

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: adalimumab-aacf (CF) Crohn 40 mg		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: N/A		
<ul style="list-style-type: none"> • (COMMERCIAL): 3 kits per 365 days • (MEDICAID): 3 kits per 365 days • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (COMMERCIAL) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); HIX/SG 2024 & 25 – Simlandi (adalimumab-ryvk) and adalimumab-adbm; (MEDICAID) Humira pen/syringe (Abbvie mfg only); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: adalimumab-aacf (CF) PS-UV 40 mg	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:		
<ul style="list-style-type: none"> • (COMMERCIAL) 2 kits per 365 days • (MEDICAID): 2 kits per 365 days • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (COMMERCIAL) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); HIX/SG 2024 & 25 – Simlandi (adalimumab-ryvk) and adalimumab-adbm; (MEDICAID) Humira pen/syringe (Abbvie mfg only); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Aqneursa™ (levacetylleucine) for oral suspension: 1-gram levacetylleucine in a unit-dose packet		INDICATION: Treatment of neurological manifestations of Niemann-Pick disease type C (NPC) in adults and pediatric patients weighing ≥15 kg
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 grams per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Augtyro™ (reprotrectinib) 40 mg capsules		INDICATION: For the treatment of adult patients with locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC); Adult and pediatric patients 12 years of age and older with solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion and are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity; or have progressed following treatment or have no satisfactory alternative therapy
REASON FOR CHANGE: Change Drug Tier 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	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT:		
<ul style="list-style-type: none"> • (COMMERCIAL): 6 capsules per day • (MEDICAID): 6 capsules per day • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Augtyro™ (repotrectinib) 160 mg capsules		INDICATION: For the treatment of adult patients with locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC); Adult and pediatric patients 12 years of age and older with solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion and are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity; or have progressed following treatment or have no satisfactory alternative therapy
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Aurlumyn™ (iloprost) injection concentrate, for IV use 100 mcg/mL		INDICATION: For the treatment of severe frostbite in adults to reduce the risk of digit amputation
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		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: carbamazepine 200 mg chewable tablets		INDICATION: For use as monotherapy in the acute treatment of hypomania and mild to moderate mania or episodes with mixed features associated with bipolar disorder; For use as monotherapy and adjunctive therapy in the treatment of patients with focal onset seizures and generalized onset seizures; For the treatment of trigeminal or glossopharyngeal neuralgia
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL) carbamazepine 100 mg chewable tablets; (MEDICARE) carbamazepine 100 mg chewable tablets		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Cobenfy™ (xanomeline and tropisium hydrochloride) capsules (all strengths)		INDICATION: For the treatment of schizophrenia 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	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: <ul style="list-style-type: none"> • (COMMERCIAL): <ul style="list-style-type: none"> • 2 capsules per day (all strengths) • 56 capsules (1 starter pack) per 365 days • (MEDICAID): <ul style="list-style-type: none"> • 2 capsules per day (all strengths) • 56 capsules (1 starter pack) per 365 days • (MEDICARE): <ul style="list-style-type: none"> • 2 capsules per day (all strengths) • 56 capsules (1 starter pack) per 180 days 		
FORMULARY ALTERNATIVES: (COMMERCIAL): aripiprazole tablets, clozapine tablets, olanzapine tablets, quetiapine IR/ER tablets, risperidone tablets/solution, ziprasidone capsules; (MEDICAID): aripiprazole tab, clozapine tab, lurasidone, olanzapine ODT/tab/IM, quetiapine fumarate ER, quetiapine tab, risperidone ODT/ soln/ tab, Vraylar™, ziprasidone cap		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Crexont (carbidopa and levodopa) extended-release capsules, for oral use (all strengths) 35 mg / 140 mg, 52.5 mg / 210 mg, 70 mg / 280 mg, 87.5 mg / 350 mg		INDICATION: For the treatment of Parkinson's disease, post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication 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: N/A <ul style="list-style-type: none"> • (COMMERCIAL): 6 capsules per day (all strengths) • (MEDICAID): 6 capsules per day (all strengths) • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: carbidopa-levodopa ER 25-100 & 50-200 mg tablets		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Ebglyss™ (lebrikizumab-lbkz) 250 mg/2 mL single-dose prefilled pen/syringe with needle shield		INDICATION: For the treatment of moderate to severe atopic dermatitis in adults and pediatric patients ≥12 years of age weighing ≥40 kg whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
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:		
<ul style="list-style-type: none"> • (COMMERCIAL): 1 injection per 28 days • (MEDICAID): 1 injection per 28 days • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (MEDICAID): Adbry™, Dupixent®, (both require prior authorization); (MEDICARE): Dupixent® (requires prior authorization)		

