Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: adalimumab-aaty (CF) 80 mg Crohn's Pack		**INDICATION:** Humira Biosimilar FDA approved to treat seven inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older and moderate-to-severe ulcerative colitis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 3 auto-injectors (1 pack) per 365 days		
FORMULARY ALTERNATIVES: (COMMERCIAL): **COMMERCIAL/FAMIS** - Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty), Simlandi (adalimumab-ryvk) and adalimumab-adbm **[Group Specific Preferreds**]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: adalimumab-adaz (CF) 10 mg/0.1 mL prefilled syringe		**INDICATION:** Humira Biosimilar FDA approved to treat seven inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older and moderate-to-severe ulcerative colitis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 2 syringes per 28 days		
FORMULARY ALTERNATIVES: : (COMMERCIAL): **COMMERCIAL/FAMIS** - Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty), Simlandi (adalimumab-ryvk) and adalimumab-adbm **[Group Specific Preferreds**]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Amnesteem (isotretinoin) 30 mg capsules		**INDICATION:** For the treatment of severe recalcitrant nodular acne unresponsive to conventional therapy (including systemic antibiotics)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	N/A
STANDARD FORMULARY	Tier 2	N/A
EXCHANGE FORMULARY	Tier 2	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

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

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Bisoprolol fumarate 2.5 mg tablets		**INDICATION:** For the management of hypertension
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary Bran	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic bisoprolol 5 & 10 mg tablets; (MEDICAID): generic bisoprolol 5 & 10 mg tablets; (MEDICARE): generic bisoprolol 5 & 10 mg tablets		

DRUG NAME: Bkemv™ (eculizumab-aeeb)		**INDICATION:** Biosimilar and interchangeable to AstraZeneca's Soliris® (eculizumab)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Botulinum Toxin Products – Botox® (onabotulinumtoxinA), Daxxify® (daxibotulinumtoxinA), Dysport® (abobotulinumtoxinA), Myobloc® (rimabotulinumtoxinB), Xeomin® (incobotulinumtoxinA)		**INDICATION:** For use in the treatment of a variety of medical conditions including but not limited to overactive bladder, urinary incontinence, chronic migraines, spasticity, cervical dystonia, severe underarm sweating, eyelid spasms, crossed eyes, and drooling. All cosmetic indications are excluded from benefit coverage.
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	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Combogesic® (acetaminophen and ibuprofen) 325/97.5 mg tablets		**INDICATION:** For the short-term management of mild to moderate acute 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	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 12 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic ibuprofen tablets; (MEDICAID): ibuprofen tablets (Rx & OTC), acetaminophen 500 mg tablets; (MEDICARE): generic ibuprofen tablets		

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Crenessity™ (crinecerfont) capsules & oral solution		**INDICATION:** For use as adjunctive treatment to glucocorticoid replacement to control androgens in adults and pediatric patients ≥4 years of age with classic congenital adrenal hyperplasia
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: • 25, 50 & 100 mg = 2 capsules per day • 50 mg/mL = 4 mL per day		
FORMULARY ALTERNATIVES: (MEDICARE): hydrocortisone tablets		

DRUG NAME: Ctexli™ (chenodiol) 250 mg tablets		**INDICATION:** For the treatment of adults with cerebrotendinous xanthomatosis (CTX)
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	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 3 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Dapsone 7.5% gel tube		**INDICATION:** For the topical treatment of acne vulgaris in patients ≥9 years of age
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): dapsone 5% gel (*requires step-edit); (MEDICAID): Acne Medication gel/lotion, benzoyl peroxide wash/cream/gel/lotion (OTC), clindacin ETZ 1% pledget, clindamycin ph 1% solution/pledget/swab/gel, clindamycin/benzoyl peroxide (Duac®), erythromycin solution, Panoxyl 4 Acne Cream Wash (OTC), Panoxyl 10 cleansing bar/foaming wash (OTC); (MEDICARE): tretinoin cream/gel, clindamycin gel/solution		

DRUG NAME: Dolobid (diflunisal) 250 & 375 mg tablets		**INDICATION:** For the treatment of osteoarthritis and RA; For the treatment of mild to moderate 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	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 2 tablets per day, both strengths		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic diflunisal 500 mg tablets; (MEDICAID): diclofenac sodium, ibuprofen tablets, meloxicam tablets, naproxen tablets, sulindac; (MEDICARE): generic diflunisal 500 mg tablets		

