DIAZEPAM	X	4 TABLETS PER DAY	100	ORAL
VALIUM 2 MG TABLET	DIAZEPAM	X	4 TABLETS PER DAY	100	ORAL
VALIUM 5 MG TABLET	DIAZEPAM	X	4 TABLETS PER DAY	100	ORAL
VALTREX 500 MG CAPLET	VALACYCLOVIR HCL	X	2 TABLETS PER DAY	30	ORAL
VERKAZIA 0.1% EYE EMULSION	CYCLOSPORINE	W	120 VIALS PER 30 DAYS	120	OPHTHALMIC (EYE)
VEVYE 0.1% EYE DROP	CYCLOSPORINE	W	2 ML PER 30 DAYS	2	OPHTHALMIC (EYE)
VIGABATRIN 500 MG POWDER PACKT	VIGABATRIN	Y	6 PACKETS PER DAY	1	ORAL
VIGABATRIN 500 MG TABLET	VIGABATRIN	Y	6 TABLETS PER DAY	100	ORAL
VIGADRONE 500 MG POWDER PACKET	VIGABATRIN	Y	6 PACKETS PER DAY	50	ORAL
VIGADRONE 500 MG TABLET	VIGABATRIN	Y	6 TABLETS PER DAY	100	ORAL
VIGPODER 500 MG POWDER PACKET	VIGABATRIN	Y	6 PACKETS PER DAY	1	ORAL
VISTOGARD 10 GRAM PACKET	URIDINE TRIACETATE	W	20 PACKETS PER 30 DAYS	4	ORAL

label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
VIVELLE-DOT 0.025 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	8	TRANSDERMAL
VIVELLE-DOT 0.0375 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	8	TRANSDERMAL
VIVELLE-DOT 0.05 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	8	TRANSDERMAL
VIVELLE-DOT 0.075 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	8	TRANSDERMAL
VIVELLE-DOT 0.1 MG PATCH	ESTRADIOL	X	8 PATCHES PER 28 DAYS	8	TRANSDERMAL
VOGELXO 12.5 MG/1.25 GRAM PUMP	TESTOSTERONE	W	300 GRAMS (4 BOTLLES) PER 30 DAYS	75	TRANSDERMAL
VOGELXO 50 MG/5 GRAM GEL	TESTOSTERONE	X	2 TUBES PER DAY	5	TRANSDERMAL
VOGELXO 50 MG/5 GRAM GEL PACKT	TESTOSTERONE	W	2 PACKETS PER DAY	5	TRANSDERMAL
VYTORIN 10-10 MG TABLET	EZETIMIBE/SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
VYTORIN 10-20 MG TABLET	EZETIMIBE/SIMVASTATIN	X	1 TABLET PER DAY	21	ORAL
VYTORIN 10-40 MG TABLET	EZETIMIBE/SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
VYTORIN 10-80 MG TABLET	EZETIMIBE/SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
WIXELA 100-50 INHUB	FLUTICASONE PROPION/SALMETEROL	Y	1 PACKAGE PER 30 DAYS	60	INHALATION
WIXELA 250-50 INHUB	FLUTICASONE PROPION/SALMETEROL	Y	1 PACKAGE PER 30 DAYS	60	INHALATION
WIXELA 500-50 INHUB	FLUTICASONE PROPION/SALMETEROL	Y	1 PACKAGE PER 30 DAYS	60	INHALATION
XENICAL 120 MG CAPSULE	ORLISTAT	W	3 CAPSULES PER DAY	90	ORAL