DRUG NAME: Femlyv™ (ethinyl estradiol and norethindrone acetate ODT) 1 mg – 0.02 mg		INDICATION: For pregnancy prevention
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: Aurovela, Junel, Larin, Loestrin, Microgestin, norethindrone-ethinyl estradiol tablets		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: FreeStyle Libre 2 plus sensors		INDICATION: The latest innovation to the existing FreeStyle Libre 2 system with the following new features/updates from the FreeStyle Libre 2 sensor: Extends the sensor wear up to 15 days, can work with insulin pumps & expands the age indication to 2 years and older. The FreeStyle Libre 2 Plus sensor is compatible with the current FreeStyle Libre 2 app and FreeStyle Libre 2 reader
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	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Medical Part B Benefit	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 sensors per 30 days		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Hyrimoz (adalimumab-adaz) (CF) all strengths & formulations		INDICATION: Humira Biosimilar FDA approved to treat nine inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe hidradenitis suppurativa in adults, treatment of non-infectious intermediate, posterior, and panuveitis in adults
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: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); HIX/SG 2024 & 25 – Simlandi (adalimumab-ryvk) and adalimumab-adbm; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Itovebi™ (inavolisib) tablets, all strengths		INDICATION: For use in combination with palbociclib and fulvestrant for the treatment of adults with endocrine-resistant, PIK3CA-mutated, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test, following recurrence on or after completing adjuvant endocrine 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:		
<ul style="list-style-type: none"> • 3 mg – 2 tablets per day • 9 mg – 1 tablet per day 		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lagevrio (monupiravir) 200 mg capsules		INDICATION: An investigational medicine used to treat adults with mild-to-moderate COVID-19 who are at risk for progression to severe COVID-19 including hospitalization or death, and for whom other COVID-19 treatment options approved or authorized by the FDA are not accessible or clinically appropriate
REASON FOR CHANGE: Exclude Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Excluded Benefit	N/A
STANDARD FORMULARY	Excluded Benefit	N/A
EXCHANGE FORMULARY	Excluded Benefit	N/A
FAMIS FORMULARY	Excluded Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Excluded Benefit	N/A
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: Paxlovid™ (nirmatrelvir/ritonavir) tablets		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Livdelzi (seladelpar) 10 mg capsules		INDICATION: For the treatment of primary biliary cholangitis in combination with ursodeoxycholic acid (UDCA) in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA
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: 1 capsule per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lumryz™ (sodium oxybate) for extended-release oral suspension 4.5-6-7.5 mg starter pack		INDICATION: For the treatment of cataplexy or excessive daytime sleepiness (EDS) in patients 7 years of age and older with narcolepsy
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:		
<ul style="list-style-type: none"> • (COMMERCIAL): 28 packets (1 pack) per 365 days • (MEDICAID): 28 packets (1 pack) per 365 days • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (MEDICARE) Xyrem & sodium oxybate solution (both require prior authorization)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Miplyffa™ (arimoclomol) capsules, all strengths		INDICATION: For use in combination with miglustat for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) in adult and pediatric patients 2 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 3 capsules per day (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Neffy (epinephrine nasal spray) 2 mg/0.1 mL of epinephrine per spray		INDICATION: For emergency treatment of type I allergic reactions, including anaphylaxis, in adult and pediatric patients who weigh 30 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) epinephrine 0.3 mg injection; (MEDICAID) epinephrine 0.3 mg (authorized generic EpiPen®), Brand Epipen®; (MEDICARE) epinephrine 0.3 mg injection		

