Sentara Health Plans Pharmacy Changes

Effective: October 1, 2026

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

DRUG NAME: Arynta™ (lisdexamfetamine dimesylate) 10 mg/mL oral solution		**INDICATION:** For the treatment of attention deficit hyperactivity disorder (ADHD) in adults and patients 6 years and older; moderate to severe binge eating disorder (BED) in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 7 mL per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): generic lisdexamfetamine capsules/chewable tablets; (MEDICAID): Brand Vyvanse; (MEDICARE): amphetamine salts combo (generic for Adderall IR), amphetamine salts combo XR (generic for Adderall XR)		

DRUG NAME: Atmeksi® (methocarbamol) 750 mg/5 mL suspension		**INDICATION:** As an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions in patients 16 and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 30 mL per day		
FORMULARY ALTERNATIVES: generic methocarbamol tablets		

DRUG NAME: Avlayah™ (tividenofusp alfa-eknm) 150mg vial		**INDICATION:** For the treatment of neurologic manifestations of Hunter syndrome (Mucopolysaccharidosis type II, MPS II) when initiated in presymptomatic or symptomatic pediatric patients weighing ≥5 kg prior to advanced neurologic impairment
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: azilsartan medoxomil tablet – 40 and 80 mg (Edarbi ABA)		**INDICATION:** For the management of hypertension in adults
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	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): irbesartan, losartan, olmesartan, telmisartan, valsartan; (MEDICAID): irbesartan, losartan, olmesartan, sacubitril/valsartan, telmisartan, valsartan; (MEDICARE): candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan		

DRUG NAME: Byqlovi (clobetasol propionate) 0.05% ophthalmic suspension		**INDICATION:** For the treatment of postoperative inflammation and pain following ocular surgery
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): dexamethasone 0.1% eye drop, fluorometholone 0.1% eye drop, loteprednol 0.5% drops, prednisolone acetate 1% eye drops; (MEDICAID): Durezol 0.05% eye drops, prednisolone acetate 1% eye drops		

DRUG NAME: Cardamyst™ (etripamil) nasal spray		**INDICATION:** For the conversion of acute symptomatic episodes of paroxysmal supraventricular tachycardia to sinus rhythm in adults
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	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL& MEDICAID) 2 cartons (4 devices) per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Cipotrex (calcipotriene) 0.005% cream and hydrofilm dressing kit		**INDICATION:** For the treatment of plaque psoriasis
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: calcipotriene 0.005% cream/ointment/solution		

DRUG NAME: clonidine hydrochloride 0.05 mg tablet		**INDICATION:** For the management of hypertension; Treatment of attention-deficit/hyperactivity disorder (monotherapy or as adjunctive therapy) in pediatric patients ≥6 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 4 tablets per day		
FORMULARY ALTERNATIVES: clonidine HCl 0.1 mg tablets		

DRUG NAME: Contepo® (fosfomycin) 6 gram in a single-dose vial		**INDICATION:** For the treatment of patients 18 years and older with complicated urinary tract infections (cUTI), including acute pyelonephritis, caused by susceptible isolates of *Escherichia coli* and *Klebsiella pneumoniae*
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: Desmoda™ (desmopressin) 0.05 mg/mL oral solution		**INDICATION:** For the management of central diabetes insipidus (arginine vasopressin deficiency) as antidiuretic replacement therapy in patients of all ages
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICARE): 24 mL per day		
FORMULARY ALTERNATIVES: desmopressin acetate 0.1 mg and 0.2 mg tablets		

DRUG NAME: Dexcom G7 15 Day sensor		**INDICATION:** A real time, continuous glucose monitoring device indicated for the management of diabetes in persons 18 years and older
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	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Medicare Part B	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 sensors per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Edarbi® (azilsartan medoxomil) tablet – 40 and 80 mg		**INDICATION:** For the management of hypertension in adults
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): irbesartan, losartan, olmesartan, telmisartan, valsartan; (MEDICAID): sacubitril/valsartan, irbesartan, losartan, olmesartan, telmisartan, valsartan; (MEDICARE): candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan		

DRUG NAME: Egrifta® (tesamorelin for injection), for subcutaneous use – 11.6 mg WR kit and 2 mg SV solution		**INDICATION:** For the reduction of excess abdominal fat in HIV-infected adults with lipodystrophy
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formlary	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formlary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formlary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formlary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): • SV – 1 vial per day • WR – 4 vials per month		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Epioxa (riboflavin 5'-phosphate ophthalmic solution) 0.177%, for topical ophthalmic use		**INDICATION:** For use in epithelium-on corneal collagen cross-linking for the treatment of keratoconus in adults and pediatric patients aged 13 years and older, in conjunction with the O2n System and the Boost Goggles
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: Fesilty™ (fibrinogen, human-chmt), lyophilized powder for reconstitution, for intravenous use		**INDICATION:** For the treatment of acute bleeding episodes in pediatric and adult patients with congenital fibrinogen deficiency, including hypo- or afibrinogenemia
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: Foundayo™ (orforglipron) tablets – 0.8, 2.5, 5.5, 9, 14.5 & 17.2 mg		**INDICATION:** For use in combination with a reduced-calorie diet and increased physical activity to reduce excess body weight and maintain weight reduction long term in adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3 – Group Specific Benefit	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3 – Group Specific Benefit	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non- Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): orlistat, Xenical, phendimetrazine IR and ER, phentermine, benzphetamine, diethylpropion IR and ER		