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
XERMELO 250 MG TABLET	TELOTRISTAT ETIPRATE	W	3 TABLETS PER DAY	84	ORAL
XYOSTED 100 MG/0.5 ML AUTO-INJ	TESTOSTERONE ENANTHATE	W	2 ML (4 AUTO-INJECTORS) PER 28 DAYS	0.5	SUBCUTANEOUS
XYOSTED 50 MG/0.5 ML AUTO-INJ	TESTOSTERONE ENANTHATE	W	2 ML (4 AUTO-INJECTORS) PER 28 DAYS	0.5	SUBCUTANEOUS
XYOSTED 75 MG/0.5 ML AUTO-INJ	TESTOSTERONE ENANTHATE	W	2 ML (4 AUTO-INJECTORS) PER 28 DAYS	0.5	SUBCUTANEOUS
ZEGERID 20 MG PACKET	OMEPRAZOLE/SODIUM BICARBONATE	X	1 PACKET PER DAY	30	ORAL
ZETONNA 37 MCG NASAL SPRAY	CICLESONIDE	W	1 CANISTER PER 30 DAYS	6.1	NASAL
ZITUVIO 100 MG TABLET	SITAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
ZITUVIO 25 MG TABLET	SITAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
ZITUVIO 50 MG TABLET	SITAGLIPTIN	W	1 TABLET PER DAY	30	ORAL
ZOCOR 10 MG TABLET	SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
ZOCOR 20 MG TABLET	SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
ZOCOR 40 MG TABLET	SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
ZOCOR 80 MG TABLET	SIMVASTATIN	X	1 TABLET PER DAY	30	ORAL
ZOKINVY 50 MG CAPSULE	LONAFARNIB	W	4 CAPSULES PER DAY	30	ORAL
ZOKINVY 75 MG CAPSULE	LONAFARNIB	W	4 CAPSULES PER DAY	30	ORAL
ZOLPIDEM TART 1.75 MG TAB SL	ZOLPIDEM TARTRATE	Y	1 TABLET PER DAY	30	SUBLINGUAL

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label_name	hicl_desc	sub_code	Recommended QL	pack_size	route_desc
ZOLPIDEM TART 3.5 MG TABLET SL	ZOLPIDEM TARTRATE	Y	1 TABLET PER DAY	30	SUBLINGUAL
ZYPITAMAG 2 MG TABLET	PITAVASTATIN MAGNESIUM	W	1 TABLET PER DAY	90	ORAL
ZYPITAMAG 4 MG TABLET	PITAVASTATIN MAGNESIUM	W	1 TABLET PER DAY	90	ORAL

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1/1/2026 Commercial Formulary Update Table

RECOMMENDED CHANGE	LABEL NAME	CHEMICAL NAME	SI	2026 INTENT	ALTERNATIVE(S)
COVERAGE	APRETUDE ER 600 MG/3 ML VIAL	CABOTEGRAVIR	W	MEDICAL BENEFIT	N/A
COVERAGE	CABENUVA ER 400 MG-600 MG SUSP	CABOTEGRAVIR/RILPIVIRINE	W	MEDICAL BENEFIT	N/A
COVERAGE	CABENUVA ER 600 MG-900 MG SUSP	CABOTEGRAVIR/RILPIVIRINE	W	MEDICAL BENEFIT	N/A
COVERAGE	SUNLENCA 463.5 MG/1.5 ML VIAL	LENACAPAVIR SODIUM	W	MEDICAL BENEFIT	N/A
FORMULARY	NUCYNTA 100 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydrocodone/acetaminophen, hydromorphone, morphine sulfate, oxycodone, oxycodone/acetaminophen, oxymorphone, tramadol
FORMULARY	NUCYNTA 50 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydrocodone/acetaminophen, hydromorphone, morphine sulfate, oxycodone, oxycodone/acetaminophen, oxymorphone, tramadol
FORMULARY	NUCYNTA 75 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydrocodone/acetaminophen, hydromorphone, morphine sulfate, oxycodone, oxycodone/acetaminophen, oxymorphone, tramadol
FORMULARY	NUCYNTA ER 100 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets

FORMULARY	NUCYNTA ER 150 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	NUCYNTA ER 200 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	NUCYNTA ER 250 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	NUCYNTA ER 50 MG TABLET	TAPENTADOL HCL	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	CORLANOR 5 MG/5 ML ORAL SOLN	IVABRADINE HCL	W	NF ON ALL CLOSED FORMULARIES, TIER 3 ON OPEN	generic ivabradine hcl tablets (Corlanor®)
FORMULARY	DELSTRIGO 100-300-300 MG TAB	DORAVIRINE/LAMIVU/TENOFOV DISO	W	NF ON ALL CLOSED FORMULARIES; T4 ON OPEN	Biktarvy®
FORMULARY	PIFELTRO 100 MG TABLET	DORAVIRINE	W	NF ON ALL CLOSED FORMULARIES; T4 ON OPEN	Edurant®, generic efavirenz, generic etravirine, generic nevirapine