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

DRUG NAME: Nemluvio™ (nemolizumab-ilto) for injection 30 mg		INDICATION: For the treatment of prurigo nodularis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT:		
<ul style="list-style-type: none"> • (COMMERCIAL): 1 injection (30 mg) per 28 days • (MEDICAID): 1 injection (30 mg) per 28 days • (MEDICARE): 2 injections (60 mg) per 28 days 		
FORMULARY ALTERNATIVES: (MEDICAID) Dupixent® (requires prior authorization)		

DRUG NAME: Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq) solution in a single-dose vial containing 20 mg ocrelizumab and 23,000 units hyaluronidase per 23 mL (40 mg and 1,000 units per mL)		INDICATION: For the treatment of primary progressive multiple sclerosis (MS) in adults and relapsing forms of MS, including clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease 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	Non-Formulary [Pharmacy]	Prior Authorization (PDL Criteria)
	Medical Benefit [Medical]	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Kesimpta® (requires ST);		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: oxycodone HCL abuse deterrent tablets (5, 10 & 30 mg)		INDICATION: For the management of acute or chronic moderate to severe pain when the use of an opioid analgesic is appropriate and for which alternative treatments are inadequate
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: oxycodone IR 10 mg tablets (*requires prior authorization)		

DRUG NAME: Roxybond (oxycodone HCL abuse deterrent tablets) 10 mg		INDICATION: For treatment of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. It is formulated with SentryBond™ abuse-deterrent technology which reduces potential abuse by intranasal and intravenous routes.
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: oxycodone IR 10 mg tablets (*requires prior authorization)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Tecelra® (afamitresgene autoleucl) suspension for IV infusion		INDICATION: For the treatment of adults with unresectable or metastatic synovial sarcoma who have received prior chemotherapy, are HLA-A*02:01P, -A*02:02P, -A*02:03P, or -A*02:06P positive and whose tumor expresses the MAGE-A4 antigen as determined by FDA-approved or cleared companion diagnostic devices
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: April 1, 2025

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

<p>DRUG NAME: Tecentriq Hybreza™ (atezolizumab/hyaluronidase-tqjs) subcutaneous injection 1875 mg/30,000 units</p>	<p>INDICATION: For the treatment (as a single agent) of unresectable or metastatic alveolar soft part sarcoma in adults; Treatment (in combination with bevacizumab) of unresectable or metastatic hepatocellular carcinoma in adults who have not received prior systemic therapy; Treatment (in combination with cobimetinib and vemurafenib) of BRAF V600 mutation-positive (as determined by an approved test) unresectable or metastatic melanoma in adults; Adjuvant treatment (as a single agent) following resection and platinum-based chemotherapy in adults with stage II to IIIA non-small cell lung cancer (NSCLC) whose tumors have PD-L1 expression on $\geq 1\%$ of tumor cells, as determined by an approved test; First-line treatment (as a single agent) of metastatic NSCLC in adults whose tumors have high PD-L1 expression (PD-L1 stained $\geq 50\%$ of tumor cells [TC] or PD-L1 stained tumor-infiltrating immune cells [IC] covering $\geq 10\%$ of the tumor area), as determined by an approved test, and with no EGFR or ALK genomic tumor aberrations; First-line treatment (in combination with bevacizumab, paclitaxel, and carboplatin) of metastatic nonsquamous NSCLC in adults with no EGFR or ALK genomic tumor aberrations; First-line treatment (in combination with paclitaxel [protein bound] and carboplatin) of metastatic nonsquamous NSCLC in adults with no EGFR or ALK genomic tumor aberrations; Treatment (as a single agent) of metastatic NSCLC in adults with disease progression during or following platinum-containing chemotherapy (patients with EGFR or ALK genomic aberrations should have disease progression on approved NSCLC therapy for EGFR or ALK genomic tumor mutations prior to receiving atezolizumab/hyaluronidase); First-line treatment (in combination with carboplatin and etoposide) of extensive-stage small cell lung cancer in adults</p>
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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 Health Plans Pharmacy Changes