DRUG NAME: Edurant® PED (rilpivirine) tablets for oral suspension		**INDICATION:** For use in combination with other antiretroviral agents for the treatment of human immunodeficiency virus (HIV)-1 infection in treatment-naïve patients 2 years of age and older and weighing at least 14 kg with HIV-1 RNA less than or equal to 100,000 copies/mL
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	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)
MEDICARE FORMULARY	Specialty (Tier 5)	N/A
QUANTITY LIMIT: (COMMERCIAL): 6 tablets per day		
FORMULARY ALTERNATIVES: (MEDICAID): Brand Edurant® tablets		

DRUG NAME: Encelto™ (revakinagene taroretcel-lwey) implant, for intravitreal use		**INDICATION:** For the treatment of adults with idiopathic macular 13 telangiectasia type 2 (MacTel)
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: Ensacove™ (ensartinib) 25 & 100 mg capsules		**INDICATION:** For the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced or metastatic non-small cell lung cancer (NSCLC) who have not previously received an ALK-inhibitor
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 25 mg – 2 capsule per day • 100 mg – 2 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Epysqli® (eculizumab-aagh)		**INDICATION:** Biosimilar to AstraZeneca's Soliris® (eculizumab)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Ferric citrate 210 mg tablets (Auryxia® ABA)</td><td>INDICATION: For the control of serum phosphorus levels in patients with chronic kidney disease (CKD) receiving dialysis and for the treatment of iron deficiency anemia in patients with CKD not on dialysis</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>Tier 2</td><td>Step-Edit, 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>Medicare Part B Benefit - Dialysis Bundle</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: 12 tablets per day</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): calcium acetate 667mg capsules/tablets & sevelamer carbonate tablets; (MEDICAID): calcium acetate 667mg cap, calcium acetate 668 mg, sevelamer carbonate tab</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Grafapex™ (treosulfan) 1- & 5-gram vial for injection, for intravenous use		**INDICATION:** For use in combination with fludarabine as a preparative regimen for allogeneic hematopoietic stem cell transplantation (alloHSCT) in adult and pediatric patients 1 year of age and older with acute myeloid leukemia (AML); For use in combination with fludarabine as a preparative regimen for allogeneic hematopoietic stem cell transplantation in adult and pediatric patients 1 year of age and older with myelodysplastic syndrome (MDS)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: HemiClor™ (chlorthalidone) 12.5 mg tablets		**INDICATION:** For use as adjunctive treatment (e.g., added to loop diuretics) of edema associated with heart failure, renal impairment, hepatic cirrhosis, or corticosteroid and estrogen therapy and for the management 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	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: generic chlorthalidone 25 mg tablets		

DRUG NAME: Hemophilia Factor Drugs (e.g., Hemophilia A - Adynovate®, Advate®, Afstyla®, Alphanate®, Altuviiio®, Eloctate®, Esperoct®, Jivi®, Hemofil M, Humate-P®, Koate®, Kogenate®, Kovaltry®, Novoeight®, Nuwiq®, Obizur®, Recombinate®, Wilate®, Xyntha®; Hemophilia B - AlphaNine SD®, Alprolix®, BeneFIX®, Idelvion®, Ixinity®, Profilnine®, Rebinyn®, Rixubis®; Hemophilia A or B - NovoSeven® RT, Sevenfact®)		**INDICATION:** For use in the prevention and control of bleeding episodes, surgical prophylaxis and/or routine prophylactic treatment to prevent or reduce the frequency of bleeding episodes in patients with hemophilia A or B where indicated
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	N/A	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: ivermectin 6 mg tablets</td><td>INDICATION: For the treatment of onchocerciasis due to the immature form of Onchocerca volvulus and for the treatment of intestinal (e.g., nondisseminated) strongyloidiasis due to Strongyloides stercoralis.</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>Formulary</td><td>Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL): 10 tablets per 90 days
(MEDIACID): 4 tablets per 90 days
(MEDICARE): N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL) ivermectin 3 mg tablets; (MEDICARE) ivermectin 3 mg tablets</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Jubbonti® (denosumab-bbdz) injection 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>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>N/A (PHARMACY)</td></tr>
<tr><td rowspan="2">MEDICARE FORMULARY</td><td>Medical Benefit</td><td>N/A (MEDICAL)</td></tr>
<tr><td>Specialty (Tier 5)</td><td>Prior Authorization, Quantity Limit (PHARMACY)</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: 1 syringe per 180 days</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Ketoprofen 50 mg capsules		**INDICATION:** For the management of the signs and symptoms of osteoarthritis; For the management of pain; For the treatment of primary dysmenorrhea; For the management of the signs and symptoms of rheumatoid arthritis
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 4 capsules per day		
FORMULARY ALTERNATIVES: (MEDICAID): diclofenac sodium, ibuprofen tablets, meloxicam tablets, naproxen tablets, sulindac; (MEDICARE) generic ibuprofen tablets		