FORMULARY	PREZCOBIX 800 MG-150 MG TABLET	DARUNAVIR/COBICISTAT	W	NF ON ALL CLOSED FORMULARIES; T4 ON OPEN	generic darunavir (Prezista) & generic ritnoavir (Norvir)
FORMULARY	SYMTUZA 800-150-200-10 MG TAB	DARUNAVIR/COB/EMTRI/TENOFALAF	W	NF ON ALL CLOSED FORMULARIES; T4 ON OPEN	Biktarvy®
FORMULARY	BAFIERTAM DR 95 MG CAPSULE	MONOMETHYL FUMARATE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	EXTAVIA 0.3 MG KIT	INTERFERON BETA-1B	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	EXTAVIA 0.3 MG VIAL	INTERFERON BETA-1B	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAVENCLAD 10 MG X 10 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAVENCLAD 10 MG X 4 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)

FORMULARY	MAVENCLAD 10 MG X 5 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAVENCLAD 10 MG X 6 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAVENCLAD 10 MG X 7 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAVENCLAD 10 MG X 8 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAVENCLAD 10 MG X 9 TABLET PK	CLADRIBINE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAYZENT 0.25 MG TABLET	SIPONIMOD	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAYZENT 0.25MG START-1MG MAINT	SIPONIMOD	W	NF ON ALL CLOSED FORMULARIES;	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate

				TIER 4 W/ PA ON OPEN	(Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAYZENT 0.25MG START-2MG MAINT	SIPONIMOD	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAYZENT 1 MG TABLET	SIPONIMOD	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	MAYZENT 2 MG TABLET	SIPONIMOD	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	PONVORY 14-DAY STARTER PACK	PONESIMOD	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	PONVORY 20 MG TABLET	PONESIMOD	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	REBIF 22 MCG/0.5 ML SYRINGE	INTERFERON BETA-1A/ALBUMIN	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)

FORMULARY	REBIF 44 MCG/0.5 ML SYRINGE	INTERFERON BETA-1A/ALBUMIN	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	REBIF REBIDOSE 22 MCG/0.5 ML	INTERFERON BETA-1A/ALBUMIN	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	REBIF REBIDOSE 44 MCG/0.5 ML	INTERFERON BETA-1A/ALBUMIN	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	REBIF REBIDOSE TITRATION PACK	INTERFERON BETA-1A/ALBUMIN	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	REBIF TITRATION PACK	INTERFERON BETA-1A/ALBUMIN	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	dimethyl fumarate (Tecfidera®), Glatopa® or glatiramer acetate (Copaxone®), fingolimod (Gilenya®), teriflunomide (Aubagio®)
FORMULARY	TYMLOS 80 MCG DOSE PEN INJECTR	ABALOPARATIDE	W	NF ON ALL CLOSED FORMULARIES; TIER 4 W/ PA ON OPEN	generic teriparatide injection (requires prior authorization)