Effective: April 1, 2025

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

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: Tofidence™ (tocilizumab-bavi) vial for intravenous administration, all strengths	INDICATION: Biogen’s manufacturer’s first FDA-approved biosimilar to IV Actemra. For use in adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs); Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (PJIA); Patients 2 years of age and older with active systemic juvenile idiopathic arthritis (SJIA)
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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 [Pharmacy]	Prior Authorization (PDL Criteria)
	Medical Benefit [Medical]	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization

QUANTITY LIMIT: N/A

FORMULARY ALTERNATIVES: (MEDICAID) Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®)

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Tremfya (guselkumab) 200 mg/20 mL (10 mg/mL) solution in a single-dose vial for intravenous infusion		INDICATION: For the treatment of adult patients with moderately to severely active ulcerative colitis (UC)
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 [Pharmacy]	Prior Authorization (PDL Criteria)
	Medical Benefit [Medical]	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID) Enbrel [®] pen/sureclick/syringe/vial, Humira [®] pen/syringe, infliximab (generic Remicade [®])		

DRUG NAME: Tremfya (guselkumab) 200 mg/2 mL in a single-dose prefilled pen & syringe		INDICATION: For the treatment of adult patients with moderately to severely active ulcerative colitis (UC)
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:		
<ul style="list-style-type: none"> • (COMMERCIAL): 2 pens/syringes per 28 days • (MEDICAID): 2 pens/syringes per 28 days • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (MEDICAIAD) Enbrel [®] pen/sureclick/syringe/vial, Humira [®] pen/syringe, infliximab (generic Remicade [®]); (MEDICARE) Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty), Stelara, Skyrizi		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Tyenne® (tocilizumab-aazg) vial for intravenous administration, all strengths		INDICATION: Biosimilar to Actemra®. For treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs); Adult patients with giant cell arteritis; Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis; and Patients 2 years of age and older with active systemic juvenile idiopathic arthritis	
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 [Pharmacy]	Prior Authorization (PDL Criteria)	
	Medical Benefit [Medical]	Prior Authorization	
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization	
QUANTITY LIMIT: N/A			
FORMULARY ALTERNATIVES: (MEDICAID) Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®)			

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Tyenne® (tocilizumab-aazg) 162 mg/0.9 mL prefilled syringe/auto-injector for subcutaneous administration		INDICATION: Biosimilar to Actemra®. For treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs); Adult patients with giant cell arteritis; Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis; and Patients 2 years of age and older with active systemic juvenile idiopathic arthritis
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: <ul style="list-style-type: none"> • (COMMERCIAL): 3.6 mL (4 injections) per 28 days • (MEDICAID): 3.6 mL (4 injections) per 28 days • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (MEDICAID) Enbrel® pen/sureclick/syringe/vial, Humira® pen/syringe (Abbvie mfg only), infliximab (generic Remicade®); (MEDICARE) Actemra (*requires prior authorization)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Tryvio™ (aprocitentan) 12.5 mg tablets		INDICATION: For use in patients whose BP is not adequately controlled on other antihypertensive medications
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:		
<ul style="list-style-type: none"> • (COMMERCIAL): 1 tablet per day • (MEDICAID): 1 tablet per day • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (MEDICARE) amlodipine tablets, valsartan tablets, hydrochlorothiazide tablets, spironolactone tablets		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Undecatrex (testosterone undecanoate) 200 mg capsule		INDICATION: For the treatment of testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter syndrome, chemotherapy, or toxic damage from alcohol or heavy metals; gonadotropin or luteinizing hormone-releasing hormone deficiency; or pituitary-hypothalamic injury from tumors, trauma, or radiation
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: N/A <ul style="list-style-type: none"> • (COMMERCIAL): 2 capsules per day • (MEDICAID): 2 capsules per day • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: (COMMERCIAL) Kyzatrex 200 mg capsules, testosterone cypionate injection (*both require prior authorization); (MEDICAID) testosterone cypionate injection (*requires prior authorization); (MEDICARE) testosterone cypionate injection (*requires prior authorization)		