DRUG NAME: Lithium 8 mEq/5 mL solution		**INDICATION:** For the treatment of acute mania, acute episodes with mixed features, and maintenance treatment in patients ≥7 years of age with a diagnosis of bipolar disorder
REASON FOR CHANGE: 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 1	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) lithium carbonate IR capsules/ER tablets; (MEDICAID) lithium carbonate IR capsules/ER tablets		

DRUG NAME: Lutrate® Depot (leuprolide acetate for depot suspension) 22.5 mg		**INDICATION:** For the treatment of advanced prostate cancer
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 vial per 84 days		
FORMULARY ALTERNATIVES: (MEDICARE): Lupron Depot® 22.5 mg kit (*requires prior authorization)		

DRUG NAME: Lutrate Depot (leuprolide acetate for depot suspension) 22.5 mg		**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: Neffy (epinephrine nasal spray) 1 mg/0.1 mL		**INDICATION:** For emergency treatment of type I allergic reactions, including anaphylaxis, in adult and pediatric patients aged 4 years and older who weigh 15 kg or greater.
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic epinephrine 0.15 (Epipen® Jr); (MEDICAID): epinephrine 0.15 mg (authorized generic EpiPen® Jr), Epipen® Jr; (MEDICARE): generic epinephrine 0.15 (Epipen® Jr)		

DRUG NAME: Onapgo™ (apomorphine) injection, for subcutaneous use		**INDICATION:** For the treatment of motor fluctuations in adults with advanced Parkinson's disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 6 cartons (30 cartridges; 600 mL) per 30 days		
FORMULARY ALTERNATIVES: (MEDICARE): Apokyn® (apomorphine) – Medical part B benefit		

DRUG NAME: Onapgo™ (apomorphine) injection, for subcutaneous use		**INDICATION:** For the treatment of motor fluctuations in adults with advanced Parkinson's disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Paxlovid™ (nirmatrelvir and ritonavir) 300/150-100 mg tablet therapy pack (severe renal impairment)		**INDICATION:** For the treatment of mild to moderate COVID-19 in adults who are at high risk for progression to severe COVID-19, including hospitalization or death
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Quantity Limit
STANDARD FORMULARY	Tier 2	Quantity Limit
EXCHANGE FORMULARY	Tier 2	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 22 tablets (2 packs) per 365 days • (MEDICAID): 22 tablets (2 packs) per 365 days • (MEDICARE): 11 tablets (1 pack) per 5 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: All Pemtrexed injections (MFG: Accord, Bluepoint Hospira, Sandoz,) & Pemetrexed ditromethamine		**INDICATION:** For use in combination with cisplatin for the initial treatment of patients with locally advanced or metastatic, non-squamous NSCLC; For use as a single agent for the maintenance treatment of patients with locally advanced or metastatic, non-squamous NSCLC whose disease has not progressed after four cycles of platinum-based first-line chemotherapy; For use as a single agent for the treatment of patients with recurrent, metastatic non-squamous, NSCLC after prior chemotherapy. For use in combination with cisplatin, for the initial treatment of patients with malignant pleural mesothelioma whose disease is unresectable or who are otherwise not candidates for curative surgery
REASON FOR CHANGE: 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	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: penpulimab-kcqx injection		**INDICATION:** For use in combination with either cisplatin or carboplatin and gemcitabine, to treat adults with recurrent or metastatic non-keratinizing nasopharyngeal carcinoma (NPC), or as a single agent while on or after platinum-based chemotherapy and at least one other prior line of therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Priftin® (rifapentine) tablets		**INDICATION:** A rifamycin antimycobacterial drug indicated in patients 12 years of age and older for the treatment of active pulmonary tuberculosis (TB) caused by Mycobacterium tuberculosis in combination with one or more antituberculosis (anti-TB) drugs to which the isolate is susceptible; For the treatment of latent tuberculosis infection (LTBI) caused by M. tuberculosis in combination with isoniazid in patients 2 years of age and older at high risk of progression to TB disease
REASON FOR CHANGE: Change Drug Tier and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Quantity Limit
STANDARD FORMULARY	Tier 3	Quantity Limit
EXCHANGE FORMULARY	Tier 3	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: 8 tablets per day; 952 tablets per 119 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Qfitlia™ (fitusiran) injection, for subcutaneous use, 50 mg/0.5 mL single-dose prefilled pen & 20 mg/0.2 mL single-dose vial		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients aged 12 years and older with hemophilia A or B with or without factor VIII or IX inhibitors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: • 0.5 mL (1 pen) per 28 days • 0.2 mL (1 vial) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Qfitlia™ (fitusiran) injection, for subcutaneous use, 50 mg/0.5 mL single-dose prefilled pen & 20 mg/0.2 mL single-dose vial		**INDICATION:** For routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients aged 12 years and older with hemophilia A or B with or without factor VIII or IX inhibitors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria) **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rapiblyk™ (landiolol) for injection, for intravenous use		**INDICATION:** For the short-term reduction of ventricular rate in adults with supraventricular tachycardia including atrial fibrillation and atrial flutter
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 B	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: Revuforj® (revumenib) 25 mg tablets		**INDICATION:** For the treatment of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation in adult and pediatric patients 1 year and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 8 tablets per day		
FORMULARY ALTERNATIVES: N/A		