FORMULARY	BIMZELX 160 MG/ML AUTOINJECTOR	BIMEKIZUMAB-BKZX	W	NF ON CLOSED (EXCEPT SG2026); T4 W/ PA ON OPEN AND SG2026	Taltz®, preferred adalimumab* (Self funded: Humira®, Cyltezo®, Yuflyma®; Fully Insured/Exchange/FAMIS: adalimumab-adbm, Simlandi®) *both require prior authorization
FORMULARY	BIMZELX 160 MG/ML SYRINGE	BIMEKIZUMAB-BKZX	W	NF ON CLOSED (EXCEPT SG2026); T4 W/ PA ON OPEN AND SG2026	Taltz®, preferred adalimumab* (Self funded: Humira®, Cyltezo®, Yuflyma®; Fully Insured/Exchange/FAMIS: adalimumab-adbm, Simlandi®) *both require prior authorization
FORMULARY	BIMZELX 320 MG/2 ML AUTOINJECT	BIMEKIZUMAB-BKZX	W	NF ON CLOSED (EXCEPT SG2026); T4 W/ PA ON OPEN AND SG2026	Taltz®, preferred adalimumab* (Self funded: Humira®, Cyltezo®, Yuflyma®; Fully Insured/Exchange/FAMIS: adalimumab-adbm, Simlandi®) *both require prior authorization
FORMULARY	BIMZELX 320 MG/2 ML SYRINGE	BIMEKIZUMAB-BKZX	W	NF ON CLOSED (EXCEPT SG2026); T4 W/ PA ON OPEN AND SG2026	Taltz®, preferred adalimumab* (Self funded: Humira®, Cyltezo®, Yuflyma®; Fully Insured/Exchange/FAMIS: adalimumab-adbm, Simlandi®) *both require prior authorization
FORMULARY	VYVANSE 10 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization
FORMULARY	VYVANSE 20 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization
FORMULARY	VYVANSE 30 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization

FORMULARY	VYVANSE 40 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization
FORMULARY	VYVANSE 50 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization
FORMULARY	VYVANSE 60 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization
FORMULARY	VYVANSE 70 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	X	NF ON CLOSED; TIER 3 W/ AGE EDIT PA ON OPEN	generic lisdexamfetamine capsules (Vyvanse®) *requires prior authorization
FORMULARY	SUNOSI 150 MG TABLET	SOLRIAMFETOL HCL	W	NF ON CLOSED; TIER 3 W/ PA ON OPEN	generic armodafinil (Nuvigil®), generic modafinil (Provigil®)
FORMULARY	SUNOSI 75 MG TABLET	SOLRIAMFETOL HCL	W	NF ON CLOSED; TIER 3 W/ PA ON OPEN	generic armodafinil (Nuvigil®), generic modafinil (Provigil®)
FORMULARY	SUNLENCA 300 MG TABLET	LENACAPAVIR SODIUM	W	NF ON CLOSED; TIER 4 W/ PA ON OPEN	N/A
FORMULARY	SUNLENCA 4- 300 MG TABLET	LENACAPAVIR SODIUM	W	NF ON CLOSED; TIER 4 W/ PA ON OPEN	N/A
FORMULARY	SUNLENCA 5- 300 MG TABLET	LENACAPAVIR SODIUM	W	NF ON CLOSED; TIER 4 W/ PA ON OPEN	N/A

FORMULARY	WAKIX 17.8 MG TABLET	PITOLISANT HCL	W	NF ON CLOSED; TIER 4 W/ PA ON OPEN	generic armodafinil (Nuvigil®), generic modafinil (Provigil®), fluoxetine, clomipramine, duloxetine
FORMULARY	WAKIX 4.45 MG TABLET	PITOLISANT HCL	W	NF ON CLOSED; TIER 4 W/ PA ON OPEN	generic armodafinil (Nuvigil®), generic modafinil (Provigil®), fluoxetine, clomipramine, duloxetine
FORMULARY	STELARA 130 MG/26 ML VIAL	USTEKINUMAB	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	STELARA 45 MG/0.5 ML SYRINGE	USTEKINUMAB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	STELARA 45 MG/0.5 ML VIAL	USTEKINUMAB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	STELARA 90 MG/ML SYRINGE	USTEKINUMAB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	BONSITY 560 MCG/2.24 ML PEN	TERIPARATIDE	X	NF/CED ON ALL CLOSED FORMULARIES	generic teriparatide injection (requires prior authorization)
FORMULARY	OXYCONTIN ER 10 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	OXYCONTIN ER 15 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	OXYCONTIN ER 20 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	OXYCONTIN ER 30 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets

FORMULARY	OXYCONTIN ER 40 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	OXYCONTIN ER 60 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	OXYCONTIN ER 80 MG TABLET	OXYCODONE HCL	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	PEN NEEDLES	PEN NEEDLE, DIABETIC	W	NF/CED ON ALL COMM/HIX/FAMIS FORMULARIES EXCEPT EMBECTA (BD) PEN NEEDLES (T1, NO UM)	EMBECTA (BD) PEN NEEDLES
FORMULARY	FLUTICASONE-SALMETEROL 113-14	FLUTICASONE PROPION/SALMETEROL	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Brand Advair HFA
FORMULARY	FLUTICASONE-SALMETEROL 55-14	FLUTICASONE PROPION/SALMETEROL	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Brand Advair HFA
FORMULARY	FLUTICASONE-SALMETEROL 232-14	FLUTICASONE PROPION/SALMETEROL	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Brand Advair HFA
FORMULARY	CDV PYZCHIVA 45 MG/0.5 ML SYR	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	CDV PYZCHIVA 90 MG/ML SYRINGE	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	IMULDOSA 130 MG/26 ML VIAL	USTEKINUMAB-SRLF	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)

FORMULARY	IMULDOSA 45 MG/0.5 ML SYRINGE	USTEKINUMAB-SRLF	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	IMULDOSA 90 MG/ML SYRINGE	USTEKINUMAB-SRLF	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	ISENTRESS 100 MG POWDER PACKET	RALTEGRAVIR POTASSIUM	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Isentress tablets/chewable tablets
FORMULARY	NORVIR 100 MG POWDER PACKET	RITONAVIR	W	NF/CED ON ALL COMMERCIAL FORMULARIES	generic ritonavir tablets (Norvir®)
FORMULARY	OTULFI 130 MG/26 ML VIAL	USTEKINUMAB-AAUZ	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	OTULFI 45 MG/0.5 ML SYRINGE	USTEKINUMAB-AAUZ	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	OTULFI 90 MG/ML SYRINGE	USTEKINUMAB-AAUZ	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	PYZCHIVA 130 MG/26 ML VIAL	USTEKINUMAB-TTWE	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	PYZCHIVA 45 MG/0.5 ML SYRINGE	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	PYZCHIVA 45 MG/0.5 ML VIAL	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	PYZCHIVA 90 MG/ML SYRINGE	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)

FORMULARY	REYATAZ 50 MG POWDER PACKET	ATAZANAVIR SULFATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	generic atazanvir capsules (Reyataz®)
FORMULARY	STEQEYMA 130 MG/26 ML VIAL	USTEKINUMAB-STBA	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	STEQEYMA 45 MG/0.5 ML SYRINGE	USTEKINUMAB-STBA	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	STEQEYMA 90 MG/ML SYRINGE	USTEKINUMAB-STBA	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	USTEKINUMAB 130 MG/26 ML VIAL	USTEKINUMAB	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	USTEKINUMAB 45 MG/0.5 ML VIAL	USTEKINUMAB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	USTEKINUMAB 45MG/0.5ML SYRINGE	USTEKINUMAB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	USTEKINUMAB 90 MG/ML SYRINGE	USTEKINUMAB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	USTEKINUMAB-AEKN 45 MG/0.5 ML	USTEKINUMAB-AEKN	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	USTEKINUMAB-AEKN 90 MG/ML SYR	USTEKINUMAB-AEKN	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	USTEKINUMAB-TTWE 130MG/26ML VL	USTEKINUMAB-TTWE	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	USTEKINUMAB-TTWE 45MG/0.5ML SY	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)

FORMULARY	USTEKINUMAB-TTWE 90 MG/ML SYR	USTEKINUMAB-TTWE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	VIREAD POWDER	TENOFOVIR DISOPROXIL FUMARATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES	generic tenofovir disoproxil fumularate tablets (Viread®)
FORMULARY	WEZLANA 130 MG/26 ML VIAL	USTEKINUMAB-AUUB	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY	WEZLANA 45 MG/0.5 ML SYRINGE	USTEKINUMAB-AUUB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	WEZLANA 45 MG/0.5 ML VIAL	USTEKINUMAB-AUUB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	WEZLANA 90 MG/ML SYRINGE	USTEKINUMAB-AUUB	W	NF/CED ON ALL COMMERCIAL FORMULARIES	Selarsdi™ & Yesintek™ (both require prior authorization)
FORMULARY	INVEGA HAFYERA 1,092 MG/3.5 ML	PALIPERIDONE PALMITATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Invega Sustenna®, Invega Trinza® & Erzofri®
FORMULARY	INVEGA HAFYERA 1,560 MG/5 ML	PALIPERIDONE PALMITATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Invega Sustenna®, Invega Trinza® & Erzofri®
FORMULARY	PERSERIS ER 120 MG SYRINGE KIT	RISPERIDONE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	risperidone ER injection (Risperdal® Consta®), Rykindo® ER, Uzedy® ER