DRUG NAME: Vyalev™ (foscarbidopa and foslevodopa) injection for subcutaneous, injection contains 120 mg foscarbidopa and 2,400 mg foslevodopa per 10 mL (12 mg foscarbidopa and 240 mg foslevodopa per mL)		INDICATION: For the treatment of motor fluctuations in adults with advanced Parkinson's disease
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 6 cartons per 30 days		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Vyloy (zolbetuximab-clzb) 100 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		

DRUG NAME: Yorvipath (palopegteriparatide) single-patient use prefilled pen injection, for subcutaneous use (all strengths)		INDICATION: For the treatment of hypoparathyroidism in adults
REASON FOR CHANGE: New Drug		
FORMULARY	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 pens per 28 days (all strengths)		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Yuflyma® (adalimumab-aaty) (CF) all strengths & formulations		INDICATION: Humira Biosimilar FDA approved to treat nine inflammatory diseases including moderate-to-severe rheumatoid arthritis in adults, moderate-to-severe polyarticular juvenile idiopathic arthritis in patients 2 years of age and older, psoriatic arthritis in adults, ankylosing spondylitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe Crohn's disease in adults and pediatric patients 6 years of age and older, moderate-to-severe ulcerative colitis in adults, moderate-to-severe chronic plaque psoriasis in adults, moderate-to-severe hidradenitis suppurativa in adults, treatment of non-infectious intermediate, posterior, and panuveitis in adults
REASON FOR CHANGE: Change Drug Tier and 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	Non-Formulary	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:		
<ul style="list-style-type: none"> • COMMERCIAL): 2 injections per 28 days • (MEDICAID): 2 injections per 28 days • (MEDICARE): <ul style="list-style-type: none"> • 20 & 80 mg: 2 injections per 28 days • 40 mg: 4 injections per 28 days 		
FORMULARY ALTERNATIVES: (MEDICAID): Humira pen/syringe (Abbvie mfg only)		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Zituvimet (sitagliptin-metformin) IR tablets, all strengths		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), 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: N/A		
<ul style="list-style-type: none"> • COMMERCIAL): 2 tablets per day (both strengths) • (MEDICAID): 2 tablets per day (both strengths) • (MEDICARE): N/A 		
FORMULARY ALTERNATIVES: Janumet®		

DRUG NAME: Zituvimet XR (sitagliptin-metformin) extended-release tablets, all strengths		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		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

DRUG NAME: Zituvio (sitagliptin) IR tablets, all strengths		INDICATION: For use as adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
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: Januvia®		