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

DRUG NAME: RSV vaccines: Abrysvo® & Arexvy (respiratory syncytial virus vaccine) only		**INDICATION:** For active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in adults 50 – 59 years of age who are at increased risk of severe respiratory syncytial virus (RSV) disease. ACIP recommends expanded use.
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: 1 injection per lifetime		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ryoncil® (remestemcel-L-rknd) suspension for intravenous infusion		**INDICATION:** For the treatment of steroid-refractory acute graft versus host disease (SR-aGvHD) in pediatric patients 2 months of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Sevenfact® [coagulation factor VIIa (recombinant)-jncw] Lyophilized Powder for Solution, for Intravenous Use, 2 mg vial		**INDICATION:** For the treatment and control of bleeding episodes in adults and adolescents ≥12 years of age with hemophilia A or B with inhibitors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Simlandi® (adalimumab-ryvk) 80 mg/0.8 mL auto-injector		**INDICATION:** Humira Biosimilar FDA approved to treat seven inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older and moderate-to-severe ulcerative colitis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY **(Fully Insured)**	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY **(Self Funded)**	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY **(Fully Insured)**	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY **(Self Funded)**	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 2 syringes per 28 days		
FORMULARY ALTERNATIVES: (COMMERCIAL) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty), Simlandi (adalimumab-ryvk); (MEDICIAD) Humira pen/syringe (Abbvie mfg only); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

DRUG NAME: Sirturo® (bedaquiline) tablets, all strengths		**INDICATION:** For the treatment of pulmonary tuberculosis (TB) resistant to at least rifampin and isoniazid, as part of combination therapy, in pediatric patients ≥5 years of age (weighing ≥15 kg) and adults
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: • 100 mg – 188 tablets per 168 days • 20 mg – 940 tablets per 168 days		
FORMULARY ALTERNATIVES: isoniazid tablets, ethambutol tablets, rifampin capsules		

DRUG NAME: Tepylute® (thiotepa) 15 mg/1.5 mL & 100 mg/10 mL multi-dose vials for intravenous injection		**INDICATION:** For the treatment of adenocarcinoma of the breast or ovary
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Tremfya® (guselkumab) Induction Pack for Crohn's Disease		**INDICATION:** For the treatment of adult patients with moderately to severely active Crohn's disease (CD)
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: 12 mL (3 cartons) per 365 days		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®)		

DRUG NAME: Tremfya® (guselkumab) 100 mg/mL pen		**INDICATION:** For the treatment of adult patients with: moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy, active psoriatic arthritis, moderately to severely active ulcerative colitis, & moderately to severely active Crohn's disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 1 mL (1 pen) per 56 days • (MEDIACID): 1 mL (1 pen) per 56 days • (MEDICARE): 2 mL (2 pens) per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®)		

DRUG NAME: Tezruly™ (terazosin) 1 mg/mL oral solution		**INDICATION:** For the treatment of signs and symptoms of benign prostatic hyperplasia (BPH), and for the treatment of hypertension alone or with other antihypertensive agents, to lower blood pressure
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 10 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL) generic terazosin capsules; (MEDICIAD) generic terazosin capsules); (MEDICARE) generic terazosin capsules		

DRUG NAME: umeclidinium-vilanterol 62.25 inhalation (Anoro Ellipta® ABA)		**INDICATION:** For the maintenance treatment of patients with chronic obstructive pulmonary disease
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): Brand Anoro Ellipta®; (MEDICAID): Brand Anoro Ellipta®,(MEDICARE): Brand Anoro Ellipta®		

DRUG NAME: Vanrafia™ (atrasentan) 0.75 mg tablets		**INDICATION:** For use to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: (MEDICARE): Filspari® (sparsentan) *requires prior authorization		