FORMULARY	PERSERIS ER 90 MG SYRINGE KIT	RISPERIDONE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	risperidone ER injection (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	XTAMPZA ER 13.5 MG CAPSULE	OXYCODONE MYRISTATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	XTAMPZA ER 18 MG CAPSULE	OXYCODONE MYRISTATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	XTAMPZA ER 27 MG CAPSULE	OXYCODONE MYRISTATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	XTAMPZA ER 36 MG CAPSULE	OXYCODONE MYRISTATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY	XTAMPZA ER 9 MG CAPSULE	OXYCODONE MYRISTATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets

FORMULARY	ZYPREXA RELPREVV 210 MG VIAL	OLANZAPINE PAMOATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Abilify Asimtufii®, Abilify Maintena®, Aristada® ER, Erzofri®, Invega Sustenna®, Invega Trinza®, risperidone ER (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	ZYPREXA RELPREVV 210 MG VL KIT	OLANZAPINE PAMOATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Abilify Asimtufii®, Abilify Maintena®, Aristada® ER, Erzofri®, Invega Sustenna®, Invega Trinza®, risperidone ER (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	ZYPREXA RELPREVV 300 MG VIAL	OLANZAPINE PAMOATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Abilify Asimtufii®, Abilify Maintena®, Aristada® ER, Erzofri®, Invega Sustenna®, Invega Trinza®, risperidone ER (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	ZYPREXA RELPREVV 300 MG VL KIT	OLANZAPINE PAMOATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Abilify Asimtufii®, Abilify Maintena®, Aristada® ER, Erzofri®, Invega Sustenna®, Invega Trinza®, risperidone ER (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	ZYPREXA RELPREVV 405 MG VIAL	OLANZAPINE PAMOATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Abilify Asimtufii®, Abilify Maintena®, Aristada® ER, Erzofri®, Invega Sustenna®, Invega Trinza®, risperidone ER (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	ZYPREXA RELPREVV 405 MG VL KIT	OLANZAPINE PAMOATE	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Abilify Asimtufii®, Abilify Maintena®, Aristada® ER, Erzofri®, Invega Sustenna®, Invega Trinza®, risperidone ER (Risperdal® Consta®), Rykindo® ER, Uzedy® ER
FORMULARY	ABILIFY ASIMTUFII 720 MG/2.4ML	ARIPIPRAZOLE	W	T2 W/ AGE EDIT PA ON ALL	N/A

				COMM FORMULARIES	
FORMULARY	ABILIFY ASIMTUFII 960 MG/3.2ML	ARIPIPRAZOLE	W	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 10 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 20 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 30 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 40 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 50 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 60 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	LISDEXAMFETAMINE 70 MG CAPSULE	LISDEXAMFETAMINE DIMESYLATE	Y	T2 W/ AGE EDIT PA ON ALL	N/A

				COMM FORMULARIES	
FORMULARY	ASMANEX HFA 100 MCG INHALER	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX HFA 200 MCG INHALER	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX HFA 50 MCG INHALER	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX TWISTHALER 110 MCG #30	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX TWISTHALER 220 MCG #14	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX TWISTHALER 220 MCG #30	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX TWISTHALER 220 MCG #60	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ASMANEX TWISTHALR 220 MCG #120	MOMETASONE FUROATE	W	T2 W/ NO UM ON ALL COMM FORMULARIES	N/A
FORMULARY	ERZOFRI 117 MG/0.75 ML SYRINGE	PALIPERIDONE PALMITATE	W	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	ERZOFRI 156 MG/ML SYRINGE	PALIPERIDONE PALMITATE	W	T2 W/ AGE EDIT PA ON ALL	N/A