DRUG NAME: Granisol (granisetron) 2 mg/10 mL oral solution		**INDICATION:** For the prevention of nausea and vomiting associated with initial and repeat courses of emetogenic cancer therapy, including high-dose cisplatin; nausea and vomiting associated with radiation, including total body irradiation and fractionated abdominal radiation
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 50 mL (10 mg) per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): generic granisetron tablet; (MEDICAID): ondansetron ODT/solution/tablet		

DRUG NAME: halobetasol propionate 0.05% lotion		**INDICATION:** For the treatment of plaque psoriasis in patients 12 years of age and older; relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICAID): halobetasol propionate 0.05% cream; (MEDICARE): halobetasol propionate 0.05% cream/ointment		

DRUG NAME: Juxtapid® (lomitapide) 2 mg capsules		**INDICATION:** A microsomal triglyceride transfer protein inhibitor indicated as an adjunct to a low-fat diet and exercise and other low-density lipoprotein cholesterol (LDL-C) therapies, to reduce LDL-C in adult and pediatric patients aged 2 years and older with HoFH
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 capsule per day		
FORMULARY ALTERNATIVES: generic atorvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin tablets		

DRUG NAME: Juxtapid (lomitapide) capsules – 5, 10, 20 & 30 mg		**INDICATION:** A microsomal triglyceride transfer protein inhibitor indicated as an adjunct to a low-fat diet and exercise and other low-density lipoprotein cholesterol (LDL-C) therapies, to reduce LDL-C in adult and pediatric patients aged 2 years and older with HoFH
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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • 5 & 10 mg – 1 capsule per day • 20 & 30 mg – 2 capsules per day		
FORMULARY ALTERNATIVES: generic atorvastatin, lovastatin, pravastatin, simvastatin or rosuvastatin tablets		

DRUG NAME: Kygevvi® (doxecitine-doxribtimine) 2 g-2 g powder, for oral solution		**INDICATION:** For the treatment of thymidine kinase 2 deficiency (TK2d) in adults and children whose symptoms started when they were 12 years of age or younger
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 16 packets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lerochol™ (lerodalcibep-liga) 300 mg/1.2 mL (250 mg/mL) solution in a single-dose prefilled syringe		**INDICATION:** For use as an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDLC) in adults with hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 300 mg (1 syringe) per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): Repatha® (requires prior authorization); (MEDICAID): Leqvio®, Praluent®, Repatha® (all require prior authorization)		

DRUG NAME: Lifyorli™ (relacorilant) capsule – 125 and 150 mg dose packs		**INDICATION:** For use in combination with nab-paclitaxel for the treatment of adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received one to three prior systemic treatment regimens, at least one of which included bevacizumab
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 125 mg dose pack - 18 capsules (3 cartons) per 28 days • 150 mg dose pack - 27 capsules (3 cartons) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Loargys® (pegzilarginase-nbln) 2mg/0.4mL and 5mg/mL in a single-dose vial		**INDICATION:** For the treatment of hyperargininemia in adult and pediatric patients 2 years of age and older with arginase 1 deficiency (ARG1-D), in conjunction with dietary protein restriction
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: Neulasta (pegfilgrastim) 4 mg/0.4mL vial		**INDICATION:** For use to increase survival in patients acutely exposed to myelosuppressive doses of radiation. To decrease the incidence of infection (as manifested by febrile neutropenia), in patients with nonmyeloid malignancies receiving myelosuppressive cancer chemotherapy associated with a clinically significant incidence of febrile neutropenia
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	Non-Formulary	Prior Authorization (PDL Criteria) **PHARMACY**
	Medical Benefit	N/A **MEDICAL**
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Neupogen disp syringe/vial		

DRUG NAME: Ozempic® (semaglutide) tablets – 1.5, 4 & 9 mg		**INDICATION:** For use as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (T2DM) and to reduce the risk of major adverse cardiovascular (CV) events (MACE) (CV death, nonfatal myocardial infarction or non-fatal stroke) in adults with T2DM who are at high risk for these events
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Formulary	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 1.5 mg – 30 tablets per 365 days • 4 & 9 mg – 1 tablet per day		
FORMULARY ALTERNATIVES: (MEDICAID): Trulicity™, Victoza®		

DRUG NAME: propranolol-hydrochlorothiazide tablets – all strengths (40-25mg, 80-25mg)		**INDICATION:** For the treatment of hypertension
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	N/A
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): propranolol tablets, hydrochlorothiazide tablets; (MEDICAID): atenolol/chlorthalidone, bisoprolol/HCTZ		