DRUG NAME: Vykat™ XR (diazoxide choline) 25, 75 & 150 mg extended-release tablets		**INDICATION:** For the treatment of hyperphagia in adults andpediatric patients 4 years of age and older with Prader-Willi syndrome (PWS)
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: • 25 mg – 4 tablets per day • 75 mg – 7 tablets per day • 150 mg – 3 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vyloy® (zolbetuximab-clzb) 300 mg lyophilized powder in a single-dose vial for IV infusion		**INDICATION:** For use in combination with fluoropyrimidine- and platinum-containing chemotherapy for the first-line treatment of adults with locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative gastric or gastroesophageal junction adenocarcinoma whose tumors are claudin (CLDN) 18.2 positive as determined by an FDA-approved test
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Vyvgart Hytrulo® (efgartigimod alfa/hyaluronidase-qvfc) injection for subcutaneous use, 1,000 mg efgartigimod alfa and 10,000 units hyaluronidase per 5 mL (200 mg/2,000 units per mL) in a single-dose prefilled syringe		**INDICATION:** For the treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive and chronic inflammatory demyelinating polyneuropathy (CIDP)
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 syringes per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Wyost® (denosumab-bbdz) 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial		**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
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**)
	Formulary	N/A **(PHARMACY)**
MEDICARE FORMULARY	Medical Benefit	N/A **(MEDICAL)**
	Specialty (Tier 5)	Prior Authorization **(PHARMACY)**
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: October 1, 2025

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

DRUG NAME: Xelria FE (norethindrone-ethinyl estradiol/iron) 0.4-0.035 mg chewable tablets		**INDICATION:** For the prevention of pregnancy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 1	N/A
STANDARD FORMULARY	Tier 1	N/A
EXCHANGE FORMULARY	Tier 1	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): NORETH-EE-FE 1.5-0.03MG(21)-75, NORETH-EE-FE 1-0.02(21)-75 TAB, NORETH-EE-FE 1-0.02(24)-75 CHW; (MEDICARE): NORETH-EE-FE 1.5-0.03MG(21)-75, NORETH-EE-FE 1-0.02(21)-75 TAB		

DRUG NAME: Xpovio® (selinexor) 10 mg tablets		**INDICATION:** For use in combination with bortezomib and dexamethasone for the treatment of adult patients with multiple myeloma who have received at least one prior therapy; For use in combination with dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior therapies and whose disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody; For the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, after at least 2 lines of 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: 16 tablets per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Xromi (hydroxyurea) 100 mg/mL oral solution		**INDICATION:** For use to reduce the frequency of painful crises and reduce the need for blood transfusions in pediatric patients 6 months of age and older with sickle cell anemia with recurrent moderate to severe painful crises
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Age-Edit ≥ 9 years of age
STANDARD FORMULARY	Non-Formulary	Age-Edit ≥ 9 years of age
EXCHANGE FORMULARY	Non-Formulary	Age-Edit ≥ 9 years of age
FAMIS FORMULARY	Non-Formulary	Age-Edit ≥ 9 years of age
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Droxia capsules & generic hydroxyurea 500 mg capsules; (MEDICAID): Siklos; (MEDICARE): generic hydroxyurea 500 mg capsules		

<table>
<tr><td colspan="2">DRUG NAME: Zevtera® (ceftobiprole medocaril sodium for injection), for intravenous use, 667 mg vial</td><td>INDICATION: For the treatment of Staphylococcus aureus bloodstream infection (bacteremia) in adults, including those with right-sided infective endocarditis, caused by methicillin-susceptible and methicillin-resistant isolates; For the treatment of community-acquired bacterial pneumonia in adult and pediatric patients ≥3 months of age, caused by susceptible isolates of S. aureus (methicillin-susceptible isolates), Streptococcus pneumoniae, Haemophilus influenzae, Haemophilus parainfluenzae, Escherichia coli, and Klebsiella pneumoniae; For the treatment of acute bacterial skin and skin structure infections in adults, caused by susceptible isolates of S. aureus (methicillin-susceptible and methicillin-resistant isolates), Streptococcus pyogenes, and K. pneumoniae</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

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Effective: October 1, 2025

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DRUG NAME: Zunveyl® (benzgalantamine) 5, 10 & 15 mg delayed-release tablets		**INDICATION:** For the treatment of mild to moderate dementia of the Alzheimer's type 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: 2 tablets per day (all strengths)		
FORMULARY ALTERNATIVES: (COMMERCIAL): galantamine IR/ER tablets; (MEDICAID): donepezil ODT & tab rivastigmine (transdermal patch; (MEDICARE): galantamine IR/ER tablets		