				COMM FORMULARIES	
FORMULARY	ERZOFRI 234 MG/1.5 ML SYRINGE	PALIPERIDONE PALMITATE	W	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	ERZOFRI 351 MG/2.25 ML SYRINGE	PALIPERIDONE PALMITATE	W	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	ERZOFRI 39 MG/0.25 ML SYRINGE	PALIPERIDONE PALMITATE	W	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY	ERZOFRI 78 MG/0.5 ML SYRINGE	PALIPERIDONE PALMITATE	W	T2 W/ AGE EDIT PA ON ALL COMM FORMULARIES	N/A
FORMULARY AND UM	ACCU-CHEK AVIVA PLUS TEST STRP	BLOOD SUGAR DIAGNOSTIC	W	NF ON ALL COMMERCIAL FORMULARIES	Test Strips manufactured by Abbott
FORMULARY AND UM	ACCU-CHEK GUIDE TEST STRIP	BLOOD SUGAR DIAGNOSTIC	W	NF ON ALL COMMERCIAL FORMULARIES	Test Strips manufactured by Abbott
FORMULARY AND UM	ACCU-CHEK SMARTVIEW TEST STRIP	BLOOD SUGAR DIAGNOSTIC	W	NF ON ALL COMMERCIAL FORMULARIES	Test Strips manufactured by Abbott
FORMULARY AND UM	HUMALOG 100 UNIT/ML CARTRIDGE	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMALOG 100 UNIT/ML KWIKPEN	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A

FORMULARY AND UM	HUMALOG 100 UNIT/ML VIAL	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMALOG 200 UNIT/ML KWIKPEN	INSULIN LISPRO	W	NF/CED ON ALL COMMERCIAL FORMULARIES (EXCEPT SG2026)	Humalog 100 unit/mL vial/kwikpen
FORMULARY AND UM	HUMALOG JR 100 UNIT/ML KWIKPEN	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMALOG MIX 50-50 KWIKPEN	INSULIN LISPRO PROTAMIN/LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMALOG MIX 50-50 VIAL	INSULIN LISPRO PROTAMIN/LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMALOG MIX 75-25 KWIKPEN	INSULIN LISPRO PROTAMIN/LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMALOG MIX 75-25 VIAL	INSULIN LISPRO PROTAMIN/LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMULIN 70/30 KWIKPEN	INSULIN NPH HUM/REG INSULIN HM	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMULIN 70-30 VIAL	INSULIN NPH HUM/REG INSULIN HM	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMULIN N 100 UNIT/ML KWIKPEN	INSULIN NPH HUMAN ISOPHANE	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A

FORMULARY AND UM	HUMULIN N 100 UNIT/ML VIAL	INSULIN NPH HUMAN ISOPHANE	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMULIN R 100 UNIT/ML VIAL	INSULIN REGULAR, HUMAN	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMULIN R 500 UNIT/ML KWIKPEN	INSULIN REGULAR, HUMAN	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	HUMULIN R 500 UNIT/ML VIAL	INSULIN REGULAR, HUMAN	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	INSULIN LISPRO 100 UNIT/ML PEN	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	INSULIN LISPRO 100 UNIT/ML VL	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	INSULIN LISPRO JR 100 UNIT/ML	INSULIN LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	INSULIN LISPRO MIX 75-25 KWKPN	INSULIN LISPRO PROTAMIN/LISPRO	W	T2 ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	ONETOUCH ULTRA TEST STRIP	BLOOD SUGAR DIAGNOSTIC	W	NF ON ALL COMMERCIAL FORMULARIES	Test Strips manufactured by Abbott
FORMULARY AND UM	ONETOUCH VERIO TEST STRIP	BLOOD SUGAR DIAGNOSTIC	W	NF ON ALL COMMERCIAL FORMULARIES	Test Strips manufactured by Abbott
FORMULARY AND UM	GLUCAGEN 1 MG HYPOKIT	GLUCAGON	W	NF ON ALL CLOSED FORMULARIES	Baqsimi®, Gvoke®, generic glucagon injection