DRUG NAME: Relgaabi (gabapentin) 200 mg capsules		**INDICATION:** For the management of postherpetic neuralgia in adults; Adjunctive therapy in the treatment of partial onset seizures, with and without secondary generalization, in adults and pediatric patients 3 years and older with epilepsy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID) 3 capsules per day		
FORMULARY ALTERNATIVES: gabapentin 100, 300 & 400 mg capsule; gabapentin 600 & 800 mg tablet; gabapentin 250 mg/5 mL solution		

DRUG NAME: Saphnelo® (anifrolumab-fnia) 120 mg/0.8 mL single-dose pen for subcutaneous injection		**INDICATION:** For the treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE), who are receiving standard 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	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 4 pens per 28 days		
FORMULARY ALTERNATIVES: (MEDICARE): Benlysta injection *requires prior authorization*		

DRUG NAME: Spinraza® (nusinersen) vial – 28 mg/5 mL and 50 mg/mL		**INDICATION:** For the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients
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	Prior Authorization (PDL Criteria) **PHARMACY**
	Medical Benefit	Prior Authorization **MEDICAL**
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

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

DRUG NAME: tolectin DS 400 mg capsules		**INDICATION:** For the treatment of juvenile rheumatoid arthritis (JRA) in pediatric patients ≥2 years; For the relief of signs and symptoms of rheumatoid and osteoarthritis, including acute flares and the long-term management of the chronic 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 & MEDICARE): diclofenac sodium, ketorolac, sulindac, etodolac, indomethacin; (MEDICAID): diclofenac sodium, ibuprofen cap, ibuprofen tab 100mg, 200mg, 400mg, 600mg, 800mg (OTC & Rx), meloxicam tab, naproxen tab, naproxen sodium (OTC), naproxen EC (Rx), sulindac		

DRUG NAME: Umeclidinium Ellipta 62.5 mcg inhalation powder (Incruse AG)		**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), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL): 1 inhaler per 30 days		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDIARE): Brand Incruse® Ellipta®, Spiriva® Respimat®; (MEDICAID): Spiriva® Handihaler, Spiriva® Respimat®		

DRUG NAME: Vabrinty (leuprolide aceteate) 7.5 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 aceteate) 7.5 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: (COMMERCIAL & MEDICAID): 7.5 mg – 1 kit per 28 days		
FORMULARY ALTERNATIVES: Eligard (*requires prior authorization)		

DRUG NAME: Wainua® (eplontersen) 45 mg/0.8mL syringe		**INDICATION:** For the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis 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	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 syringe per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Wegovy® (semaglutide) – 1.5, 4, 9 & 25 mg tablets		**INDICATION:** For use in combination with a reduced calorie diet and increased physical activity: To reduce the risk of major adverse cardiovascular (CV) events (MACE) (CV death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established CV disease and either obesity or overweight; To reduce excess body weight and maintain weight reduction long term in adults with obesity, or in adults with overweight in the presence of at least one weight-related comorbid condition
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3 – Group Specific Benefit	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3 – Group Specific Benefit	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day (all strengths)		
FORMULARY ALTERNATIVES: (MEDICAID): orlistat, Xenical, phendimetrazine IR and ER, phentermine, benzphetamine, diethylpropion IR and ER		

DRUG NAME: Wegovy® (semaglutide) HD 7.2 mg/0.75 mL pen		**INDICATION:** For use in combination with a reduced calorie diet and increased physical activity to reduce excess body weight and maintain weight reduction long term in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3 – Group Specific Benefit	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3 – Group Specific Benefit	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 3 mL per 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): orlistat, Xenical, phendimetrazine IR and ER, phentermine, benzphetamine, diethylpropion IR and ER		

DRUG NAME: Widaplik (telmisartan-amlodipine-indapamide) tablets, 10-1.25-0.625 mg, 20-2.5-1.25 mg & 40-5-2.5 mg		**INDICATION:** For the treatment of hypertension 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	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 tablet per day		
FORMULARY ALTERNATIVES: (COMMERCIAL & MEDICARE): telmisartan tablet, amlodipine tablet, indapamide tablet; (MEDICAID): telmisartan tablet, amlodipine tablet, indapamide tablet, amlodipine/olmesartan		

DRUG NAME: Yuvezzi™ (carbachol/brimonidine tartrate) 2.75%-0.1% eye drop in a single-dose vial		**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), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): 1 vial per day		
FORMULARY ALTERNATIVES: pilocarpine 1, 2, and 4% ophthalmic drops		

DRUG NAME: Yuviwel® (navepegritide) lyophilized powder in a single-dose vial for reconstitution, all strengths – 1.3, 2.8 & 5.5 mg		**INDICATION:** To increase linear growth in pediatric patients ≥2 years of age with achondroplasia with open epiphyses
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: (COMMERCIAL & MEDICAID): • 1.3 & 2.8 mg vials – 4 kits (1 carton) per 28 days • 5.5 mg vial – 8 kits (2 cartons) per 28 days		
FORMULARY ALTERNATIVES: N/A		