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

4/1/2025 Commercial Formulary Updates

Formulary Changes								
APPLICABLE TO OTHER FORMULARIES (Y/N)	Label Name	SI	Drug Class	Current Formulary Status	Current Tier	Proposed Formulary Status	Proposed Tier	Preferred Alternatives for Clinically Equivalent Drugs (CED) & Non-Formulary (NF) Drugs
(CED/NF) ALL COMM EXCEPT SG2024 AND MDC CUSTOM	ACCUTANE 10 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 10 MG CAPSULE, CLARAVIS 10 MG CAPSULE, MYORISAN 10 MG CAPSULE, ZENATANE 10 MG CAPSULE
(CED/NF) ALL COMM EXCEPT SG2024 AND MDC CUSTOM	ACCUTANE 20 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 20 MG CAPSULE, CLARAVIS 20 MG CAPSULE, MYORISAN 20 MG CAPSULE, ZENATANE 20 MG CAPSULE
(CED/NF) ALL COMM EXCEPT SG2024 AND MDC CUSTOM	ACCUTANE 30 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 30 MG CAPSULE, CLARAVIS 30 MG CAPSULE, MYORISAN 30 MG CAPSULE, ZENATANE 30 MG CAPSULE
(CED/NF) ALL COMM EXCEPT SG2024 AND MDC CUSTOM	ACCUTANE 40 MG CAPSULE	Y	F	Y	1	N	10	AMNESTEEM 40 MG CAPSULE, CLARAVIS 40 MG CAPSULE, MYORISAN 40 MG CAPSULE, ZENATANE 40 MG CAPSULE
(CED/NF) ALL COMM EXCEPT SG2024 AND MDC CUSTOM	DILTIAZEM 24H ER(LA) 420 MG TB	Y	F	Y	2	N	10	TIADYLT ER 420 MG CAPSULE, TIAZAC ER 420 MG CAPSULE
(CED/NF) ALL COMM EXCEPT SG2024 AND MDC CUSTOM	LIDOPIN 3% CREAM	Y	F	Y	1	N	10	LIDOCAINE 5% OINTMENT
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	AMABELZ 0.5 MG-0.1 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	AMABELZ 1 MG-0.5 MG TABLET	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	AMNESTEEM 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	AMNESTEEM 20 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	AMNESTEEM 40 MG CAPSULE	Y	F	Y	1	Y	2	N/A

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

APPLICABLE TO OTHER FORMULARIES (Y/N)	Label Name	SI	Drug Class	Current Formulary Status	Current Tier	Proposed Formulary Status	Proposed Tier	Preferred Alternatives for Clinically Equivalent Drugs (CED) & Non-Formulary (NF) Drugs
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	CLARAVIS 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	CLARAVIS 20 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	CLARAVIS 30 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	CLARAVIS 40 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	DOTTI 0.025 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	DOTTI 0.0375 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	DOTTI 0.05 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	DOTTI 0.075 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	DOTTI 0.1 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	ESTRADIOL-NORETH 1-0.5 MG TAB	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	LYLLANA 0.025 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	LYLLANA 0.0375 MG PATCH	Y	F	Y	1	Y	2	N/A

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

APPLICABLE TO OTHER FORMULARIES (Y/N)	Label Name	SI	Drug Class	Current Formulary Status	Current Tier	Proposed Formulary Status	Proposed Tier	Preferred Alternatives for Clinically Equivalent Drugs (CED) & Non-Formulary (NF) Drugs
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	LYLLANA 0.05 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	LYLLANA 0.075 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	LYLLANA 0.1 MG PATCH	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	MYORISAN 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	MYORISAN 20 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	MYORISAN 30 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	MYORISAN 40 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	ZENATANE 10 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	ZENATANE 20 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	ZENATANE 30 MG CAPSULE	Y	F	Y	1	Y	2	N/A
(T2) ALL COMM EXCEPT SG2024, VCUHS, COS, AND MDC CUSTOM	ZENATANE 40 MG CAPSULE	Y	F	Y	1	Y	2	N/A
T4 ALL COMM EXCEPT MDC CUSTOM	EULEXIN 125 MG CAPSULE	X	F	N	11	Y	4	N/A

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2025

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

APPLICABLE TO OTHER FORMULARIES (Y/N)	Label Name	SI	Drug Class	Current Formulary Status	Current Tier	Proposed Formulary Status	Proposed Tier	Preferred Alternatives for Clinically Equivalent Drugs (CED) & Non-Formulary (NF) Drugs
T4 ALL COMM EXCEPT MDC CUSTOM	FLUTAMIDE 125 MG CAPSULE	Y	F	Y	1	Y	4	N/A
T4 ALL COMM EXCEPT MDC CUSTOM	TOREMIFENE CITRATE 60 MG TAB	Y	F	Y	2	Y	4	N/A
T4 OPEN/ & VCU ONLY (+ CHANGE)	FARESTON 60 MG TABLET	X	F	Y	3	Y	4	N/A
T4 ALL CLOSED FORMULARIES EXCEPT MDC CUSTOM (+ CHANGE)	XERMELO 250 MG TABLET	W	F	N	12	Y	4	N/A