				(EXCEPT SG2026); TIER 3 W/ ST ON OPEN	
FORMULARY AND UM	GLUCAGON 1 MG EMERGENCY KIT	GLUCAGON	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026); TIER 3 W/ ST ON OPEN	Baqsimi®, Gvoke®, generic glucagon injection
FORMULARY AND UM	TRESIBA 100 UNIT/ML VIAL	INSULIN DEGLUDEC	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026); TIER 3 WITH PA ON OPEN	Brand Lantus® & Toujeo®
FORMULARY AND UM	TRESIBA FLEXTOUCH 100 UNIT/ML	INSULIN DEGLUDEC	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026); TIER 3 WITH PA ON OPEN	Brand Lantus® & Toujeo®
FORMULARY AND UM	TRESIBA FLEXTOUCH 200 UNIT/ML	INSULIN DEGLUDEC	W	NF ON ALL CLOSED FORMULARIES (EXCEPT SG2026); TIER 3 WITH PA ON OPEN	Brand Lantus® & Toujeo®
FORMULARY AND UM	OXYCODONE HCL ER 10 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES;	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets

				TIER 3 W/ PA ON OPEN	
FORMULARY AND UM	OXYCODONE HCL ER 15 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY AND UM	OXYCODONE HCL ER 20 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY AND UM	OXYCODONE HCL ER 30 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY AND UM	OXYCODONE HCL ER 40 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY AND UM	OXYCODONE HCL ER 60 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets
FORMULARY AND UM	OXYCODONE HCL ER 80 MG TABLET	OXYCODONE HCL	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	hydromorphone ER tablets, morphine sulfate ER tablets, oxymorphone ER tablets, tramadol ER tablets

FORMULARY AND UM	PULMICORT 180 MCG FLEXHALER	BUDESONIDE	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	Asmanex Twisthaler/HFA, Arnuity Ellipta, Qvar Redihaler
FORMULARY AND UM	PULMICORT 90 MCG FLEXHALER	BUDESONIDE	W	NF ON ALL CLOSED FORMULARIES; TIER 3 W/ PA ON OPEN	Asmanex Twisthaler/HFA, Arnuity Ellipta, Qvar Redihaler
FORMULARY AND UM	SELARSDI 130 MG/26 ML VIAL	USTEKINUMAB-AEKN	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY AND UM	SELARSDI 45 MG/0.5 ML SYRINGE	USTEKINUMAB-AEKN	W	T4 W/PA ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	SELARSDI 90 MG/ML SYRINGE	USTEKINUMAB-AEKN	W	T4 W/PA ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	YESINTEK 130 MG/26 ML VIAL	USTEKINUMAB-KFCE	W	MEDICAL BENEFIT	Selarsdi & Yesintek (both require prior authorization)
FORMULARY AND UM	YESINTEK 45 MG/0.5 ML SYRINGE	USTEKINUMAB-KFCE	W	T4 W/PA ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	YESINTEK 45 MG/0.5 ML VIAL	USTEKINUMAB-KFCE	W	T4 W/PA ON ALL COMMERCIAL FORMULARIES	N/A
FORMULARY AND UM	YESINTEK 90 MG/ML SYRINGE	USTEKINUMAB-KFCE	W	T4 W/PA ON ALL COMMERCIAL FORMULARIES	N/A
UM	RECTIV 0.4% OINTMENT	NITROGLYCERIN	X	ADD UM TO OPEN	N/A

UM	NITROGLYCERIN 0.4% OINTMENT	NITROGLYCERIN	Y	ADD UM TO OPEN AND SG2026	N/A
UM	TRIMIPRAMINE MALEATE 100 MG CP	TRIMIPRAMINE MALEATE	Y	ADD UM TO OPEN AND SG2026	N/A
UM	TRIMIPRAMINE MALEATE 25 MG CAP	TRIMIPRAMINE MALEATE	Y	ADD UM TO OPEN AND SG2026	N/A
UM	TRIMIPRAMINE MALEATE 50 MG CAP	TRIMIPRAMINE MALEATE	Y	ADD UM TO OPEN AND SG2026	N/A